ROYAL PHARMACEUTICAL SOCIETY Scotland

BMA Scotland

Joint RPS and BMA Scottish GP Committee statement on the Pharmacotherapy Service

This is an updated version of our joint statement published in August 2021. It builds on two of the recommendations we made in that statement and makes one additional recommendation.

In summary, we recommend improvements to the pharmacotherapy service in three areas:

1. Better use of skill mix, including more clearly defining roles and responsibilities
2. Improved IT enablers to reduce administrative burden
3. Further developing a tandem model of working comprising hubs and in-practice activity

Introduction

The 2018 General Medical Services contract in Scotland introduced a substantial programme of service redesign and transformation of primary care. One of the fundamental elements of service redesign is the introduction of a comprehensive **pharmacotherapy service** that embeds greater numbers of pharmacists, pharmacy technicians, and pharmacy support workers in GP practices to provide pharmacy and prescribing support for patients. We jointly agree that full delivery of the pharmacotherapy service is essential to improving primary care for patients, GPs, pharmacists and pharmacy teams.

The refreshed Memorandum of Understanding 2 in July 2021 re-emphasised the need to prioritise delivery of all parts of the core level 1 service to deliver a more manageable GP workload, delivered principally by pharmacy technicians, pharmacy support workers, practice managerial and administrative staff. In tandem, it acknowledged that the interdependencies of level 1 with levels 2 and 3, delivered principally by pharmacists, required a focus on the pharmacotherapy service as a whole.

There has been progress towards the implementation of the pharmacotherapy service. We know that as of April 2022 a total of 1,257 whole time equivalent pharmacy staff were working in the service (734WTE or 58% pharmacists, 380WTE or 30% pharmacy technicians and 143WTE or 11% pharmacy support workers). There are also 96WTE pre-registration pharmacy technicians in training. Of the pharmacists, 78% are either qualified or in training to be an independent prescriber. This has been a significant achievement of pharmacy teams in NHS Boards who have recruited and trained many new staff in a short space of time. Together, these general practice pharmacy teams are working towards delivering patients a comprehensive service with core and additional elements.

Much progress has been made, with significant investment in general practice pharmacy teams, however significant challenges remain, and further investment is required in workforce, skill mix, training and development, and infrastructure to realise the full benefits of the service. These challenges are undermining the professional role of some pharmacists and have prevented workload reduction for GPs which would help to free up time to perform their role as expert medical generalists. These issues need to be addressed urgently to ensure that roles are and remain

attractive, to recruit and retain pharmacists and pharmacy technicians, provide positive patient care, free up GPs to spend more time as EMGs, and build a sustainable pharmacotherapy service. Inadequate funding and workforce shortages are real risks to the delivery of the pharmacotherapy service.

1. Better use of skill mix

Best use of skill mix will ensure a high-quality service, good working relationships, a professionally fulfilling role for all involved, career progression, and improved recruitment and retention.

One important issue with the pharmacotherapy service is that the core (level 1) service, which was prioritised specifically in the SG/BMA joint letter from December 2020 and the refreshed MOU, requires an appropriate skill mix that has not been established in many areas. It continues to be the case that some pharmacists are undertaking work that would often be more appropriately provided by pharmacy technicians, pharmacy support workers or practice administrative staff, resulting in an underuse of pharmacists' clinical skills.

The 2018 GP contract suggested that skill mix was required for the pharmacotherapy service – but we believe that more careful consideration would be of benefit to define the right person for the right role. In our statement last year, we recommended that the roles of all pharmacy team members are clearly defined. We understand the Pharmacotherapy Strategic Group is currently looking at this, and this work must be urgently prioritised. The definitions should include the roles and responsibilities of pharmacists, pharmacy technicians, pharmacy support workers, as well as GPs and practice managerial and administrative staff; and these definitions must then be widely understood in practices.

Once clear definitions are in place, effective workforce planning is crucial to understand the gaps. We recommend that the Scottish Government prioritises workforce planning for the pharmacotherapy service (and for the whole pharmacy service) and links Primary Care Improvement Plan requirements based on appropriate skill mix with national workforce planning. We need to ensure that actions are taken to improve the workforce supply to meet the gaps identified through workforce planning so that the pharmacotherapy service can be optimised.

In addition, efficient and effective prescribing management processes and systems in practices are needed to realise the full benefits of skill mix and maximise the efficiency of pharmacy input and reduce practice workload. Currently there is significant variation in these processes between practices which results in inefficiencies and potential risks for pharmacy teams working across practices. We welcome the toolkits produced by Healthcare Improvement Scotland to improve the processes for acute and serial prescribing. In order to reduce variation, we urge all practices to adopt these processes, and for pharmacy teams to lead implementation of these processes in practices.

We recommend that use of pharmacists' clinical skills is maximised. Pharmacists should be focused predominantly on patient-facing clinical roles and responding to medicines-related enquiries from GPs, the wider multidisciplinary team and patients: using pharmaceutical expertise and independent prescribing skills to deliver clinical medication review, support safer use of high-risk medicines, and improve complex pharmaceutical care. To properly support clinical pharmacists in this complex role it is vital that the appropriate number of pharmacy technicians and pharmacy support workers are available. At present, shortages of these roles in many areas necessitates pharmacists having to provide services that could be provided by pharmacy technicians or pharmacy support workers: addressing this gap would markedly improve efficiency and release pharmacists' clinical capacity. We urge Scottish Government to reconsider its recent decision to reduce funding for training pharmacy technicians. In addition, given the current financial climate, it is essential to reach a common understanding of where pharmacists' and pharmacy teams' efforts should be focused to maximise their impact on GP workload and improving patient care, combined with a focus on reducing inefficiencies in processes.

