Interview with Integrated Care Coordinator 1 (IC Coordinator 1)

Venue: Integrated Care team office, Romulus Park, Leicester  
Date: May 2016

Present: Integrated Care Coordinator 1 (IC Coordinator 1) and main researcher Phyllis Navti  
(Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. I am Phyllis Navti and I am the main researcher and the interview should take about 30 to 45 minutes. Could I start by collecting the consent form?

IC Coordinator 1
Yes

Researcher PN
Can I start by asking, what does integrated care mean to you?

IC Coordinator 1
Integrated care is where health and social care are working together to ensure that patient services are joint up.

Researcher PN
Where do you see integrated care fitting in with other care the patient receives?

IC Coordinator 1
Link with social care services based in community within Gp practices. It is a brilliant idea – working really well because social care is provided in the community, in a local identifiable place where patients have got access to you. I think it fits in really well with the module of being in the GP practice because you are in there with the health care professionals and the patient as well as the professionals find it quite useful to have somebody from social care being within their team. It is easy access to access information and you build up really good relations with the staff and patients. The pharmacists has seen some patients in the past and whilst you are being visible in the surgery they might see you and recognise you and come up to you. The see you and recognise the input you have put in and in that sense, I think it works really well. Have background knowledge to access service and can access service and deliver and refer on.

Researcher PN
Could you please list who is part of the integrated care team in your opinion?

IC Social Coordinator 1
- Social coordinators from social service
- GP receptionist and GPs
- Practice nurse
- Band 7 you work regularly; with
- Physio therapist
You get in touch with various people within the environment

Researcher PN

Is it mostly primary care – no secondary care?

Other people who should be part of the team?

IC Coordinator 1

Yes

Community care team and CPNs (community psychiatric nurses) as many patients with mental care. Also, physio team, voice clinic

Recently had an MDT team meeting and it was beneficial to have all strands of health having pharmacist on board. Pts also benefited from that because there have more access to medication advice. For example, I have here copies of emails with the pharmacist in which she advises on what to look at with regards to a patient’s medication when I visit (Shows email re patient with incontinence at night on water tablets. Pharmacist asked me to enquire what time taken. Patient confirmed taken at 8am and 6pm-pharmacist asked me to inform patient that she will ring and discuss as best to take at 8am and 2pm latest)

Researcher PN

You have already touched on that but what do you think it means to a patient to have a pharmacist as part of the integrated care team?

IC Coordinator 1

From my experience, having worked for few months with pharmacists it was very useful because some patients on medication didn’t know what it was for and it was useful to have pharmacists on board to liaise with patients to answer queries, doing home visits, sitting with patients and explaining what medications were for. The other thing is that sometimes patients had side effects so it was useful to have pharmacists to explain these to patients and liaise with GP or consultants to see whether the medicine should be changed or not. Discussing at MDT was useful to discuss whether to reduce dose. Pharmacist picked up where patient was prescribed medications in past but not taking it and pharmacist coming on board highlighted that maybe the medication should not be on repeat anymore

So, the practice benefited and the patient also benefitted

Researcher PN

Did you sport any barriers or disadvantage?

IC Coordinator 1

The amount of time was limited because they (the pharmacists) were shared and covering a very big area. It would be advantageous to have a pharmacist who had just one of two localised surgeries they would practice within making it easier to access and liaise with the pharmacist.

Researcher PN
Was there any disadvantage?

IC Coordinator 1
No I don’t think there is any disadvantage – it was an add on extra support that patients were befitting from and it was really good so I don’t see any reason why there should be a disadvantage.

Researcher PN
Was there anything in the model – pathway you had you would change?

IC Coordinator 1
In terms of where the pharmacist came in, it was at the initial stage when we had the referral the pharmacist would be on board and we will do the visit and highlight any issue for them to look at the patient records and medications before the visit and advice to query whether they were for example taking the inhalers, if they were for example taking furosemide at morning and midday as prescribed, so that kind of input was really useful.

Researcher PN
What do you think there were benefits to other team members?

IC Coordinator 1
It was really useful to have the pharmacists at the multidisciplinary meeting alongside the band 7 and district nurses and it was really useful for ourselves and the Gp practices and discussing the meds with the GP. It was really useful and it worked really well and was really effective.

Researcher PN
Where the any barriers that could have affected output

IC Coordinator 1
They didn’t have access to social care records but had access to system one which was good so they could access that and work alongside ourselves Barrier would be if they didn’t have permission to access the records they would not be able to work efficiently?

Researcher PN
Are there any possible facilitators?

IC Coordinator 1
Being mobile would be handy, having equipment would be handy, having a base – you need a touch down place. So, if you don’t have access to surgery if all rooms are being used which is often somewhere else to access information. Ensuring you have allocated slot to access info when you go to surgery.

Researcher PN
Some of the barriers will be addressed as part of the pilot of pharmacist in GP practice hubs.

What do you think of the model of integrated care pharmacist working for GP hubs but, based in practices?

IC Coordinator 1
It would be very good – if there was a pharmacist everywhere- embedded in practice and you have access to them as required

Once we had advantage of having pharmacist on board once we lost it, it felt like a great lost, we appreciated the value of having a pharmacist on board

Researcher PN
How do you think the role should be evaluated?

IC Coordinator 1
Patient feedback, feedback from professionals
Not sure of others

Researcher PN
(Prompts) – How about measuring outcomes and key performance indicators?

IC Coordinator 1
Yes, in terms of medication – going back to patient and asking if the medication changes have made a difference to their quality of life

Researcher PN
How could the role be developed?

IC Coordinator 1
Have one embedded within the practice for all patients not just those on the pilot so all patients referred for that month have access to pharmacists

There was a case were pharmacist was going in and looking eg
- medications not ordered for long time to understand what was going on
- if not taking medications to dig further and find out is it side effect or what exactly going on
- someone on diabetes getting prompt to check if taking insulin
- do they suffer from pain and are they taking any medication for it
- do they use inhalers? if so what colours and how often

The pharmacist developed this into prompts for us to check when we go to the patient.

With us not having a medical background, it was great to get this advice from someone else

Training support for the integrated care team with proactive input and training at the meetings

Other thing I found useful was that you could take questions to them about what the medication is for, what the side effects are and it gives you a better feedback and info on impact on their health.
Researcher PN
Could community pharmacist be part of Integrated care team?

IC Coordinator 1
We did not have any access to community pharmacist – not met any. Is it something we can access?

Researcher PN
We are looking into their role as part of this research. Any final comments?

IC Social Coordinator 1
It would be great to have the pharmacists back

End of interview

Figure I.1: Illustration of coding for IC Coordinator 1 interview
Interview with Integrated Care Coordinator 2 (IC Coordinator 2)

Venue: GP Practice Consulting Room, Leicester  Date: July 2016

Present: Integrated Care Coordinator 2 (IC Coordinator 2 and main researcher Phyllis Navti

(Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. I am Phyllis Navti and I am the researcher and the interview will take about 30 to 45 minutes. Could I start by collecting the consent form?

IC Social Coordinator 2
Yes. You are welcome

Researcher PN
And I might take a few notes are you happy with that?

IC Social Coordinator 2
Yes

Researcher PN
But most of it will be recorded and transcribed. So, can I start by asking? Health care is about providing care for patients. Where do you think integrated care fits into this?

IC Coordinator 2
Well its really being able to see the whole picture, to be able to go out and do the holistic assessment and then be able to get the various different agencies on board. And to be able to do that quickly. I think is quite an important factor in integrated care. That you do have a line to different agencies as such, and for the patient you are going out and you are not just concentrating on the one thing but it’s the whole person.

Researcher PN
What does integrated care mean to you personally?

IC Coordinator 2
To me? To me as a person, again it’s the same kind of thing, you can go out and so many times you have one job to do and you go out and you can see there are lots of other issues, but really, it’s a case of its not your job, you don’t have the time to do it. Whereas with integration you are able to go out and to look at these other issues. Which obviously contributes to the whole bigger picture.

Researcher PN
Good. When you think of integrated care who do you think is part of the integrated care team, who makes up the team in your opinion?

IC Coordinator 2
Well obviously, I am social care background so that’s first, you have then got the health side of things. It’s the whole lot, it’s the whole housing, for some people it can be integrated. Mainly I see social care and health.
Researcher PN
For social care you have got yourself and for health are you able to just name a few of the health professionals?

IC Coordinator 2
GPs, district nurses, incontinence nurses, pharmacy obviously, you have got diabetic nurses, chiropody, mental health.

Researcher PN
And what are the different roles, what do they do, so what do the social care do and what would the health care people do?

IC Coordinator 2
Well there has always been a big battle between health and social care, its whose job is whose. That has always been the big battle. And it has been a problem to resolve that issue at times and it always has been a bit of a them and us kind of feeling. So, the social care is you are looking after the person at home mainly, you do get people in residential care. The personal care aspect, managing, well prompting the supervising of medication. All the activities of daily living and the general health and well-being.

Researcher PN
And the health care, what would the GP do, that’s different to what the nurse would for example? A GP is health care and band seven nurses is health care so what is the difference for Integrated care?

IC Coordinator 2
Well the GPs are dealing with the presenting factor in the surgery, making referrals out if need be to various consultants. The nurses tend to go out and do more of the I would say nursing care, you know, but also you get the nurses the prescribing nurses that do more now.

Researcher PN
You mentioned about conflict between the two do you see that as well with the pharmacy, can you give me an example of one maybe?

IC Coordinator 2
A lot of problem with social care is over medication, you would find that people only want a care call for prompting medication and that is not something that social care will go and do, that is a health task. So that’s always been a big issue. We now have access to assisted technology you know prompting reminders, dispensers and things like that that you would look at putting in but that has always been a big problem.

Researcher PN
So, you listed the staff that make up the current integrated care team, do you think that any others should be added to the current team?
IC Coordinator 2
We have got occupational therapists on the team as well, I don't think I mentioned those. The pharmacist, I am lucky that I do have R (IC Pharmacist 2) but there are lots of services that haven't got the pharmacist and I think they are invaluable. Who else could we have, I don't know, I don't know that a social worker would be necessary, we don't get an awful lot of cases which require a social worker as opposed to a community support worker. That's my role, I am a community support worker so I am not a social worker, I am not a registered social worker.

Researcher PN
Thank you for that clarification because I sometimes get confused.

IC Coordinator 2
So, everyone in our team are community support workers and not actual qualified social workers. And to be honest we will take on a lot of the work that they would do but then it would get to a point where it would have to go to a social worker perhaps for long term work. So, I don't know that necessarily a qualified social worker would be necessary in the team.

Researcher PN
That would depend on the case then?

IC Coordinator 2
Yes, because at the moment if we do get a case that is, we put it out to locality and then they get a social worker.

Researcher PN
Getting to the pharmacist’s role, what do you think having an integrated care pharmacist means to a patient?

IC Coordinator 2
Well one of the big things when you go out to see patients they say a number of different medications they are on and a lot of them say do I need to be on it. They don't know why they are on it always. And sometimes they go into hospital it all gets changed they come out on different medications and they don't then know what it’s for. So that to me is one of the best things about having the pharmacist in the team, so a lot of them are just on so many and they say they don't know why they are on it and do they need to be on it all.

Researcher PN
What should a pharmacist do for patients, so you have mentioned R (IC Pharmacist 2) and what exactly do they do for the patient?

IC Coordinator 2
They will go through the medication that patients are on as a matter of course. So, when I send out a letter, once a patient has said yes they want me to go and see them, I then send that information to R (IC Pharmacist 2) and then they look at all the medication just to make sure that they are not on something they have been on for years that they don't need to be.
They can look by the various results whether they are taking the medication. And also sort of I would imagine well I know they do they look at cost as well. Things like the nutrition drinks I know some are on and they were able to put it down to the powdered ones which are cheaper.

Researcher PN

**Any other advantages for the patient of having the pharmacist?**

IC Coordinator 2

Well yes if I go out to someone and they say oh, like today I saw someone and she didn't know whether she ought to be on the iron again, she had stopped taking the iron so she was going to put herself back on it. And the co-codamol was making her constipated. And I just had a quick word with R (IC Pharmacist 2) about it and its just being able to resolve these queries quicker for the patient. Sometimes the patient says they have had the medication review, by the chemist or whatever, but I just feel like with R's (IC Pharmacist 2) reviews are much more detailed and in depth.

Researcher PN

**Is there any disadvantage of having a pharmacist?**

IC Coordinator 2

No.

Researcher PN

**And what do you think having integrated care pharmacist means to other members of the integrated care team?**

IC Coordinator 2

It can only be a positive, I know that the other coordinators that haven't got them miss them. And they can come out with us, or they did, just to check up. Because I am not a qualified pharmacist so the things that I wouldn't perhaps be picking up. If I go out to see someone and I have just real nagging concerns and I can't quite work out why they say they are taking their medication and yet you can see they are not really. Just general worries and R (IC Pharmacist 2) has been out with me just to go through everything. And things that I had never thought about, that you can have your prescriptions in large print which to some people makes a difference.

Researcher PN

**And for any other of the team members, the nurses, the doctors, can you see any advantages of the pharmacist?**

IC Coordinator 2

Yes, when I had my meeting with Dr S and R (IC Pharmacist 2) they really interact well, it makes such a difference having R (IC Pharmacist 2) there. Unfortunately, R (IC Pharmacist 2) is not in surgery the day that I have the meeting with the doctors but here it really works well. And also the clinical lead nurse she sits in it and she was like wow this has been a real education.
Researcher PN
I suppose picking up on the example of R (IC Pharmacist 2) not being there on the day of the surgery just moving on to the barriers or facilitators to the work, so can you think of any barriers to the pharmacist role or anything that would facilitate it?

IC Coordinator 2
In what way?

Researcher PN
An example of a barrier is not having a pharmacist full time, or other people have mentioned the geography so if the practice is across a wide geography. So can you think of any?

IC Coordinator 2
Yes, I send my cases to R (IC Pharmacist 2) I don’t actually get to meet her and she is not able to come to the meetings so there is, that is a problem because there is a lack of communication. And also at that surgery they don’t get to understand how it all fits in with the team.

Researcher PN
Can you think of any other barriers or anything that would make the working easier? So I am trying to understand for example the workflow and there might be an IT access issue. I am trying to think of things to improve the role.

IC Coordinator 2
There is a problem with things like secure emails, sending the information across to the pharmacist. At the moment, I send it to through our social care emails to our team support who then has got secure email and then sends it out to R (IC Pharmacist 2). So that’s a problem, it is the confidentiality and data protection I think really, one of the biggest barriers.

Researcher PN
And is that because you work for different organisations?

IC Coordinator 2
Yes, it just happens that we are across, but you can quite easily go months weeks without seeing anyone.

Researcher PN
So maybe having someone who is maybe more regular gives you more opportunities?

IC Coordinator 2
Yes, when the two pharmacists worked in our office you knew that they were there and you could get them if you needed them.

Researcher PN
Do you have anything else to add before I move on?

IC Coordinator 2
And I suppose the fact that they can't always get to see the patients or review the patients before you see them. So you are going out there and perhaps if you had gone out there to see them and then you had that information you can query it there and then.

Researcher PN
So, it would be useful for them to either see the patient before you saw the patient or see the patient maybe with some of your notes?

IC Coordinator 2
Yes, what they do is they, it used to be that R (IC pharmacist 2) would try and review the patient before I went out to see them, she obviously doesn't go out to see them. So I was then able to ask her questions while I was there. If not she would look at my assessment afterwards and I would put in the assessment, you know the pharmacy queries.

Researcher PN
It's just a different way of working, because now in this role (At time of interview, pharmacist 2 was working as GP hub pharmacist, the role that developed from the IC pharmacist role) she is not doing just the integrated care coordinator she is doing other roles so she is kind of brought in.

IC Coordinator 2
Yes, before she was just doing our work and now we are sort of sharing with everyone else.

Researcher PN
And how do you think the role should be evaluated?

IC Social Coordinator 2
The pharmacy role?

Researcher PN
Yes.

IC Coordinator 2
I don't know, I don't know, that is a thing about our job how do we evaluate what we do, we have not really come up with a solution apart from patient feedback. I don't know, you can tick boxes, the number of referrals you, and the outcomes. But from the surgery would it be down to the cost, it depends how they work doesn't it. I suppose if the patient finds that they are not having to take so much medication that is one thing that they all say, that's got to be good for the patient hasn't it.

Researcher PN
Yes, and the cost you mentioned, that's one of the things that we want to look at, what is the patient was taking before.
IC Coordinator 2
That’s something as well the patients often bring up the fact that they are on so much medication do they really need to be on it. They are wary the amount of money it must be costing.

Researcher PN
That is called poly pharmacy which is one of the things that they can, and we are interviewing patients and asking them questions. Also in the literature, it mentions that a pharmacist could help prevent hospital admissions but how do you measure that.

IC Coordinator 2
I don’t know. A lot of times you can prescribe patients medication but they may not take it.

Researcher PN
And how do you think, I think you have touched on this before, but again just to ask the specific question, how do you think the role could be developed?

IC Coordinator 2
As in pharmacy within the integrated care?

Researcher PN
Yes.

IC Coordinator 2
Well it would be lovely if every surgery had a pharmacist and again to know that you could get in contact with that pharmacist where they are, where they are based. And you do know that you are fitting in with the other work that they are doing at the moment. When we had them before that was what they were doing, it was just great.

Researcher PN
Is there anything else, training I am thinking about because I think what they did before was part of the meetings you had there were one or two sessions where they did training.

IC Coordinator 2
Yes, they came along and things like dossette boxes it went in to explain why they are not always such a good thing. Some patients need them, explaining that, it made sense. To a lot of people its like oh dossette box that’s the answer but there is more to it than that. So yes that was really interesting, yes any sort of information that you can get has got to be good. So yes they were always able to help out and explain things to us.

Researcher PN
Were there any other comments you want to add about anything?

IC Coordinator 2
Only that I really miss them, were you in on the pilot?

Researcher PN
Yes, so this is actually more about the pilot, but it’s all tied in and that’s why I am doing this to be able to inform what happens next.

IC Coordinator 2

I wasn’t doing the job then, when you were involved in it and when they are talking about how you really missed everything. And it was only when we got R and K (IC pharmacists 1 and 2) that you realise what a big role, what a big contribution they make to our job. I think as well it’s just somehow having R (IC Pharmacist 2) at the meeting with the doctor it just seems to make it a complete picture almost. I do tend to feel in other surgeries that I am still sitting there with my social care hat on and there is the health. But with R (IC pharmacist 2) there she seemed to be the person that joins us together.

Researcher PN

I think I am going to use that quote. Anything else?

IC Coordinator 2

I guess one barrier mentioned by my colleague is difficulty in getting access in the practice- access to the working space like a desk or a computer. Some practice receptionists are not very accommodating so you could have wasted trips. Also one or two Gps are not too quite on board so it’s difficult to proceed without the rapport.

Researcher PN

That’s interesting – anything else?

IC Coordinator 2

No I can’t think of anything, I did realise when they were taken off how much I did miss them.

Researcher PN

Thank you

INTERVIEW FINISHES
Figure I.1: Illustration of coding for IC Coordinator 2 interview
Interview with Community Nurse (CN)

Venue: Warren Park Enderby Date: October 2016

Present: Community Nurse (CN) and main researcher Phyllis Navti (Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. I am Phyllis Navti and I am the researcher and the interview will take about 30 to 45 minutes. Could I start by collecting the consent form?

