

Working in primary care — the role of a pharmaceutical adviser



My current career path happened thanks to being in the right place at the right time. I heard about an opportunity to become involved in an interesting project and decided to take the risk of moving in a new direction. This involved working on a part-time basis in a GP practice, which I really enjoyed. Primary care pharmaceutical work gradually took over more and more of my job “portfolio”. Soon I found myself working full time in primary care and not looking back.

My current role is largely strategic and managerial, varied and professionally fulfilling. I have found it a huge advantage, if not essential, to have had both hospital and community pharmacy experience before working in primary care, so that I can draw from this for every piece of work and discussion. It is also essential for primary care pharmacists to have an understanding of the healthcare systems and medicines management issues in all care settings to enable us to work with and influence all healthcare professionals and managers, ranging from consultants to chief executives, GPs to community matrons and from community pharmacists to hospital pharmacy teams.

Pharmaceutical advisers are able to advise from a wide clinical and health service management perspective and are seen as change agents able to find solutions to problems. We are valued beyond our pharmaceutical expertise and are consequently always busy. There are primary care roles for pharmacists in GP practices, at the interface of hospitals and

social services, in community teams, in facilitating community pharmacy services, and in working with trusts and primary care teams to develop new services and improve health care. As can be gathered from the National Prescribing Council’s document “PCT responsibilities around prescribing and medicines management” and the accompanying “Competency framework for primary care pharmacists” (www.npc.co.uk/npc_pubs.htm), interpersonal and communication skills are just as important to a pharmaceutical adviser as clinical expertise.

In order to allow future pharmacists to develop an understanding of what happens in primary care pharmacy, a joint preregistration training programme has been pioneered with my local hospital. Each preregistration student comes to the primary care trust to work with the pharmacy team for a total of 10 weeks during their preregistration year. While they are with us, each student carries out an audit, assists with the work of the team, and also works in a GP practice for a few days as part of a structured, experiential programme. This has been popular and successful and has now been extended to include two days of primary care experience for each of the fourth year pharmacy undergraduates placed with the local hospital for the NHS Summer Student experience placement.

To help bridge the long career gap between a post-registration pharmacist and a specialist pharmacist, the most common entry level grade for a primary care post, a natural progression is to

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develop a local primary care placement as part of a rotational junior pharmacist training programme, such as the innovative “Structured training and experience for pharmacists” (STEP) programme in South East London (*Hospital Pharmacist* 2002;9:253–4).

So what might happen during a typical day in a PCT?

As always, the day starts with checking e-mail and post and what is booked in the diary. Just when it seems safe to start working on the complex “shared care guideline” (a document developed to ensure safe and effective use of drugs that require complex monitoring and care by hospitals and by GP practices) that I have been developing with a consultant in my local hospital, the telephone rings with a query from a GP.

The GP has been asked to start prescribing a new anti-epileptic drug that the GP is not familiar with, and for which there is no local “shared care guideline” yet. The GP asks for more clinical information about the new drug, monitoring requirements, other patient care aspects and also asks for advice about whether they should accept prescribing responsibility under these circumstances. To add to the situation, the patient has run out of the tablets dispensed by the hospital and is sitting in the GP’s waiting room, so the GP needs an answer straight away. After giving some preliminary advice to the GP, so that he may issue a prescription to meet the patient’s immediate need, I use the next hour to research the full clinical information, another hour to contact the local consultant and GP, and then 20 minutes to formally log the query formally into our clinical database for future reference.

It is now time to drive to a GP practice where a meeting has been arranged with all the partners and the manager to discuss the prescribing analysis that I researched, wrote and sent them a week ago. A prescribing analysis involves using the national online electronic “Prescribing and cost trends” (PACT) database to create spreadsheets and graphs, looking at different aspects of prescribing patterns for individual GP practices, how they differ from national and local

averages and how each practice compares with others across a local area. The graphs and data are combined with clinical information and local quality improvement messages into a single document, tailored to the individual needs of each practice, and designed to stimulate discussion during the meeting and to act as a lasting reference source for prescribers.

During a lively discussion, the GPs ask a lot of questions relating to clinical evidence behind some of my suggestions for improvement and ask for my advice as to how they could improve the prescribing of antibiotics and ulcer healing drugs at their practice. The GPs also request the PCT pharmaceutical team to help review their repeat prescribing system and assist with an audit of their benzodiazepine prescribing. After agreeing three practice action points with the GPs, as required by the new GP contract and agreeing to provide further information, I drive back to the PCT offices to write up a report of the meetings, and confirm the main points in a letter to the senior partner.

On my desk is a message to return a call to the local pharmaceutical committee chief executive officer. After a discussion about recent changes to the waste regulations, how they are affecting local community pharmacies, and agreeing some additional information to send out to local contractors, I have a quick discussion with the primary care prescribing support technician who has developed a patient information leaflet concerning waste medicines disposal. After a last minute minor change to incorporate the additional information discussed with the LPC CEO, we agree that it is ready to be printed, how many to get printed and how to distribute them.

The PCT head of commissioning appears at my desk to ask if I could contribute a section on “Medicines management, pharmacy and prescribing” for the service level agreement (SLA) with the local hospital. This is the document that describes in some detail all the services that the PCT wishes to “buy” from the local hospital, at what standard they should be provided, and in what care settings, etc. A quick discussion establishes that my colleague would be

happy for me to write a holding paragraph to insert into the SLA while a full document is developed and agreed with the local hospital pharmacy and medical team before the end of the financial year. I start to map out what the section might contain, who would need to be involved in its development and how best to consult with all the stakeholders.

By now, it is time to gather my thoughts and papers for a meeting on “Falls in older people”, where I give clinical evidence for various prevention and pharmaceutical support strategies, discuss and promote the role of community pharmacy in falls prevention, and discuss joint projects with social services and the local hospital discharge co-ordinator. During the meeting, other related issues that have needed pharmaceutical input include whether to develop a local policy across health and social care for use of monitored dosage systems (“blister packs”), prevention of osteoporosis and hip fractures and how medicines use reviews in the new community pharmacy contractual framework could possibly be targeted at those patients most likely to be at risk of a fall related to their prescribed medicines.

At the end of my day, I have just enough time to touch base with my team colleagues who have had a similarly full day, reflect on what new knowledge I have learnt that can contribute to my CPD portfolio, realise I have discovered new learning needs around commissioning, and feel guilty for not having found time to enter it all into the portfolio itself.

I can also reflect on how much I have enjoyed the professional challenge of my busy job today, but how glad I am to be going home! 🏠