

1 **Clinical pharmacists in general practice: An initial evaluation of**
2 **activity in one English primary care organisation**

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27

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31

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33 authors had access to the data set. JB and CAL analysed and interpreted the data.
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35 revised it critically and approved the submitted version.

36

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38 practitioners of Dudley Clinical Commissioning Group on whose valuable work this
39 manuscript is based.

40

41 **Conflict of interest statement**

42

43 JB and CL have no conflicts of interest to disclose.

44

45 DJ is employed by Dudley CCG.

46

47 JJ offers consultancy services to Dudley CCG.

48

49 CH is employed by Dudley CCG.

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51 **Clinical pharmacists in general practice: An initial evaluation of**
52 **activity in one English primary care organisation**

53

54 **ABSTRACT**

55

56 **Objectives**

57

58 This aim of this research was to characterise the breadth and volume of activity
59 conducted by clinical pharmacists in general practice in Dudley Clinical
60 Commissioning Group (CCG), and to provide quantitative estimates of both the
61 savings in general practitioner (GP) time and the financial savings attributable to
62 such activity.

63

64 **Methods**

65

66 This descriptive observational study retrospectively analysed quantitative data
67 collected by Dudley CCG concerning the activity of clinical pharmacists in GP
68 practices during 2015.

69

70 **Key findings**

71

72 Over the nine month period for which data were available, the 5.4 whole time
73 equivalent clinical pharmacists operating in GP practices within Dudley CCG
74 identified 23,172 interventions. Ninety five per cent of the interventions identified
75 were completed within the study period saving the CCG in excess of £1,000,000.

76 During the four months for which resource allocation data were available, the clinical
77 pharmacists saved 628 GP appointments plus an additional 647 hours that GPs
78 currently devote to medication review and the management of repeat prescribing.

79

80 **Conclusions**

81

82 This research suggests that clinical pharmacists in general practice in Dudley CCG
83 are able to deliver clinical interventions efficiently and in high volume. In doing so,
84 clinical pharmacists were able to generate considerable financial returns on
85 investment. Further work is recommended to examine the effectiveness and cost-
86 effectiveness of clinical pharmacists in general practice in improving outcomes for
87 patients.

88

89 **Keywords:** clinical pharmacists, English National Health Service, general practice,
90 general practitioners, primary care

91 **INTRODUCTION**

92

93 In July 2015, National Health Service (NHS) England announced the launch of the
94 'Clinical Pharmacists in General Practice Pilot' – a £15 million, three year initiative to
95 fund, recruit and employ clinical pharmacists in General Practitioner (GP)
96 surgeries.(1) The pilot intended to build upon the experiences of the limited number
97 of GP surgeries, including surgeries within Dudley Clinical Commissioning Group
98 (CCG), that already had clinical pharmacists in patient facing roles. The NHS
99 England pilot would see pharmacists employed directly by GP surgeries to assist
100 patients whilst easing GP workload and improving communication between general
101 practice, hospitals and community pharmacists. In October 2015, the budget for the
102 pilot was increased to £31 million with NHS England claiming that this would "*part-*
103 *fund 403 new clinical pharmacist posts across 73 sites, covering 698 practices in*
104 *England, supporting over 7 million patients*".(2,3) No surgeries within Dudley CCG
105 were selected to be pilot sites.(4)

106

107 Whilst interest in employing pharmacists in GP surgeries has increased markedly
108 since the announcement of the NHS England pilot in July 2015, GP surgeries in
109 Dudley have been utilising the skills of pharmacists in practice settings since 2002.
110 As part of Dudley CCG's Prescribing and Medicines Management Function, the CCG
111 commissions the services of a team of practice-based pharmacists (PBPs) to
112 promote safe, high quality and efficient prescribing within Dudley. The majority of
113 these PBPs are independent prescribers¹ and, in addition to a focus on the
114 promotion of appropriate and cost-effective prescribing, the service provided by the
115 PBPs has become increasingly clinically focussed.