CN
You are welcome -Yes

Researcher PN
(Collects checks and files consent form) I might take a few notes are you happy with that?

CN
Yes. I am sorry I must apologize that we are short staffed today so I might need to pop out if needed.

Researcher PN
That is ok. I am not in a rush.

I will start by asking your opinion- health care is about providing care for patients where do you think integrated care fits into this?

CN
It is about treating the whole patient as an entity not different bits as part of a multidisciplinary team. And it is good to have access to social workers because sometimes the needs are mostly social and just a little health although they have an impact on each other.

Researcher PN
Can you explain the last sentence please? What do you mean by impact?

CN
I mean for most patients, if the social support is not there , their health deteriorates e.g. a discharged patient who perhaps only need wound dressings from health might have a fall and end back in hospital and that becomes a bigger health problem

Researcher PN
What does Integrated care mean to you as a community nurse?

CN
To me the meaning has changed. I used to work for the west CCG (neighboring Leicestershire clinical commissioning group) until a year ago. Their model of Integrated care is different in that a nurse is the coordinator as opposed to the east where a social worker is the coordinator. The dynamics and outcomes are slightly different. But overall it (Integrated care) is better integration of services to improve the care the patient gets. It is still complicated to juggle and attend multidisciplinary meetings at the practice because we are not based there as well as see patients.

Researcher PN
Who do you think is part of the integrated care team, who makes up the team?
That is another different one. In the west it was the GP, social, community nurse and others as required e.g. dietician or physiotherapist. The East module included a pharmacist. Initially i was unsure what a pharmacist could contribute because there was no description of their responsibilities so it took me a while to appreciate what they could bring on board as i always thought they mostly dispensed medication and a chemist could do that. However now i have worked with our pharmacist i can see the significant contribution.

Researcher PN
Can you explain further?

yes - when the pharmacist asked to shadow me initially i was sceptical as i was busy and it took me a while to agree a date. I was also a bit worried that they might be duplicating the work i did from what i had heard. But when she accompanied me on my visit and made really useful suggestions to the medication even simple things like the best dressings and emollients to use, i began to appreciate how we could work together to improve patient care.

Researcher PN
We will come back to that but can i ask you to comment on the aspect of health and social joint working?

That one is interesting - there has always been tension between health and social care as we felt they could do better and probably vice versa. There is less of a " them and us" now we work together and have access and familiarity to each other. You have a named social colleague as opposed to completing a form. That has made a big difference.

Researcher PN
So you listed the staff that make up the current integrated care team, do you think that any others should be added to the current team?

no not really

Researcher PN
How about the patient?

oh gosh of course - they are at the centre and carers too.

Getting to the pharmacist's role, you mentioned a bit of the support to you as a nurse what do you think having an integrated care pharmacist means to a patient?

It means several things - a lot of the patients i see are elderly and on so many many medication. I often collect lots and drop at the chemist and always wanted to audit these but there is never time. So the pharmacist can audit the unused medicine and discuss with the MDT. The pharmacist can advise the patients about how to take the medicines, side effects and even how to order so there is less waste. So many patients on inhalers i wonder about. Also, when they get discharged with bags of medicines and can get confused about what is what.
Any other advantages for the patient of having the pharmacist?

**CN**
Yes i know the GP and practice nurse review medication but the pharmacist will do a more thorough review and a prescriber pharmacist could even prescribe. We also started discussing the wound and emollient formulary which will make the use of these better. I now understand how savings can be made to benefit other patients, from discussing with the pharmacists.

**Researcher PN**
Are there any more advantages to you?

**CN**
Yes definitely - i can contact them to ask quick questions about medication. They have also put together some prompts for common medication explaining what to think about e.g. water tablets in the morning, medication that cause a fall. They also devised a medication record chart that i can explain to patients. We are planning joint audit of returned medication. My colleague who works as a practice nurse says she spends less time on medications and can prioritise other nursing tasks e.g. injections etc. It is a win win

**Researcher PN**
I think you touched on this already but i will ask- what do you think having integrated care pharmacist means to other members of the integrated care team?

**CN**
As i mentioned - a lot of positives the coordinators loved having them and most of the GPs as well. They are proactive and contribute a lot when they attend the MDTs though one for two patients might not need much of their input can. But it is so many things- both complicated and simple - it is always like an education. i brought a student nurse and she too was surprised and could add their contribution to her reflection.

**Researcher PN**
All positive so far - can you think of any barriers?

**CN**
well i think more access would be good as she only worked twice a week and could not attend all MDTs. So one is reluctant to refer any patients in case there is a delay as it is hard to predict when she will get to it, though she did try to respond to all queries when she was around. It would also be useful to work in the same office? More funding would be great to have one in every practice every day of the week just like other health professionals if you think that most patients are on medicines.

**Researcher PN**
can you think of any facilitators?

**CN**
More funding to embed the pharmacists, better communication of the role, regular clinics in the surgery, direct phone number. If they could attend the board round (nurse handover meeting) at our office in the morning they will get to know all the patients and help prioritise input.

**Researcher PN**
Is IT access an issue as that has come up in other interviews

**CN**
Oh yes there is that as we are not sure about confidentiality and emails and she was unable to access some patient records from practices not on System one
Anything else to add before I move on?

CN
Oh yes my colleague in Rutland said geography was an issue and their pharmacist was even less accessible

Researcher PN
And how do you think the role should be evaluated?

(There is a knock on the door, nurse pops out for 5 mins to resolve patient query)

CN
Sorry where was I? (Following reminder continues) Yes how to evaluate the pharmacist. I think patient feedback. I don't know, you can tick boxes, the number of referrals you, and the outcomes. But from the surgery would it be down to the cost, it depends how they work doesn't it. I suppose if the patient finds that they are not having to take so much medication that is one thing that they all say, that's got to be good for the patient hasn't it.

Researcher PN
Yes, and the cost you mentioned, that's one of the things that we want to look at, what is the patient was taking before.

CN
That's something as well the patients often bring up the fact that they are on so much medication do they really need to be on it. They are wary the amount of money it must be costing.

Researcher PN
That is called poly pharmacy which is one of the things that they can, and we are interviewing patients and asking them questions. Also in the literature it mentions that a pharmacist could help prevent hospital admissions but how do you measure that.

CN
I don't know. A lot of times you can prescribe patients medication but they may not take it.

Researcher PN
And how do you think, I think you have touched on this before, but again just to ask the specific question, how do you think the role could be developed?

CN
As in pharmacy within the integrated care?

Researcher PN
Yes

CN
Well it would be lovely if every surgery had a pharmacist and again to know that you could get in contact with that pharmacist where they are, where they are based. And you do know that you are fitting in with the other work that they are doing at the moment. When we had them before that was what they were doing, it was just great.
Is there anything else, training I am thinking about because I think what they did before was part of the meetings you had there were one or two sessions where they did training.

CN
Yes, they came along and things like dossette boxes it went in to explain why they are not always such a good thing. Some patients need them, explaining that, it made sense. To a lot of people its like oh dossette box that’s the answer but there is more to it than that. So yes that was really interesting, yes any sort of information that you can get has got to be good. So yes they were always able to help out and explain things to us.

Researcher PN
Were there any other comments you want to add about anything?

CN
No I can’t think of anything, I did realise when they were taken off how much I did miss them.

Researcher PN
Thank you

INTERVIEW FINISHES

Figure I.3: Illustration of coding for Community nurse interview
Interview with General Practitioner 1 (GP1)

Venue: GP Surgery, GP 1's consultation room Date: October 2016
Present: General Practitioner 1 (GP1) and main researcher Phyllis Navti (Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. I am Phyllis Navti and I am a researcher and the interview will take about 30 to 45 minutes. Could I start by collecting the consent form?

GP1
Yes

Researcher PN
Thank you. To start off- health care is about providing care for patients - where you think integrated care fits into this?

GP1
I think its useful in terms of getting a bit more of an holistic care. So the problem is at the moment patients have more and more problems, we have less and less time and so in a perfect world some of the more complicated patients you would want to spend half an hour or forty minutes with them, look through all the aspects of physical mental health all the sorts of signs, now the house is, how they are. But the reality is you don't have that much time and where integrated care comes in you have got the skills of lots of different people, plus the time that they can then actually look at it properly. And so its just good at getting a sort of more rounded holistic care.

Researcher PN
So what does it mean to you personally, is it the same?

GP1
So yes the same thing to me, I think what I quite like is, I am the sort of GP lead here on it, is that it allows you to get all that information about a patient and make a change without not necessarily needing to see the patient, which is quite nice. But I think most people who have gone into general practice its because you want to look after everything for the whole person, so actually it feels like you are doing proper general practice which is quite nice. So that's what I like about it.

Researcher PN
So how long have you been the integrated care lead for the practice?

GP1
Since it began so oh gosh it must have been going now for two or three years its been a little while its been going. So since it started I have been doing it but its been good.

Researcher PN
And do you do the MDT meetings?

GP1
Yes so once a month we have our own MDTs so there is me, whoever our integrated care coordinator is, there is usually one or two district nurses there and often we have another GP or students are there so its quite good.

Researcher PN
And what sort of patient numbers do you review at the MDT?
GP1
So I think its about eight, so there are eight new ones and we look at any of the follow up ones as well so it can be anything between eight and twelve.

And it lasts about an hour, two hours?

GP1
yes anything between, it depends, sometimes its relatively straight forward there are no major issues but if there is difficult problems it can take a bit longer. So anything between one or two hours. But never more than two hours.

And who do you think is part of the integrated care team?

GP1
So there are the three of us who meet, so the district nurses, there is the coordinator and the GP, we obviously had the pharmacist for a little while which was useful. They are the ones we meet with, but in terms of who else is part of it M__ or whoever our coordinator is, often gets the physio OT. So its a bit wider the spread of who gets involved. But in terms of the core team that's who I would see. At the moment district nurse, GP, coordinator plus the pharmacist if you are lucky.

Researcher PN
And do you think that's sufficient, is there any, if you had to change the set up of the team…

GP1
I think that's fine if you have got the four -the only additional that might be useful is a sort of the physio OT who might be useful. Because a lot of the issues that come up are very physio OT related and it might be useful to have them there just for their input at that point as to whether they could think its something they can do something about. So in a perfect perfect world you would have the three of us who are already doing it, the pharmacist and a physio and that would be a perfect mix.

Researcher PN
One of the models that was considered included community pharmacists. Do you think there is a potential that it would be useful to have them as part of the IC team?

GP1
Yes, that would be really useful. The short time that we had a pharmacist involved all of the patients there was something that was brought up that could be done differently or better which I didn't necessarily pick up myself so it was good.

Researcher PN
I meant a chemist (smiling).

GP1
Oh sorry, would that be useful, in the sense that looking at medication and doing med reviews but in the sense of just having the chemist involved probably not. From a dispensing point of view I don't see they would be a lot to be done differently.

Researcher PN
The initial consideration was that it might be more sustainable to commission a service where the community pharmacist would provide the clinical pharmacy input.
If they could the help with the med reviews and the medicines advice then that would be useful. But if it was just from a dispensing point of view then no.

**Researcher PN**

What do you think having an integrated care pharmacist means to a patient?

**GP1**

So I think from the experience we have had I think it was good because they made sure they were on the right medicines so its safe for them, it helps make the prescribing safe. It helps optimise the drugs they are on. But equally I think they spent a lot of time explaining why they were on them, which I am not sure the doctors are always very good at explaining why patients are on medication, the side effects to explain. So I think it gets patients on board and it helps the compliance in things. Even the safety, say for instance if, I hope that everyone being given aspirin has been warned about GI side effects but I suspect some of them aren't aware. And actually when the pharmacist did a med review explained why they were on them, asked about the side effects, its an education for a patient and I think that's good as well. So there is a lot of, plus its education of the GP because some of the things they came back with I was thinking oh I didn't realise that. So its good for the patient but its education as well.

**Researcher PN**

So those are the advantages of having a pharmacist, were there any disadvantages perhaps?

**GP1**

No because I think it worked better because sometimes what I find is when we work separately changes are made to medication and the pharmacist may not necessarily understand why that drug was picked or the history behind it. And so changes are made which then make the patient unhappy. Whereas the way we did it this time they were reviewed, it was all done with the patient and then we came and discussed it. And actually you could work in tandem so I think it was more successful. Because actually I was saying well the reason we picked that was because of this and it was a more informed process if that makes sense. Disadvantages you said didn't you?

**Researcher PN**

Yes

**GP1**

I didn't come across any disadvantages I have to say no I didn't come across any.

**Researcher PN**

One of the disadvantages in the literature was sometimes its conflicting advice because if you had your band seven nurse saying one thing and the pharmacist and sometimes the patient gets confused.

**GP1**

Yes that can happen but I think you can get that even with GPs, you can have three different pieces of advice because you are all coming at it from a different point of view. But I didn't come across any experiences when we were doing it, where the advice that was coming out was particularly different to our advice.

**Researcher PN**
And you have mentioned, you have talked about my next question some what, about the advantage to the GP, is there any benefits to other members of the team in having an integrated care pharmacist?

GP1
I think its educational for us all because all of us are involved in prescribing, using drugs and noticing the side effects and whether they are being used properly. So I think everyone would be useful. But even from a nurse point of view I would think they are involved in suggesting drugs or often with dressings and all those side of things, and wound care. And I think so all of us could get something out of it. Particularly education but also I think if nothing else it reminds you that you need to be aware of the effect the drugs are having and the cost and the side effects and all those sorts of things. So actually not only for the patients you discussed but when you go and look at other patients it helps those ones because I think oh yes they mentioned that so its quite useful. And for example with something about metformin and B12 deficiencies which I had never come across but that was picked up in one of the med reviews that we had and actually that's been useful in seeing other patients so it does spill on to other people.

Researcher PN
And can you think of any barriers and also facilitators for the work of the integrated care pharmacist?

GP1
Barriers, let me think, I guess everyone involved has got to be on the same page probably. So, I think if you believe in the process of integrated care and therefore you want to make it work. The experience I have had we all got on very well we were all on the same page and actually work well as a team. I could see that if your agendas were very different you might clash because we all come at something from a different angle and actually your motive and experience is different. So, there could be barriers from that side just because no one has got the full picture so there could be moments where that is an issue. Any other barriers, it's just another person going, so although it's very useful the patient has to be on board because essentially you can have the integrated care coordinator going, then the pharmacist going, and then the district nurse going and then the GP and actually for some patients it's a lot of interference. So, a barrier there could be again explaining to the patients why the time is worth spending. Time isn't really a barrier because it comes into integrated care team meeting so from my point of view it's not a barrier. I presume it's a barrier for pharmacists if they have got enough time to get involved. What else could be a barrier, I think that's it really.

Did you always have access when you wanted to the pharmacists. because one of the barriers...

GP1
I used email because its quick and efficient, there was never ever really a query that I needed an answer there and then. So, to me that wasn't a problem. I guess if you needed to speak to someone on the phone and you couldn't get hold of them it could be. But the nature of this is its chronic problems and its reviewing, it's not really acute case. So, I never had a reason where I needed to contact the pharmacists urgently and I emailed and I used to get a response the same day so I never had any problems so it was good.

Researcher PN
And can you think of any facilitators, anything that could facilitate ...

GP1
That could help the process?
Researcher PN
Yes.

GP1
I think what used to happen was the pharmacists, so we would allocate a patient and then the integrated care coordinator would go, the pharmacist would go, and then they would come back and discuss it. I think what might help facilitate it is if there was a discussion with the pharmacist before they went. It might speed up their process because I think sometimes they come back and a lot of the questions were like I could have let them know before they went. So actually I wonder if the process would be better if we discussed the patient, the pharmacist and the GP, in the meeting you discussed the patient, just had a look at the medicines before and highlighted perhaps things that I think are issues and what they think are issues. And if there is any immediate odd prescribing say you can say well the reason for that is because so and so. And it might make the pharmacists job easier because they go out with the knowledge. The patient's notes are so detailed and thick you can't actually get that information so then I just wonder whether the pharmacist spends more time than they need to with the patient because they could have got the information beforehand. But otherwise I can't think of any thing else.

Researcher PN
And the next question is how do you think the role should be evaluated? Because it was a pilot and what sort of markers or best way to evaluate the …

GP1
I think you would want to know what changes they are making, so it would be useful to look at it from just a purely, if you look at medications before and then medications after what changes had been made. That's one simple way. I guess we could look at it from a cost point of view, whether they saved costs. I think if the pharmacist had highlighted anything that was a potential harm it would be useful to note those because the cost, just from a point of view of the cost to the patient and the NHS actually if they came along and said look, I can't think of an example, your prescribing? and no wonder they have got muscles aches and pains, actually there is harm being done there and they have prevented that harm. So, I think you would have to evaluate the harm reduction they have got. I guess you would want to get the patients perspective and see what the patient, do the patients think that that makes it, because we are looking at it from purely a prescribing and a safety issue but actually do the patients say sitting down with a pharmacist for a certain amount of time helps their understanding and their compliance, and I suspect they will say yes.

Researcher PN
How do you think the role could be developed?

GP1
I guess it's the number of patients we can get through is limited by the number of patients the coordinator can visit. So there may be patients that would benefit from a bit of an MDT or just a bit more people looking at the notes but not necessarily a full assessment. And that's the difficulty there is no half way house, they either get a full assessment or they get nothing. And I suspect there is a lot of patients that you could work with the pharmacist on and look and educate the patient who aren't necessarily, don't need a full assessment of their home circumstances and everything else but actually would benefit. I think there is a lot of scope for more joint working from that point of view. Because at the moment the pharmacist had the same clientele as the coordinator, you could do it so they had slightly different patients. You would still discuss them in the MDT but actually the people that the pharmacist can make a difference to isn't necessarily the same people that they need to see. And so whether you made the search criteria slightly different. What we did was we would look at the eight patients and I would say look these are probably the three that you are going to, the most useful going
to see, prioritise them and if you get a chance see some of the other ones. Which is sort of
doing that isn't it but I guess you could push that a bit further and say the best criteria for these
are people who it's a slightly different criteria so that was the only other thing.

Researcher PN
I think we have partly picked that up with the GP hub pharmacists pilot? The aim is
to kind of embed clinical pharmacists in the practice who work to improve use of
medication

GP1
And that would be really useful.

Researcher PN
So, it would be useful to include integrated care as part of their main role remit?

GP1
Yes that would be good.

Researcher PN
Is there any other comment about this any specific examples of the encounter?

It's been a while since it was. I can't think off the top of my head of any. I think just generally
most, I can't think there was one patient that we discussed that there wasn't a change made
to their medication or an improvement made or a problem found. So, I think that alone
highlights, if you can look at all those, there wasn't any that they looked at said the patient
understands everything they are taking, they have got no side effects and all these drugs are
perfectly safe. There was no one patient that happened to. I think what stuck out to me was
that the fact that oh gosh there is a role for this because it does make a difference. And
not just from a cost point of view but actually just from a best care and safety point of view I
think it makes a difference to the patients.

INTERVIEW FINISHES

Figure I.4: Illustration of coding for GP1 interview
Interview with General Practitioner 2 (GP2)

Venue: East Leicestershire and Rutland CCG board room  Date: October 2016

Present: General Practitioner 2 (GP2) and main researcher Phyllis Navti (Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. I am Phyllis Navti and I am the researcher and the interview will take about 30 to 45 minutes. Could I start by collecting the consent form?

