Abstract

Objectives: To explore the experiences of primary-care based professional stakeholders in a dual-sector training programme for foundation pharmacists.

Methods: Professional stakeholders were defined as foundation pharmacists or members of staff working with foundation pharmacists such as general medical or nurse practitioners and administrative staff. Stakeholders were invited to participate via email and through gatekeepers. Participants were asked how they were involved in the training pathway, what their experiences had been and what they hoped for the future. Interviews were audio-recorded, transcribed and thematically analysed using computer software.

Key findings: Twenty-eight face-to-face semi-structured interviews were conducted. Five major themes were identified i) benefits of integration ii) appropriateness of the work iii) perceived impact iv) identity development and v) training and peer-support. These findings outline participants’ experiences of establishing a scope of practice in primary and secondary care settings and developing mechanisms to negotiate non-prescriber status to save general practitioners, practice nurse, community pharmacy and administrator time. Foundation pharmacists were able to develop a professional identity whilst working in each care setting, highlighting the dominance of hospital pharmacy exposure in clinical knowledge acquisition and establishing a community of practice across organisational and geographical boundaries using WhatsApp as a peer-support tool.

Conclusions: Foundation pharmacists are able to work within their own competencies in two different care settings, developing scopes of practice and contributing clinically to service provision. This work provides evidence that this type of training
pathway can offer an appropriate landscape for pharmacy practitioner development.

Further work is needed to explore the longitudinal outcomes of the programme.

Key words (no more than 5)

Pharmacy practice, primary care, secondary care, foundation pharmacists, Vanguard
Introduction

The National Health Service (NHS) is currently experiencing unprecedented demand for services that jeopardise the sustainability of current models of care within the United Kingdom. In addition, over the past twelve months, directors from commissioning and delivery organisations within the NHS believe the quality of care in their area has deteriorated. Measures to meet the demand have included exploring new modes of service delivery, including increasing the availability of step-down facilities, offering increased remuneration rates for agency staff and outsourcing elective care, as well as integrating services. With multiple contributory factors to the increases in demand, the service estimated deficits in the region of £873 million for 2016/17. Strategies to transform the sustainability of the NHS also include initiatives such as NHS England’s Vanguard scheme, Sustainability and Transformation Plans and the Five Year Forward View. Many of these programmes represent an opportunity to explore novel approaches to healthcare services by examining current clinical support mechanisms, workforce development and integration of care services. As part of the Vanguard programme in Northumberland, an integrated clinical pharmacy service was established in 2016 that facilitated the exploration of a novel training pathway for pharmacists working in primary and secondary care settings.

The Northumberland Vanguard is made up of Northumbria Healthcare NHS Foundation Trust, NHS Northumberland Clinical Commissioning Group and Northumberland County Council. The Vanguard has integrated primary and secondary care services in the region, restructuring existing models of service
delivery into a single ‘accountable care organisation’. The Vanguard reports that care is delivered “by an aligned, integrated workforce, operating as once team, in one system with joined-up systems and processes”. One of the aims of the Vanguard is to develop the pharmacy workforce, so that pharmacy staff are vertically integrated and trained in both settings simultaneously, to develop unique knowledge and skills required to deliver primary and secondary care services. This would enable pharmacists to, for example, review the medicines initiated in secondary care, in a follow-up appointment in a primary care setting that may have otherwise been continued unnecessarily.

