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Implementation of pharmacist-led falls-related medication reviews: a quality improvement project (QIP)

Pharmacists have an important role to play in minimising the risk of falls in patients who are taking medicines known to contribute to that risk. This paper outlines a service to implement medication reviews for patients at high risk of falls on a gastroenterology ward, which was the one with the highest number of reported falls in the Trust concerned. The time previously taken in conducting a medication review on a patient at high risk of falls was 2 hours and 40 minutes. The introduction of a structured tool for reviews (STOPIT) and targeting medicines at high risk of being implicated in a fall resulted in decreased time of 45 minutes per review. A total of twelve new patients were reviewed, sixteen recommendations were made and seven were accepted. These are relatively small numbers but they do form a baseline to further develop use of the tool and the approach. It is hoped that further work will confirm the benefit of the approach and the effect on fall rates.

How GP clinical pharmacists are developing respiratory medicines optimisation

The introduction of pharmacists into GP surgeries is a current and high profile topic. Pharmacists will have a general awareness of the potential contribution that can be made to patient care generally as a result of this initiative. The article will, however, be of specific interest to those who seek to develop a service for patients with respiratory disease. It will serve as a useful support document to support proposals for such a development as well as being a helpful baseline to be adapted for other therapeutic areas.

Advanced Pharmacist Practitioner, Northumberland Older Adult Community Treatment Teams

There has been much focus recently on the need to improve mental health services. It is, therefore, encouraging to include a Face2Face on the above role, which sets out the part being played by a pharmacist. The role was initially funded as a pilot but its success in demonstrating the value to an Older Adult Community Treatment Team has led to it being introduced on a permanent basis. The role involves undertaking all activities from medication review through to prescribing cognitive enhancing medication and acting as a single point of contact for patients who have difficulties during their treatment journey. This will be of immense interest and help to those who wish to introduce a similar service locally.

Trouble at the mill!

It can be disruptive when conflict arises between staff and it is not always easy to resolve but our commentators give some superb, practical advice that will most certainly help!

Leadership dialogue – creative approaches to negotiation

‘Negotiating should develop a ‘partnership’ approach - not an adversarial one.’ That is the key message in the Leadership section, which outlines some ‘must do’ approaches to help.

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Implementation of pharmacist-led falls-related medication reviews: a quality improvement project (QIP)

Alexandra Cardoso, Senior Rotational Pharmacist; Patricia McCormick, Lead Pharmacist for Integrated Medicine; Poureya Aghakhani, EPMA pharmacist; Pharmacy Department, Whittington Health NHS Trust, London. Correspondence to: alexandra.cardoso@nhs.net

Abstract

Title
Implementation of Pharmacist-led falls-related medication reviews: a quality improvement project (QIP)

Author List
Cardoso A, McCormack P, Aghakhani P.

Introduction

The risk of falls is multifactorial. Medication reviews can play an important role for patients taking medicines known to contribute to falls.

The aim of this project was to implement medication reviews for patients at high risk of falls on a gastroenterology ward and, therefore, contribute to a reduction in falls risk. A process map showing the multifactorial approach on falls risk reduction was created and helped to highlight the problem. This project was the first of its kind at Whittington Health, where formal documented falls-specific medicines reviews were not a part of standard practice.

Methods

Medication reviews were conducted by reviewing the patient’s history and medication reconciliation, followed by targeted screening of medication that could contribute to falls risk. For this project the Plan-Do-Study-Act (PDSA) cycle methodology was used as it allowed for small changes in a quick and efficient process through repeated PDSA cycles. PDSA cycles 1 and 3 involved conducting medication a review; PDSA cycle 2 was comprised of a literature search to obtain a suitable tool to enhance medication review efficiency.

Results

Initially, a medication review was completed on patients at high risk of falls (time taken for a review 2 hours and 40 minutes). During the third PDSA cycle, during which the tool was implemented, a total of 12 patients were reviewed; sixteen recommendations were made and seven were accepted. The average number of reviews per day was 2 and the average time taken per review dropped significantly with the introduction of the tool (to 45mins per review at the end of the project).

Conclusions

The main outcome of the third PDSA cycle was that the medication review tool made a significant impact on the time taken to complete reviews. However, the tool may need to be reviewed and adjusted for systematic use by pharmacists and doctors.

Keywords: care plan, gastroenterology, risk factors, PDSA.
completes a number of actions outlined on the ‘very high risk falls’ sticker (the sticker is designed to be clear and user friendly) and this must be placed in the patient’s medical notes. A sign is also placed on the patient’s bed and a yellow magnet is added to the main whiteboard of the ward, which lists all patients. This magnet allows the remaining ward based teams to identify that the patient is at increased risk of falls.

When patients are admitted to the Whittington Hospital they are assessed regarding the risk of falls and a care plan is put in place during admission; this is a part of the Trust’s ‘STOPfalls’ campaign. One aspect of the initial assessment is a simple review of medications associated with falls. If any ‘falls risk medications’ are identified then the patient should have a formal falls medication review by doctors and/or the pharmacist.

The Whittington Hospital policy states that the pharmacy department is responsible for reviewing a patient’s medication on admission and following a fall on the ward. Pharmacists are not currently conducting formal/documentated medication reviews as a part of routine practice. This has highlighted an area of improvement where pharmacists can play a very important role in falls prevention.

The project was undertaken with the cooperation of the AIFG, a multidisciplinary team that had no pharmacist representation until the project began. The primary aim of this project was to implement medication reviews for 100% of patients identified to be at high risk of falls on the ward and, therefore, contribute to falls risk reduction. The secondary aim was to monitor progress against pre-defined process measures.

**Method**

**Setting**
The project ran on a 33 bedded ward, mainly comprising of gastroenterology patients (Victoria ward), which is the ward with the highest incidence of reported falls at the Trust.

**Intervention**
The baseline measurement was that no patients on Victoria ward at high risk of falls had a medication review formally documented by a pharmacist and/or doctor.

The review methodology involved obtaining the past medical history from the patient’s notes, reviewing (or conducting) a medication reconciliation and, finally, clinically screening prescribed medicines as per standard clinical practice. Following this, a targeted review

“... the pharmacy department is responsible for reviewing a patient’s medication...following a fall on the ward.”
focusing on medicines that can increase risk of falls was thoroughly undertaken. Individual medications were reviewed against relevant hospital and NICE guidelines; recommendations were cross-referenced with the STOPP/START tool.4

From PDSA cycle 3 onwards, reviews included using the STOPIT tool2 to identify and review high risk medication. This tool was obtained by contacting the corresponding authors of the paper describing the use of this tool for deprescribing purposes.1 The STOPIT tool was also used to document the review and make recommendations to the medical team.