GP2
Yes
Researcher PN
Thank you

GP2
That’s fine.

Researcher PN
So, this is about the role of understanding the contribution a pharmacist makes to integrated care and informing how that role develops. And will just ask a few questions about this but feel free to expand because that would also help to inform the process going forward. So, where do you think integrated care fits in to the provision of care to the patients?

GP2
Integrated care generally?

Researcher PN
Yes, integrated care generally.

GP2
So we are in a challenging time in health care at the moment where I think all services are struggling to meet the demands put upon them. So having an integrated approach to managing patients is more likely to generate better clinical outcomes, more efficiencies and have a much more effective service. So working with social care, pharmacists, physiotherapists, district nurses together as part of a multi disciplinary team is much more likely to generate better clinical outcomes.

Researcher PN
What role did you play as part of integrated care and what does that mean to you as a practitioner?

GP2
So to me it has meant identifying a cohort of patients that are potentially at risk and whether that be at risk of hospital admission or high resource utilisation those patients are identified and managed proactively rather than reactively. And so to me integrated care can mean that.
I should ask at this point are you asking me about integrated care generally or integrated cared pharmacists?

Researcher PN

We are getting to the pharmacists but I want to understand where the pharmacists fit into the bigger picture because its what the P did for this pilot and what potentially they could contribute which we are trying to tease out.

GP2

So that’s proactive integrated care, obviously you have more reactive integrated care which is managing patients in crisis which are often not just a medical issue its often medical and social and it brings Patients into it there tends to be iatrogenic causes of deterioration where a Pharmacist can play a part.

Researcher PN

So how did the sessions work for you in the practice, did you have MDTs once a month or once every two weeks>

GP2

We as a practice ran the integrated care coordinator pilot and as part of that we had monthly MDTs it was at least monthly if not more frequent where we would review patients electronically and then decide which health professional should see them. Whether it be the social care coordinator or P I can’t remember if occupational therapists were involved as well but certainly Pharmacists and social care were involved. And now its moved on and we have an integrated care coordinator that comes to our MDTs but not a Pharmacist. so initially as the pilot we had a pharmacist but not now.

Researcher PN

You have mentioned some of the roles, there is some overlap with the questioning here, who do you think is part of the integrated care team?

GP2

So fundamentally I think you would have to have a primary care clinician, a district nurse, sorry I am going to retract that, it depends which point in the patients journey. If we are talking about the proactive care then you need social care, primary care, ideally physiotherapy and then Pharmacist. but I wouldn’t necessarily say a Pharmacist would be essential for every patient.

Researcher PN

And when you say Pharmacist, this is something that came up in a previous participant, would this be a Pharmacist who works as part of the practice or a community Pharmacist?

GP2

Good question, so the conversation I have had, up to this point in interview I have been talking about an integrated care so a Pharmacist that is aligned to the MDT but actually there is a wider question, about how you can integrate Pharmacists into primary care so that they become very much a part of the primary care team. I think they have got a much
greater scope of being able to help manage demand, but also be part of the MDT in primary 
care. So I think the Pharmacists has got a lot of different roles, in the practice as part of an 
MDT proactively managing a cohort and then reactively when patients deteriorate.

Researcher PN

So, is there any specific reason why you think it would be better, the pharmacist in a 
practice would have a better chance of integrating?

GP2

Yes absolutely because my experience is that when you see someone more frequently and 
you interact with them more on a daily basis and they understand the organisation they are 
more likely to be able to find a fit for that individual in an organisation, whereas when they 
tend to come in as an outsider they don't tend to appreciate how the system works and so 
you don't necessarily realise the benefits.

Researcher PN

Another part of the theme that came across from other stakeholders was patients, do you 
think patients would form part of integrated care?

GP2

Oh good question, I think maybe yes, I hadn't thought about patients being part of the 
integrated care team, particularly if you had expert patients. So for example you have a 
patient with COPD who is identified as somebody who you would want to proactively 
manage an expert patient would be excellent at being able to promote self care and self 
management, so yes, I hadn't thought of that.

Researcher PN

What do you think having an integrated care Pharmacist means to a patient?

GP2

Good question, I think it means that they will have a deeper understanding of their 
medications. The rationale behind taking them and its likely to improve compliance.

Researcher PN

And what should they do, so how do you think the integrated care pharmacist or 
pharmacist who works in that setting, should work to get the best outcome for the 
patients?

GP2

Do you mean as in doing clinics or home visits?

Researcher PN

Yes, so anything, clinics, home visits, what point in the process should they be involved so 
an example I had was there was a discussion around whether the Pharmacist should look 
at every single patient identified by the risk stratification tool because potentially 
prescribing is the most common intervention in primary care. So if you look at every single 
patient record you might pick up something What the pharmacist for example said was
“you don’t know what you don’t know”. Whereas some of the integrated care coordinators would mention that a pharmacist should be brought in after the initial review of the patient. So what your thoughts are about this issue?

GP2

I think for most patients that are on more than five medications there is a role for a P to be involved. And I am using five as an arbitrary number. The more poly-pharmacy you have the more of a role of integrated P has. One thing that general practitioners are very good at is prescribing medications and they are not very good at stopping medications. And what could be quite helpful would be the discussion with patients about what they are using how compliant they are and discussion around evidence for certain medications. An example would be an 80-year-old on a statin or a 99 year old on a statin might be a better example and what is the value in that if their quality of life is quite poor, could that be something that could be stopped. And there are many patients with memory concerns, really tricky discussion that you have and a Pharmacist can help and inform those discussions.

Researcher PN

So, the example you have given is prescribing support for patients as an advantage of having a Pharmacist are there any other advantages?

GP2

Are you talking about in primary care as part of the team?

Researcher PN

Yes, as part of the team.

GP2

So if you had a pharmacist, there are loads of them(advantages). So, every day we see I probably see on the on call at least ten medication related queries, I am fairly sure that the majority of those medication related queries could be dealt with by the pharmacist. So, there is a role there. So obviously, we have done a lot of work together on, so for me in primary care there is lots of processes that occur which the governance around those processes would be stronger if a pharmacist was involved in developing them. There is a lot of medicines waste and pharmacists have got a role to play in the interface between patients administrative teams and the organisation and general practitioners. And how that interface could work more smoothly to reduce waste so there is certainly a role there.

Researcher PN

Do you see any disadvantages of having a pharmacist working as part of an integrated multidisciplinary team?

GP2

I do, I think there is sometimes, pharmacist the way that pharmacist tend to be trained the impression I get is that they focus very much on quality and in primary care because the demand is so high quite often we as practitioners we are balancing benefit, risk, quality, quality of life, lots of different agendas we have to manage. And we have to do that within a very short specified time frame. And I think pharmacists find that quite difficult and I think
there is an expectation when patients see the pharmacist than when they see their GP and they are expecting a medication review as an example it might be that they expect, it might devalue the role of the GP roles in medication reviews as a potential, I am not sure about that.

Researcher PN
And is there any way of mitigating these disadvantages from your experience?

GP2
I think having pharmacists in primary care early on in their training so for example in our practice we have just started taking DMU students in the first year or third year.

Researcher PN
I think its third year or pre-registration

GP2
yes, possibly they came and they sat and they looked at consultations and saw what it’s like to be a GP. So, I think to see that to see how we are juggling so many different things their view on when they manage a patient might be different. So rather than looking at, say for example there was a query about specific medication to think about just that query and deal with that in isolation rather than thinking ok there are 20 medications and I am dealing with this but I need to just deal with all the other 19 as well.

Researcher PN
what do you think having an integrated care Pharmacist means to other members of the integrated care team eg the coordinator?

GP2
Support, advise, because quite often when its a medication related query its felt that the Gp is the person that is going to be able to answer that query the best., whereas actually a pharmacist is probably more appropriate to answer a medication related query than a GP. Also education and training and that sort of thing.

Researcher PN
Can you think of any barriers or facilitators to the work of the integrated care pharmacist?

GP2
Money, so you need to be able to resource it. And the challenge is at the moment because most pharmacists are not trained in primary care, quite often you are not seeing the benefits early on. So you almost have to wait quite a while to see the benefits so quite often what happens is people may dismiss the value of a pharmacist because they have not had a chance to embed into an organisation. As a GP when I trained whenever I moved to a new role its taken me at least 6 months to 12 months to get to grips with it. So for a pharmacist that’s having a new role but also a new role that has been unexplored its going to be more than 6 to 12 months. So we are talking two years before you are really going to see any benefits.
Other things that came up as barriers is they are also spread thin on the ground because we
had the pilot where the pharmacist was in several practices.

Yes that’s right. So I think you need to have someone that’s there ideally more than two
days a week in your practice. I don’t see the IT issue as being much of a barrier because
most people can come and learn the system and if they are there for more than 3 months
they will learn how the system works.

Researcher PN
The IT issues were regarding accessing the social care system, so if they were at the
special care site then they couldn’t get into the patient care record held by social.

GP2
yes that is a barrier.

Researcher PN
you probably wouldn’t have to deal with that.

GP2
There is talk about integrating the two systems.

Researcher PN
How do you think the role should be evaluated?

GP2
So, I think it would be useful for it to be evaluated by, if we are talking about pharmacist in
practice it depends on what role you are giving them, so for example if the role is a savings
based role then it would be about the savings that are generated. If it’s around helping with
process then you can do it on time saved or time generated for other members of the team.
If it’s on quality then it could be on audits that are done based on recent guidance, so it
really depends on what you are looking at. But there is obviously patient satisfaction and
clinician satisfaction as well.

Researcher PN
So, this role was a quality based focusing on prevention and quality elements of
medication use as opposed to cost savings?

GP2
Then I suggest satisfaction surveys for patients and GPs so using the NHS type
There is a friends and family test so patients could after they have seen an integrated
pharmacist, could fill out a friends and family test, what was the value of that interaction. I
probably should have mentioned earlier on about the disadvantages of pharmacist is that
when a pharmacist has done a piece of work quite often the outputs of that require a GP to
action them. So sometimes more work is generated rather than reduced. So we need to be
mindful of that.
Researcher PN
I think that takes us nicely to the final question which is about how do you think the role could be developed? So thinking for example if they are prescribers they might be more likely to save GP time?

GP2
So being an independent prescriber, working in different primary care settings, so I think it would be useful for integrated pharmacists to work in an urgent care centre to see what kind of role they have there. There is certainly a role for pharmacists improving the governance of primary care because at the moment the way that prescriptions flow through the system I can't say there is a very clear process that is followed. I would say its safe but its not as efficient as it could be and pharmacists I think have a massive role in being able to identify a better process and syphoning some of that work generated in a different way.

And not necessarily by pharmacist it could be by different nurses in the team or GPs in a different way. So for me developing their role within the practice and also you maybe think about the management side of things so pharmacist might be good practice managers, they might be good nurse managers, I think there is a management role that pharmacist may want to take on in primary care. Because the majority of primary care is prescribing. Yes I can see that.

Researcher PN
Any other comments?

GP2
No I think it can only be a good thing.

Thank you for your time

INTERVIEW FINISHES

Figure I.5: Illustration of coding for GP2 interview
Interview with Integrated Care Pharmacist 1 (IC pharmacist 1)

Venue: Integrated Care Team office, Romulus Court  Date: February 2016

Present: Integrated Care Pharmacist 1 (IC pharmacist 1) and main researcher Phyllis Navti (Researcher PN)

Researcher PN

Thank you very much for agreeing to this interview. As you know I am Phyllis Navti and I am the main researcher and interviewer. The interview will take about 30 to 45 minutes. Could I start by collecting the consent form?

Phar 1

Yes

Researcher PN

Thank you. Next I will start with the interview. What does integrated care mean to you?

Phar 1

Integrated care means involving all parties who are part of that patients care, whether that be medical, physical, social all being able to speak to one another about that patient and being able to have access to their notes where its applicable. So its just for me to be able to contact other people to find out what information they’ve had about a patient. Rather than just working in my own little way.

Researcher PN

So, in terms of the general provision of care for patients where do you think integrated care fits in?

Phar 1

In respect of....

Researcher PN

So, if you think about health provision to patients where does integrated care fit in to the whole health care provision, where do you see it?

Phar 1

I suppose integrated care to me is around the patient, so it’s part of the community and their home and part of them living as opposed to identifying it as medical care. To me it would just sort of be assisting a patient in terms of their living so its not, I wouldn’t define it as health care I would define it as well holistic care I suppose. So its to do with looking after the patient in their home and making them able to be self-sufficient for as long as they can be if that’s what they want.

Researcher PN

And who do you think is part of the integrated care team?

Phar 1

Everybody that has a part in that patients well being so that could be even go as far as the family or carers, GPs nurses, physios, anybody that is involved in keeping the patient well.

Researcher PN

And can you give me some examples of your non traditional team members and what you think they do for the patient?

Phar 1

Non-traditional, you could even say a pharmacist is non traditional I suppose couldn’t you in terms of being involved directly with a patient outside the community pharmacy. But for example a lady phoned this morning and its the daughter in law of a patient that phar 2 has been decreasing her, she has stopped her Zomorph she has stopped that gradually since October and since Christmas she has stopped her Diazepam slowly, so that’s the only thing really we have had anything to do with her. She phoned me today to find out what to do about her mums constipation. And its got nothing to do with anything to do with what we have been doing for her but its to do with the fact that she is a panicky lady and if she panics, that’s when she needs the Diazepam. And she needs something to worry about and at the minute she is worried about her bowels and could I suggest anything.

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lady back about some medication you changed. And I assumed it was something to do with the statin because that’s usually (4.45) and it was nothing to do with anything I had to do with and nothing to do with anything we had done. **But its assumed because its do with medicines that we can sort it out.**

**Researcher PN**

**So, I think this is actually an overlap with the last question, and the question who do you think should be part of the integrated care team?**

**Researcher PN**

Yes, in general so you have what the current structure looks like, do you think that’s sufficient or do you think that should be expanded?

**Phar 1**

I think ideally you would have a group of, not the patients GP specifically but a GP that you can refer to to be able to make changes yourself, the pharmacist, a nurse, anybody that has got a specific role that you could be able to contact if you need to have any information about anything. So if we go and do a med review and there is something about access or we can’t get round the back or whatever it is, you have the coordinator but that might not be the person that you are talking to, so its just the knowledge of the other people in the team. I think we had, the original diagram and I think everybody that’s on there needs to be part of the team. Because you don’t want someone that’s random and outside of your remit as it were because you don’t feel you can approach them then. You want to have specifically this is the integrated care team and this is the person you need to contact if its about medicines, or this is the person you need to contact about if there is a seeping wound on their leg, or this is the person you contact if they are having trouble getting places. And then the coordinator sort of keeps all those people together and does things like the social care in terms of applying for allowances or telling them about clubs that they can visit or you know the social side of it.

**Researcher PN**

Do you think that the community pharmacist has a role potentially?

**Phar 1**

It depends how much you are going to right down, I think if they weren’t paid in the way that they are and they had the additional training yes because there are lots that are interested in having an advanced role. And I think if you take away the pressure of dispensing numbers and having to make the books add up then most pharmacists want to be a pharmacist. But you can’t be because you have got to hit too many targets and do too many MURs and tick too many boxes. But the ones that, the only way that we have conflict with community pharmacists is when it involves cutting the funding in some way, which we are not doing on purpose but if we think something is a better idea we ask them to do something, or we need to change something it effects their funding or effects their payments that’s when it gets a bit touchy. Even though they can see that what you are saying makes sense. And you can understand that especially the local ones because they are independent and it does make a difference. So its difficult, I don’t know whether this thing will go through about taking away the money from the dispensing side of things and making that more an automated thing, and community pharmacists being more involved with advice and the sort of thing we do now. If it did that would make far more sense than just numbers for numbers.

**Researcher PN**

Reducing volume of prescribed items is a disincentive?

**Phar 1**

Yes if you do less prescriptions then you are less likely to make a profit. Even silly things, we have prescriptions here for two or four tablets just to make up the difference on a dosette box, bring it in line for the next time. That’s just silly money isn’t it, make a prescription for two tablets because I don’t think they think about the fact that that’s a whole prescription fee.

**Researcher PN**

So, what do you think having an integrated care pharmacist means to a patient?

**Phar 1**

I think it means someone they can go to speak about things that they don’t feel they have time to speak, to their doctor about. Just to be able to speak to somebody that has got an overarching picture of their illnesses and medications. As opposed to a practice nurse who can talk to them about their hypertension and can talk to them about their breathing or can talk to them about their statin, its individual skills of a practice nurse. Whereas a pharmacist can look at everything so if you go and see somebody about one thing in particular we can then go on and talk about everything. I think it gives them a better understanding of what they are taking, I think it helps them to be more. I can’t think of the word but its not understanding, its to do with concordance and feeling they are a part of taking their medicines and they have a choice. And you tell them why they are taking something and give them an understanding of what it would mean if they didn’t take it. And give them that choice. I think its more about a mutual this is what we think but this could also happen and this is also making something happen to you to have a
different tablet... And so they can turn round and say what would happen if I didn't do this. Whereas they don't tend
to have that conversation with anybody they are just told to take something and they either do take it because the
doctor told them to or they don't take it because they don't want to. But nobody actually has any discussion with
them about what would be the best thing for them and let them make their own decision. Because I don't think
people are allowed to, don't feel they can make their own decision.

**Researcher PN**

So, empowering them?

**Phar 1**

Yes, that's the world! I couldn't think of the word and it does empower them. Speaking to this lady today about the
constipation and I said how is she getting on with her Diazepam and she said she is down to one milligram at night
and she was on two twice a day and she had been taking that forever. She is on one milligram a night and she
said she is so proud of herself because she is not taking the Diazepam and she has been taking it for ten to twenty
year because she panics and it helps her to calm down. But she realises she feels better without taking it and she
doesn't feel groggy in the morning when she doesn't take her zopiclone. but no one has ever said to her do you
want to come off that. And that was just at St. M which is sheltered housing by the church and we went there and
saw the patients individually. And then just chatted to them about different things and she just happened to mention
do you want to still be taking that and she said well no I don't really but I don't think I can come off it. And R(Pharmacist 2) has phoned her every week just to see how she is getting on. So its just that knowledge that there
is somebody there and somebody cares about what you are taking and what is best for you as opposed to the...I
think normally when people have had letters from us its always been about stopping things its always been about
cost, and we are trying to get over to them what we are trying to do is optimise things for you. And yes cost is part
of it its bound to be but its not the driving force. And I think once they know that they are more willing to talk to you
about things.

**Researcher PN**

And how did the GPs receive, the Diazepam lady?

I don't think it said anything on there, there is no mention.

**Phar 1**

Yes, I am sure, it tends to be just switching the authorisation doesn't it, it does medication review but I don't think
anybody has spoken to her. But it would be interesting, I think phar 1 will feedback at one of her clinical meetings.
They will just turn round and say we haven't got time to do that, and we haven't.

**Researcher PN**

So, what do you think pharmacist should work as part of this role, how do you think the pharmacist work
maximises the benefits for the patient?

**Phar 1**

I don't understand the question.

