In late 2014, the Royal Pharmaceutical Society (RPS) made the case for it to become normal practice to have pharmacists working much more closely with GPs across England. Noting the current and future shortfall in GP and nurse numbers, the RPS argues that pharmacists are ideally placed to support their fellow professionals and improve the quality of patient care. The joint report from the NHS Alliance and the RPS made reference to the immediate crisis of falling workforce and rising demand in primary care, and noted the availability of significant numbers of suitably qualified pharmacists. This report, while recognising the potential benefits from the skills and value that pharmacists working in general practice could offer, also identified some barriers to the establishment of a clinical pharmacy role within primary care.

In early 2015 the RPS and the RCGP issued a joint statement on GP practice-based pharmacists. This expressed the view that pharmacists, with the appropriate skills and experience, based in GP practices will be able to contribute to the clinical work related to medicines, relieve service pressure and increase capacity to deliver improved patient care.

Though various countries have seen an expansion of pharmacists into primary care teams, few studies have evaluated the barriers that pharmacists experience when attempting to integrate into this new role. In a Canadian study, seven key themes emerged to describe the barriers and benefits that the teams experienced during pharmacist integration. These centred around relationships, trust and respect; pharmacist role definition; orientation and support; pharmacist personality and professional experience; pharmacist presence and visibility; resources and funding; and value of the pharmacist role. In an Australian study, although the role of a pharmacist in the general practice setting was thought to offer potential benefits to practice staff,
patients and pharmacists, barriers to this integration included limited funding, infrastructure and practitioner perceptions.\(^5\)

In our own study, we set out to gain an understanding of what GPs in one CCG think of pharmacists undertaking a clinical role in surgeries.

**Method**

Across Cornwall, locality-based prescribing meetings are held four times a year. These meetings, organised by NHS Kernow CCG Prescribing Team, are intended to have a focus on clinical prescribing and medicines optimisation issues. A GP prescribing lead from each surgery is invited to attend these meetings and disseminate the learning within their own practice.

At each of the three locality meetings in July 2015, the GPs were asked to complete a questionnaire during the tea break, having been advised that it was anonymous and would take only a few minutes to complete. The survey contained a small number of questions seeking their views on pharmacists undertaking clinical work in GP practices.

The introduction to the survey briefly summarised the RCGP and RPS joint statement, emphasised that the survey was not about pharmacists providing a dispensing function, and explicitly stated the assumption that funding and pharmacist workforce availability were not an issue. This small survey consisted of a mixture of closed questions and questions that allowed respondents to make free-text comments.

**Results**

The three meetings were attended by a total of 54 GPs, with completed questionnaires returned from 48 (89 per cent), with 26 of these being from a dispensing surgery. No other GP characteristics were recorded.

Two GPs responded that they worked in surgeries that already had a pharmacist employed in a clinical role full time; five GPs had a part-time or sessional pharmacist in their surgery; and the remaining 41 had no such post. Thirty-nine (81 per cent) GPs thought having a pharmacist working in their surgery is, or would be, a good idea. Four thought this was not a good idea and five were unsure. Free text comments from those nine GPs who thought it was not a good idea or who were unsure identified the following issues:

- concerns over what a pharmacist could add to how a practice operates (three respondents)
- whether such a post would create extra work for the GP as the pharmacist would not be able to action problems independently (three respondents)
- the viability of such a post for a small practice (two respondents)
- conflict of interest over control of prescribing choices, especially within a dispensing surgery (two respondents)
- recognition that existing support from the CCG prescribing team and use of Eclipse Live is adequate and hence why employ a pharmacist (one respondent)
- such a role may lead to fragmented care and decision making (one respondent)
- a reluctance to allow pharmacists to prescribe (one respondent).

The final question asked which tasks or functions such a pharmacist could undertake, allowing respondents to tick as many answers to the predetermined suggestions as applied (see Table 1). The free text responses under ‘Other’ described additional roles such as: medication searches, audits and delegating jobs to the GPs; responding to drug safety alerts; practical management of the dispensary; home visits to housebound patients; liaising with the CCG on prescribing matters; and supporting the Quality, Innovation, Productivity and Prevention (QIPP) agenda. One additional free text comment questioned whether pharmacists are able to cope with uncertainty in the way that GPs do.