During this project, senior pharmacist support was required (particularly from a specialist with experience of conducting falls risk medication reviews). Extensive support was provided by senior clinicians who incorporated the study into the AIFG working group. A specific quality improvement (QI) group was created to support the project, which included the head of governance and risk, the quality improvement and compliance manager, the ward manager and a senior nurse.

Awareness of the project was raised through the members of the QI group via clinical multidisciplinary meetings (including board rounds and nursing handover). Medical and nursing teams welcomed the idea, particularly the nurses as this project could improve the reputation of the ward regarding falls. An audit was conducted to check baseline data regarding compliance with the ‘Falls risk assessment and care plan’ to see if there was a need for further training. All patients had the ‘Falls risk assessment and care plan’ completed (100%) but it was presumed that the time taken to complete this fully was prohibitive.

Study of the intervention
For this project the ‘Model for Improvement’ (MfI)5 was used to provide a methodological structure. The MfI was selected as it allowed for small changes in a quick and efficient process through repeated Plan-Do-Study-Act (PDSA) cycles. This project focussed on the use of repeated PDSA cycles rather than the full MfI.

According to AIFG, there were no medication reviews taking place on the ward in view of reducing the risk of falls, thus the main aim of the project was to implement falls reviews and measure implementation.

The study was not designed to determine if medication reviews had an impact on falls risk.

Measures
The outcome measure was the implementation of medication reviews for 100% of patients identified as being at high risk of falls.

Regarding the process measures, this project focussed on:

- a) time taken per review (hours)
- b) number of reviews completed per day
- c) number of recommendations made
- d) number of recommendations accepted by the medical team.

Analysis
Quantitative data were collected of the process measures described above. This project was designed to explore the implementation of medication reviews on a ward with no baseline data as the aim was to change the current standard of practice.

Discussion

Summary
This study describes the process of implementing targeted falls risk medication reviews on a ward where this is not standard practice. The most significant finding of the project was the reduction in the average time taken per review following the implementation of a structured tool. One challenging aspect of incorporating medication reviews for all patients with a high falls risk was the time required to complete the review.

Interpretation
The initial review (during PDSA 1) had taken 2 hours and 40 minutes, which was found to be prohibitive when trying to incorporate medication reviews into standard clinical practice. The main reasons for this were lack of familiarity with falls specific medication reviews by the reviewer and the unstructured approach to reviewing medication. Whilst the experience would cover the former, it was determined by the project team that a structured tool could support targeting...
Figure 1: A process map showing the multifactorial approach on falls risk reduction
<table>
<thead>
<tr>
<th>Cycle</th>
<th>Plan</th>
<th>Do</th>
<th>Study</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To reduce falls risk on Victoria ward by conducting medication reviews to reduce the number of high risk falls medication.</td>
<td>A single review was conducted.</td>
<td>The review was completed in 2 hours and 40 minutes. Four recommendations were made following the review. Two were accepted by the medical team.</td>
<td>The review was not found to be time efficient.</td>
</tr>
<tr>
<td>2</td>
<td>To conduct a literature search to identify evidence based tools to support medication reviews.</td>
<td>A brief, non-systematic search of Medline and Embase was conducted using the key words ‘falls’ and ‘medication reviews’.</td>
<td>Several tools were identified, including the Beers criteria, the STOPP tool and the STOPIT tool.</td>
<td>The tools identified were assessed for practicality and the STOPIT tool was selected. This was due to the convenience of being in ‘ready-to-use’ format.</td>
</tr>
<tr>
<td>3</td>
<td>To incorporate the STOPIT tool into the medication review process.</td>
<td>Twelve patient reviews were conducted.</td>
<td>The average number of reviews per day was 2. The average time per review was 1.03 hours (days in which there were no new patients were excluded). In total 16 recommendations were made and 7 were accepted (44%).</td>
<td>The tool was found to enhance time efficiency.</td>
</tr>
</tbody>
</table>

### Table 1: PDSA cycles in the implementation of medication reviews as an intervention to reduce falls risk

<table>
<thead>
<tr>
<th>Cycle</th>
<th>Do</th>
<th>Study</th>
<th>Act</th>
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</tr>
</tbody>
</table>

### Table 2: Results of process measures for PDSA cycles 1 and 3

<table>
<thead>
<tr>
<th>Number of patients at high risk of falls and medication review requested on ‘Falls risk assessment and care plan’</th>
<th>PDSA 1</th>
<th>PDSA 2</th>
<th>PDSA 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients at high risk of falls already reviewed</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Number of new patients at high risk of falls reviewed</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total number of recommendations made</td>
<td>4</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total number of recommendations accepted</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Average time taken per review per week (hours)</td>
<td>2.67</td>
<td>1.29</td>
<td>1.06</td>
</tr>
</tbody>
</table>
of evidence based ‘high risk’ falls medication.

This led to PDSA cycle 2, which involved a literature search to find a practical tool. The literature search identified several screening criteria and evidence based guidance and tools available for medication review. Ultimately, the STOPIT tool was selected for three main reasons; designed for practical use by a clinical pharmacist, the basis for the tool was a broader study comprising of five different hospitals in London including documentation of medication reviews as an outcome measure and, finally, the tool was presented in ready-to-use format. Whereas criteria/guidance such as STOP/START and the Beers criteria present medication lists and make recommendations on their appropriate use (or discontinuation), the STOPIT tool was designed for a structured medication screening process and also clear documentation which can readily be filed in the patient notes. Thus, for practical reasons, the STOPIT tool was selected.

Following the implementation of the STOPIT tool, reviews were significantly shorter in duration, decreasing from an average time of 2 hours 40 minutes (during PDSA 1) to 45 minutes (the final week of PDSA 3). The drastic reduction in time spent from PDSA 1 to the first week of PDSA 3 (average of 1 hour 17 minutes) is very likely to be the impact of the tool and less likely to be due to the impact of increasing reviewer familiarity or growing experience. The impact of reviewer experience can be seen between the difference of week 1 to week 3 during the third PDSA cycle (from 77mins to 45mins). Though this project was not designed to measure the difference between structured approaches to medication reviews with an unstructured approach, it may be noted from the reduction in average review time that the impact of a structured tool makes a greater immediate impact than that of growing user experience, with the reduction in review time over three weeks highlighting the need to incorporate the reviews into standard practice and allowing time for the process to embed.