**Researcher PN**

I suppose what I am trying to get is where the pharmacist should be placed as part of the integrated care
team. Should they look at every single patient or should they triage them and see some of the patients and
not all the patients, and where along the process before the coordinator goes into the home to review the
patient before or after or both?

**Phar 1**

Both I think, but having tried working with pharmacist technicians, its probably better to delegate this to them than
the coordinators. Because what we were doing for the second pilot was we would look at the medication first and
if there was anything we thought just by looking at it they want to talk to a patient we would tell the technicians and
then they would go and do that before their visit. So then they would know, they would be sort of pre armed. But
then additionally we would also have referrals after they had been into the home, that was more about physical
issues and getting mixed up and it wasn't so much about reviewing their medicine and saying what they were and
weren't taking. But having new technicians they are probably better placed to do that than the coordinator. Because
there is always a problem with an additional knowledge set that they hadn't got, so if they went pre armed with
something then they would go and do that before their visit. So then they would...

Phar 1

...and I think in terms of

Phar 2

...empowering them?
here all day and if they had queries they could come in. I think that would be useful rather than specific clinics so
be accessible like a community pharmacist but without the (16.53) so you could have a drop in.

We would have talked about what a pharmacist means to a patient do you think there are other advantages?

It wouldn't necessarily be an advantage for those patients, but the advantages in general to have a sort of word of
mouth thing that says we have seen a pharmacist and this is what they were able to do. Because I don't think
people quite know that you are able to do stuff. And they don’t know that pharmacists can work in GP practices
and they don't know they can have access to your records so you can know a little bit more about, you can be
more specific with your advice than you can in community pharmacy. So I think it would be just more educational
for lots of people to know what pharmacists are capable of because I don’t think they do now.

Researcher PN
And do you think there is any disadvantage to the patient?

Some don’t want to know the information that you want to give them, so sometimes you have to be careful about
what you are telling somebody because they might get more confused. Or they are not interested in that information
they just want to have their medicines and that’s fine, they don't want to know what its for, they don't want to know
what is wrong with me. I can’t really think of any real proper disadvantages because I can only see it as a positive
thing I really can, I can’t think of anything where you think oh I wish they hadn’t told me that or I wish the pharmacist
hadn’t been involved. I suppose you could say the knock on effect is we are asking questions that are not
being asked so that’s creating work for the GP practice. But they are questions that should be asked.

And example of a disadvantage that is mentioned in the literature is potential confusion if maybe the
pharmacists advice is not in line with maybe what the nurse or doctor said. So again I think its just how to
clarify it.

Phar 1
Yes, when we have the conversations, certainly when I have them I am sure phar 2 is the same, we say these
things, we will talk to your doctor, but this potentially could be something that we could do. And I think once you
embed yourself in a practice then you begin to know what they want to, what things that they would recommend
and so on. But also what your remit is in terms of what you are able to do without referring back to them, so adding
things on prescriptions and taking things off and stopping things or changing things. There will be lots of things that
they would probably be OK with you changing. And if you are prescribing you could come in and do quite a lot
more. So if the blood pressure has not been controlled and you can add something in or increase doses or the
same with the respiratory and so on. So you could do the same thing as a practice nurse does, as long, there are
usually protocols they work with anyway the practice nurse, so you could have a similar thing but for lots of different
conditions and make the amendments and so on.

Researcher PN
What do you think having an integrated care pharmacist means to other members of the integrated care
team?

I think its wonderful! I think as long as you are not treading on other peoples toes and you make yourself available
to everybody which takes time, I think they see it as a positive thing. All the coordinators I have spoken to have,
and the patients that want to see you have. You area always going to have people saying I don't need that, but the
ones that do, I have not seen anybody that says well that’s not been very helpful, don’t bother coming again. They
usually say that it has been helpful. And I think the nurses its difficult to tell because we have not really had many
nurses involved that I have had anything to do with. And they are quite often band six aren’t they, band seven, so
they know quite a lot anyway. You always feel that you might be, its probably wrong, but you might be treading on
their toes. And its more difficult here, that’s what we are trying to ? into the respiratory reviews because they are
not really done very well. But you can't tell someone you are not doing them very well. Its finding out how you can
be a part of that team and influence what they are doing without criticising what they are doing.

Researcher PN
How about the GPs?

Other than the additional work load I think, at the moment it doesn’t really takes us very long because the majority
of the things that we do we can do without referring back to them. But when we do have to ask questions and then
it involves a knock on effect, additional work, I think that's a big question mark. But they see less of the benefit that
they are getting from it and more of the additional work that it involves. But what we are trying to do is to complete
all that work before they ask the question. So if we are suggesting something well why are you suggesting that,
and when was it started and why was it started and why do you think they don't need it any more. If you have got
all those answers. But if you go with a recommendation and you don’t have the answers then you have to go away
and find out and it just makes it more long winded. So just be prepared when you go and be prepared to whip
through everything really quickly. So you know what you have got to ask and you know what you don’t need to ask.
And they give us pretty much access to everything so I think in terms of we can, they let us set an appointment up
with the GP if that's what we think they need to do. They will let us order bloods and all the things that you probably
with your integrated care hat on, not being a member of the practice, weren't allowed to do. So its more difficult to
arrange things that you thought were necessary. Whereas here we can do all of that or we can ask the GPs I have
done that sort of thing, its much easier. So I think overall its a positive thing but I think as it embeds itself I think it
will be better for them.

Researcher PN
Can you think of any barriers and then facilitators to the work of the integrated care pharmacist? So what
are the barriers that might prevent an integrated care pharmacist from doing what they are meant to be
doing?

Phar 1
Funding, apart from that. It depends where you are based doesn't it, I think it works much better if you are based
in the practice. But then on the negative side you have got other things you have to do as part of that role. So you
are not only just available to the things that you need to be able to do in terms of integrated care. I think it was
being known really, I think the biggest value was the large geographical area we had to cover so the fact that you
couldn't get out to, if you are just here then you know you have only got to go to L( village) and the villages around
and you can be based back here and you go backwards and forwards and that's all fine. But if you have got a large
are to cover and not a specific base or specific practice then its more difficult to get the information back in a timely
way. Although having said that L is not great for that anyway. But to be able to just catch somebody if you are not
based in a surgery you can't just catch them with a, like I know Dr M he is around about 2 o'clock so I can race
down if I have just got one query and he can just answer it for me. Whereas some of the others I have just asked
the technicians to book me a block half hour next week so I can just go to one GP and just work my way through
everything I need to. So I think you just need to be able to be around and if you are not that's a big barrier. And I
suppose time is a massive, massive thing, if you are going out to patients homes it takes a long time to review
them when you are in your home. Whereas if they come to the surgery they don't tend to talk as much I have
noticed whereas in your home you just can't get away, you can be there for such a long time. And its not just
because they say do you want a cup of tea its lots of things. It does seem to take longer whereas here I think they
are used to coming in having a conversation with somebody and then leaving. So its much easier I think.

Researcher PN
Do you get as much information out of them?

Phar 1
They are probably not as relaxed and they haven't got all their medicines and you can't see the situation that they
live in. And that makes a lot of difference because Sarah has come back from a couple and she went its chaos in
that house, there is stuff everywhere, she says its no wonder they don't know what they are taking. You just get a
feel for that person better in their home. But I think you only really need that for the really difficult patients.

Researcher PN
I think you have touched on facilitators, are there any other things that can facilitate the work?

Phar 1
I think they are useful for being a central hub for everybody to refer back to and they can keep all that information
in one place to know what's available. Because I didn't know all sorts of things like the assisted living team next
door. I didn't know about any of that stuff that it was available to anybody and that you could get it from the local
authority. I just thought you got a catalogue from the chemist and had a look and thought oh yes that will help her
or that would help. I didn't realise you could get an assessment and people find out what would be useful for people.
So actually the coordinators know a lot about everything they really do, they will say how about this or how about
that. And its not until you talk to them that you know what is available for patients. And I think that awareness and
the awareness that you can talk to other people about somebody and they will have an idea that you didn't know
existed. Or if you did know you wouldn't know how to access it. So there are all sorts of things that I didn't know
was available for patients. So I think the coordinator is really useful because otherwise you are going to end up still
working in your own little area, you do talk to people but unless you are talking about someone specific you won't
talk necessarily about the different things that are available.

And how do you think the role should be evaluated?

Phar 1
How can we evaluate it, I think its really difficult isn't it, if we knew that.... I think feedback from patients the users
and the rest of the team is the biggest indicator of whether something is working or not. And you can't do that in
the short term. I don't think you can do it by numbers of inventions or amount of money saved, I think you just do
it by asking somebody do you feel better about your medicines, do you feel more able to cope, do you feel healthier
because you are not taking something or you are taking something. And I suppose you can't quantify that can you,
in terms of questionnaires and that sort of thing.
How do you think the role could be developed?

Phar 1
Pretty much like we are doing now I think, I think you just need to have, you have got everyone else as part of a team within a practice you haven't got pharmacists and pharmacist has never been seen as part of the team, they just are somebody who works in the shop. Or if its prescribed advice then its someone who's on your back to make you reach indicator targets and save money. But there has never really been anybody that has said well have you thought about looking at this, I just think you need to be part of the team. So to develop the role you need to make patients and members of health care team know what pharmacists can do. And you can only do that by having someone in here and doing it. So its chicken and egg isn't it, you can't show somebody what you can do unless you are in there and you can't get in there because no one is willing to take a punt are they and say lets see if this works. But I think being part of the practice as opposed to being part of the integrated care team that is based in an office, actually being part of the practice is the way to go. But whether you can do that and be part of a group of practices and just cover integrated care or poly pharmacy or whatever I think its too big a role to be in a practice and do all the CCG work and the prescribed. It would be useful to be able to do orders like they want us to on the Aspirin, so basically just making sure that you have got proper prescribing within a practice and individual medication reviews. Because once you do the bulk of the work its just maintenance really and new patients and medicines reconciliation when patients come into practice all that sort of thing. And that's something you could do on a regular basis provided you weren't tickning boxes and making reports and doing all the things that we have to do because it does take up a huge amount of your time. Its just that everything that we do we have to write on a form so that doubles the time it takes you to do it because you are having to write it on a form. And when its on that form you have to put it onto a report and then you have to send it to somebody else. And I know that's got to be done because you said what is the best way to quantify it and you can't other than write down numbers. But if you write down everything you are doing it doubles the time it takes to do what you have already done.

Researcher PN
What you are describing about how the role should be developed sounds like the NHS England ???

Phar 1
Yes I think so..

Researcher PN
Because its sort of having a practice pharmacist without doing the switch work.

Yes because the switch work if its not done as switch work its done as knowledge that the most cost effective product is this, then that is part of your med review. Its not that it wouldn't get done but its done on mass then if you don't, we have found if you don't make phone calls and speak to somebody then you are not going to know a reason why. Because with the best will in the world some of it is not documented, so we have had three or four patients with statins and I have had that before, there is nothing on your record well I didn't like it, it didn't suit me and I am not having it again. But there is nothing on the record so if you just telephone them as part of medication review or you have seen them, this is what we are looking to do, and that is not the formula item and this is the one we would prefer you to have. They just say no I have had that before and it doesn't suit me. So its not that your quick work wouldn't be done and if you worked through all your patients, which you would do if you were in a practice because they all get reviewed on a yearly basis anyway, then your quick actions would be done at the same time. Its not that they wouldn't get done because they are being done. But they are not done as I am going to come in and switch everybody’s statins.

But it doesn’t, it doesn't bode well in the practice because you are bound to get, if you deal with a hundred switches ten percent wont like it and they will all come back the same week and they will all ring on the day you are not here, they just will because that’s how it works. So I think it would be better if all the quick switches or whatever it was, if you have got an awareness of them, you have got an awareness of all the guidelines or local guidelines or national guidelines, they are all in your head. So its not like you don't think of them, so if you are looking at anything really when you look to step down the PPI or you could say well actually you are only on 20 milligram of ? and you have had a previous event you should really be on 80 but you have got that in your head. And you have got, perhaps not the branded generics I don't know most of those, but if I did have them in my head then I would be able to do that at the same time. So its not like it wouldn't be done, it would be done.

Researcher PN
Anything else about the role?

Phar 1
I think we have covered everything.

Researcher PN
So, no other comments?
I just think you need a pharmacist in a GP practice and you need an awareness of what they can do. And you need confidence in what they can do and you need to be able to refer to them when you think its appropriate. So there are all sorts of queries that are covered under that, can we prescribe this or should we prescribe this or is this the most cost effective thing. My lady last week said can you change all the meds to soluble because she can’t swallow. So I had a look and I said well can I call her in, why, well because I can see at least 6 drugs there that are giving her dry mouth so that will be why she can’t swallow because its getting stuck. And she said well you can if you want and I said OK I will do and we have, we have stopped four of them we have changed another one to something else and she is willing to have a go without, I did give her soluble paracetamol because she was really struggling to swallow those. And then a lot of medication she had stopped taking, the Quinin she had stopped taking because she couldn’t get it down, Gabapentin she had stopped taking because she couldn’t get it down. She hadn’t taken either of those for three months and I said well shall we leave them off then, have you noticed the difference, well no not really. I said shall we just stop them then, yes why not. But you wouldn’t think to stop any of those, she said well I can’t manage without those because I get cramp. I said well have you got cramps since Christmas because you have not been taking them. There are lots of things, and we had quite a long chat about different things. But she just said I can’t swallow, so her GP had said we’ll get them all soluble for you. I think oh god that will be expensive, the first thing I thought. There are just things that we would think of and notice that I think there is a niche that pharmacists fill. Because when we go into patients, well I don’t know if you do, but when I go to patient records the first thing I look at is the repeats. I don’t look at their history, I don’t look at their problems I just look at their repeats first and get a feel for that. And then I go and look into each one individually to find out why and wherefore and all the rest of it. But nobody else does that, nobody looks at the drugs first, they have a quick flick but then don’t look how often its ordered, whether they are over using it. They don’t look at anything like that. Just have a quick look and ask them and believe them.

Researcher PN

So you basically approach the practice pharmacist work with a different focus?

Phar 1

Yes, you have got a different starting point.

Researcher PN

Anything else to add?

Phar 1

Just that it was a very worthwhile pilot

Researcher PN

Thank you very much

INTERVIEW FINISHES

Figure I.6: Illustration of coding for Integrated care pharmacist 1 interview
Interview with Integrated Care Pharmacist 2 (IC pharmacist 2)

Venue: Gp Practice Patient Consultation Room Court Date: April 2016

Present: Integrated Care Pharmacist 2 (IC pharmacist 2) and main researcher Phyllis Navti (Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. As you know, I am Phyllis Navti and I am the interviewer. The interview will take about 30 to 45 minutes. Could I start by collecting the consent form?

Phar 2
Yes

Researcher PN
Thank you. Next i will start with the interview. What does Integrated care mean to you?

Phar 2
I think it helps optimise the outcomes for patient’s health by factoring in the social care needs. So where it fits in I think is a prime example is the elderly who have a lot of social care needs as well as health needs so that’s where I would say it probably fits in. Is that you what you are asking?

Yes how it fits in for the patient but also maybe for the teams?

Phar 2
It also helps raise awareness of what’s holistically going on with the patient. Because when you look at their care record and isolated attendance to practice for example as a health care professional you are looking at their record, you don’t get the holistic picture of what is actually going on in their social environment that could be contributing to their changes in health status. So, I think the combined working brings that all together because sometimes what I have come across is some of the health needs that come up are not necessarily needs they are social needs and vice versa. So, I think the integration helps to clarify that so the needs are met properly.

And I think this question is similar to the first one, but sometimes I get different answers to it so I will ask anyway. So what does integrated care mean to you?

Phar 2
So, its working as a team a multi-disciplinary team bringing different perspectives of care together to deliver centrally I guess for one patient. So its trying to draw on skills from each other based on your specialty.

And who do you think is part of the integrated care team?

Phar 2
So, at the centre of the team is the patient because they are who we are providing the care for. The GP or it could be a specialist even, so thinking outside of this project a little bit you do sometimes need to liaise with secondary care, the GP, a nurse that may see the patient regularly. The community pharmacy, the social work team, carers, family. So I would say that’s part of the integrated ….

And what do you think all the different roles, what do they do?

Phar 2
So, say for example a nurse might review more of the end of bed type of situations, the care, the more intense care of patient, when they see them in practice, detailed reviews. A GP will probably deal with acute or chronic health needs. Social teams and social aspects of keeping people at home and providing support for them to stay well at home. Families obviously are integral, families/carers to keep the continuity of providing all of that care. So there are some examples, does that answer your question?

Yes it does. And who do you think should be part of the integrated care team, this question is about saying whether there are any professionals that you think should be part of the team?

Phar 2
So, I think one of the experiences that I have come across is the community pharmacies I would say are involved because people like myself in that role would reach out to them. But I think its in slight isolation, so it would be in an acute situation where you need their support. But it actually may be helpful particularly depending on your environment of your practice, the patient population, if actually they were a little bit more integrated. So maybe if you say for example in this area you have got for K (sub locality where hub situated) patients you have got a small handful of pharmacies that deal with them. it actually might be useful to get their regular pharmacist to come along. Because although someone like me might reach out to them with a query they may not necessarily know I
am on the radar looking at that patient before I start. So there could be things that get missed or that they know
about the patient that nobody else does. So that would be possibly one gap I would say.

And what do you think having integrated care pharmacist means to a patient?

Phar 2
I think they don't realise the value until they have experienced it definitely because they have not come across the
concept. I think a lot of the medication related queries some of the smaller things that are smaller to start off with
but grow, I think they get addressed earlier for patients. So some of the feedback I've had is there is not always
someone to listen to some of these aspects or issues that they are having and they are not necessarily what they
perceive to be big enough to make a GP appointment. Sometimes they community pharmacist is not empowered
even easy to say and its those
types of support that I think its the small things that add up to support a patient. And actually timings and reducing
medication they don't need because patients don't always realise that things can stop, that they might need to stop.
A lot of people have this perception that cumulating results in better outcome and that's not necessarily true.

Researcher PN
And what should integrated care pharmacist do for a patient and how should they work?

Phar 2
I think its definitely engaging the patient into reviewing the medication more detailed. So its prompting some of the
questions for them to ask themselves, has this helped, is this still useful, I think that's a big part of what the
integrated care pharmacist should be doing, engaging the patient in that journey in a more detailed fashion. And
supporting some of that understanding with access to records. So that's where I kind of see a lot of their role and
rationalising on behalf of the patient, actually pulling all the bits of care together and do they still need to be on
this. And then advocating for that, the medication aspect particularly because that's our area of expertise within
the multi disciplinary environment.

Researcher PN
And I think you have touched on this, so you mentioned advantages are there any other advantages you
want to add for the patients having a pharmacist?

Phar 2
I think its good in the confidence in knowing that somebody is there to maybe review regularly, give a bit more time.
So I think that's one of the advantages of having an integrated care pharmacist rather than just a pharmacist is
actually that they are able to advocate those things back.

Any others?

Phar 2
There are lots, I am just drawing a bit of a blank, I might come back to it at the end if that's OK.

Researcher PN
Can you think of any disadvantages?

Phar 2
Of having integrated care pharmacist, now there is not enough. So, it's not a fair service because not everybody
has access, that's definitely a disadvantage.

Researcher PN
For this pilot do you mean?