116

117 While evidence of the effectiveness and cost-effectiveness of pharmacist activity in
118 GP surgeries is generally lacking, a 2014 systematic review found that pharmacists
119 deliver a range of interventions in general practice and these services often have
120 beneficial impacts on outcomes in chronic diseases, principally in diabetes and
121 cardiovascular disease, and in improving the quality of medication management
122 services.(5) The majority of studies identified by this review were based in the United
123 States with literature examining pharmacist activity in GP practices in England being
124 sparse. However, two English-based randomised controlled trials suggest that
125 pharmacist review of medication is effective at controlling prescribing
126 expenditure.(6,7) Whilst the lack of evidence of effectiveness and cost-effectiveness
127 of PBPs specifically is not surprising, given the relatively small number of pre-NHS
128 England pilot PBPs and the comparatively recent announcement of the pilot, if the
129 PBP model is to be accepted and embedded in general practice it is vital that
130 thorough evaluation around effectiveness and cost-effectiveness is conducted.

131

132 The aim of the research reported here was to characterise PBP activity in Dudley
133 CCG. The research had the following objectives:

- 134 • To describe the breadth and volume of interventions conducted by PBPs; and,
- 135 • To provide quantitative estimates of both the savings in GP time and the
136 financial savings attributable to PBP activity.

137

138 **METHODS**

139

140 This descriptive observational study used quantitative data collected by the
141 Pharmaceutical Public Health Team within Dudley CCG to analyse retrospectively
142 PBP activity during 2015. Data covering the period from April to December 2015
143 were collected by the Pharmaceutical Public Health Team within Dudley CCG.
144 These activity data were routinely entered into a bespoke database by PBPs as per
145 their work protocols. Data were extracted from the database in the form of
146 spreadsheets which were then supplied to the authors.

147

148 Fields included in the spreadsheets were:

- 149 • The date that the activity took place.
- 150 • The name of the GP practice where the activity took place.
- 151 • A unique PBP identifier.
- 152 • The type of activity undertaken. Activities were selected from a 'dropdown' list
153 of 20 pre-coded options (these can be found in Table 1). The options were
154 defined by service leads and training was provided to PBPs to promote the
155 consistent and appropriate use of these options. Only one type of activity
156 could be accepted per intervention.
- 157 • The number of potential interventions identified by PBPs.
- 158 • The number of potential interventions identified by PBPs which were
159 subsequently completed.
- 160 • Financial savings realised by the identified interventions which were
161 completed.

162

163 Following an update to the data collection sheets to enable quantification of resource
164 allocation, the spreadsheets for the months of September through December 2015
165 included the following additional information:

- 166 • The number of GP appointments avoided as a result of the identified
167 interventions which were completed.
- 168 • Amount of GP time saved by the involvement of the PBP in the review or
169 reconciliation of medicines.
- 170 • Amount of GP time saved by the involvement of the PBP in the management
171 of repeat prescriptions.

172

173 Data were manipulated and collated into one 'master' document in Microsoft Excel
174 2013®. To this master document, the patient list size of each GP practice was
175 added. This enabled per population comparisons between interventions at different
176 GP practices.

177

178 Data were analysed in Microsoft Excel®. Analysis was descriptive with assessment
179 of central tendency and variability. Where available, data on the number of GP
180 appointments saved, GP time saved by the involvement of PBPs in the review and
181 reconciliation of medicines and GP time saved by the involvement of PBPs in the
182 management of repeat prescriptions were exported from the master document and
183 imported to a new document specifically for costs analysis. Unit costs for GP
184 services were extracted from the Unit Costs of Health and Social Care 2015 –
185 produced by the Personal Social Services Research Unit at the University of Kent –
186 and added to these data to enable an estimation of financial savings resulting from
187 the transference of GP activity to PBPs.(8)

188

189 Ethical approval for this work was not sought as the research was limited to
190 secondary use of information previously collected in the course of normal care and
191 the research involved no patient identifiable information.⁽⁹⁾ The research was
192 considered to be a 'service evaluation' by Dudley CCG.

193

194 **RESULTS**

195

196 Over the period April-December 2015, 23 PBPs (5.4 whole time equivalent)
197 operating in 49 GP practices within Dudley CCG identified 23,172 interventions. The
198 median number of interventions identified per month was 2,433 (interquartile range
199 (IQR) ± 1352) and the median number of interventions identified per GP practice was
200 210 (IQR ± 331). Of the identified interventions, 95% (n=21,954) were completed by
201 practices within the study period. The number of interventions completed per 1,000
202 listed patients varied considerably between practices ranging from 4 per 1,000 to
203 1,131 per 1,000 listed patients (median = 43 (IQR ± 40))².