During this study a total of 9 recommendations were accepted by the medical team, mainly comprising of dose reduction of antihypertensives such as ramipril, atenolol and amlodipine; gliclazide and zopiclone were stopped in two patients. The main limitation to accepting recommendations by the medical team was that junior doctors did not feel confident to change therapy without consulting a senior doctor. This finding, though not formally measured as an outcome, is consistent with similar studies. Future work should consider the timing of presenting recommendations to the medical teams, as there will likely be greater acceptance rates when registrar or consultant grade doctors are available (e.g. ward rounds).

At the end of the study period, the tool was presented to doctors on the ward (representatives of the two main clinical teams) and feedback was given. The feedback settled on two main recommendations: to reduce the information available on the tool and to attempt to risk stratify the ‘high risk’ medicines. The doctors found the comprehensive list of ‘high risk’ medication difficult to read, though this may change as the doctors become more familiar with the tool. Nonetheless, future work could involve a combination of risk stratification of ‘high risk’ medicines with a reimagining of how the information is displayed. On balance, between brevity and detail this cohort of junior doctors would have preferred brevity; however, this may not be appropriate where context or greater detail is required to make a more informed clinical decision. Alternatively, the tool could be adapted for display as a poster (with separate sections for different medicine classes); this would be a consideration for future work to enhance the awareness of medication reviews amongst junior doctors, which is known to be lacking. Future work will include adapting the tool to enhance ease of use by pharmacists and doctors on all wards.

The involvement of the entire multidisciplinary team was very important for the STOPfalls strategy and also this project. Fortunately, the AFAIG was very supportive of this project and invited pharmacist representatives to attend the

### Table 3: Number of recommendations made and accepted by medical team.

<table>
<thead>
<tr>
<th>Falls risk medication class</th>
<th>Total number of recommendations accepted</th>
<th>Falls risk medication discontinued</th>
<th>Falls risk medication dose reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEi – Ramipril</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>CCB - Amlodipine</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>z-drugs - Zopiclone</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Antidiabetics - Gliclazide</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Beta-blockers - Atenolol</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
regular STOPfalls meeting. Anecdotal feedback from the AFAIG included the belief that a comprehensive medication review was most easily incorporated into the usual role of the pharmacist due to their specialist knowledge of medication (including uses, doses, side effects, etc), the practicalities of medicines administration and medication safety; the group ultimately believed the incorporation of the pharmacist was important in creating a comprehensive STOPfalls strategy and particularly when focussing on medication reviews.

Limitations
This project was limited due to the design being unable to formally analyse whether pharmacist-led medication reviews produce an impact on falls incidence. The number of ‘high risk’ medications, and the use of a proportion of recommendations accepted by the medical team as proxy measures of falls risk limit the practical use of such studies. Experimentally designed studies following patients over a prolonged period of time are still required to determine if reducing the number of ‘falls risk’ medications produces a reduction in the number of, or the harm caused by, a fall. This study was also limited by the lack of formal statistical control and analysis. Future studies should be designed to allow for statistical validation of the process measures.

Due to limitations of time, the search strategy employed during PDSA 2 was not systematic (lack of MeSH terms) or comprehensive (only two databases searched). The search was conducted with an aim of finding an evidence-based and immediately available tool in ready-to-use format. This limitation of the search strategy may have precluded the identification of other practical tools.

Conclusions
Marvin et al supports that medication reviews should be carried out for inpatients at risk of falls to minimise the risk of harm and that the involvement of a pharmacist reduces the number of high falls’ risk medicines.1

This article describes the process of implementing formal medication reviews with an aim of reducing the number of high risk medicines prescribed to patient’s identified as being at greater risk of a fall. The implementation modality was via three PDSA cycles.

Following completion of PDSA cycle 3 the number of medication reviews increased. The project did not meet the aim of implementing medication reviews for 100% of patients identified to be at high risk of falls; however, the time taken per review was significantly reduced with the implementation of the tool (from 2 hours 40 minutes to 1 hour 29 minutes per review).

The project found that, in order for the medicine review tool to be used by pharmacists and doctors, there is a need for an assessment of whether adaptation of the STOPIT tool can enhance efficiency. This study identified that more training will have to be provided to the nurses, highlighting the group of medicines that can contribute for the risk of falls so that the initial identification of ‘high risk’ patients (typically conducted by nurses) is accurate.

Declaration of interests
The authors have nothing to disclose.

REFERENCES
Diary Dates with Pharmacy Management in 2019

JoMO-UKCPA Cardiovascular Workshop
Date: Wednesday 2 October 2019
Venue: Amba Hotel, Marble Arch, Bryanston Street, London W1H 7EH.

Pharmacy Together Conference
Date: Friday 8 November 2019
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How GP clinical pharmacists are developing respiratory medicines optimisation

Kay Saini, Lead Prescribing Advisor and Lead Commissioner for Adult Respiratory Services, NHS Waltham Forest Clinical Commissioning Group. 
Correspondence to: kay.saini@nhs.net

Abstract

How GP clinical pharmacists are developing respiratory medicines optimisation.

Title

Author List

Saini K.

Summary

The article outlines how role of the GP clinical pharmacist has developed in optimising medicines for patients with respiratory disease.

Keywords: GPCP, inhaler, adherence, monitoring, coding, holistic, self-management.

Aim

This paper sets out how medicines optimisation can be implemented for patients with respiratory disease by a pharmacist working in a GP practice i.e. a GP clinical pharmacist (GPCP). It also seeks to identify the various roles that can be performed by a GPCP to improve patient outcomes.