Phar 2
Yes, and also to some degree when you have a pharmacist looking at it I do sometimes wonder does it reduce the
doctor looking at the medicines. If a pharmacist did engage on the medication part does it limit what the GP is
asking because they feel like somebody has already looked at it. So that I guess could be a slight disadvantage
but not a strong one I have come across.

Researcher PN
And what do you think an integrated care pharmacist offers to other members of the team?

Phar 2
I think it highlights the impact of medication. And actually, the complexity for patients in managing their own
medicines. I think that awareness is raised. It's a resource, they get asked a lot of questions from other members
of the team that wouldn't necessarily normally put that question forward. So for example the clinical nurse might
raise things that they maybe wouldn't have necessarily mentioned and particularly the social care team. So that
duplicate of opioids or things that the patient has said about medicines that they take but nobody, that they buy themselves so the GP wouldn't necessarily know. That definitely come out a lot more.

Researcher PN
Anything else?

Phar 2
In terms of benefits to other members?

Researcher PN
Yes.

Phar 2
The community pharmacists are able to bridge links with data, often more social support for medication taking. I think the biggest thing is reducing medicines that are not necessarily the high risk ones where patients don't necessarily need to be taking things any more.

Researcher PN
And can you think of any barriers or facilitators to the work of the integrated care pharmacist?

Phar 2
One I would say is resource, the geographical distance of patients can be a bit of a barrier because it can take time to get out and see them. Also the age of the patient group means that your whole day, you are not able to see people from 9 to 5. A lot of patients in this pilot they won't necessarily be up and mobile and ready to talk to you at 9 o'clock. So that's a bit of a barrier. Do you mean things that are missing?

Researcher PN
Yes, things that could make the role easier, access to notes?

Phar 2
Yes, that's exactly what I was saying, access to a patient record remotely. I think that would really, so some practices did agree but some did not. And then that makes it very difficult because you waste a lot of time not being able to see the notes before you go. And then typing them straight up as soon as you get back or reviewing them while you are out and about. And actually being able to resolve some of the queries as they arise. So that's definitely one that would help.

Researcher PN
You have mentioned reviewing the notes, so how about the pathway - where the pharmacist is placed would that facilitate it as well?

Phar 2
Yes, so I think it definitely needs to be seen before they see the patient rather than after. The other thing is who you feed back to, so some practices have one GP who you liaise with and you speak to about all the patients. Others it will be like a group environment which is much harder because there has to be somebody allocated to take responsibility for the recommendations or the actions that need to come of that meeting. Sometimes that's quite difficult to chair because there is GP sitting equivalently around a table so its hard to select if they don't volunteer who is going to do it. So I find it much easier when there is one nominated GP, who you have a set time and you see them and they follow up and you can discuss the patient directly. Rather than a group in that MDT where there might be other things they are discussing at the same time. So your slot is a little bit less dedicated if that makes sense.

Researcher PN
It does a bit but to clarify are you suggesting an MDT as well as a “one to one?”

Phar 2
No so basically a structured MDT where you have got an essential carer and you have got a band 7 and a doctor. A dedicated MDT is much better versus where a meeting where they will be talking gold standards or palliative care patients and they bring everything that needs a clinical input.

Researcher PN
Anything else?

Phar 2
I think one of the other things, I think it is the patient selection so although the at risk stratification tool is useful, patients are sometimes missed or displaced by the priority of the risk factor. So some GPs are very proactive to referring and others don't they let you just work through the list. But they may actually have a patient who may
benefit that they haven't been quite as good at identifying as say we would if we are more involved at an earlier stage.

Researcher PN
And how do you think the role should be evaluated?

Phar 2
I think feedback from patients is definitely a big one, it would be interesting to review the changes and what happens to those changes that are made that are actioned by pharmacists. I think feedback is the biggest thing, that’s all I can think of.

Researcher PN
And how do you think the role could be developed?

Phar 2
I think some of it is that it might be useful to have drop in opportunities for patients to self refer to you. Because a patient who has not necessarily got a social worker and not necessarily at high risk may still be struggling with their medicines and it may not be on anyone’s radar. So it would be a good access point for the pharmacist to then integrated care for that patient. Because at the moment the driver is the social care team identify the patients but actually if you flip it and let patients self refer in and then a pharmacist decides whether they could benefit. But that doesn’t happen now so that’s one possibility.

Researcher PN
You mentioned about the nurses in the MDT please can you elaborate?

Phar 2
Community nurse is the other one, and if that could be another way to develop. Its actually invite them into the MDT and start to see what they toss out. And they could refer patients in.

Researcher PN
That was the last of my questions, do you have any other comments?

Phar 2
Overall I found it a very beneficial project. I sometimes do think for the patients who you don't visit they don't necessarily realise the benefits of what you have reviewed. Because sometimes its not massive changes to their medication but just generally the overall check. So they don't always recognise the full value if you don't, if you haven't spoken to them in great detail. So that's one of the things that, I think the value of the project is very very good and a lot is achieved from that detailed review that is useful.

Researcher PN
One thing I wanted to talk about is training.

Phar 2
Yes, one hundred percent, particularly for carers, and carers not just being formal carers where there is a care service but actually carers as in family that are caring as well. Training definitely for them and realising what resources are available to them and what the medicines are for. It does happen but actually you know how the patients have these dementia cafes and things like this, carers don't have that support for medicines. They can go in for a MUR but do they know the resources available to them. And actually its some of the social elements so a lot of the discussions sometimes I have is I can do a chart for a patient or I can help them set up a routine but that’s on an individual level. but its actually giving people ideas to take away that suit themselves. So like packing their medicines down into dossette boxes and understanding their own, so they understand what things are for and why they are taking them. There could be a bit better support for the carers to understand how to collate all the medicines together. So yes I think the training there and prescription teams as well. Because when you do the integrated care role a lot of it is sometimes bringing things into line, training for, just community pharmacies realising when you say are saying there is waste I don't sometimes think they realise the value of that waste and impact of delivering patients in and out of care. So I think there are definitely big training gaps.

Researcher PN
Any other comments?

Phar 2
No I think that’s it for me.

Researcher PN
Thank you
INTERVIEW FINISHES

Figure I.6: Illustration of coding for integrated care Pharmacist 2 interview
Interview with Patient 1 (Patient 1)

Venue: Patients home Date: April 2016

Present: Patient 1 (Patient 1) and Wife and main researcher Phyllis Navti (Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. I am Phyllis Navti and I am a researcher. The interview will take about 30 to 45 minutes. Could I start by collecting the signed consent form the coordinator gave you to read sign please?

Patient 1
Yes

Researcher PN
What does IC mean to you?

Patient 1
(looked unsure so prompted) To me, being looked after by my doctor and also the pharmacist …

Researcher PN
How about the social care coordinator – G in your case?

Patient 1
Yes of course G (IC coordinator) and also my wife- she looks after me, she is my main carer, she really looks after me as my main carer

Researcher PN
Yes of course, any one else?

Patient 1
The hospital as well

Researcher PN
So to follow on – you have said to you IC care is care provided to you by your doctor, pharmacist, your wife, the social care coordinator and the hospital - is there any one else?

Patient 1
No not really- I cant think of anyone else (asks wife- can you?- wife says no)- I mean they are the main people of IC I think so

Researcher PN
How about a community pharmacist who supplies your meds- do they make up part of your care team?

Patient 1
The pharmacist?

Researcher PN
Yes the chemist

Patient 1
Oh sorry yes the chemist- they do look after me because ocassionally I forget to put something down and I go over there and they'll help me out
Researcher PN
And how about your dentist?
Pt Yes Mr Patel is very good - we use the local dentist and he always ask me regarding what medication I am on and if its changed etc. Usually I say no but if it has changed then I will have to say yes it has changed so he will readjust

Researcher PN
Ok that sounds good. Do you think all this people you listed are who should make up the IC team or should anyone else be brought it?

Patient 1
No I cant think of anyone else to be truthful apart from going to private care because if I dint get the answers I wanted I would have to go private

Researcher PN
Do you think the patient makes up part of the IC team?

Patient 1
(laughing) – yes of course I do- I do look after myself. But its not always possible to look after yourself- you do need someone around you – close to you

Researcher PN
Do you feel as part of the IC team that your voice is heard?

Patient 1
Well as a patient, if I want something I will speak up for it

Researcher PN
And you always get?

Patient 1
No I don’t always get it but I will do my best to get it

Researcher PN
What does having an IC pharmacist mean to you as a patient?

Patient 1
I’ve never had it before until recently, but its really good because they keep an eye on what medication you are on because I am a big believer in – if I don’t need medication, I don’t want to take it. But if I do need it I want to take the right medication

Researcher PN
So can you describe to me your encounter with the pharmacist... did they ring you to book an appointment or did they come out and see you.

Patient 1
Oh you mean how I got hold of R.. ( the pharmacist)?

Researcher PN
Yes

Patient 1
Oh through G ( ICC2) – I broke my ankle ten weeks ago and I asked G to speak to someone to put in a bar as I was struggling to get into the bath and the shower. And that’s how it started with Gill (ICC2). We just went on from there didn’t we? She got me a bar put outside
the front door and then she organised for me to be able to use the toilet as I had broken my ankle. That’s how it started with IC2 through the Integrated care.

Researcher PN
And then she looked at your medication and put you in touch with the pharmacist?

Patient 1
No she didn’t look at my medication – the pharmacist phoned me up –and initially I couldn’t add two and two together for a start as I thought “how did they know?” I thought it were my local pharmacist down here. Cos they had been looking after me and checking my medicines, reviews out recently and what I had over the last 12 months. So I thought it was part of that. So until she explained who she was – R (the pharmacist) I thought it was the chemist. Then she told me that G (the coordinator) had spoken to her because I told her that I took a lot of medication. That’s how it started.

Researcher PN
So did you have anyone describe the IC team process to you?

Patient 1
Yes we did have a letter initially explaining before G (IC2) came .. but before she came I wasn’t sure what it was all about...

Researcher PN
It’s about health and social care working together

Patient 1
Yes its good – no I am very pleased that someone is thinking about it because at the end of the day you go to your doctor and they don’t always have time. In fact no time at all – so you need somebody – people like G (IC2) and R (the pharmacist) to move things forward

Researcher PN
Good – you mentioned the community pharmacist had done some reviews already?

Patient 1
Yes in the last 12 months – one of the chemist- the Asian girl I cant think of her name now- she/they started taking asking what I was on because at the top of my prescription it was written due for a review but the doctors never had time for a review. So what she does is at the end of the pharmacy she has a little office. she takes you in – goes over all your medication, the reason you take them and if you are not taking them, she wants to know why

Researcher PN
That good

Patient 1
Yeah and that’s how it started – they’ve been doing it for a little why now have there?: and that’s why I thought it was about that to start off

Researcher PN
So did that confuse you initially?

Patient 1
Yes it did confuse me because I thought it was from our pharmacy- but then she said she worked at K (village surgery) and I could work it out so anyway as it turned out its been good because as I say she looked into what I have been taking and she spoke to Dr S about it and they’ve had a meeting and ehhm im still taking the medication but I am taking less.
Researcher PN
Ok – can you think of what you could improve in the process?

Patient 1
Yes basically - contact her (the IC pharmacist) I can’t contact her – well I can contact her but I have to go through the system of our doctor through reception to ask for her and I might have to go through MH (the branch surgery) because the system they use it could go to any of the receptionist of the three surgeries and somebody in the other branches might not know who she is because she is only based at one. That’s the only downfall I feel - its contacting her directly.
I must admit that I have never asked for her number because you don’t ask for ladies mobile number.

Researcher PN
They do have work mobile numbers …

Patient 1
Oh I see - that is my only negative about it- what she did was very good

Researcher PN
I will feed back that back

Patient 1
Yes please do. She has phoned me 4 times in a month on diff aspects of what tablets I take and that is pleasing for me because someone is looking after me

Researcher PN
That’s good - so do you follow all the advice she gave re your medication?

Patient 1
I follow the advice – yeah yeah but found out that what they asking me to do with this particular one - lansoprazole I had to increase it myself and told my doctor and he said that it was ok and he said that he will look at it and he said it was ok and I have an appointment with him next Tuesday and he will look at it but he said for the time being carry on

Researcher PN
Ok – can I ask – the advice R (IC pharmacist) gave you was it in line with what the advice the community pharmacist gave you?

Patient 1
No not at all - she (IC pharmacist) must have had a list of what I was taking as she knew what I was taking and went through it with me and then when I said to her re what I was taking like the pantoprazole 40 mg morning and 40 mg at night – she thought it was a lot and suggested reducing it.. what was the other one (asking wife?) oh the water tablet.. she said to me come of your water tablet..

Researcher PN
Ok – and you have been off it?

Patient 1
Yes I have been ok off it – it’s the long word one..

Researcher PN
Bendrofluimethiazide?
Patient 1
Yes, that one

Researcher PN
is it nice to be off it?

Patient 1
Yes it is – my wife is on the same one takes for high blood pressure
So I want to ask you – why is only for one person in the family?

Researcher PN
You mean IC?

Patient 1
Yes – why is my wife not part of it?

Researcher PN
That’s a good question – it has to be to with the tool that selects the patients based
on a different parameters that add up eg if you have been admitted into hospital etc

Patient 1
Oh I see I have been in hospital a lot – you see I had an emergency bypass and had been
complaining for years as I had been on the tablets for the generation of that – so I went to
see my consultant and he took me off one of the tablets I had been on for the past 9 years –
ivabradine – angina

Researcher PN
Oh interesting

Patient 1
I had angina before my bypass but after the bypass I have not had sight of it. and I went into
hospital over Christmas and was in over Christmas so it was not very good

Researcher PN
Oh – that is not good

Patient 1
They did an angiogram and my graph was clear but I suffer from hiatus hernia and was on
eh what is it called?

Researcher PN
Isosorbide mononitrate ?

Patient 1
That’s it – I was on 10mg in morning and 10 mg at nigh time but Dr.H(Cardiologist) put be
on 60 mg and got rid of the 10mg because it not only clears angina but helps with hiatus
hernia

Researcher PN
See I didn’t know that …

Patient 1
Yes it does – I was having spasm really bad and it was round the heart area so they gave
me an angiogram and put me on that and I went to see him this week and he took me off
that ivabradine – so I am taking less – another one off
Going back to the question re R (the pharmacist), she went through all the medication I was taking at that particular time and it has been reduced – which is great for me because if I don’t need to, I don’t want to be taking them. If she can tell me and explains enough to say to me – you don’t really need that one” or I need to run it by the doctor then that’s very good and I am prepared to look at it as that’s how I think – people should not be taking tablets they don’t need to be taking.

Can you think of anything else that could help the work of the IC pharmacist? You mentioned a direct line – anything else?

Oh a face would help as I don’t know what she looks like

Yes – never saw her once – I think a face to face would have been more beneficial because you talk to people over the phone you don’t know what – you can’t get you can’t get (was struggling to articulate)

Oh I see – so all your interaction was over the phone?

So how would that work best for you? Her to come out and see you at home? or you going to surgery

I could go – or she could come and it depends on where

We are looking at doing this so IC pharmacist have clinics at Gp practices where they can meet with pts? So patients bring all the medication

Telephone is practical and I guess that’s why it was done

Telephone is practical – I have been in sales so I know. But going to see somebody is no problem but its getting to see them and it can be hard as time is precious. and if phone is only way that that’s ok but I just feel that when you have been talking to them for a while then you should know who you are talking to.
We will take this on board. So my next question: How do you think the role should be evaluated to determine if it improves pt care if it works or not? Any thoughts?

Patient 1
I think we just spoke about it. The pharmacist should be on top of the patient to see and discuss what they are taking because you want to say to them this is what I am taking. I don’t want to make a fuss really but you need to hear my side of it really...

Researcher PN
So speak to the pt

Patient 1
Yes definitely speak to the patient because it’s all about the patient at the end of the day so no matter what medication you are on - it’s about the patient. I know patients can be a pain in the backside but they need to be heard.

Researcher PN
That’s correct because we all are patients or will be

Patient 1
That’s correct – we should all be treated the same – it doesn’t matter what colour you are how much money you have - it doesn’t matter – everyone should be treated the same.

Researcher PN
And the next question: Do you think the role should be kept going in the future?

Patient 1
Too right – definitely – I do – don’t start it then stop because I’ll be the first to complain – I would – you can’t stop it. If it’s beneficial to the patient and it should be continued for all patients no matter their age.
I am a pensioner but there are people younger than me on medication who need the service and should have it. You need a mixture of ages – no point having all old people or you would be there all day.

Researcher PN
Thank you any other comments?

Patient 1
Just to repeat that that service should continue and please ask the pharmacist to call me to discuss my medication.

Researcher PN
I will
Thank you
End

Figure I.7: Illustration of coding for Patient 1 interview
Interview with Patient 2 (Patient 2)

Over the Phone September 2016

Present: Patient 2 (Patient 2) and main researcher Phyllis Navti (Researcher PN)

Researcher PN
Thank you very much for agreeing to this interview. I am Phyllis Navti and I am a researcher. The interview should take about 25 to 45 minutes but we can stop at any time if you wish.

Thank you for completing and posting the consent form the Coordinator gave you back to me. Can I confirm that you are still willing to progress the interview?

Patient 2
Yes duckie

Researcher PN
I will have to speak slowly and loudly because we are on loud speaker. Could I ask you to also speak slowly and loudly please?

Patient 2
Of course

Researcher PN
My first question is - What does receiving integrated care mean to you?

Patient 2
It means many people look after me at the same time – like now I just came out of hospital after I fall over and struggle to walk.

Researcher PN
That’s good. When you say people looking after you, Can I ask which people you mean?

Patient 2
S from social (IC Coordinator 3), my doctor, my nurse and my physio

Researcher PN
Do you think the patient makes up part of the IC team?

Patient 2
Yes yes … and my daughter who looks after me sometimes but she works and has two children so not got much time

Researcher PN
Is there anyone else?

Patient 2
No not really

Researcher PN
How about the pharmacist?

Patient 2
Oh yes my chemist – they send me my medication but I don’t see them much so I am not sure.

Researcher PN

And how about the pharmacist at the GP surgery who discussed your medication with you? This interview is about that service?

Patient 2

Oh yes – of course. Yes yes of course - she was very helpful. She explained my medicine to me and reduced my sleeping tablet and sent me the medication record card.

Researcher PN

Where did you meet her?

Patient 2

At the Gp practice.

Researcher PN

Are you able to describe the meeting to me?

Patient 2

Oh it was S (IC Coordinator 3) who came to see me about the rails and to check my bathroom after I had the first fall. She told me about the pharmacist. She said that the pharmacist had looked at my medicine and had a few questions. She asked if she (the pharmacist) could ring me and discuss. The pharmacist rang me the same day and asked if I could meet her at the practice two days after and bring all my medicine. She said bring everything even the ones I bought from the chemist like my hay fever tablets. I was surprised. At surgery we sat at the desk in the Gp room and she asked me many questions about the medicines and said she had many suggestions that she will discuss with the GP. I can’t remember all but I remember she asked if we could reduce my sleeping tablet the one with the Z. I said yes. She said my antihistamine was expired. Oh and that I was taking double vitamins. I also had three purple inhalers as I always forget to use them at night and she advised about that and asked me to show how I use them. She showed me a different one that I don’t press as I was struggling a bit. She gave me a green bag to use to carry my medication.

Researcher PN

Then what happened after?