There is a growing evidence base to support the integration of services. The PINCER study used horizontal integration across professional groups to show that pharmacists can play a vital role in reducing medicines errors in primary care. The study implemented pharmacy-led interventions to a randomised group of 72 general medical practices across the U.K. The results demonstrated a significantly reduced number of clinically important prescription and monitoring errors in the intervention group compared to the control group. Such errors included use of beta-receptor antagonists in patients with asthma and angiotensin converting enzyme inhibitors in elderly patients without assessing electrolytes. Indeed, more recent work has demonstrated that pharmacists are enthusiastic to take on roles in non-traditional care settings, such as general practices. Such studies highlight the positive impact pharmacists can have on patient outcomes and have provided an opportunity for pharmacists to contribute to the delivery of pharmaceutical care within emerging models of health service delivery.
Whilst the clinical development of other non-medical professionals is a recognised solution to the sustainability of health services, disciplinary boundaries can be prohibitive. Conventional approaches to healthcare are represented by patient journeys that rely on cross-sector service delivery, with healthcare provision organisationally structured in discrete components of primary, secondary and tertiary care settings within disciplinary boundaries. Models of inter-professional collaboration between general medical practitioners (GPs) and clinical pharmacists have demonstrated the importance of interactional, environmental and practitioner determinants to success. Indeed existing literature suggests co-location, shared experiences and regular communication helps to construct shared perspectives that can enable specific patient outcomes, such as medication adherence, to be improved. Although pathways to support pharmacists to work collaboratively with GPs in primary care are established, these focus on senior pharmacists (with more than three years experience) rather than newly-qualified foundation pharmacists. Little is known about the professional development of newly qualified pharmacists working in primary care settings.

The term ‘foundation’ was originally used by the medical and dental professions to denote newly qualified professionals establishing their practice. In recent years the pharmacy profession have moved to use this term to describe pharmacists that have been registered for less than two years. Foundation pharmacists are likely to have fewer responsibilities, for example prescribing responsibilities, than more senior pharmacists. There is currently no statutory requirement for newly qualified pharmacists to complete specific training, however the Royal Pharmaceutical Society provides a structured programme that is applicable to multiple sectors and settings.
A key component of successful inter-professional collaboration is ‘pharmacist role definition’ and professional identity.\textsuperscript{[13,14]} The literature reports the difficulty some pharmacists face when reconciling expectations of professional life and the lived experience of practice, that leads to practitioners ‘finding new ways to be pharmacists’.\textsuperscript{[15]} Emerging models of care may be dominated by senior pharmacists that have developed their practice, and professional identity, in conventional discrete settings before transferring to an emergent service, for example, senior hospital pharmacists that move to general medical practices.\textsuperscript{[16]} However, little is known about the development of foundation pharmacists that practice within new models of care, such as integrated accountable care organisations. Our dual-sector training pathway provided a programme of development that enabled pharmacists to develop bespoke professional practices and identities, simultaneously. The programme included 4-week rotations in two sectors (primary care and secondary care) delivering pharmacy services in each setting. The Northumberland Vanguard recruited foundation pharmacists who had just completed a pre-registration training programme and paired them with a senior clinical pharmacist and GP to act as mentors. Training across both sectors was a combination of mini-Cex case reviews, case presentations, one-to-one teaching (with GPs and clinical pharmacists) and didactic teaching. Teaching hubs across Northumberland brought together pharmacists from across the organisation and structured learning events, involving pharmacists from other organisations and sectors (including mental health), were set up across then North of Tyne area.

The aim of this study was to explore the experiences of primary care based professional stakeholders in a dual-sector training pathway for foundation pharmacists.
Method

This paper follows the COREQ reporting guidelines for qualitative research.\[^{17}\]

Research team and reflexivity

Participants were given a standardised information sheet to read and consent was taken prior to the interview. Participants were made aware that the interviewer was a pharmacist researcher employed to evaluate the current service. The NHS Research Authority ‘Is my study research’ and ‘Do I need NHS REC approval?’ tools were used to consider the need for research ethics approval and determined ethical approval was not required for this study. NHS R&D approval was granted by Northumbria Healthcare NHS Foundation Trust.

Study design

A phenomenological theoretical approach was used to underpin the study.\[^{18}\] This approach positions reality as constructed of experiences and only by exploring experiences of individuals can reality be understood.

Setting

The ‘Northumberland Vanguard Foundation Pharmacy Programme’ provides a foundation pharmacist training pathway to deliver healthcare services in secondary care and primary care practice settings. Practices are provided with one whole time equivalent pharmacist, as two individuals, rotating through practice and hospital settings. Two foundation pharmacists, one is the first year of the programme and the other in their second or third year, are paired up to share experiences and act as ‘buddies’. The Vanguard programme was developed with the intention that the
complexity of practice progressed through the programme (see Supplemental Material) as pharmacists completed the training pathway. Upon completion of the third year, the programme aimed to produce bespoke practitioners with clinical and prescribing expertise suitable for practice in primary and secondary care settings.