Introduction

According to the British Lung Foundation, an estimated 12.7 million people in the UK (approximately one in five) have a history of asthma, chronic obstructive pulmonary disease (COPD) or another longstanding respiratory illness.1 They also report that lung disease costs the UK over £11 billion each year.1 In the current climate, where the focus of the NHS is on promoting value for money in spending on medicines, it is paramount that medication is prescribed appropriately and used correctly to ensure outcomes for patients with respiratory disease are optimised whilst minimising medicines waste.2

Until recent years, GPs and nurses traditionally undertook the management of patients with respiratory disease. Although pharmacists have always been involved in various ways, the opportunity to contribute further increased significantly following the launch of the NHS England Clinical Pharmacists in General Practice Programme in 2015. This pilot scheme recruited more than 490 pharmacists to work across 658 GP practices with the aim to improve value and outcomes from medicines. As a result of this large scale pilot scheme, the landscape has evolved with the GPCP now playing a crucial role in the management of patients with long term conditions such as respiratory disease.3

As experts in medicines and their use, pharmacists play an integral part in ensuring patients are on the right medication and that they are able to use their medicines effectively.3 It is their location in a GP practice that provides an opportunity to enhance this role and engage further in direct patient contact. The scope of the GPCP need not be limited to the chronic disease management of patients with respiratory disease; they can also have a pertinent role in the management of acute exacerbations.3 GPCPs can assist patients discharged from hospital following an exacerbation or manage patients who are at a high risk of an exacerbation to prevent them from being admitted to hospital.3,4,5 GPCPs can support patients to identify triggers and recognise symptoms that may indicate a deterioration in their condition.4 The GPCP can tailor advice to the individual patient to ensure the patient can manage their condition better and adopt strategies to avoid triggers, combined with appropriate pharmacological interventions.3 This innovative practice of having GPCPs as part of the practice workforce means that their skills can be integrated as part of coordinated care to improve patient outcomes and safety, whilst reducing prescribing and downstream care costs.3

“. . . having GPCPs as part of the practice workforce means that their skills can be integrated as part of coordinated care to improve patient outcomes and safety . . .”

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Inhaler technique

Effective management of respiratory disease requires a move towards clinician-patient partnership, which features high in the medicines optimisation agenda. Before adjusting the dose of treatment in response to poor control, consideration should be given to the inhaler device. Choosing the correct device for the patient is key in optimising overall clinical outcomes. The most cost-effective inhaler is the one that the patient can use effectively and is willing to use on a regular basis. Suitable trained GPCPs with knowledge of the different devices available on the market and how each device works are able to help patients make informed decisions to identify the most suitable inhaler device for their clinical management. GPCPs with the skills to be able to identify devices that are not suitable for a patient and who are able to switch or recommend an alternative device, may improve the quality and cost effectiveness of care in the long term.

Embedding good inhaler technique remains one of the key goals of medicines optimisation in respiratory disease. This has become vital when considering the plethora of inhalers available on the current UK market, which continues to grow and confuse both patients and prescribers. As part of the proactive review process, suitably trained GPCPs are able to assess inhaler technique. They are able to identify critical errors and address these to ensure the patient can use the device effectively. In addition to this, GPCPs can use certain tools to measure the patients’ inspiratory flow rate and train them to achieve rates, which are suitable for effective use of their inhalers.

Prescriber education

The introduction of a number of branded generic devices across the UK market means that there is an urgent need to educate prescribers on the importance of prescribing inhalers by brand and device type. Should this issue remain unaddressed, there is a risk that patients may receive unfamiliar devices that they are not able to use effectively, resulting in possible therapeutic failure and associated poor outcomes for the patient. To alleviate this issue, GPCPs can interrogate the clinical practice system to identify all patients who are prescribed inhalers generically and seek to help the patient select the most suitable inhaler device.

Optimising therapy by ensuring that patients are on one single inhaler device type for their overall management encourages good inhaler technique. Optimising treatment with the same inhaler device and simplifying medication regimes can ultimately help improve patient outcomes and is an important consideration when choosing a new device or optimising treatment.

Adherence

It is well documented that suboptimal adherence to medication is associated with poor symptom control, higher
healthcare utilisation, reductions in quality of life and increased healthcare costs. A suitably trained GPCP is well placed to undertake a pragmatic individualised structured review, tackling not only the issue of inhaler technique but also addressing adherence issues. Non-adherence is often complex, involving a number of factors. Non-adherence may be the outcome of patient perception or associated with the practicalities of medicine-taking or even a combination of the two and therefore can be classified as non-intentional or intentional. The perceivable benefits of prophylactic therapy with inhaled corticosteroids (ICS) may not always be apparent to the patient, resulting in non-adherence. GPCPs are in a good position to help promote an open dialogue of the rationale and likely benefits of regular ICS therapy versus perceived disadvantages of treatment.

Monitoring treatment for outcomes

The GPCP remit is currently restricted to management of the patient once a confirmed diagnosis is in place. GPCPs can therefore monitor for therapeutic outcomes and take appropriate follow-up actions to ensure medication is optimised and appropriate for the patient. In recent years, a new body of evidence has emerged which suggests that the continuous use of high dose inhaled steroids increases the risk of pneumonia in patients with COPD. GPCPs are suitably qualified to assess the risks of ICS against the benefits of treatment on a case-by-case basis. They are able to fine-tune the dose of the ICS to minimise the risk whilst ensuring that the dose remains effective for the patient. GPCPs are able to decide if it is possible to withdraw the ICS safely in patients with a low risk of an exacerbation, minimising side effects and as a by-product reducing the cost of prescribing.

Some patients have a poor perception of their condition or may either have unconsciously accommodated to their symptoms or attributed their symptoms to other causes. Medical records alone may not truly reflect control. Suitably trained GPCPs who are skilled at using tools such as the asthma control test (ACT) or COPD assessment test (CAT) can standardise assessments as part of the medication review process. Based on the numerical score, the GPCP can distinguish between different levels of control and adjust therapy accordingly. The patient’s perception of their control and attitude towards their condition is an area that the GPCP can then evaluate effectively as part of the structured medication review. A GPCP can be an invaluable resource in terms of educating clinicians and other healthcare professionals on the use of these validated tools to assist in assessing symptom control.

Although diagnosis is currently not within the GPCP’s scope of practice, they are, however, able to highlight patients who require a diagnosis to be revisited. This may be required where the GPCP has explored and ruled out all factors that could possibly result in therapeutic failure. GPCPs can help to identify patients where a differential diagnosis may be required, facilitating a review of the disease registers. This intervention can ultimately ensure patient outcomes are improved by enabling the patient to receive an early and accurate diagnosis, enabling the correct disease management to be implemented.

Improving coding

Anecdotal evidence suggests that coding remains one of the greatest challenges facing general practice. Suitably trained GPCPs are able to support practices to improve clinical coding, complete system templates whilst conducting reviews and ensure patients are coded correctly. This simple intervention can assist practices to ensure that patients are followed up in a timely manner and that high risk patients do not slip through the safety net.

Holistic care

Many GPCPs can bring additional benefits to patient care e.g. those who are suitably trained to deliver vaccinations. This allows practices to meet their vaccinations targets. It also brings with it benefits to the wider health economy, minimising the risk of spread of disease whilst improving patient outcomes and reducing mortality from disease like pneumonia and influenza.