The development of roles for pharmacy technicians to lead on the technical aspects of medicines management, supported by pharmacy support workers undertaking non-clinical tasks, will ensure that level 1 and 2 aspects of the pharmacotherapy service are completed, while releasing time for pharmacists to work at a more advanced level. Our view is that a more planned and appropriate staffing approach to the pharmacotherapy service will accelerate implementation of all three levels of the pharmacotherapy service which will still enable prioritisation of level 1 services and deliver high quality care for patients and ensure safe use of medicines. If this does not happen, we are concerned that it could impact the recruitment and retention of pharmacists, which should be a principal concern given the need to grow and maintain this workforce.

2. Improved IT enablers to reduce administrative burden

We need better IT systems to support the pharmacotherapy service to improve efficiency, reduce administrative burden and deliver safer systems. Better IT should be combined with improved processes for managing prescribing.

We know that electronic prescribing systems should reduce the burden of repetitive tasks for both pharmacists and GPs. In our last statement, we recommended an increased level of urgency and priority for the NHS Scotland National Digital Prescribing and Dispensing Programme to introduce electronic prescribing. Our message remains exactly the same: progress with achieving electronic prescribing is still too slow and we urge Scottish Government to prioritise this programme.

Medicines reconciliation creates a significant time burden on health and care professionals in all care settings. We are encouraged to hear of ongoing work to improve data sharing between professionals which would improve medicines reconciliation and would welcome the opportunity to be more involved with the Scottish Government's Digital Health Directorate on this.

A further IT development that should be prioritised is making improvements to the serial prescribing system. Serial prescribing is a good idea: where it is fully implemented, the ability to move stable repeat medication onto an annual prescription avoids significant time spent on processing repeat prescriptions. Practices that have moved 60-70% of repeat prescribing onto serial prescriptions report a significant long-term improvement in workload but acknowledge that this comes with an increase in workload in the short-term while transitioning to serial prescriptions. It is therefore little surprise that overall uptake across Scotland remains low. We recommend ensuring serial prescribing is part of the new electronic prescription process; undertaking work to increase practice and community pharmacy awareness of recent improvements to serial prescribing and agree joint working to optimise use; improving patient awareness of the benefits of serial prescribing; encouraging use of serial prescribing in care homes; and exploring the opportunity of the introduction of new GP IT systems to standardise serial prescription management processes. Moving patients to serial prescribing is a task that pharmacotherapy services are well positioned to progress where there is sufficient pharmacy resource.

3. Further developing a tandem model of working comprising hubs and in-practice activity

Many NHS Boards have developed pharmacotherapy hubs from which pharmacy teams provide pharmacotherapy services to multiple practices. Hubs offer advantages in terms of delivering efficiencies of scale, overcoming issues of working spaces in practices, promoting effective use of skill mix and enabling provision of absence cover for pharmacy team members.

We are supportive of the use of hubs as part of a tandem model for delivery of the pharmacotherapy service. This means hubs should focus on the delivery of the Level 1 and 2 service, enabling pharmacy team members within practices to focus more on delivering the Level 3 service. This tandem model ensures all levels of the service are delivered, makes best of use of all members of the pharmacy team, ensures practices retain face to face working relationships with pharmacists in practices and addresses the concerns we state above about future sustainability of the pharmacotherapy service.

We strongly believe that there needs to be a balance between hubs and in-practice activity to ensure continuity, familiarity, good working relationships and workforce retention. To be effective, the pharmacy team needs to be fully embedded within the GP practice team, working closely with practice clinical and administrative staff, whether that is in person or virtually. They also need to liaise closely with the multidisciplinary team working across health and social care, and with pharmacy teams in community pharmacy and hospital. Pharmacy staff, particularly pharmacists involved in clinical discussions with patients and who provide medicines advice to GPs, are an important part of the practice team. In order to build high trust professional relationships (which deliver effectiveness, patient safety and quality outcomes), it is essential that pharmacy professionals deliver clinical care directly within practices.

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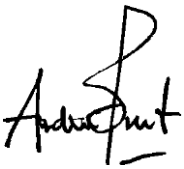
To improve the functioning of hubs, better IT is required. This should be addressed through the prioritisation of electronic prescribing: a current issue with hub working is the requirement for wet signatures on prescriptions where prescriptions are generated in the hub and then printed in a practice, this would be overcome by electronic prescribing.

Finally, we re-emphasise our previous statement that the potential for community pharmacists to take on some aspects of the pharmacotherapy service is explored. This may include some aspects of prescription management being undertaken in community pharmacy through extension of the Medicines Care and Review service. As a minimum, stronger links between pharmacists in GP practices and community pharmacy practice should be achieved to deliver seamless care for patients. Longer term, closer alignment of the community pharmacy and GMS contracts may be useful.

In conclusion

We have outlined recommendations in this letter that will help to address continuing issues and increase the pace of implementation. We believe that our recommendations are achievable and that together they would improve the wellbeing of both pharmacy and GP teams through realistic workload, best use of skills and professional satisfaction. This will deliver a sustainable pharmacotherapy service for the future with resulting improvement in clinical efficiency and patient safety.

Dr Clare Morrison MBE
Director for Scotland
Royal Pharmaceutical Society



Dr Andrew Buist
Chair
BMA Scottish GP Committee