**Discussion**

The RCGP predicts that in the future, successful general practices will be working closely with pharmacists, either within their practice teams or in partnership with community pharmacists. This view is supported by several others, including The King’s Fund.\(^6\) This way of working is the future of general practice, allowing all healthcare professionals to work together in teams, sharing their knowl-

<table>
<thead>
<tr>
<th>Role in Surgery</th>
<th>GPs (n=48)</th>
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<tbody>
<tr>
<td>Reviewing the medicines of patients, particularly those who have complex conditions, or who take medicines with a higher element of risk associated with them</td>
<td>43 (90%)</td>
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<tr>
<td>Responding to patient queries about medication</td>
<td>41 (85%)</td>
</tr>
<tr>
<td>Helping to manage the repeat prescribing process</td>
<td>41 (85%)</td>
</tr>
<tr>
<td>Rationalising repeat prescription lists to avoid waste and duplication</td>
<td>40 (83%)</td>
</tr>
<tr>
<td>Education and training for GPs on complex prescribing problems</td>
<td>39 (81%)</td>
</tr>
<tr>
<td>Being a link to neighbouring community pharmacies, and ensuring that problems highlighted during medicine use reviews and new medicines service are followed up</td>
<td>35 (73%)</td>
</tr>
<tr>
<td>Managing patients with common minor illnesses – diagnosing and prescribing (if necessary)</td>
<td>26 (54%)</td>
</tr>
<tr>
<td>Being an independent pharmacist prescriber and prescribing for certain groups of patients with long-term conditions</td>
<td>26 (54%)</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 1. Number of GPs who responded with agreement to predetermined suggested roles for pharmacists in our survey (n=48). GPs were also invited to suggest additional tasks for pharmacists under ‘Other’
edge, skills and expertise, to help improve patient care. Being a part of the primary care team means that professional relationships can also be formed with the community-based healthcare professions to provide joined up, holistic, person-centred care.

In our small survey the vast majority (81 per cent) of GPs agreed that having a pharmacist working in a clinical role in the surgery would be a good idea. All the pharmacist’s tasks that we outlined received support from more than half the respondents, though with varying degrees of support. Certainly, GP support for a wider role for practice pharmacists in relation to chronic disease management has been noted elsewhere. The NHS Alliance and the RPS have compiled a much larger list of primary care activities that pharmacists could perform in general practice – some of these additional activities were mentioned by our GPs as free text comments.

Although the survey asked respondents to assume that funding was not a consideration, two GPs did question how such a role would be funded. Others have suggested that this could come in part from reduced GP sessions per practice list, support from top-slicing practice drug budgets (though some GPs may feel that their practice drug budget is in itself insufficient to cover the pressure on prescribing costs), or by additional general medical services (GMS) contract resources. More recently (and since this survey was conducted), NHS England has committed at least £15 million to partially fund employment of clinical pharmacists within GP practices.

As found elsewhere, a small number of GPs expressed concerns over lack of adequate evidence for the need for such a role and the increase in GP workload that may arise by the pharmacist wishing to engage GPs in case conferencing or other time-consuming activities. However, a review of 38 randomised controlled trials that explored the role of pharmacists co-located within primary care settings, including general practice, favoured implementation. This review considered those studies where pharmacists had a regular and ongoing relationship with the general practice clinic. For the majority of studies, pharmacists were able to deliver a variety of interventions – aimed at optimising prescribing for, and/or medication use by, clinic patients – with most studies reporting positive effects in at least one clinical outcome.

Two of the respondents from dispensing surgeries expressed concerns about conflict of interest over prescribing choices (and it is not clear if this relates to conflict of interest for the surgery or for a practice pharmacist who may also have a community pharmacy position). However the Dispensing Doctors Association (DDA) notes that dispensing practices are the ideal place to pilot the introduction of pharmacists into general practice, given that they provide both medical and pharmaceutical services. The DDA argues that a full-scale evaluation should also accompany any pilot, including an assessment of the effects on the demand for services; where capacity is increased, new work is bound to be generated.

One respondent explicitly made negative comments about pharmacists not having a prescribing role. This was one of the least supported task in our survey, with only 54 per cent agreeing with this role. This concept of a “turf war” – GPs being protective of their role, especially prescribing rights – has been noted elsewhere.

**Conclusion**

Overall, the majority of GPs in our small survey would, in theory, welcome a pharmacist working in their surgery. Any negative views or perceived barriers do not appear insurmountable. The findings are limited by the small sample size in a specific geographical region and, as with other surveys, the use of closed questions with predetermined options. In addition, this brief survey did not ask about the level of training pharmacists should receive prior to working in general practice, nor did it consider the view of pharmacists, especially community pharmacists, towards this initiative. A range of other factors (job descriptions, recruitment, retention, workforce planning) also need to be considered and these are part of the NHS England pilot.

**References**


**Declaration of interests**

None to declare.

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