GPCPs also have expertise in intervening in minor ailments and advising respiratory patients on conditions that lend themselves better to self-management with medicines available over-the-counter. Familiarity with products that are available to patients for the management of minor conditions enables GPCPs to support practices in implementing the new NHS England recommendations on over-the-counter medicines.

The GPCP role is not restricted to just pharmaceutical input, but can be extended to patient education, prevention and smoking cessation. The GPCP can be very influential in promoting smoking cessation and is able to offer advice and support on the most appropriate course of action for patients.

“GPCPs can therefore monitor for therapeutic outcomes and take appropriate follow-up actions to ensure medication is optimised and appropriate for the patient.”
who are willing to quit. They can recommend suitable smoking cessation products that can aid the patient and support them with the withdrawal symptoms associated with tobacco dependency. GPCPs who are proficient in the use of the ‘pack year calculator’ to assess the patient’s lifetime exposure to tobacco can document this in the patient notes. This numerical value can act as a useful tool to help practices proactively case find patients who may have developed COPD due to the long-term effects of smoking but who have not yet received a confirmed diagnosis.

The role of the GPCP as a clinician has been further strengthened by the development of prescribing rights, allowing both supplementary and independent prescribing. Utilising these prescribing skills of a pharmacist within a GP practice is a commodity, which enables patients to receive the correct medication without undue delay.

Having a GPCP as part of the clinical team within a practice can relieve pressure on GPs and free up their time to focus on the patients with complex medical needs. GPCPs can also be an excellent resource in managing respiratory patients with complex medicines requiring frequent monitoring or those patients with problematic polypharmacy. The GPCP can undertake holistic patient medication reviews, taking into consideration patient co-morbidities, whilst simplifying medication regimes to avoid polypharmacy. As well as identifying, evaluating and assessing for medicine-related problems, GPCPs can aid the development and the implementation of pharmaceutical care plans.

Self-management plans

Published in September 2014, the National Review of Asthma Deaths report (NRAD) highlighted the need for patients to be furnished with personalised action plans with the aim to empower patients to manage their own condition better. Now recognised as an essential part of patient self-management, the plan is intended to facilitate the early detection and treatment of an asthma exacerbation. GPCPs who have the skills to complete a management plan can, as part of the review process, issue these to patients and educate them to ensure effective use. In the same manner, GPCPs can play a pivotal role to support and motivate patients to develop and adhere to their individualised COPD management plans, encouraging them to make lifestyle modifications and implement self-care strategies to help avoid hospital admissions.

Facilitating effective communication

There are currently gaps in communication between the specialist who sees the patient in an out-patient clinic and the GP, who sees the patient irregularly or possibly in the time of a crisis, with little knowledge of what is being provided in the specialist clinic. This issue brings with it the opportunity to further develop the role of the GPCP to undertake medicines reconciliation and identify inappropriate polypharmacy post discharge from hospital. GPCPs can help to bridge the gap between the different sectors to ensure effective communication is in place and care is
seamless across the interface for the patient.

Opportunities for further development of the role

The scope of the GPCPs role can be further developed in several areas as their skills develop. Diagnosis is not an area often explored by the GPCP, however further opportunities are on the horizon with accreditation courses available to GPCPs to perform spirometry and interpret spirometry results; enabling them to venture into the diagnosis of respiratory conditions.

Making timely and appropriate referrals to specialists where interventions in primary care have been optimised, would positively contribute to ensure patients receive optimal care.27 Although this may be considered as a relatively simple intervention, the impact would manifest itself into benefits for the whole local health economy.

Involvement in the management of patients with respiratory disease in care homes is an arena that requires further development. The scope of interventions by GPCPs is potentially vast. From optimising vaccination opportunities to the implementation of effective systems for the ordering of medicines, GPCPs can implement a number of invaluable interventions that will not only benefit patient outcomes but can also prove advantageous to the entire healthcare system.

Educating and supporting school nurses to empower children to manage their own condition would be a positive move for the future, enabling the skills of the pharmacist to be used effectively. With school nurses on the decline and more children suffering from respiratory problems such as asthma and allergy, it is pertinent to ensure that the risk of an exacerbation is minimised.28 Implementing asthma action plans in schools and educating children to take their medicines correctly would be a positive contribution to the widening scope of a GPCP.

Measuring success

Success of the GPCP could be measured in a number of ways. In NHS Waltham Forest Clinical Commissioning Group, GPCPs have contributed hugely in reducing prescribing spend on respiratory medicines. Prescribing data comparing 2017/2018 to 2018/2019 for a 12 month period indicates a reduction in spend by £286k accompanied by a reduction of 6,884 in the number of items issued.31 Local data also highlights that, in 2018/19, an additional 812 patients with a confirmed diagnosis of asthma were issued with an asthma action plan and 238 more patients received a spirometry test to confirm diagnosis of COPD. The success of the GPCP is not restricted to simply these parameters, as they can also have an impact on reducing non-elective admissions. For practices, one of the benefits of having a GPCP is that they are able to positively contribute to Quality and Outcomes Framework (QoF) attainment, which brings with it financial benefit to the practice.27

Summary

Practices continue to face unprecedented and growing demand due an ageing population, polypharmacy and multiple comorbidities. GPCPs can be a vital source of clinical care, especially if they are independent prescribers. They are able to contribute hugely to patient care and support the medicines optimisation agenda as well as implementing local medicines formularies. Despite this, GPCPs are still to some extent a significant unexploited potential who are able to deliver clinical interventions efficiently and in high volume, generating considerable financial returns on investment, but more importantly are able improve patients’ quality of life and outcomes.

Declaration of interests

The author reports:

• family member currently practicing as a GPCP
• current membership of the London Respiratory Clinical Network
• personal fee offered by Pharmacy Management to write the article.

“. . . GPCPs are still to some extent a significant unexploited potential . . .”
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Pharmacy Management
Progress through partnership
**Question:**
What is your job title?

**Answer:**
Advanced Pharmacist Practitioner – Northumberland Memory Service and Older Adult Community Treatment Teams.

What are your main responsibilities/duties?
The Northumberland Memory Service is a specialist assessment and diagnostic pathway for people experiencing cognitive difficulties. For those who are given a diagnosis of dementia some will be eligible for treatment with cognitive enhancing medication such as donepezil or memantine. My role is to review these patients once they have been commenced on these medications to ensure they are not suffering with any major adverse effects, titrate doses as clinically indicated and issue prescriptions as required. Where patients do not tolerate first-line therapy I identify suitable alternatives wherever possible and consult closely with patients and their families to ensure we find a treatment that suits the patient best.