**Participant identification and recruitment**

Purposive sampling was used to include foundation pharmacists in the first or second year of the programme, who then recruited a convenience sample of professional stakeholders who had direct experiences of working with them, using a conventional gatekeeper method. All foundation pharmacists involved in the programme (n = 12) were contacted initially by email invitation to their professional email address and then by telephone to co-ordinate interviews. Interviews were conducted until theoretical data saturation occurred, this is defined as the point at which no new insights emerge.¹⁹

**Data collection**

One-to-one, face-to-face interviews were carried out by an experienced qualitative researcher (APR) between November 2016 and April 2017. Interviews were conducted at times and in places convenient to the participant; these included consultation rooms within primary care sites, as well as other places such as offices, side rooms and classrooms. Locations were conducive to interviewing i.e. were quiet and private. An interview schedule was used to guide interviews and facilitate a standardised approach however as a suitable interview guide was not found in the literature, two authors (APR and WB) developed, piloted and reviewed the interview
schedule prior to data collection (see Supplementary Material). Questions in the interview guide were general and specific and included ice-breaker questions and prompts for the researcher. Topics included positive and negative experiences of the training pathway, hopes for the future, as well as experiences of working with trainees and mentors. Interviews were audio-recorded and transcribed verbatim by one author (APR) and quality checked by another to highlight errors (WB). Repeat interviews were not carried out, field notes were not made. Where verbatim transcription was not made to protect confidentiality, participants were contacted to confirm the meaning of the data had not been lost.

Data analysis

Qualitative data analysis was conducted using QSR NVivo Version 11 and used a conventional iterative process. Data analysis was conducted by APR, TR and WB. Immersion in the data occurred through multiple readings to identify codes that were developed into coding clusters. Codes emerged from the data and team members met regularly to discuss emerging themes. Coding was presented to members of the Pharmacy Academic Research Group (PARG) based at Northumbria Healthcare NHS Foundation. PARG includes a range of practitioners and academics with expertise in operational management, oncology, clinical pharmacy, primary care practice, technical services, service evaluation, audit and research. Anonymous transcripts were shared with members of PARG to verify themes through discussion. Three foundation pharmacist participants were randomly identified and asked to member check the final themes to verify the findings were accurate and no important components of their experience had been missed.
Results

Saturation was considered achieved after twenty-five interviews. Interviews lasted between twenty and sixty minutes. Twenty-eight interviews were conducted and transcribed. Participants included twelve foundation pharmacists, four general practice tutors, two community pharmacists, two practice managers, three practice nurses, five practice reception and administration staff. Each foundation pharmacists invited at least one stakeholder to participate in the study. Data analysis demonstrated five themes regarding the role of the foundation pharmacist and their training. Themes are summarised below. Supporting quotes can be found in Table 1. The number of participants that refused to take part was not recorded however reasons for refusal were informally reported to be exclusively due to time restraints.

Theme 1: Benefits of integration

The type of work undertaken by each foundation pharmacist varied from practice to practice and included a range of different classifications (see Figure 1). Participants reported more time for patient contact in primary care compared to secondary care settings (Quote 1.1 and 1.2).

Foundation pharmacists were able to contribute to the care of a wide variety of clinical areas as part of their training. Foundation pharmacists were able to take on work previously completed by GPs (Quote 1.3). As working patterns developed, the quantity as well as range of activities increased as perspectives of pharmacists’ abilities changed (Quote 1.4). Improved communication was also reported between the community pharmacy team and the practice team (Quote 1.5). Foundation
pharmacists were able to support the transition of care (Quote 1.6). Experiences of primary care was reported to change the way tasks were completed in secondary care, for example preparing discharge summaries in secondary care was influenced by reading discharge summaries with missing information in primary care (Quote 1.7).