Patient 2

She called two days after and send that my GP was happy with the changes she suggested. She said they had sent the new prescription to the chemist.

Researcher PN

What did having the integrated care pharmacist mean to you as a patient?

Patient 2

It is quite good really because I did not know they had them. I only know chemist pharmacist in the shop who send my medicine with the driver. As I said she help reduce my sleeping pills and I feel less tired. She also gave me a medicine reminder chart and helped me write in it. I use it to fill my dossette box myself and my daughter use it to help sometimes. So someone who helped with my medicine. She also was kind and told the chemist driver to wait because some times by the time I get to the door they had gone and I had to keep ringing the chemist as I ran out sometimes.
Researcher PN
Is there anything you think could improve the process?

Patient 2
Yes yes, it is good – but its too many people coming and I feel bewildered. Every day someone else came and I don’t know who which is why I did not open the door when you came last week. One person came and when they heard the dog bark before I opened the door they had left and I had been waiting all day so they could look at the railing. It was not like this last year.

Researcher PN
I will inform the ICC I am so sorry to hear that. Is there anything else to improve?

Patient 2
I have come out of hospital this time with different medicine and would like to meet the pharmacist again but the coordinator said there was no pharmacist and asked that I booked an appointment with the GP. The GP only had five minutes and looked a bit rushed so I did not show him the medicine and ask because he did not ask. I have hay fever but in hospital they said maybe hay fever tablet caused the fall so I stopped tablets but sneezing all the time.

Researcher PN
Do you know you could take it to the community pharmacist?

Patient 2
I did wonder but there is always a queue and they seem busy too

Researcher PN
I think there is a pharmacist we can get to come and look at your medicine. I will organise and S (IC coordinator 3) will confirm the time with you?

Patient 2
Thank you very much

Researcher PN
You are welcome.
Can you think of anything else that could have helped the work of the pharmacist?

Patient 2
It will be good to have a phone number to call and ask questions?

Researcher PN
Yes, we are looking into that because the other patient mentioned as well. Can I ask how to do you think the role should be evaluated?

Patient 2
Sorry I don’t understand.

Patient 2
I am sorry, I mean can you suggest how you think can we could find out if the pharmacist helps patients?
Patient 2
Oh I see- you could call and ask the patients and I think S (IC Coordinator 3)?

Patient 2
Good idea.

Do you think the pharmacist should continue because it was just for a trial period?

Patient 2
Yes yes. And they should have a direct telephone number.

Researcher PN
Thank you. Any other comments?

Patient 2
Also to have less people coming too many this time as I said. Otherwise its a very good service and should continue.

Researcher P
Thank you

Patient 2
Cheers

Figure I.8: Illustration of coding for Patient 2 interview
Focus group  
December 2016  
Two Steeples Surgery Wigston

Participants  
Researcher (Researcher PN)  
General Practitioner 1 (GP1)  
Integrated Care Pharmacist 1 (IC Pharmacist 1)  
Integrated care Pharmacist 2 (IC Pharmacist 1)  
Integrated Care Coordinator 1 (IC coordinator 1)  
Integrated Care Coordinator 2 (IC coordinator 2)  
Integrated Care Coordinator b3 (IC coordinator 3)

Present  
Pharmacist 3 (Phar 3) (note taking and admin support)

Researcher PN  
Thank you very much attending this focus group.  
I will start by collecting the completed consent forms.

Collected – Thank you  
It would be really useful to have a quick introduction of our roles in the integrated care programme because I know you all work in different patches and at different times and might not have met.

I will start – I am Phyllis Navti my role in this is a researcher so I am doing research on behalf of De Montfort University because I teach there one day a week, and also for the CCG because they would like to use the pilot outcome to inform the future.

GP1  
I am SA and I work here in W... and I take part in integrated care MDT as the practice lead and we had K (Pharmacist 2) with us for a little while.

IC Pharmacist 1  
My name is KC I am a pharmacist, I have been involved I think right from the start so I was the integrated care team pharmacist in the original two pilot sites which was S (village) and some north practices, I can’t remember their names. And then we rehashed it and did the second pilot and then rolled out that out further. And then I have also been involved as a hub pharmacist and been an integrated care pharmacist for the practice you were based in.

And currently I am a practice pharmacist in L and again I work as part of the clinical pharmacist in GP practices, I work with AS who is one of the social coordinators who is based in those practices so I have gone right from the very initial start bits to now.

Phar 3  
I am KP. I am a pharmacist at CCG and in a previous role when I was working in west Leicestershire I was involved in a little bit of integrated care work so I am familiar with the process. I am here to provide administrative support to PN (Researcher PN)

IC Coordinator 3
I am SK and I am integrated care coordinator and I am based at HM Surgery and NF surgery. When I first started, a year and a half ago now I think, and so I work quite closely with K on a few patients referring a few patients to her. And I just found the whole process really useful to gain a bit of knowledge about the medication and how to take it. And look at any queries on it as well and reviews were really good so yes very helpful.

IC Coordinator 2
I am GH and I am an integrated care coordinator. I work at KH centre, the two S medical practice and B surgery. I have been in post for just over three years now and it was really good when we had the pharmacy input and then when they left it was a big hole in our role really.

IC Coordinator 1
I am SG the integrated care coordinator covering the OC surgery, C Surgery and R Surgery. I have been involved when R was part of the surgery, she was attached to us and we found that quite useful as well.

Researcher PN
I will now present a summary of all the interviews I did as part of phase 1 and some data from phase 2. Unfortunately although I interviewed a nurse and 2 patients, they are unable to make it here today. Insights from their interviews are included here for discussion. So I will just go through the 8 slides so not so many.

Slide one is the introduction and so going to slide 2 the flow chart which illustrates how the integrated care model works. KP its different for the west I think but this is the ELR CCG which has social carer coordinators unlike the west where coordinators are nurses. So basically the patient records are interrogated by the risk stratification tool and the patients requiring integrated care are identified and the coordinator decides the next step. The next steps include MDTs. The role of the pharmacist within that was that they reviewed IC patients. These were usually patients with a lot of medication requiring pharmacist reviews. Pharmacist reviews were sometimes through home visits and other times over the telephone or at the surgery. The pharmacist would also attend some of MDT meetings to be part of the discussions.

To go through the summary outcome of phase 1 interviews. If you recall I had topic guide. Questions 1 and were about what you think integrated care is and who makes up the IC teams. So almost of everyone responded that doctors, nurses, the pharmacist, some mentioned possibly community pharmacists and some mentioned carers and receptionists as well. One person mentioned that the patient is part of the integrated care team so its where they see the patient in all of that.

The next question I asked was what does integrated care mean to you. Most said it was about health and social working together to ensure joined up services. And the most streamlined patient care. And for a lot of people it meant good relationships with other MDT members, so it was the forum where you could meet other MDT members and just
have more visibility and familiarity. So if you could put a face to a name then it was easier
to pick up the phone and talk to people and that was what it meant to them. And the
social carers felt it gave them, some formalised medication training session and
information tools that were put together and that was useful as well.

One patient however mentioned that for them integrated care was supposed to be
streamlined care but it actually left him confused because it meant that initially after the
discussions he had and he was told people would come and help sort things out for him it
led to more confusion. So he felt that he was bewildered and he was stressed about it and
he was told there would be certain staff members who, health care people, coming to sort
things for him. And he would sit at home all afternoon waiting and some people didn’t
show up when they were supposed to. There was someone who had to come and review
a pile of something for him and they came and found out he had a dog and they refused
to come in and just went away. And he was upset because he had been waiting all day so
he said he had a lot of that and he was completely confused. So that was the one thing I
felt was useful to discuss about that patient but otherwise everything was positive.

What it means for the patient, I have got a few slides of that. I asked what the barriers
were and I think almost everyone said it was limited time because the two pharmacist we
had were shared across most practices and it just didn’t make sense in some cases. So
there were referrals that never happened and there was some planned work that was
pulled because there was no capacity. So that was a huge huge barrier and the suggestion
was it would be better if there were two practices per pharmacist. And IT access was also
an issue because the pharmacist didn’t get the access to social care notes so they were
reliant on social carers to get information. The other thing was some of the pharmacists
weren’t embedded in practice I think there were one or two practices where it was
difficult to book to go and review patients and just be part of the whole process, it just
felt like it was a visitor coming so it didn’t feel right.

The other question was what the disadvantages were, one of the patients felt that
because his consultation was a telephone consultation he didn’t think that was the best
process because he would have like to have seen the pharmacists and put a face to a
name as it were. And he just felt he would have been maybe more open about certain
things if it was face to face. And then he got confused because the community pharmacist
gave them slightly different advice than when they did the medicine use reviews which
community pharmacists do. So there was something about one of the drugs the
community pharmacists said carry on taking and the integrated care pharmacists said
stop. And eventually the GP agreed with the integrated care pharmacists and the
medication was withdrawn but the community pharmacists said something different. So I
think what was suggested was that there should be some further integration so they are
singing off the same page.

Then there was a question about when and where the pharmacist should be involved in
the process. Most responded that the pharmacist should review the patients from the
start as most patients reviewed by pharmacists had relevant interventions. The
suggestion was that the pharmacist should review all patients on the entire leave at
the start, before the coordinators visited the patients.
The district nurse also suggested the pharmacist should attend the board round which they have every morning for the different practices for one hour at the start of the day could just help them prioritise the patient load. It was also suggested that they provide some sort of formalised training of social care coordinators. Many discussed dosette boxes and their advantages and disadvantages e.g. including warfarin and high risk medications. Another theme was the role of community pharmacists. Some suggested that the role should be become part of a clinical pharmacists role in practice as an advanced service where they are embedded as that could be more practical and realistic to do.

The final questions was how to evaluate the role. Everyone mentioned patient satisfaction surveys feedback. Outcomes measured through Key performance indictors was also mentioned. These will be presented as part of phase 2 the quantitative section which includes the savings. But there were some questions around how real they were and if they were actually the best representation of how we should evaluate the role. So the patient feedback from some of the questionnaires was e.g. some of the patients stated “following the pharmacist review and discussions with myself, I no longer need to spend hours sorting out my medication every week” because the pharmacist helped and showed him how to manage medication. Pharmacists provided medication advice and information. Medication was checked because the patient had a chronic condition and they were happy that they had been waiting and then the pharmacist finally checked the medication and that helped. One pharmacist suggested the dosette box and that really helped him manage his medication and he felt more regular advice regarding medication and his condition would be useful. One patient he had problems and the pharmacist helped him with inhaler counselling and how to use and the patient said he could breath better because of the medication support he had and also the recommendation to change the medication. There were several other case studies provided by the integrated care programme lead. Stockpiling and medication waste shown on the picture taken in a patient home by Phar 2 also highlighted the issue. Brought this back from a patient (picture on slide (Figure 4.1)).

IC Pharmacist 2
Yes, it came out of her kitchen cupboard.

IC Social Coordinator 1
Just one patient (looking at picture)?

IC Pharmacist 2
Yes, she had been in and out of hospital quite a few times and every time she came out of hospital they gave her some different stuff. So, it was changed so she didn't want to take that but then she also had trays from hospital that were different to the trays she had previously from her GP so she had stacks of trays as well. Not sure which one she should be taking and then things that had been stopped but carried on being ordered. There were more cupboard with pills in than there were cupboards with food in the kitchen.

IC Coordinator 1
I think that’s the thing you find most when people have gone into hospital they have their medication changed and they come out and they are just confused as to what to take. And they don’t know whether carry on taking the old stuff but keep on ordering it. Especially with warfarin as well because it keeps changing the medication sometimes that’s creating confusion as well.

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IC Pharmacist 2

I think what really doesn't help. I have had a conversation this week with a community pharmacist about the delivery of dosette boxes and I just said can you just clarify for them that this drug has changed and this one has stopped, it’s important they don't take both. And they said no we can't do that, the delivery driver will be taking it, and I thought a delivery meant someone got. Because what is happening is you get someone that is untrained is delivering medication to someone so they never actually speak to somebody that knows something about their medication. So they never have anybody where they can ask a question if they have got queries about anything. And you say have you got anything you are not taking and I can take it back with me and that’s the sort of interaction you need. Rather than just have somebody turn up with a tray and just hand over the carrier bag and leave.

Researcher PN

And presumably these would be the patients who need the most input?

IC Pharmacist 2

Yes they need the most input because they are house bound.

Researcher PN

And then another thing which stood out was the medicine reminder chart, which a lot of patients found really useful. So something simple but if they had something with their medication written down and especially the second column what its for and extra instructions so they found it really useful.

IC Pharmacist 1

I am for not pushing people towards having dosette boxes because I prefer people to have some sort of input into what they are taking and why they are taking it. If they can understand that, so if the confusion is just about numbers and remembering to take them and not about the content. So, if you have got a dementia patient and you have just got to work through then that is fair enough. But if you have got patients that have just been given their medication while they have been in hospital and they just got used to not taking it themselves because they have been given it you have just got to re-educate them to be able to do that.
IC Coordinator 2

At least they can look at it and read it and yes. They try to describe the colour and that could get confusing because they can change. And I guess some of the chemists will still have that way blue or red.

IC Pharmacist 1

No because it can be different each time can’t it.

Researcher PN

The quantitative data was not the favourite task for the pharmacists hated doing the data collection. However there were huge savings of about 193,000 annualised. The key assumption for the calculations was that one in every ten review would prevent an admission for high risk patients or for patients who are medium to high risk. So for every tenth patient we got a figure for the cost of a hospital admission an average from our contracts person and then came up with that figure. And it went to the CCG contract people and they agreed that was a fair assumption. So, we thought it was really good value for money.

GP1

The problem with that is it doesn't include the things you can't quantify. So for instance if R (IC Pharmacist 2) educated me about something to do with the drugs and then I stopped making that mistake and therefore you have the ongoing savings of all the other patients. So there is the other things that backfire off it that you can't quantify. So, its probably more than that actually isn't it. Because if you came to me and said actually you are doing this with this patient and I think I am doing that with all my patients I will then change what I am doing with all my CPD patients and actually it has a domino effect doesn’t it.

IC Coordinator 2

Yes because I found doing the project i learned about falls risk I can say before I joined the project I didn’t know anything about it and I think a lot of GPs I came across the patch they have heard of it but not actively stopping things because they didn't necessarily know how. And when you add it all up and show someone a particularly at risk patient I think people become a little bit more aware. And being in K (GP surgery) now I can see GPs who are leading on that risk there she is a lot more proactive at reviewing medication with the falls risk. And things like that you wouldn't be able to quantify.

GP1

But you have got your cohort of 5 GPs at K that now are aware of it and its not just integrated care patients is it its all the other ones on the periphery.

IC 1

And also with the patients what we found was they weren’t taking them at the time prescribed or the timing of certain medication they weren’t quite sure. And it was helpful to get some input from the pharmacist explaining to them its important you take them before or after food. Alendronic acid for example it has to be taken first thing in the morning you
have to sit for half an hour and not do anything. And things like that, you have to take
hours before ..

I think also you can reassure people about what is important. Some of the things that are
written aren’t as they are written so I had one this week where someone was getting up and
the first thing she was doing was taking one of her medication because ‘I have got to take it
two hours before I take my iron” she said. And I said it needs to be apart from the iron but
you don’t have to get up especially to take it, you can take it at lunch time, the iron you can
take at lunch time and the you take in the morning as you always have. Well I thought it
needed to be exactly two hours, no it just needs to be at least two hours. So its just the way
you phrase things and it was never actually communicated to somebody by mouth then
they just read what’s on the label and take it exactly as it said.

GP1
And that’s not a question in a consultation that I would ever ask, it would just never come
in to it because I would never dream of asking that question.

Researcher PN
Yes if you have just got five minutes, that is the other thing as well which came up, GPs just
don’t have time to get into that level of depth about, so the pharmacist could spend a little
bit more time. I think actually that brings us to a discussion about cost savings because as
part of the, when we did the other pilot we also had to guestimate the savings of what the
pharmacist did. Some of the GPs were saying the other thing, because we had a KPI for GP
time saved and they felt that by having a pharmacist highlighting issues or scrutinizing
things that would improve patient care it was costing the GP more time.

GP1
Its an interesting thought process isn’t it. I guess its pros and cons isn’t it, so yes I would
have to take five or ten minutes out to speak to the pharmacist but if its stopping someone
from having a CPD exacerbation that I need to go and do a home visit for and that’s going to
take me 45 minutes. So its quid pro quo. I certainly with my experience was not aware that
it created any more level of work. Yes you had to have the discussion and change some
notes a bit and do some other things but I can’t think of an examples where I thought it
made my life that much more difficult.

IC Pharmacist 2
And I think maybe those comments come from the GPs that weren’t involved in it not the
ones that were. Certainly when, I am not allowed to name names am I, that’s where it came
up, it was that well if you are going to bring up something that I have got to do something
about you are supposed to be saving time and you are not. But on the other hand how I am
doing it now at the practice I am at, I am given more autonomy to be able to do that myself.
So I have got something based on evidence and questions I have had about previous
patients then I know that I can carry that forward to another patient. So I only have to ask
the question once whereas if you are there as an outsider and going in then you have to ask
that question every time, its a different patient and its a different doctor. If you are working
in the same practice then you know what your limitations are but you also know what you
would be allowed to change or implement based on previous decisions.
I also found it much better working with yourself was much more fluid than some of the
other areas I was covering, and its no criticism of individual GPs at all its just the process. So
some places, and I am sure you guys found this, some of your meetings you go and
everyone is sitting there and you have got gold standards and everything being discussed
and all of the primary care issues they can bring into one meeting, because everyone is
together which is great in collaborative working. But when we were working, you could give
me things back and I could go away and I would know exactly what you had said to me
about that ...

**GP1**

So we had a dedicated session with myself, district nurses, yourself and M (IC social
coordinator) and there was just us. So actually getting the job done.

There was a bit more lean in terms of time saved, whereas when you are tasking somebody
that you don't know that well you can sometimes be tasking back and forth because you
don't understand each other’s skill set or areas of expertise or understanding the project. So
I think that partly contributes to it.

It’s a tricky one isn’t it because I don’t see why you would give it any different than say an
outpatient consultant review of a patient and they decided they needed to change their
medication and therefore I had to update their records. It’s not any different is it.

**IC Pharmacist 2**

But you have a very open approach.

**GP1**

But they would say it’s my role as GP to, my patients in out patients they do all these
investigations make a conclusion and then I have to change the notes, update the notes and
implement it. It’s no different, all it is is that the pharmacist is going to the house speaking
to them looking at their meds coming back and saying this is what I advise, update the
notes. It’s not any different.

**IC Pharmacist 1**

I think it’s just alien.

**GP1**

I think it’s the concept to it, GPs at the moment are very protective because they feel over
burdened, which we are over burdened but I am not sure its the right battle to pick. I think if
you view it as a new process but actually if this is the same as any other patient journey
when you go through areas of expertise and actually they all feed back to the GP as the
collator, it’s not any different is it?

No. I think it’s also there is not a wide awareness of what a pharmacist’s skill set is, I think I
have mentioned this to you before, I think the pilot has really helped with that. Because I
think the GPs that were involved in the pilot got more of an understanding. Because we
don't really collaboratively work together at undergrad, you don’t actually know what a
pharmacist is going to know or not going to know. Before I qualified or even came into
primary care I can’t say that I did either to be honest this was completely unknown to me.
So I think that’s another thing of why GPs presume it to be more time, like they used to give
me things back to then find out, can you find out this, and there was a lot more that I could
do.