204

205 The type of interventions suggested by PBPs within Dudley CCG, the volume of
206 these interventions identified and subsequently completed, and the savings
207 attributable to these interventions can be seen in Table 1. Both the nature and
208 volume of interventions varied markedly. The most common type of intervention
209 completed was 'medication reviews' (n=4,413)³. The interventions completed yielded
210 a total of £1,079,864 in savings (assuming activity was consistent throughout the
211 calendar year, this would equate to an annual saving of £1,439,819). The type of
212 activity yielding the highest financial saving (£355,491) was 'planned changes to

213 medicines/ QIPP' and the most productive type of intervention was the review of
214 'specials' (yielding savings of £1,147 per completed intervention).

215

216 Using data on the number of GP appointments and GP time saved for the months of
217 September through December 2015, Table 2 provides information on the time and
218 financial savings attributable to the transference of activity away from GPs to PBPs
219 in Dudley (as opposed to the savings directly attributable to the interventions
220 completed which are described above). Activities transferred from GPs to PBPs were
221 patient consultations (ranging from consultations for minor ailments through to the
222 management of long term conditions; with an emphasis on the latter), review or
223 reconciliation of medicines and the management of repeat prescriptions. If the
224 savings reported in the September to December period were consistent throughout
225 the year, this would equate to an annual saving of 1,884 GP appointments, a saving
226 of an additional 2,309 hours that GPs in Dudley currently devote to medication
227 review/reconciliation and the management of repeat prescribing, and financial
228 savings totalling £354,643.

229

230 Total annual savings (i.e. savings attributable to the interventions of PBPs detailed in
231 Table 1 and the savings attributable to the transference of activity away from GPs to
232 PBPs detailed in Table 2) attributable to PBP activities in Dudley CCG are estimated
233 at £1,794,462. This equates to a saving of £149,538 per calendar month or £3,052
234 per GP practice per month. These figures exclude costs related to the provision of
235 PBPs as these are currently met by the CCG rather than by the practices
236 themselves.

237

238 Labour costs attributable to PBP provision for the period April to December 2015
239 were £234,990. This was comprised of 7,833 hours of PBP input at an average
240 hourly rate of £30 per hour (the majority of PBPs in Dudley CCG are contractors and
241 are not directly employed by the CCG). Extrapolating from this figure for 9 months'
242 worth of PBP provision, the annual costs of PBP provision can be estimated as
243 £313,320 comprising of 10,444 hours of PBP activity. In terms of return on
244 investment (ROI), using the formula $ROI = (\text{total savings generated} - \text{the costs of PBP provision}) / \text{the costs of PBP provision}$, the data analysed in this work suggest
245 that for every £1 invested in PBP provision, savings of £4.73 may be realised (for
246 every hour of PBP activity costing £30, savings of £141.82 may be realised).

248

249 **DISCUSSION**

250

251 Over the nine month period for which data were available, PBPs operating in
252 practices within Dudley CCG identified 23,172 interventions, 95% of which went on
253 to be implemented within GP practices. The annual financial saving to the CCG
254 attributable to PBP activity was estimated to be approximately £1.5 million (inclusive
255 of labour costs).

256

257 The use of PBPs in Dudley predates the NHS England 'Clinical Pharmacists in
258 General Practice' pilot and, as such, the data presented here on the nature and
259 volume of interventions, and the potential savings attributable to PBP activity may be
260 some of the first data available in this area. While there is no published plan of
261 evaluation for the NHS England pilot, the differences in the model adopted by Dudley
262 CCG – where provision of PBPs is funded centrally and the CCG provides clinical

263 and systems leadership, supervision and action planning – and the model adopted in
264 the NHS England pilot – where funding is delivered directly to the GP practices –
265 mean that any results which emanate from the NHS England pilot may not be
266 directly comparable to the results presented in this manuscript. Furthermore, this
267 study was reliant on data from one English CCG meaning that the results reported
268 are unlikely to be generalisable across primary care in England.

269

270 Neither patient outcomes nor patient or GP acceptability of the PBP programme
271 were explored in this study. While training was provided to PBPs to promote the
272 consistent coding of activity data, no assessment of potential inter-PBP variability in
273 coding was made. Perhaps the most notable limitation of this study concerns the
274 assumptions and extrapolations that have been included in this manuscript. The
275 validity of such assumptions and the reliability of such extrapolations is difficult to
276 accurately assess and figures reliant on such extrapolations should be treated with
277 an appropriate degree of caution.