**Theme 2: Appropriateness of work**

The appropriateness of work took time to develop with pharmacists completing work they previously considered outwith scopes of their practice in hospital or community roles (Quote 2.1) yet despite the variety of clinical areas covered, foundation pharmacists were able to appropriately identify scenarios that required referral (Quote 2.2). The upper threshold of the appropriateness of work was highlighted with regard to prescribing governance (Quote 2.3). The technical process and legal requirements of prescribing created some uncertainty as foundation pharmacists had non-prescribing status (Quote 2.4) however, participants reported reassurance from prescribing protocols (Quote 2.5) and general practitioners described a checking process, which provided oversight to junior decision making (Quote 2.6). Conversely, the appropriateness of work was also challenged at a lower threshold, where work was considered clerical rather than clinical (Quote 2.7).

**Theme 3: Identity development**

Foundation pharmacists established their professional identity through role definition, skill acquisition and spatial differentiation. For example, ensuring the clerical team understood the foundation pharmacists clinical capabilities appeared to be linked to their physical location within practice settings (Quote 3.1). One participant described how this experience is reflected in their experience of practice in secondary care
Professional identities were constructed through regular informal feedback on their performance of tasks associated with their new identity (Quote 3.3). Primary care colleagues of foundation pharmacists appreciated the important role hospital experiences played in clinical knowledge development and clinical practitioner identity, particularly how this differs from community pharmacists’ identities (Quote 3.4). Training sessions also enabled new opportunities for skill development that were typically outside of the scope of the pharmacist identity, as participants began to tackle less ‘pharmacy’ work, for example with reviews for patients with depression (Quote 3.5). Foundation pharmacists felt that their exposure to secondary care was important to their professional practice in primary care settings (Quote 3.6).

**Theme 4: Training and peer support**

Initial training focussed on inducting foundation pharmacists into the general practice community (Quote 4.1). This was reinforced through group training with GPs that established shared perspectives between the disciplines (Quote 4.2). Within the programme, foundation pharmacists had additional training with a GP Mentor (Quote 4.3). Despite the arrangements made for group training, pharmacists reported more team-based experiences of secondary care and experiences of isolation in primary care settings (Quote 4.4). In some instances annual leave and short rotations prevented participants from equal exposure to different settings, this may have prohibited professional network development (Quote 4.5 and 4.6). However, using WhatsApp enabled participants to construct a network of foundation pharmacists, who shared references and social resources across organisational and geographical boundaries (Quote 4.7). This established a community of practice for the pharmacists.
that empowered them to support one another, developing solutions to problems collectively, as a group discrete from other groups of practice-based and hospital pharmacists.

**Theme 5: Perceived impact**

The impact of the foundation pharmacists was perceivable in the day-to-day running of the practice (Quote 5.1). This reduced GP and Nurse Practitioner workload and provided reassurance to GPs (Quote 5.2). Although enabling foundation pharmacists to work to capacity took time (Quote 5.3) the impact on the working practices of the administrative team was also reported (Quote 5.4). Foundation pharmacists were also able to support Practice Nurses as an immediate pharmaceutical resource that prevented queries being sent to GPs (Quote 5.5). For some types of work, such as discharge reconciliations, which had previously been devolved to clerical staff, GPs were able to recognise a reduced number of queries from the administrative team as well as noticing an increase in workload when foundation pharmacists were on annual leave (Quote 5.6). Integrated practice enabled foundation pharmacists to solve problems perceivably more quickly and permanently in a way that suited multiple stakeholders (Quote 5.7).

**Discussion**

This study has described experiences of a novel training pathway for foundation pharmacists. Foundation pharmacists were able to develop clinical practice commensurate with their level of qualification that, whilst appropriate, is varied. Perceived impact focused on primary care, were foundation pharmacists were able to release GP time, improve relationships between GP practices and community
pharmacies and contribute to improved administration. Foundation pharmacists were able to establish boundaries within their professional practice to identify when and how referrals to more senior colleagues should be made, using social messaging technologies to develop their knowledge base, professional networks and a community of practice.