**Researcher PN**

It must be true for other people as well, S( IC Social Coordinator 2) and S( IC social
Coordinator 1) I don’t know what your thoughts were, what you thought the pharmacist did
before?

**IC Coordinator 2**

I think when I came in you were doing the pilot and I was like oh do we need a pharmacist,
is that something just a bit extra. And then you actually get to work you realise. Because we
are not trained so sometimes a patient will say something and you think oh I am not sure
about that. So just the fact that you know you have got somebody you can go to and ask the
questions.

**IC Pharmacist 1**

I think that’s the only down side of being in a practice now and not having, being able to
work in the same office like we used to. So not often but we would be all together
sometimes or you would be with some coordinators and like P for example was always
asking questions, always asking me questions about everything and she is not able to do
that now. I have always said she can ring me anytime but she hasn’t because you don’t feel
if you are not part of the team any more you can do that. And equally A doesn’t phone me
even though I work with him on the patients he refers, I think he rings me if he has any
queries about medication. So you have lost that part of it. So I think it was nice to be part of
a team in that you were the go to person for people who had queries, whether that is from
the patients or just for your own knowledge. But is it better to be within a practice in terms
of working with the GPs.

The good thing about working in the same office is that you can triage things away from the
GP as well so we could ? things and resolve them amongst ourselves so quite often they
didn’t even hit the practice. Especially if it was a link between say community pharmacy or
there was a lack of understanding. Like some of the ones we sent you recently it was more
the patients understanding that needs to be reiterated. Because I have contacted a few and
its actually that they have not understood what the doctor has already told them so its that
re information. Whereas a GP didn’t necessarily need to be the person to do that and when
you haven’t got that close working relationship that is probably not happening and it does
go to the GP which in some ways it possibly didn’t need to. So its kind of triaging them away.

**GP1**

And that’s another way to sell it to the GP isn’t it, that actually there is someone else that
can answer those questions about medications that I either can’t or don’t want to.

**IC Pharmacist 1**

I am .. those in practice.
Yes I am as well.

Every single query, I don’t think the GPs have had a query since I have been there.

And actually those queries do take a lot of time, they are a significant impact. So that is always a plus point.

Are you going into peoples homes still?

No I don’t think that would be cost effective.

It takes a lot of time.

Because of the time it takes you?

Yes, you can’t really, I used to find that you can’t see anybody before ten because they are quite often not up and around and its quite difficult to interrupt in the day. But on the flip side what I am hoping to do is call some of these people in to me, get them to bring everything in.

As in have a clinic in the practice?

Yes that’s what I would like to do moving forward, rather than, home visits will, I think the GPs will support it if you are really actually preventing a strong GP appointment. But if you are going to go in and see them and then they are still going to need to see a GP and then you have spent an hour out of the practice doing that home visit then they are probably not going to want to, its the cost balance. But if I can get people to come in and see me I was thinking about trying to do some drop in, bring your bag.

But that’s also where you guys would play a role, so actually you may see someone and go “actually I think a home visit in this instance is going to make a difference” On an ad hoc basis it probably is cost effective. Or if you catch a glimpse of the fact that under the sofa there is 72 inhalers then actually it might be sensible that you go because that in itself with save the NHS thousands.
And you have had those kind of scenarios happening already, it's been useful. And the other thing that was useful is you sit down with the patient list and you go through all the medication and their history before you actually do the visit. And that can be quite revealing in terms of you are mindful about looking out for whether they are taking this medication or not, what kind of side effects they may have had. And that was really really useful I think having some background information before you go sometimes.

**GP1**

Is that what your GPs do? Do they go through all the patient medication, do they give you a heads up before you go?

**IC Coordinator 1**

Not the GP.

**GP1**

It was you doing it?

**IC Pharmacist 2**

It depended on how much time, if I had time before I would try.

**GP1**

You would have a quick whiz through.

**IC Pharmacist 2**

I would do a review before Shabnam would go out and then I would say alright they have not ordered their? can you check what is happening. And it saved me a bit of time but also gave a bit more information.

**GP1**

I am not doing that.

**Researcher PN**

So it seems a pre-meeting before pharmacist medication review with patient would be a good one to take forward as a recommendation /alteration of the pathway? What do you all think?

**All**:

Yeah/yes-Nodding

Just thinking about the point you made about the location, so where is the best place then for the pharmacist to be sat or could they do what the district nurse said about attending the board round. Because are you at the board round when the district nurses do them?

**IC Coordinator 1**

No I have not heard of this.

**IC Coordinator 2**
I have heard of board rounds but I don’t know that the district nurses do them.

I went to an office of Warren Parkway and she mentioned and she said coordinators come there and they have the board rounds in the morning.

**GP1**

But the board round would be a different collection of patients than the integrated care wouldn’t it?

**IC coordinator 2**

Yes. So its not relevant is it. That would be an absolute waste of your time.

**Phar 2**

I think it is hard, maybe not the board round, I think the MDTs work quite well. And we did a pilot of me being on, because its a different site to me and the problem is Harborough site is about 15 to 20 minutes which I know doesn’t sound much but when you are trying to do all the letters and everything else the commute time, because I am not over at Harborough on the day of the MDT so we did it by phone, I thought it worked quite well.

**IC coordinator C2**

I think Skype next time.

**Phar 2**

MDT attendance? I actually found it better from that point of view because I could log on. Whereas sometimes when I am sat with a GP because I don’t have a laptop any more I couldn’t progress other work while they are looking at the bits they are interested in if that makes sense. Its quite frustrating because we do the MDT on the big screen and so the coordinator does the clicking backwards and forwards and then clicking all over the place and all sorts of things are flying around. And I have not said what I want to say.

You doing your assessments at the same time as looking at, because as you were talking I was like what else might you have said in your assessment, because your assessment is very detailed. So I could look through because I was looking through at anything else that you might have mentioned that I could pick out because obviously I have not see the patients. So I did find that quite challenging

**Researcher PN**

So always have access via a laptop then?

**Phar 2**

Yes.

I think its better to be in a practice though.

**GP1**

Most computers have got two screens haven’t they now.
I am on Misweb and on misweb you can so you can have one window on the meds while we are flicking through.

In the practices is the right place because then you are searching out the patients but I think outside is more challenging. have you got any practice pharmacists?

IC coordinator 2
I have got one in Hazel Mere but he sits across from me so I can ask him questions about things. But no I don't know if there is plans, it feels like the role is still developing, we are just starting to get a clinic so he has got a clinic there as well. So it might be worth suggesting.

Because the Hazel Mere pharmacist how many days is he?

IC coordinator 2
I am not sure, is it four days.
He is not full time but he does every afternoon.

GP1
Is he practice based?

IC Coordinator 2
Yes he is practice based.

Researcher PN
How senior is he because we are finding it makes a difference ?

Phar 1
He is either an independent prescriber or he is doing the independent prescriber course now and his background is primarily community. He is focusing on repeat prescriptions I think he is going be handling the repeats, I think he is doing his independent prescribing it in hyper tension.

Scheduling clinics moving forward must be done as now you get to the end of the day and think I haven't started what I want, I really want to look at this now. And you can see all the things that are not quite right within a practice in terms of repeat prescriptions and medication reviews and all the things that you want to be able to look at in clinics. But you are sort of peddling to keep up with the everything.GP land is like that in general isn’t it. You just seem to be peddling to keep up with the people that need to be seen now.

GP1
There is a bit of a false economy to them so like today I have done all the essential jobs but none of the jobs that make a big difference.

Phar 2
That’s how it feels isn’t it. But all my tasks were urgent and that’s why I was late because it all said urgent today and I was like, can I leave it until tomorrow yes great. But I didn't finish
anything else except for urgent tasks and letters. So it is difficult because you know the stuff
that you want to do and like you say is going to make a difference in terms of medication
review of, but when it comes to ?? and you know why is he taking that and I want to do
something about this one. But you don’t have time to do it when you see it, because you
have to just get the repeat put through because its been ordered and they need it by Friday.
So you do that so you haven’t got time to look at the things you want to look at.

GP1

Our pharmacist isn’t doing anything like that.

Phar 2

I am not doing the repeats either I have not been authorised, the doctors look at it. But I do
do all the letters.

GP1

At the moment our pharmacist isn’t doing either of those things she is mostly doing audits

IC Pharmacist 2

is it K (Gp practice pharmacist ) ?

GP1

No L ( another GP practice pharmacist ) , but again there are other things that she keeps
saying I can get my teeth into it. We are trying as a practice not, because there are a lot of
roles that I do as a GP that you could also do but whether you should be doing them is
debatable. Its who is the best person, because if I overwhelm you with the jobs that I don’t
want to do or you can do which we both can do, you are not going to get the other jobs
done that only you can do. And actually maybe I just need to do more of those jobs that we
can both do, its a balancing act isn’t it. So at the moment we are doing all the med reviews,
the consultation from the letters all those sort of things but its tricky it is tricky. But there is
a temptation to shove it off.

IC Pharmacist 2

I can see that, I can see by doing, by making those processes better then there will be time
to do the other stuff but you can see the holes in it and what needs to be sorted out.,

GP1

About 18 months ago we completely revamped our med review and it took so much time, I
thought I was going to lose the will to live because it was taking so much time. But now we
are coming through 12 months later and its so much easier because they are all linked to
the drugs they have all been done before they have all been stopped, everyone has had a
conversation with the GP its much better.

IC Pharmacist 2

That’s what I am going to try and do.
But it took an awful lot of effort to do that. But it’s about getting the right person to do the right job. So again with integrated care there are jobs that we can both do but there are jobs that either you can do better or only you can do and that’s probably what you need protecting to do in an ideal world.

So the next slide, so this was like a breakdown of the numbers of patient for whom the pharmacists completed clinical medication reviews. It was 238 patient reviews and it was interesting to see the recommendations or the numbers around that. So 56 patients out of that were reviewed through phone calls and 20 were visited at home. R (Phar 2) explained to us earlier about how long visits take. The remainder of them were done remotely from the practice by accessing the patient medical records. For 209 of the 238 patients reviewed there were suggestions/interventions made. For these 209 patients, the actual number of interventions made was 708. The GP/MDT agreed with all but 34 of the recommendations for changes. It is highlighted in red because I would like for us to discuss the reasons for those recommendations that did not get the GP/MDT approval to learn from them.

GP1
So these are the ones that the pharmacist has suggested and the MDT said no?

Researcher PN
Yes so off the top of your head what sort of recommendations would you say no to

GP1
It’s quite a lot, it’s about 5 percent isn’t it.

IC Pharmacist 2
They might have been if they are slightly more complex out of our clinical area of expertise. Because sometimes I think, I can’t remember I will be honest, but the type of example I would suspect if we have said let’s try and get this patient off a Z drug and they have said actually there is a lot more going on socially and what else is happening in their life or something that the GP will know from knowing that patient. I don’t remember having any where that they said what the hell is this suggestion, not really.

GP1
It’s usually about background that they are not aware of.

Actually we tried all these things before and this is the only thing that works.

IC Pharmacist 2
from looking through the notes it’s never always written exactly why they have made a decision but when it’s explained to you you think oh yes right fair enough. So I think that was

IC Pharmacist 1
Or if there is something specific as a practice that, say for example you said oh like when we were working in L there are some things that the doctors have got more experience, so I know I hear GPs say all the time I don’t really like G too many side effects I know this person is going to come back to me. So I know the guidelines will say try A and G before you go to P
but they may base something on their actual experience. So you might say try a lower dose
and that's when they come back and said actually our experience with our patient group is
not that so we tend to go with this first of all. So I think its more those sorts of things.

GP1
Its maybe the word disagreed that sounds strong
maybe use turned down or declined.

Researcher PN
Good point.
And then there was the medicines reconciliation of discharge medication and the
recommended changes for these?

IC Pharmacist 1
Sorry just to add to the disagreed, the other thing I can't remember is whether any of that is
patient choice. Because sometimes we made recommendations, you would meet the
patient you would get a feel for them you look at their drugs and then you might say oh you
could really do with calcium supplement and then they go oh I don't want another pill. So
they make an educated choice or a Statin and you say shall we try an alternative Statin and
they say no I just don't want to. I do remember a lady saying I am not willing to compromise
my quality of life so I understand what you are saying but I don't want to try and alternative
Statin. So it could have been patient choice as well.

Researcher PN
An experience from social care, any recommendation that maybe the pharmacist made that
was disagreed by ...

IC Coordinator 1
I am sure there has been but I can't actually remember. I think things like the diet
supplement drinks those are the kind of things that spring to mind they have been
recommended but then the patient has said no I don't want them. But there probably has
been other things but I can't remember.

Another one is just a recent thing, it wasn’t when the pharmacist was working with us but
somebody struggling to swallow the tablets, when discussing liquid paracetamol it was
declined due to cost. Which was a bit of a shame really.

Researcher PN
So what did the patient end up having?

IC Coordinator 1
Well it was suggested that they break the tablets in half or crush the paracetamol. But this
was quite an advanced dementia patient, its a shame.
I suppose from a CCG point of view you get the cost savings but then there is a role for soluble paracetamol, it wouldn't be unreasonable. It was just a recent one really.

GP1
That would depend on who you spoke to, I would probably come back another day and speak to someone else to be honest. That is not a black or white one.

IC Coordinator 1
Its expensive soluble particularly.

GP1
In the grand scheme of things its not hugely expensive is it.

IC Coordinator 1
I had another experience where one of my patients had problems swallowing and went into hospital and came out and they had put him on all liquid medication and there wasn’t a problem with it.

IC Pharmacist 1
Oh I am a meany because I try and switch them all where possible because some of them are really expensive.

GP1
So actually our pharmacist saved loads of money recently, because I had this patient who is lactose intolerant and she said I can't take them. And I was looking at the price of the liquid and its like insane, its £350 a month and I was like this is stupid. Anyway she managed to find these lactose free tablets for £15 a month, brilliant. But I wouldn't have known that and actually I would have had my hands tied a little bit but I would have had no one to go to to ask. And I probably eventually would have been bullied into prescribing it because I would have had no other suggestion. And it was brilliant and I was like I know who to ask, it was brilliant, she came back the next day, and said this is how you prescribe it.

IC Pharmacist 1
I do get the weirdest tasks now, exactly like that.

IC Pharmacist 2
Yes I have had a few like that as well.

GP1
The other way of looking at those statistics is if you want to sell it to the GP is actually you have got 710 suggestions, 30 of which were questionable or disagreed so you have got 670 decisions that actually we agree are better for the patient care. So there is that many incidences of patients getting less than best care actually that we as GPs haven't spotted. Because we haven't changed it so the presumption is we don't know about it and we are not
going to do anything about it. So it’s that’s selling, well hold on a minute there are 670 odd episodes of care that is not as good as it could be and actually we have reduced it.

RESEARCHER PN

I think for certainly that is the good news one, I think because its a research thing the recommendation, although there is something we need to get out of this, certainly that is the reason the CCG felt yes this is positive this is really really good. And no one actually besides my supervisor no one at the CCG has asked me about that 34 to say why is it not, its like you say said its higher percentages.

And the next slide is this one, which delves into specific areas where most interventions were suggested. These were blood pressure out of range, blood test over due, unnecessary medication stopped.

GP1

Its a lot.

RESEARCHER N

Yes its a lot. My supervisor and I looked at anti psychotics in dementia and there was no recommendations and we wondered if its because its been a focus for a while and all patients have been picked up and reviewed as part of mandatory audits.

GP1

I can remember you stopping a Z drug for a lady, I remember you ringing her every week every time she reduced the dose and eventually stopped.

IC Pharmacist 2

I have to say having done the PINCER I can’t remember if it was captured or not, the benzodiazepines most practices I came across had done a lot of work.

GP1

We have done a lot of work on it.

Anti-psychotics came up a couple of years ago.

It was reviewed because there were quite a lot in nursing homes who were taking it.

IC Pharmacist 2

The majority of my reviews were in particular practices the ones that engaged the most and they had already done a lot of work on Benzo so it wasn’t that I never came across patients on Benzos it was that they had really already really worked at it to try and stop. And if they were still on it it was because they really really couldn’t.

GP1

And you weren’t going to make the suggestion.

IC Pharmacist 2

Exactly. And anti psychotics wise having done Pincer as well the main thing with anti psychotics I think for the Pincer study, I don’t know how many people know we did a review
of anti psychotics in patients who have got, I can't remember what the coding was, they
hadn't had a psychotic episode I think or they were not coded as psychosis and then they
are at risk of dementia. They are recommended usually by a specialist so there are very few
situations where they have been started by GPs and continued without any specialist input.
And so I think that’s where I can say I would have been apprehensive to stop them. And
that’s an area where this project possibly could grow a little bit more is that bridging with
secondary care. This was very much focusing with the GP but not quite that next step to
actually directly go towards specialist if it's something a specialist, does that make sense? So
I think that’s probably where I wouldn’t have challenged anti psychotic because I still don’t
come across them being used on a long term basis under sole guidance of a GP. They tend
to be under a community mental health team or a specialist.

Occasionally you will pick some up where they have been discharged from secondary care
and its been carried on by the GP but not often. Because then its three monthly you should
review it shouldn’t you.

And there was another one which I sort of thought if you had 54 med stops for elderly
people who would have the risk of osteoporosis. However it did not balance out for the
calcium initiation which was 8? Could you comment?

That’s where a lot of work had been done already and calcium initiated by different
pharmaceutical companies.

GP1

Yes we have had a few of those in.

So that brings us to the queries in the quantitative data.

Shall I go back to this qualitative one and if we could maybe look at the ones around, we
talked about the Dossette box, you know the ones I highlighted about the patient getting
bewildered, the confusion with the community pharmacy and have a discussion about how
to take that one forward as that would help. So I think it was the second one where the
patient felt that integrated care process confused him. Does anyone have any experience on
whether ...

GP1

is this something you had feedback from a patient?

Yes. Its a learning thing again, its a research piece to see if there is any learning from that to
inform.

IC coordinator 1

Is it specific to a pharmacy?

Researcher PN

No in general, integrated care.
IC coordinator 1

In general, when we do go and see patients we come back with a list of referrals we need to do on their behalf, when we do all those referrals those agencies are going to contact that patient. And I suppose if they call, come around at similar times it can sometimes become overwhelming for them. So for example somebody who has been referred to deaf and hard of hearing services assisted technology, they may have gone to social services, they may have gone to community OT team, dietitians So if they are all trying to contact, and voluntary organisations as well, volunteer driving schemes, it could be that someone is needing some support from other organisations like luncheon clubs. So it could have an effect in terms of if they are not sure why these people are calling us.

We have tried to cut that down because the first contact team that we refer to a lot, what they used to do is we do our referrals and then they would ring up the patient. So now we try to cut that down to say ring us first if you have got queries, don't ring the patient because its the same information again. Because that is the whole idea that its just one point of contact really. And I think we probably do explain to the patients that they are going to get a lot of people but you can't coordinate it all.

GP1

You gave the example that they had a dog and that turned someone away, I am not sure that is a situation that you can necessarily pre-empt. To be fair if I go and do a home visit on someone I don't ask before I go whether they have got a big dog. But I turned up the other day and they had a snake and a Rottweiler out and I said I am not seeing you until you put them away.