278

279 PBPs identified a number of different types of intervention and a large majority of all
280 types of identified intervention were completed by GP practices within the study
281 period. This suggests that the interventions proposed by PBPs are valued as either
282 clinically or financially beneficial (or both) by GPs. Data on PBP time spent at each
283 GP practice were not available but it is plausible that the variance in the number of
284 completed interventions between GP practices is a function of the amount of PBP
285 time spent at each practice.

286

287 Using the assumptions and extrapolations detailed in the results, the PBP
288 programme in Dudley as currently delivered may generate total savings in excess of
289 £1.5 million per annum. Specific evidence from general practice in England is lacking
290 but previous work has suggested that pharmacist involvement in general practice
291 may help to control expenditure.(6,7) Whilst the absence of specific patient outcomes
292 from the dataset makes an assessment of cost-efficiency of the Dudley CCG PBP
293 programme impossible, the estimated return on investment from PBP provision
294 provides promising early indications that the programme can assist the CCG in
295 meeting the efficiency savings demanded of all NHS organisations and may also
296 support ongoing workforce development in primary care.

297

298 It is recommended that longitudinal data monitoring continues and that such data are
299 routinely analysed to ensure that the PBP programme in Dudley (and PBP
300 programmes elsewhere) is meeting its aims and continues to offer a beneficial return
301 on investment. Such monitoring would also increase the number of observations
302 which would in turn provide greater insight as to the validity of the assumptions and
303 improve the accuracy of the extrapolations contained in this manuscript. An
304 assessment of the reasons for variability in the number of interventions per
305 population between GP practices and whether this variability is justifiable should be
306 conducted. Greater focus should also be placed on examining the effect of PBP
307 interventions on patient outcomes. The case for this, given the volumes in which they
308 are conducted, is perhaps strongest for medication reviews,

309

310 Further qualitative work should be conducted to add depth to the quantitative data
311 presented here. Such work will be useful in establishing the perceptions of GPs,

312 PBPs and patients regarding this emerging role and may be able to identify potential
313 areas of improvement in terms of service delivery. Given the absence of evidence
314 supporting pharmacist activity in general practice, it is imperative that a robust
315 assessment (e.g. a randomised controlled trial) of the effectiveness and cost-
316 effectiveness of PBPs in improving patient outcomes is undertaken.

317

318 **CONCLUSIONS**

319

320 In this initial review of data emanating from the Dudley CCG PBP programme, the
321 high completion rate of interventions identified by PBPs indicates that PBPs are able
322 to deliver interventions which are valued by GPs in high volume. In doing so, PBPs
323 were able to generate not inconsiderable financial returns on investment. Financial
324 savings were accrued as a result of both the interventions suggested by PBPs and
325 by the transference of activity away from 'higher cost' GPs to 'lower cost' PBPs.

326

327 This is an emerging field of practice for pharmacists and, as such, evidence
328 regarding all aspects of said practice is lacking. As PBP activity in Dudley predates
329 the introduction of NHS England's 'Clinical Pharmacists in General Practice Pilot',
330 the data presented in this manuscript may be some of the first data available in this
331 area. Further work, ideally coordinated at the national level, is recommended to
332 explore stakeholder perceptions of PBPs and their activities, and to examine the
333 effectiveness and cost-effectiveness of PBPs in improving outcomes at both patient
334 and system level. Such work is vital if this emerging model is to become embedded
335 in the English NHS.