**Strengths and limitations of the study**

The strength of the study is that data analysis was conducted by a group of experienced academics and practitioners, using data management software that provides an auditable account of the analysis and that findings were confirmed through member checking.

A limitation is that participant recruitment using the gate keeping method may introduce bias, in that gate keepers may only invite those likely to report positive experiences, and participants may have had concerns about confidentiality given the proximity of the research team to the senior management at the organisation. An attempt to mitigate this was made by emphasising that only the interviewer (APR) would know who had said what and would transcribe and delete the audio-recording following anonymisation to prevent confidentiality being breached. The study was undertaken with pharmacists employed by one organisation within the Vanguard model, working towards single accountable care organisation status, future work should look to explore experiences of training following the completion of service integration.
A further limitation of the study is that it was conducted during the development of programme, as participants were living the experience, rather than having time to reflect on their experiences. Future work should continue to explore the contemporary experiences of foundation pharmacists as they develop their professional practice within integrated services as well as longitudinal follow-up studies after completion of the programme.

**Context within existing literature and impact of findings**

This work establishes an initial scope of practice for a new generation of pharmacists that practice across two care settings and provides evidence that foundation pharmacists can contribute to health service provision within a training programme.

Whilst existing work has highlighted barriers and facilitators to pharmacists’ horizontal integration with primary care teams,⁹ this work pushes further by exploring models of training, whereby foundation pharmacists develop knowledge and skills to deliver health services in two sectors. The findings presented by this study provide evidence that pharmacists can build positive working relationships across boundaries following a period of role definition.⁹ Other work has outlined the role of a consultant pharmacist within primary care and findings from this study suggests that similar activities, such as medication review clinics, may be carried out by foundation pharmacists with support from GP and Pharmacist Tutors, supporting the sustainability of health services.¹⁰ Further investigations are needed to establish scopes of practice for foundation, senior, advanced and consultant pharmacists delivering services in emergent models of care.
Historically, the movement of hospital pharmacists into general practices presented a novel opportunity; however general practice is increasingly encouraged to collaborate with and employ pharmacists, drawing in highly trained individuals from other sectors through horizontal integration. More recently, vertical integration projects such as the Northumberland Vanguard, whereby multiple providers work together to control the delivery of healthcare across sectors in multiple settings, have recognised the need to develop a workforce with unique knowledge, skills and understanding of health needs. For example, work in the United States of America calls for pharmacists to work within integrated models of care via ‘accountable care organisations’, a key component of some sustainability and transformation plans within the U.K. This work therefore provides timely evidence of successful deployment and development of foundation pharmacists working within new models of care that is nationally and internationally relevant.

The participants in this study described taking on work typically outwith the remit of hospital, community or practice pharmacists, such as reviewing care home patients, examining diabetic patients’ feet and depression screening. Existing evidence outlines the attributes, preferences and personal traits of personas in relation to pharmacy work. This study suggests that identities such as the ‘clinical practitioner’ and ‘medicines advisor’, as opposed to ‘the business person’, ‘the medicines supplier’ and ‘the unremarkable character’, may be more readily developed within new models of healthcare. This study provides evidence that foundation pharmacists can contribute to the delivery of health services whilst part of a dual-sector training programme.
This work also provides preliminary evidence that social messaging technologies, such as WhatsApp, can contribute to the development of communities of practice across organisational, professional, and geographical boundaries. Future work may look towards the applicability of WhatsApp as a learning platform and clinical resource within postgraduate practice development within pharmacy and other healthcare professional practice.

**Impact of findings on practice and policy**

The Royal Pharmaceutical Society’s Foundation Pharmacy Framework (FPF) outlines a development structure for newly qualified pharmacists in their first one thousand days of practice.\(^{[12]}\) The FPF enables pharmacists to develop their competence, collating evidence to support their progression within a chosen setting or sector and is reportedly applicable across sectors, however little is known about the applicability of the programme to support foundation pharmacists working in more than one settings simultaneously. Future work should be directed to understanding the impact the FPF may have on post-registration development within new clinical contexts and within new models of care.