IC Pharmacist 1

I check before I go.

GP1

It's probably unrealistic of a patient to expect us to foresee all those scenarios. And actually if you are receiving help in your own home then actually part of that is making your own home safe for people to come in to. So I am not trying to be skeptical but actually there was only one patient that gave that feedback. And I suspect there probably are things to learn about warning patients you might get a few phone calls, trying to limit the amount of phone calls. But there are probably some patients that expect a very high level and you are probably never going to satisfy them completely. And I suspect with there just being the one that might very well be the case that actually they thought there was going to be this all singing all dancing service that comes in very punctually they have got nobody else to look after, and actually it's not that predictable is it.

I think its carers sometimes under stress and suddenly they are getting all these, a classic today I rang some man up about a referral for carers assessment and he said no no oh someone did come yesterday oh I don't know who it was, I haven't got a clue, she asked a lot of questions. But he didn't know her name.

IC coordinator 1
And often what we tend to do with first contact we would tell them to make sure the agencies ring up to stagger them. So its not all of them ringing all around the same time. Because referrals once they have got first contact they will be sent out to all different agencies and they will all want to make contact with the person.

Getting back to the dog, I do tend to put it in my assessment and I will put it on as like an alert.

Yes its a very friendly dog and not threatening in any way, for some people if they are allergic perhaps.

GP1
I can't stand dogs, any dog.

IC Pharmacist 1
I had a dog on my lap, it jumped up and sat there and I was fine with the dog. But I can understand that most people wouldn't be. I was quite happy with its head on my lap and just carried on. It was happier there than it was on the floor trying to get up so that was fine.

Its quite distracting really for both the patient who are concerned about what the dog or cat is doing, or the ferret, I had a ferret that was running round. I didn't know, I didn't ask the appropriate questions, do you have a ferret. But after I said can you lock it away oh OK then and she focused on what we were there to talk about. Otherwise it was just distracting.

GP1
I think on the whole the model of care having you guys as the main port of call should avoid that scenario on the whole because its usually you guys making most of the phone calls, making the referrals, and making the contact with the patient. Because most of the time I don't actually get involved with the patient too much because its discussions. So I think the model of care should on the whole prevent people getting bewildered because you explained everything, you are the port of call, people are coming to you.

I think some of it is linked to the type of person that you are targeting as an integrated care model. You have got to remember, the way I understood when we started the project, these are people that are on that brink of not being seen by loads of people but on that edge of potentially falling into that category. So of course the sudden interest is because they are at risk of lots of things and haven't known how to access services to support them. And so in some ways some of it could be staggered but some of it shouldn't be staggered especially when you come across carers who do a lot of things that actually they are not really equipped to do and need support to do. I think what the team are trying to do is get someone in quickly so I do understand it can be bewildering but actually we are trying to think of the end point for that person is to prevent them going in, prevent something going wrong. And so in some ways you will never fully get rid of it because if that person is quite astute to access services they probably won't be picked up for integrated care in the first place. So they are already removed. So I think it is quite a difficult one and we wouldn't completely eliminate it.
I think maybe is initial expectations, keep telling them this is what happens.

**IC Coordinator 1**

We do inform them, we say that expect a lot of phone calls to come in, the reason is to try and help you out so in the end you will benefit from having all those people coming through. And most of them have been fine.

I think what you said, its a cohort of patients that are unwell that rarely come into the surgery, they are just the ones that sit at home unwell and deteriorate but no one ever sees them to recognise that’s happening. And then the repeats will get carried on and unless they are acutely unwell they don't get seen. Its only the ones that come in and annoy you on a regular basis.

**IC Pharmacist 1**

It's the ones that don't really want to engage with you in the first place and you just have to keep chipping away at them. You can see there is a whole load of things that can go wrong but you just can't go charging in.

**GP1**

Yes that's not unique to elderly poorly people is it, we have got diabetics and asthmatics who refuse to come in to have reviews. And in the end you have to just say you are not having this any more we can't continue to authorise a medication if you are not allowing us to see that you are well or unwell or be assessed. And you do reach a point in the end where you have to say that. And most come in don't they. I was a bit nervous to start with.

**IC Coordinator 3**

Another thing I find quite bizarre is how poorly people understand their asthma, their inhalers, and they say they have not been shown the technique for it or they don't understand which one they are meant to take first or they just rely on the blue one all the time rather than taking the preventative.

**IC Coordinator 1**

Sometimes they wont even take it properly they just, and it will come out, having the technique, training them with the techniques is beneficial. I did send someone along to you.

**IC Pharmacist 1**

I think they probably get taught when the nurse shows it to them when they initially get the prescription and then say come back in a month, generally they don't. And then the next review would be, you can’t put down to recall everybody after a month because you have asked them to come and see how they are getting on because they just wont. So the next review will be when they see the asthma nurse when their 12 month review comes up. But also when I worked in community pharmacy if someone had an inhaler I would ask them is this new to you and then I would show them again. And then I might even show them the next time but that doesn't seem to happen any more. And I think a lot of it, like I said
earlier, its about delivery of prescriptions so you never get an input from the professional to reiterate what someone has said.

GP1

So classic, this is an example just to embarrass myself, my wife is allergic to nuts and she ate a nut so she was having an anaphylactic reaction. So we are both medics we are both doctors should know what we are doing got her epi pen, did we know how to use it?

Absolutely not. And it took us about ten minutes and I was thinking if she dies no one is going to believe me. But actually we are both medics and should know how to use things and are that way inclined and we still couldn’t do it. So actually sometimes we do expect a lot of patients, we give them an inhaler we give them a two minute demonstration you quickly whiz off use it only when you are short of breath, don’t use it all the time, use it more than twice a week come and see me blah blah blah good bye. And expect them to suddenly be proficient in using it, and they are not as you are explaining. And that is probably where community pharmacies can have contact. So if they are picking their inhaler up that’s the perfect time to say are you sure you know how to use this, do you need me to just re show you.

IC Pharmacist 2

I think if we are saying are you using it properly, yes of course I am I am not an idiot.

GP1

As they spray it onto their chest.

IC Pharmacist 1

A lot of these people have home deliveries and actually the pharmacist doesn’t get to see them. The second thing is I have seen people where I have been at home with them and I have said how do you get on with your inhaler, I am fine I know exactly what to do. And they whip it out and you are like oh dear your technique is terrible but they are convinced that they know what they are doing. So I think in defence of community pharmacist if you said are you alright with it, yes yes. And they don’t want to stay because they have stood in that queue they expected their prescription ten minutes ago they have not got it they want their bag and they want out of that door. And I think that’s the environment they work in. So I think you are absolutely right.

GP1

But I does it have to be, can they just give them a leaflet with their inhaler, a clear diagram which shows this is the steps you should be doing. Its just that drip feeding of information.

IC Pharmacist 1

I don’t like instructions though, when you are getting your furniture from Ikea you just want to get down and get on with it don’t you?
It depends on your personality type I guess. Someone like you instructions would be perfect for, everyone learns in a slightly different way don’t they. I am not sure that’s a role for community pharmacist rather than integrated care pharmacist.

I suppose if you do what R (IC Pharmacist 2) is suggesting to have the clinics where you bring your stuff in then that would be something.

IC coordinator 1

Bearing in mind you are looking at people who are house bound with lots of complications. It is a nightmare for some of them to be able to even get to the GP. So just keep that in mind.

Researcher PN

Certainly - good point. I think the other thing to quickly talk about I think this is linked to community pharmacist. I mentioned the patient being confused because the advice was different. So the pharmacist, the advice they gave was different to what the community pharmacist said to them. Thoughts on how that could be prevented.

IC Pharmacist 2

I think that’s difficult because its access to clinical information, that is my opinion, I think the community pharmacist don’t have enough access they don’t really know. I have personally never done an MUR (medicines use review) but I really cannot get my head around how they do them, without knowing, how would you know what a patient is on, what their background is. I don’t know I find that quite difficult.

That’s why they take me so long because I go back so far, people give me a task she will have a look she likes routing around.

GP1

Again its the patient not necessarily being aware that everyone has access to different bits of information or different bits of knowledge. So a good example I will send someone to a specialist the specialist says I think you need to do this and they say well that’s slightly different to what Dr A suggested. I am not going to do anything until I go back and speak to Dr A and he tells me that’s ok. He has waited like six weeks for his appointment just say yes. And again they don’t realise that they have got access to an MRI scan I didn’t see beforehand, they have got access to all the history all the investigations of the hospital. And therefore they are making a decision which might be different to what I said but its because they have got more information. And that’s where that comes from but I think if I was saying something and the patient said to me oh the pharmacist said something different I would make sure I clarified where my logic has come from. I wouldn’t just say well they are wrong they are right. I would hope that someone would say to them I understand why the pharmacist said that but actually if you look at the big picture and the reason you are not on this is because your renal function is really low, and actually that dose is different and they say I understand. You are not saying the community pharmacist is wrong but with the knowledge they had they made the right suggestion but with the knowledge you have got it is wrong. You are disagreeing but without, so there is probably just a communication breakdown there isn’t there.
IC Pharmacist 2

I think the other thing I find very different now being employed by the practice is that now I am starting to get to know community pharmacists a little bit better we are talking to each other. So I had MUR a while back, patient is on a PPI (proton pump inhibitor) which I looked you couldn’t stop or step down, quite a high dose, and the MUR said to initiate calcium supplements because of osteoporosis risk. But I had a look and I couldn’t find any evidence to suggest that’s what we should be doing. So I rang the community pharmacist back because she had told the patient, quite rightly if you haven’t heard anything chase it up with either us or the practice. So I rang and said I can’t find any evidence to say, its not NICE guidelines I understand the osteoporosis risk but this lady is quite active, vitamins D, calcium has been normal her dietary intake sounds OK. So I didn’t think we should do anything and at the end of the day its going to cost us a few more pennies as well. I am under quite a lot of pressure to save money! So I did say no, but I said if you have got anything I can read or you have got something for me to look at call me back. So I think now its that, when I used to come to the MDTs here I did wonder if it was one community pharmacist that was covering all of the patients it would have been quite nice to have them at the MDT. Because we had a few patients I think particularly in Oadby where I had to go out and speak to the pharmacy about over ordering. Or there was a lady, I can’t remember whose patient it was, but they used to ring on the door but run away before she got there and she used to get really, I know it sounds funny but she would get quite tearful because she hobbles to the door and then they had gone. And she used to feel quite inadequate not being able to get there because of her disability. And the pharmacy had no idea so it was just bridging that gap. So if they could attend because its how to get round these that may be a way, blue sky thinking, of actually integrating the community in. Because they don’t have access to records but if they came to the MDT are they entitled to understand more about the patient they are serving I don’t know.

GP1

It would work with somewhere like K (Village) because you have only got the one pharmacist that everyone goes to. But in Wigston actually we have got well Little Hill, Boots, so it wouldn’t work in that, it depends on the practices. And again O (village) wouldn’t work because they go Sainsburys, Asda …

IC Pharmacist 2

It doesn’t work in K(village) because some go to H(village), some go to O(village) there is too many. But I don’t know B(village) they have got, I don’t know where they would go. Its probably quite a small pharmacy catchment that area. Then that is one way round it is whether you actually start to collaborate a little bit more at MDT level and bring them in.

GP1

But then that would I suspect become less cost effective because if you factor in another pharmacists time then you have got two pharmacists doing the job and its probably not worth, if you are saving the pennies.
There was something I wanted to pick up about the disadvantages with integrating the integrated pharmacist role as part of the practice pharmacist role is an disincentive sometimes.

IC Pharmacist 1

Yes.

I saw that as from CCG angle that it was just streamlining resources but it sounds like sometimes the patient doesn't necessarily get ...

IC Pharmacist 1

No I would say its not as effective for the patient, personal opinion, I don't know how you guys feel about it you are probably better to advise.

GP1

Sorry I am confused what are we saying? Instead of including IC liaison as part of practice pharmacist role the pharmacist just do integrated care? So like L( practice pharmacist) would do our practice and do integrated care?

Exactly.

So that is better for you doing ...

No I don't think its better for the patient personally but that's just my opinion, how we are working now versus ??

Because Phar 2 might be rationing calcium for a patient who might need it!

IC Pharmacist 2

Maybe I made a wrong call there but i read the guidelines

But the cost saving is the end of your long list of whether this is your target or not.

Yes she was on this many medicines, I didn't just go oh, its not expensive.

Its at the end of your med review isn't it, its not at the top, can I save any money from this patient.

IC Pharmacist 2

No its not we review it all and then the most cost effective decisions are made later on.

But I didn't think there was any evidence to say we should be supplementing, now I am thinking have I done the wrong thing there. Because we are not routinely searching for patients.

I will give you an example, ? sent me a task and said is there any cost to prescribing 15 500 Cocodamol one of the locums had prescribed that. And its about 10 or 15 times more
expensive than the others and I just said yes there is just get them to give paracetamol and 30 milligram codeine and that would be the same. So that’s not a change to the patient care, you have given them exactly the same thing but in terms of how much its going to cost its a huge amount. So I don’t tend to make changes to patients medication where its pennies because there is no point because we might have to make enough changes and explain it to people as it is. If its just for pennies its not really worth it is it.

I have a lot where it cost more as well because I think they need something, ? is one of them although its one of the targets. I come across a lot of people who are on duel anti platelet and not on ?? so I would recommend it. There are lots of things where I recommend additional medicines that would incur a cost. I had a lady today.

GP1

But the point of this is not cost saving is it. Its about preventing end point so actually you are preventing a gastric ulcer end point which is worth it.

And I had a phone call today from a mum whose daughter is 14 she is ?? when she plays netball and she had read something about > being effective. And her daughter has got it in her mind that the generic is not going to be any good because it tastes slightly different when she has it. So she has got herself all worked up so her exacerbations are worse. So she said can I have a salbutamol inhaler and I was like yes, because I said use the salbutamol ? if it nots working feed back to me because that could be an ADR rather than it actually being rubbish. Because it’s still got Salbutamol? in it so why isn’t it working. And I looked and she said I have read loads of stuff on in the internet about this Salbutamol ? and I couldn’t find anything substantiated. So I said to her I can’t find anything but if you want the Ventolin have the Ventolin but try the Salbutamol first just so I know, as long as she is not having a really bad reaction don’t waste your time with Salbutamol. but that’s an example where cost doesn’t play a part, there are lots of examples of that where you have got to give them an option. I do think there is a bit of a disadvantage because you are preoccupied with other things so you don’t have as much focused time to go out and visit people and liaise with community pharmacist for example as much as you would when there is a dedicated role.

GP1

My feeling is that in five to ten years time every single practice will have a full time pharmacist that is the way its going. And in which case the model of integrated care is going to use the practice pharmacist isn’t it. So in an ideal world you may have a dedicated pharmacist to the integrated care bit. I suspect the realistic model is because most practices are getting, because we all know its a good idea and its just going to become the new model, the standard. But actually you would be the obvious person to just get involved. So in an perfect world but I suspect the realistic model its going to be ...

IC coordinator 2

I think people do go out, the practice nurse goes out for house bound patients as do the GPs visits. So there is no reason why if it was absolutely indicated to stop people going out. And any other patient that needs a med review can come in like we see anybody else.

GP1
Its just picking and choosing isn't it.

One thing as well you have got to remember a lot of patients don't want to be on all these medications, they want that review, they want to come off some if they can.

Any other final thoughts or comments?

**IC coordinator 1**

There is something you mentioned about barriers and social care needs and IT access for the pharmacist, I don't know whether that's something you want to pick up on.

You mean social care access for the practice pharmacist?

**IC coordinator 1**

In terms of them being able to access social care records which is not happening at the moment anyway.

Did you find that useful K(Pharmacist 1)?

I tended to just look at the report that you put onto the system and if I wanted some more information about a particular person I just came and asked you, background about patients.

**GP1**

The number of times you would need to go would be not worth the training and access and cost to establish it.

I don't think you would need to as long as you have got access to coordinators.

And it takes you so long to find what is needed.

**Researcher PN**

Maybe with the Strategic Transformation plans who knows we might all have one, similar IT systems.

**IC Pharmacist 2**

The other thing I was going to mention was the training, K(Phar 1) you did quite a lot of Dossette the training when you started and that's something I think moving forward would continue to be beneficial in that collaborative gap between social care and health. I know you are not trained and sometimes I know I have had feedback from a few different coordinators that sometimes in an MDT it can get a little bit too clinically focused and it can be a little bit confusing for the coordinators. That's something I was trying to work on because I get a little bit conscious of the GPs time because they are trying to get quite detailed information. I have done that bit but actually it's not over educated so you are mini pharmacist in the patients home but that little bit. Because it's quite interesting today to see how many things we have brought up about medication, knowing the difference between a preventer and a reliever and the dosing gaps and things. And they are things I think are quite useful for you to know and it's educated me a lot about the social background and how
much that impacts patient care. Because before that I probably wouldn’t have really thought about it.

There are things as well when people are you know poor vision they can’t see their repeat prescriptions, they want something in bolder print or all the different ways that you can get somebody their medication.

I think the training aspect. So we train a little bit more as, I think GPs get quite a lot with safeguarding and a lot of the social aspects of visiting patients but as pharmacists based in practice, I think K and I probably have because we have worked with the team. But I don’t know if the others would necessarily know that. Like the technology and reminding patients to take things and the voice alarms, things like that you don’t necessarily know how to access those.

**IC Pharmacist 1**
I didn’t know anything about them until I did IC I had no idea they were available.

**IC Pharmacist 2**
That’s something that didn’t come up as a theme but actually I think is quite relevant to continue whatever the role of the pharmacist or the integrated care. Even if the integrated care team didn’t exist when I used to go out to R(locality) for the carers delivering care at home that education was still quite valuable of knowing that don’t solve every question and what you can and can’t do safely.

**GP1**
That’s probably a wider CCG issue isn’t it, the CCG need to think right the model of general practice is changing, we are getting all these pharmacists into practice, we need to make sure they are educated and trained about the things we want them to know about. Because there is no formal training presumably?

**Researcher PN**
We are trying to get something off the ground with the PLT (protected learning training) but not structured.

**GP1**
That’s what I mean, if you go to the PLT there is nurse, there is doctor, there is admin reception, they probably need a pharmacist and these are the things that should be covered in those things so that the information gets out there and everyone is hearing about it.

**IC coordinator 1**
And vice versa with the social care team. Because we did do that didn’t we, we did a bit of training at the meetings.

**IC coordinator 2**
The thing that was quite useful having that, you are breaking it down in terms of laymen terms and giving that information to us.
And just things to look out for when you go into someone’s home.

**Researcher PN**
And did you have any sort of formal training slides that you did for them or was it just by osmosis? eg, social care up skilling.

**IC Coordinator 1**
I think it was just learning on the job really.

**IC Pharmacist 1**
I am not a fan of overheads I tend to just teach on the job really. And even if I want to tell you like when I came and talked to you about Dossette it was just me sat down talking to you about Dossettes I am not a fan of all this pointing.

**Researcher PN**
On that note and pointing at my final slide (sorry K) are there any final thoughts or comments?

**None?**

That was extremely useful so thank you so very much for your time and input. We got some invaluable insight and useful discussions.

I will send you copies of the write-up including recommendations

Please help yourself to drinks and cakes - lots on tables

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