Case study: Clinical pharmacists in general practice

Rachel Hall, The Old School Surgery, Bristol

Rachel Hall is a clinical pharmacist and partner at the Old School Surgery in Bristol, a busy and growing inner city practice with more than 15,000 patients.

Her development from community to clinical pharmacist began in 2006 when she became a supplementary prescriber. Within a year she had qualified as an independent prescriber and began a full-time role at the surgery in Bristol. During her training, Rachel worked for one day a week at the practice, specialising in treating patients with type 2 diabetes. This work convinced the partners to employ Rachel as a permanent clinical pharmacist, rather than taking on a salaried GP.

Rachel explains: “An audit of my work with type 2 diabetes patients showed that 82% had reduced glucose levels within a year of their first consultation. That was a big factor in being taken on full-time as a clinical pharmacist, initially on an employed basis and eventually as a partner. It showed what I could achieve.”

Rachel attributes much of this initial success to the longer consultations she was able to have with patients.

“It meant that I could explore the beliefs patients had about their long-term conditions and take a more holistic approach to their care, including looking at the impact of other conditions, social conditions and perhaps mental health issues, which can have a significant impact on their primary condition. It means I can get to know patients, establish a relationship and build up trust. You have the benefit of continuity of care.

“When I first started you would get the odd patient who would go and see the doctor a couple of days after seeing me to check what I had done. That doesn’t happen now. At first I would have to spend time explaining my role to patients; now it’s the norm. It’s rare you will get people querying why they have to see the pharmacist nowadays. Patients know they can see their GP, one of the nurses or a pharmacist - they know they will be directed to the right clinician to meet their needs.

“Identifying patients who were not taking their medication was often important as prescribing,” she adds. “Patients would be more honest with me than they would be with their GP. It was easier for them to tell me they weren’t taking their medication and I could help them with that.”

Rachel's initial focus was on patients with long-term conditions which weren't being managed and controlled effectively. In the past these would often have been referred by practice nurses to the GPs. Over three days each week she sees about 35 patients in person and carries out between 10 and 20 phone consultations, significantly reducing GP workload.

The longer appointment times mean Rachel can also deal with additional minor illness queries which patients often raise, such as chest infections, urinary tract infections and skin rashes.

"People tend not to come in with just one thing wrong with them. If there's other things I may be able to help them or, where appropriate, refer them to the GP or signpost them. I will only work within my area of clinical expertise and am fully aware of any limitations in my knowledge. The important thing we have learnt at the Old School Surgery is not to work in isolation. To help this all the clinicians now meet each lunchtime to talk about any tricky cases we have. We have open discussions and everyone gives their opinion. We all learn a lot from each other."

Initially, Rachel also took on responsibility for the reauthorisation of repeat prescriptions, again alleviating pressure on GPs. She has since put systems in place for prescription clerks to re-authorise prescriptions for items such as emollient creams, needles for insulin and moisturising creams, without having to go through a doctor. She also deals with queries from the in-practice community pharmacy, which would have gone to the GPs in the past.

"It makes perfect sense for a pharmacist to do all this work as we understand what all the drugs are and what monitoring is required. The GPs like having a medicines expert in the building and can ask me if they have a request for something unusual.

"I am fully embedded in the practice. Patients will ring up and ask specifically for me, and often I can deal with queries over the phone. There are some patients with diabetes who have never seen a GP in all the time they've been with the practice because I have managed them in their entirety."

Rachel is also now making secondary care referrals for a range of conditions, including heart failure, cancer, chest pain, rheumatology and endocrinology.

"I've never had a secondary care physician querying why a clinical pharmacist is making a referral to them. I'm accepted as a clinician now which is fantastic."

On top of her clinical work, Rachel assists with practice management, including overseeing the quality and outcomes framework (QOF) process, ensuring the practice is hitting its targets and systems and processes are being followed to ensure standards are being met.

In addition, Rachel is responsible for all medicines management and audit work, delivering training to practice nurses and trainee doctors and reconciling discharge summaries when a patient leaves hospital.

"I reconcile their medication and to ensure it's updated on their repeat prescription and make sure it's appropriate and that any monitoring which is required is adhered to.

One particular discharge case showed just how important having a clinical pharmacist in the practice can be. Rachel explains:

“I was going over the discharge summary for a man in his eighties who had diabetes and heart failure. He had been prescribed a drug for his diabetes on discharge which could have had serious consequences for his heart failure and put him back into hospital very quickly. I spotted it and managed to get it stopped.”

Rachel concludes: “It’s my vision that we should have a pharmacist in every GP practice. I’m excited that that is now a very real possibility. We are giving out one billion prescription items every year; potentially a very big chunk of the GP’s workload. It makes sense to have a pharmacist in every GP practice to keep an eye on things and keep things safe. GPs are brilliant but they are not highly trained prescribers. I look at things in a different way to the GP… I will question if an item of medication needs to be continued, examine why it was started and perhaps ask if we can change the dose.”

Rachel’s colleague, Dr Carol Buckley, a GP at the practice, says: “Pharmacists are highly trained and skilled professionals with a lot to offer patients as part of the primary health care team. We have found Rachel to be a huge asset to the practice. She is popular with patients and staff and increases both access and choice for patients for the management of their chronic diseases. She also improves the medicines management systems at the surgery, taking repeat prescribing decisions away from the busy doctors, freeing them for more clinical work with patients. Making Rachel a full-time member of the team has been a very positive move.”

Rachel Hall
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