Internationally this work showcases a model of dual-sector training for foundation pharmacists. Global pharmacy organisations, such as the International Pharmaceutical Federation (FIP), use existing structures and definitions to stratify, support and represent the profession, i.e. community and hospital, which may need to change to reflect emerging identities within the profession.

**Conclusions**
Foundation pharmacists are able to practice competently in primary care settings, developing a scope of practice and contribute clinically to service provision whilst professional identities and online communities emerge. This work provides evidence that integrated services, such as Accountable Care Organisations, can offer an appropriate landscape for pharmacy practitioner development. Further work is needed to explore the longitudinal outcomes of the dual-sector training programme.

**Declarations**

Removed for blinded review
References


Table 1 Quotes

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<thead>
<tr>
<th>Theme 1</th>
<th>Quote</th>
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<tbody>
<tr>
<td>1.1</td>
<td>“I think patients appreciate it too, like you having more time to talk to them and what not, so IHD reviews that I do, I do a medication reviews and review their symptoms as well which I guess is a bit more clinical that what we do in hospital” P15, Foundation Pharmacist</td>
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<td>1.2</td>
<td>“The patient contact, in hospital, you never see a patient, erm, if you make an intervention in hospital you never see them follow through, you never see them get better really, they’re discharged and that’s it, you don’t know, where as in the GP surgery, you get to know the patients and you can follow things up and you get to see the whole process and that gives you quite a lot of job satisfaction” P12, Foundation Pharmacist</td>
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<td>1.3</td>
<td>“it’s normally the GP that did the arthritis reviews, the nurses do other things, like diabetes and asthma and COPD but the doctors still had that rheumatoid arthritis one because of the type of meds that they were on, so the nurses, didn’t really want to do that, high risk, so the GPs kept it, erm and then when we came they said well that would be perfect for you to do because we don’t really know that much more about the medicines than you do” P16, Foundation Pharmacist</td>
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<tr>
<td>1.4</td>
<td>“so when we first started it was quite a lot, less work and then now it’s starting to get a bit too much because they’re starting to see what we can do, so we’re getting that on top of what we were already doing,” P16, Foundation Pharmacist</td>
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“he knows what information we have and what information we don’t have, so with GPs I kind of feel like they’re up there with all the information and we’re down here with only half of it, and I think he is like at the right level,” P28, Community Pharmacy Team

“if somebody has been discharged, they will chase up secondary care, because they’ve got that in that we’ve never had and passing information on to get staff to do it does well, they do that side so that is useful, having that interface” P8, General Practitioner

“you don’t really know what the thought process was when they stop or change medications or leave something off, so I always make sure everything is on it and the reasons why things have been stopped or things have been changed, just to make it easier for reconciliation of discharges in primary care,” P18, Foundation Pharmacist

“some of the acute stuff is a bit complex and some of the stuff I have seen in clinic, on the first day, chronic health reviews and that sort of stuff, was maybe a bit over my head, but I feel like every day I’m learning stuff and we’ve pitched the work at the right level now” P9, Foundation Pharmacist

“if I’ve got any problems I just ask one of the GPs or, like I had to refer someone to the rapid access chest clinic the other week” P15, Foundation Pharmacist

“with acute prescription requests, so we mentioned that, and [one of the other members of the team] that already works at that...”
practice they was the one that was a bit reserved about it and raised the point about prescription requests saying that they don’t know how we’d get round you approving something because you’re not a prescriber” P11, Foundation Pharmacist

“I will say, if the patient is happy to take the medicine, do you agree on this drug and this dose, so that they’ve checked it before I’ve put it on but then like, I’ve put it on and they might not have had time to check that so then I’ll get a thing saying yeah I agree, which is great, because they trust us, but at the same time, I want it checked because I’m not a prescriber and I’ve had discussions with different pharmacists about their views on this, and the ones that are prescribers and the ones that aren’t, and a lot of them are saying that it is part of the shared care thing, erm, as long as there is a protocol in place and you’re following that protocol and it’s fine,” P16, Foundation Pharmacist