Due to the number of patients who require this follow up, the majority of my work consists of telephone consultations although I am available to visit patients at home if any specific concerns arise. Once patients are established and stable on treatment they are discharged back to the care of their GP, whom I liaise with to hand over relevant prescribing information to facilitate safe on-going prescribing.

To whom do you report and where does the post fit in the management structure?
This has been one of the more tricky things to establish due to working in different services. Whilst I am embedded into older adult community teams I remain a senior member of pharmacy staff and am managed by a Lead Pharmacist. From an operational perspective I report to the relevant clinical lead nurse and community clinical matron who manages older adult community services as a whole.

How was/is the post funded? Is the post funded on a non-recurring or recurring basis?
The post was initially funded as a pilot with money that had been allocated for medical staff. However, due to the success of the trial, the funding was allocated on a permanent basis.

When was the post first established?
The post was established in December 2017.

Are you the first post holder? If not, how long have you been in post?
I was the first pharmacist post holder and continued in that role until April 2019 when I was tasked with establishing a new Advanced Practitioner role within a similar pathway.

What were the main drivers for the establishment of the post and how did it come about?
Until June 2018 cognitive enhancing medication had to be initiated by a specialist in secondary care, meaning that prescribing was managed by secondary services until a patient had been stabilised on a medication.

Another major driver was the amount of time the process took and what that meant in terms of preventing colleagues from conducting other activities.
need to contact the patient directly, which meant they had less time to spend with patients on diagnostic reviews. It made better sense to have the role performed by a professional who could undertake all of the activities from the medication review through to prescribing and who would act as a single point of contact for patients if they had any difficulties during their treatment journey.

What have been the main difficulties in establishing/developing the post to its current level?

There were a number of procedural difficulties. Although all of the hubs are located within the same county, Northumberland has a unique geography and all the bases were widely spread out. Each hub also operated slightly differently, which often made it difficult for me to navigate.

There was initially some trepidation from some of the psychiatrists as many had never worked closely with a pharmacist before and they didn’t know anything about me or my experience in the clinical area. This was fairly easy to overcome once I became more established in post as we developed therapeutic working relationships and they became confident that I would handle what I was competent to do but would seek guidance and have clinical discussions where necessary.

What have been the main achievements/successes of the post?

The team as a whole has worked very hard to establish this role within the pathway. We have tried to streamline this as much as possible with the use of standard templates for communicating with primary care and administrative staff booking patients into an electronic diary in advance, which allows me to focus more on the clinical rather than operational aspects of the role.

From a personal perspective the post has given me confidence in my ability as a prescriber, having only been qualified to do so since March 2017. I learned a lot of practical lessons around risk management, governance and communications than I ever expected to and this experience has made me more robust in my approach to prescribing – it’s not all about the clinical issues!

The role helped to demonstrate the value a pharmacist could bring to Older Adult Community Mental Health teams; indeed, the success of this role led me into the post I’m currently working in and developing.

My work was featured as a poster presentation Clinical Pharmacy Congress this year (2019) and at the annual College of Mental Health Pharmacy conference in November 2018 where it won the runner-up prize in the service development category.

What are the main challenges/priorities for future development within the post which you currently face?

For me personally, I found the lack of face-to-face contact with patients very difficult. I had gone from an inpatient role interacting with patients every day to spending the whole day conducting telephone reviews. There are benefits, however, associated with this approach for both the service and the users of our service. Not having to conduct face-to-face visits does save time and means that more patients can be reviewed each day.
Similarly, where patients are tolerating their medication well they may not feel the need to be seen face-to-face. In some cases reviews are conducted in the patient’s home where there may be particular concerns or risks.

**What are the key competencies required to do the post and what options are available for training?**

This was an attractive post for me as a newly qualified independent prescriber with experience and a real passion for working in old age psychiatry. Experience as a prescriber or relevant clinical experience in the specialist area would be necessary for working in this or a similar post. The Pharmacy department at Northumberland, Tyne and Wear NHS Foundation Trust has a strategy for developing our independent prescribers and this will likely support our junior staff to be equipped to do similar roles in the future. I also encourage pharmacists undertaking their independent prescribing qualification to spend time with me during their training to understand more about the role in practice whilst they are learning about the theory behind it and developing their portfolio.

**How does the post fit with general career development opportunities within the profession?**

This post is very much in keeping with the clinical developmental route within the profession. This is an ideal role for an advanced practitioner with a specialist interest in a specific clinical area and the potential to become a Consultant Pharmacist.

**How do you think the post might be developed in the future?**

As the role has become more established, the decision was made for a nurse prescriber to take over to allow me to support staff and patients in the Community Treatment Team (CTT). The CTT support clients with more complex care and treatment needs and it was felt my expertise would be better utilised with this cohort. This is another brand new role that is very much in its infancy.

For my current patient caseload I am continuing to prescribe cognitive enhancers but am also broadening my scope of practice by managing other medicines including lithium titration. I’m also identifying clients under our care who are living with dementia and are prescribed an antipsychotic medicine and actively reducing and withdrawing these wherever possible given the significant associated risks.

**What messages would you give to others who might be establishing/developing a similar post?**

It’s really exciting to have the opportunity to develop a new post, but there should be an awareness that not everything will always go to plan. Identify the key people who are there to support you and get them involved early when things start to get tricky. Most of all, you should never be afraid to make that leap of faith - even if things don’t work out quite as you expected, you will always learn a lot from the experience..

**Do you have any Declarations of Interest to make and, if so, what are they?**

Personal fee offered by Pharmacy Management as a contribution for writing the Face2Face.
Diary Dates with Pharmacy Management in 2020

JoMO-UKCPA Respiratory Workshop
Date: 12 March 2020
Venue: The MacDonald Burlington Hotel, Burlington Arcade, 126 New Street, Birmingham B2 4JQ

PM Celtic Conference
Date: 26 March 2020
Venue: Mercure Cardiff Holland House Hotel, 24 - 26 Newport Rd, Cardiff CF24 0DD

JoMO-UKCPA Diabetes Workshop
Date: May 2020
Venue: London

JoMO-UKCPA Medicines Optimisation of long-term conditions in Older People
Date: June 2020
Venue: London

Pharmacy Management National Forum for Scotland
Date: 27 August 2020
Venue: Glasgow

JoMO-UKCPA Cardiovascular Workshop
Date: October 2020
Venue: London

Pharmacy Together Conference
Date: November 2020
Venue: London

Pharmacy Management National Forum for Wales
Date: Autumn 2020
Venue: Cardiff

Pharmacy Management National Forum for Northern Ireland
Date: Autumn 2020
Venue: Belfast
MANAGEMENT CONUNDRUM

Trouble at the mill!