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381

382

383 **Table 1:** Interventions and savings by type of PBP activity, April-December 2015
 384 (excluding savings attributable to the transference of activity away from GPs to
 385 practice-based pharmacists)
 386

| Activity | Number of interventions | | Savings resulting from completed interventions (£) | |
|---|-------------------------|-------------------|--|------------------|
| | Suggested | Completed (%) | Total | Per intervention |
| Medication reviews ¹ | 4453 | 4413 (99) | 125566 | 28 |
| Other | 4563 | 4349 (95) | 133771 | 31 |
| Planned changes to medication/QIPP | 3986 | 3789 (95) | 355491 | 94 |
| Repeat prescribing & waste management | 1894 | 1883 (99) | 34143 | 18 |
| Clinic | 1708 | 1691 (99) | 37226 | 22 |
| Managing long term conditions (LTCs) | 1767 | 1668 (94) | 65275 | 39 |
| Review of hospital discharge letters | 1514 | 1514 (100) | 10327 | 7 |
| Audit | 1857 | 1311 (71) | 93184 | 71 |
| Appliance/homecare ² | 335 | 327 (98) | 19003 | 58 |
| Wound care | 272 | 265 (97) | 3744 | 14 |
| Involvement in specific campaigns | 262 | 203 (77) | 29972 | 148 |
| Specials reviews | 160 | 140 (88) | 160534 | 1147 |
| Review of hospital outpatient letters | 128 | 128 (100) | 10979 | 86 |
| Drug monitoring and review of test results | 120 | 120 (100) | 0 | 0 |
| Medication reconciliation ³ | 77 | 77 (100) | 320 | 4 |
| Managing high risk drugs | 53 | 53 (100) | 305 | 6 |
| Hospital admissions for patients with LTCs ⁴ | 9 | 9 (100) | 0 | 0 |
| Quality Premium ⁵ | 6 | 6 (100) | 0 | 0 |
| Triage & management of minor ailments | 5 | 5 (100) | 24 | 5 |
| Input to multidisciplinary team meetings | 3 | 3 (100) | 0 | 0 |
| Total | 23172 | 21954 (95) | 1079864 | 49 |

¹For patients with LTCs conducted using the Dudley Medication Review template

²Appliance Contractor and homecare including the prescribing of sip feeds and appliances

³In patients transitioning from secondary to primary care

⁴Interventions to reduce hospital admissions as a result of medication in patients with LTCs

⁵Contribution to CCG locally agreed Quality Premium focussed on increasing hypertension diagnoses and increasing the number of patients diagnosed with hypertension with a blood pressure of <140/90 mmHg

387

388 **Table 2:** GP time and financial savings attributable to transferral of activity away
 389 from GPs to practice-based pharmacists, September-December 2015

390

| Activity | Number of GP appointments saved | GP time saved (hrs) | Financial savings resulting (£) |
|---------------------------------|--|----------------------------|--|
| Patient consultations | 628 | 122.5 ¹ | 27632 ² |
| Medicines review/reconciliation | - | 272.9 | 38199 ³ |
| Repeat prescription management | - | 374.2 | 52383 ³ |
| Total | 628 | 769.6 | 118214 |

¹Based on the average length of a surgery consultation being 11.7 minutes as established by the GP Workload Survey 2006/07 and reported in Unit Costs of Health and Social Care 2015 by the Personal Social Services Research Unit at the University of Kent (8)

²Based on the unit cost of a patient contact lasting 11.7 minutes being £44 as reported in Unit Costs of Health and Social Care 2015 (8)

³Based on the unit costs of one hour of GMS activity being £140 as reported in Unit Costs of Health and Social Care 2015 (8)

391

392

393 **FOOTNOTES**

394

395 ¹*“Independent prescribers are practitioners responsible and accountable for the*
396 *assessment of patients with previously undiagnosed or diagnosed conditions and for*
397 *decisions about the clinical management required, including prescribing.”(10)*

398

399 ²Patient list size was unavailable for 2 of the 49 practices. This figure is based on the
400 47 practices for which patient list size was available.

401

402 ³All medication reviews were conducted in line with the Dudley Medication Review
403 Best Practice Guidelines.(11)

404

405 **GLOSSARY**

406

407 CCG – Clinical commissioning group; statutory NHS bodies responsible for the
408 planning and commissioning of health care services for their local area.

409

410 NHS England – An executive non-departmental public body of the Department of
411 Health which leads the National Health Service in England.

412

413 QIPP – Quality, Innovation, Productivity and Prevention; a large scale programme
414 devised by the Department of Health to drive improvements in quality of care in the
415 NHS whilst realising considerable efficiency savings.

416

417 Specials – “*Specials are unlicensed medicinal products manufactured in the UK for*
418 *human use which have been specially prepared to meet a prescription ordered for*
419 *individual patients without the need for the manufacturer to hold a marketing*
420 *authorisation for the medicinal product concerned*”.(12)