“we’re not prescribers and so we don’t start patients on medications, we don’t have any experience of that, obviously with us just starting off as newly qualified, it’s all protocol led and so we had to kind of just follow the protocols and the guidance and actually, as daunting as it was originally, the structure and the models we have are making it work” P18, Foundation Pharmacist

“We’ve managed to work around it, they tend to use task messaging, you know we’ve had this discussion with a patient, can we do x, y and z and can I do this? And I’m quite comfortable with that, it’s almost as if you get to just give them that oversight that perhaps when they’re a bit more qualified they won’t need that because they’ll be prescribers then but working here gives them the
chance to kind of develop their practice prior to that” P19, General Practitioner

“another challenge that I’ve had, getting the clerical team to understand exactly what I can do, what I’m here to do, because there has been a couple of maybe inappropriate things passed to me in the past” P12, Foundation Pharmacist

“I think the practice that I’m at, I don’t feel like that we’re as clinical as we could be, even our sort of logistics where they’ve placed us, we do sort of the admin, so we do hear the phone calls and stuff, but I’m not happy with that personally, I just feel like we’re put in a kind of admin box rather than a clinical team. I mean I still think our input is appreciated but for me it just kind of lowers my job satisfaction” P14, Foundation Pharmacist

“I mean, I still feel appreciated I just wish that I was with the other clinical people rather than the admin team. I mean you don’t always feel appreciated in hospital either because of the same thing, like pharmacy is always down stairs or away from everything, so you’re not really part of any wards or anything, and people often don’t understand what your job is” P14, Foundation Pharmacist

“pretty much every message I get back is that’s great thanks for sorting that, thanks for looking into that, and that’s a really thorough assessment and things like that, so it’s quite positive feedback from the GPs” P15, Foundation Pharmacist
“I feel like because they’ve worked in hospital, and we have locum pharmacists who work for us on a night time that are also from the hospital and they see things that are more in depth, whereas our pharmacists could just like not see it, we’ll have things like, we’ll come in the next day and if a hospital pharmacist has been in, they’ll query like a dose that they’ve been on for years and we’ve spoken to the doctor about it and they’ll know about it but they’ll look more depth into it and maybe challenge the doctor a bit and say well the GP shouldn’t just know about it, they should have a reason why so they do like a more in depth check of the prescriptions before they go out. I think they’re more clinical than what we probably are” P28, Community Pharmacy Team

“we would do it in the same way that they would so that we weren’t missing anything out and then they were getting freed up to see the patients that actually needed to see the doctor erm, so they’d be things like that that we didn’t know but when we went over it, we learned it and we realised that like, it was taking up a lot of their time, and we said if they were happy with that, then we’d do it,” P16, Foundation Pharmacist

“it was really important, because in hospital you still get to apply your clinical knowledge that you’ve gained and your training from uni gets consolidated so it’s all beneficial, I don’t think I’m losing knowledge from working in hospital I think it gives you a really good, solid foundation to start working in primary care and then going between the two like, helps you keep both knowledge bases ticking over” P18, Foundation Pharmacist
“we did a lot on consultation skills right at the beginning so that kind of set the precedent of how we would work right at the beginning, how they wanted me to document in the notes and especially if there were things that I would want to refer on to a GP, what information that they might want me to get that they’ve got access to, kind of triaging almost, and then since then I’ve come up with topics that I would want to do, and cover and he’s taught me his knowledge and things, and what he’d expect of me, that I’d need to do, when I’d need to call him” P13, Foundation Pharmacist

“we have like a teaching session, and we get invited along to that, and my mentor introduced me to everyone to see like, he probably got some screen messages off me but he hadn’t met me, so it was good to be like this is actually me [laughing] and then as you kind of spoke to them more and more, they saw that you weren’t going to do something stupid, that you were going to refer it back if you weren’t comfortable and like, they also know that they can save time, because there is stuff that they can give us to do” P16, Foundation Pharmacist