Janet Donit, Chief Pharmacist at Metropolis NHS Trust, had just outlined a problem that had cropped up between two members of staff. One had been in the department for some time and the other had joined some six months ago. They were not getting along together.

“That's a bit of a co-incidence’ said Carey Whitecoat, Head of Medicines Optimisation at Riverdale Primary Care Organisation, ‘but it's a common issue so perhaps it's not all that surprising after all!”

“Yes, unfortunately it is,” responded Janet, “and it’s one that has cropped up before in my department also and, I dare say, it will do so again.”

“I can understand the clash in your department to some extent,’ said Carey. ‘They do seem a bit incompatible. One jumps in with both feet and the other takes ages before they commit - but you’d think they would be able to get along OK! It just sours the atmosphere. It's not dissimilar, though, to what is going on in my department. All was going along swimmingly but it has come to my attention recently that two of my direct reports are hardly speaking to each other. I can’t let things go on like that.”

“We have to think of the impact on our respective teams, to say nothing of the impact on the service and patients. You have to expect that people will have different views but that shouldn’t stop them getting and getting the job done. We need to nip this in the bud and make sure we have done all we can to head off anything like that in the future”, said Janet decisively.

“Sounds good to me,” said Carey. “What’s the plan!”

What would you suggest? It can be most disruptive when team members do not get on. What can you do about it and can you really spot a potential problem in advance?

Judith Vincent, Clinical Director - Pharmacy and Medicines Management, Abertawe Bro Morgannwg University Health Board, Wales. Correspondence to: judith.vincent@wales.nhs.uk

Effective and timely conflict management starts with confident leadership

Stephen Covey’s book on ‘The 7 habits of highly effective people’, first published in 1989, is a renowned piece of leadership and management wisdom; these habits are equally applicable to having successful conflict conversations.

Conflict is an inevitable part of life when people work together. Eventually, unless they have been very fortunate, leaders will encounter conflict. This is a challenge that comes with the territory. Whilst a daunting task, conflict left unresolved and ignored has the potential to fester and grow into something bigger and more damaging. Janet and Carey must think of the wider ramifications here; it’s not just the antagonists who will be impacted, everyone in the vicinity will be feeling the antagonism.

‘Begin with the end in mind’ (Habit 2)

In managing any conflict, managers should ensure that they are clear about the destination they want to arrive at before they proceed with addressing the problems they have identified i.e. ‘begin with the end in mind’. It is worthwhile giving some advanced thought to the issue before simply plunging in to identifying the solutions. It is vital, at the outset, to gain consensus with the antagonists that they are happy to meet to discuss the factors involved in the underlying tensions.

To allow a productive discussion, it is necessary to create a safe and neutral
environment for all involved and to ensure sufficient time to air the issue. At the outset, ensure clarity of purpose for the meeting and agree that the sole purpose is to resolve the conflict. Each individual should be encouraged to summarise the issue from his or her perspective, with the managers engaging in an active and empathetic listening style. It should be clear that no one is going to take sides and the meeting should focus on the work issues, leaving the personalities to one side.

Key in these discussions is to gain a consensus and common perception of the problem before seeking any potential solution. Indeed, clarity at this point may even be the resolution itself. If the conflict is because of personality incompatibility it should be reiterated very clearly that, whilst disagreements happen, it is unprofessional and unacceptable for these to surface in the workplace.

**Think Win Win’ ( Habit 4)**

The win/win approach to generating the solution may take longer to achieve but will avoid any of the parties feeling disgruntled. The agreement should also meet the needs of the organisation and be written up with clear actions and key milestones. There should be a plan for regular follow-up and review.

**‘Be pro-active’ ( Habit 1)**

Janet and Carey must be proactive. Covey says that proactive people take the initiative and ‘work on things they can do something about’. Engaging proactively in a conflict situation leads to a worthwhile end and will preserve relationships, minimise debris from ongoing conflict and ensure that moral in the team is preserved.

“In managing any conflict, managers should ensure that they are clear about the destination they want to arrive at before they proceed with addressing the problems they have identified i.e. ‘begin with the end in mind’.”
It is a rare boss who can spend enough time with their team to spot this kind of problem developing. In fact, it is quite likely that by the time it comes to attention it has already been continuing for some time and attitudes have become entrenched.

Given that human relationships are involved it is not surprising if large teams include people who find it hard to get along. Nor is it essential that all the staff should be close friends; people can work together without having any interest in socialising. My father worked for some time with a man he disliked intensely but who happened to be a very good engineer. However, a team will not function well for long if there is friction.

There is always a temptation to delay taking action in the hope that things will improve with time anyway. This is usually a mistake; by the time the problem is big enough to come to our attention, people below us have been trying to deal with it for some time and there is a real risk that staff will be forming into camps.

This suggests a good starting point. We need to verify exactly where we are with someone we trust. Ideally, this will be someone who is still on good terms with both the individuals. Emphasising that we have no interest in taking sides, but are instead focusing on finding a resolution to the issue, we will ask them for a briefing on how this row is affecting others. Do not be surprised if nobody is quite sure how the argument began; it is a characteristic of this kind of dispute that quite often people do not agree on the trigger. If, however, there is a single known cause, then it must be dealt with on its merits. This may mean aligning with one side but be at pains to stress that there is agreement with the argument, not the person.

For example, I can recall a dispute in which A believed their line manager was not awarding a salary increase that was believed to be due. In A’s eyes, he award should be the same as that received by some other, named, colleagues. The line manager argued that the perceived difference was entirely due to length of service. On a dispassionate viewing of the facts, it was clear that the line manager was right. The problem was really that any increase expressed as a percentage benefits those who already earn more. In this case, it was possible to mollify A by agreeing that there was a point there and undertaking to raise the matter with directors.

Having ascertained the useful background, there is another choice to be made. Are the two members of staff to be interviewed together or separately? My preference is to speak to each separately in the first instance because it is easier to keep control of the discussion, but if we do this we have to create a structure that ensures impartiality and – since emotions are involved – that this impartiality can be seen. I would write myself a script to introduce the discussion. It will say that if I can resolve the point at issue then I will but, even if I cannot, this argument has to stop because it is bad for the team. I am therefore going to give each side my time to express their viewpoint, then I will take a short while to consider their comments before calling them both in for a resolution meeting. I will then ask them to confirm that they understand what is going to happen. I might also add that, for the good of the team, I will expect...
them to co-operate fully with the resolution process.