“They’re supposed to have some protected time, maybe at least once a month, to talk through cases and issues, and audits and whatever else comes up” P19, General Practitioner

“in the hospital we do work as a big team, like the pharmacy department is a big team, so if you need help then there are people there where as you’re on your own in this practice” P14, Foundation Pharmacist
“it’s difficult to get work off, to try and marry up the practice rules and the hospital rules the two different annual leave rules, but at the same time there is only one of us in the practice at a time doing this job so you can’t really restrict our leave in the practice in the first place so they just have to kind of take it as we want but to be honest a lot of my annual leave has for some reason, it seems all to have come whilst I’ve been on hospital time, so it hasn’t taken away from my rotation in the GP practice it’s been mostly from when I’ve been in hospital that I’ve spent time away, like It’s not evenly distributed” P14, Foundation Pharmacist

“I’ve tried to look for the real benefits of it but I can’t. I always try to give the positives, but that hasn’t happened here, erm. [3 second pause] it can be quite disruptive, erm, I think just as you’re getting in to the fourth week, you know, you’re getting the hang of it, it then stops, and it wreaks havoc and you have to start again with the next person” P23, Practice Manager

“Well the WhatsApp group is kind of got all the foundation pharmacists in it and we basically can put a query in there and if anyone is available they can try and answer the question for you, that’s it pretty much. I mean we’ve got one for just the junior vanguard, we’ve got one for the vanguard in general and then we’ve got one for the group of pre-regs that qualified together and a couple of the first year pharmacists that are also in, so it’s kind of, depending on the level of the, if you’re confident enough to raise the question, then we’ll put it in the main group, but we’ve got our own junior one just in case, erm, in case it’s a stupid question.” P14, Foundation Pharmacist
5.1  “I think it’s having a really positive impact on the day to day running of the practice,” P23, Practice Manager

“I think the reduction in workload feels significant, I wouldn’t know how many patients per week, as it were or how many hours per week it is reduced but, erm, as much as the reduction in workload it is the reassurance that you know it is being done right” P2, General Practitioner

5.3  “they’re seeing patients, but it’s getting them full, and that’s a patient issue, and getting them the confidence, it’s the same when a new GP or nurse practitioner starts it’s a new thing in the practice and patients are wary” P8, General Practitioner

5.4  “Well yeah, because those extra appointments, it’s not like the patients stop, so if we’ve got more appointments I can give them to the pharmacists first and keep the GPs free, but then there are so many patients ringing up that the GP appointments get filled, so it’s not like the GPs have fewer appointments it’s just like there are more patients being seen if that makes sense?” P3, Administration Team Member

5.5  “If I’ve got concerns though about somebody with inhalers, I can use [the foundation pharmacists], say one, say I’m looking at the inhalers and I’m not sure on the combination on where I’m going to manage this patient, often I’ll ring [the foundation pharmacist] and say ‘I’ve got a patient in to day, they’re not doing very well on the clenil, what’s your views on that’ and he’ll tell us, a few times they might say something like ‘oh you can’t use that one, with that one,’” P25, Practice Nurse
“particularly on weeks where one of them is on holiday, you notice that, they’re kind of not here and you think ‘oh yeah I forgot we have to do all of these’ and then most of the time, when that happens, they don’t get done, they get put to the bottom of the pile and they’re the type of things that probably sit in peoples inboxes and don’t get done [...] that probably has an impact further down the line that you can’t really see, so if we never do it, then there will be complications of that that we have to deal with when they happen, were as if the pharmacists are doing it properly and it’s actually getting done, who knows how many complications or issues that they’re preventing because that is actually being done” P19, General Practitioner

“he knows the other pharmacists at the hospital so he can just ring them or whatever and they’re more familiar with him rather than us being passed from pillar to post when we’ve been ringing, like he knows who to ring and when and it’s handy having him here to help with that, because sometimes if we think of a solution on our own, it doesn’t always work best for the hospital or the practice so having him as the go between makes sure it works for everyone and that solution then doesn’t need sorting out again next month or next week or next time the patient has problems” P28, Community Pharmacy Team