While they are giving their account it is important not to interrupt except, if necessary, to clarify factual matters or avoid misunderstanding. Any intervention runs the risk of being seen as a challenge and therefore as evidence of bias. At the end I would recite back to them the key points that I have taken from their account so that they feel that they have had a fair hearing. I would normally write up that summary and offer a copy to them.

The next key point is to invite them to clarify what, in their eyes, would make for a suitable resolution. Put the onus on the participants to help to find an answer. As with customer service issues, it is important to ask “What would be a satisfactory outcome for you?” It may also be appropriate to ask them to acknowledge the strongest parts of their opponent’s argument, though this may have to wait until the resolution meeting. Most fair-minded people will accept that there are likely to be good points on both sides, and they should not expect to get away with claiming that they are 100% right and their opponent is 100% wrong. For example, in a dispute about annual leave B acknowledged that it was probably wrong to claim that C was deliberately choosing dates that interfered with the plans of others, but was prepared to agree that it might be inadvertent. What was really wanted was for C to stop booking a long weekend over all the Bank Holidays.

Having spoken to both sides and collected their views, we need to take time to consider. This cannot be long, because there is some urgency about a resolution, but it is important to be seen to be giving mature consideration to both sides. There will then be a resolution meeting. Again, I found a script helpful. It would express my wish to end the matter that day, ideally to the satisfaction of both but, if not, then it would still end here.

There is no point in recapitulating their arguments in their entirety. If there are claims that are clearly either right or wrong they can be acknowledged, but the key here is to propose a way forward and get agreement on it. Janet will have to tell her staff that they are under no obligation to be best friends but they are expected to work together for the good of the department. If they cannot do that their future lies elsewhere. Janet will then set out her proposal for their future working. It is resolutely about the future, not the past; she will not permit reopening of anything that has gone before.

Where the dispute has been very visible or disruptive to others, it may be appropriate for Janet to address a wider audience. Again, she will not repeat what they already know, but will inform them that she has worked to promote a resolution, that the matter is now closed and that it is everyone’s responsibility to make this resolution work – and to involve her at an early stage in any future disputes that arise so that they can be dealt with before they become unmanageable.

Finally, we have to recognise that sometimes these quarrels cannot be resolved properly. Even if they appear to have quietened, it is not unusual to find that one or other party resigns relatively soon thereafter. That is always a pity, but it cannot always be avoided, nor would it be healthy to do so.

“Janet will have to tell her staff that they are under no obligation to be best friends but they are expected to work together for the good of the department. If they cannot do that their future lies elsewhere.”

Declaration of interests

- The Commentators, who are members of the Editorial Board for Pharmacy Management, have been offered a personal payment to write the commentary.
There are many kinds of leadership – some people lead from the front and are very visible and others are not so obvious but are still making essential leadership decisions. This ‘followership’ is essential as everyone is both a leader and a follower at different times. On a recent training workshop about managing change, it was very clear as we went through Kotter’s ‘8-Step Process for Leading Change’, that both leadership and followership were required - a creative collaboration that will produce results.

It is also a necessary leadership skill to be able to negotiate and feel confident that you can get to ‘yes’. In our healthcare environment, the aim of negotiation should focus on creative collaboration rather than traditional confrontation or a ‘winner takes all’ result. The ideal aim of negotiations is for those involved in the negotiation process to seek and develop new ways of arriving at better collaborative outcomes by thinking creatively and working in cooperation with the other side.

Negotiating should develop a ‘partnership’ approach - not an adversarial one. As such, negotiating teams and staff responsible for negotiating should be encouraged to take a creative and co-operative approach to finding better solutions than might first appear possible, or have historically been achieved in practice.

Every negotiation, when viewed creatively, entrepreneurially and collaboratively, provides an excellent opportunity to develop, benefit and improve synergies between both sides within the negotiated outcome.

That said, it is still important to understand and to master the traditional techniques and principles of negotiation, if only to provide a defence and strategy where the other side is firmly committed to an old-style confrontational approach.

“Negotiating should develop a ‘partnership’ approach - not an adversarial one.”
WOBL

The techniques indicated above are encapsulated with the WOBL approach.²

| W | What is it that we are negotiating about? A deceptively simple question but many negotiations fail as this is too often assumed, or not thought about. |
| O | Outcome. What would we like to get as our most desired result from this negotiation? Cover all the angles e.g. price, timescale, future deals, payment terms, less medicine wastage. |
| B | Bottom Line. What is the least amount that you would settle for and still be prepared to ‘do the deal’? Cover all the angles. |
| L | List of desires. As negotiating is about conceding in areas of lesser importance to gain in areas of greater importance, list some of the concessions here. Don’t forget to list both what you may have to concede, and what you might want to get from them in exchange. |

Once you have prepared your WOBL, you will need to prepare a WOBL from your opponent’s perspective as well.

How to Start

- Start with agreement. This can be as simple as agreeing about the timing of breaks.
- Start with a smile and be as welcoming as possible, no matter how nerve-wracking the negotiations may seem.

To get the meeting off well, start by agreeing. First of all, use something to relax everyone - perhaps just an agreement about the weather.

On another recent workshop, the use of ‘Yes Sets’ was explored. If you can create a situation where the other person says ‘yes’ three times, then they are more likely to keep saying yes. The ‘Yes Set Close’ works by setting up a repetitive pattern of ‘yes’ answers that gets the other person into a habitual response.

The questions can be quite simple to start with:

“It’s a lovely day isn’t it?”

“Do you like taking a longer coffee break?”

“Finding the budget is always a challenge, isn’t it?”

When the discussion needs to turn to the matter you need to negotiate, still start with agreements e.g. the time at which the negotiation needs to finish, that both parties wish to resolve the matter under discussion.

The Power of Questions

‘I keep six honest serving men.  
(They taught me all I knew) 
Their names are What and Why and When 
And How and Where and Who.’


Why ask a lot of questions? At this early stage you are still researching the WOBL for you and your colleague. Questions help you establish things that only your colleague knows, and asking questions enables you to control the early flow of the negotiation.

Open Questions

These are questions that start with What and Why and When and How and Where and Who. They are designed to elicit information and give the opponent a reasonable amount of leeway in the
answers they give you. They are good for establishing information.

General Open Questions
These are questions such as:

- What would you like to get out of this negotiation?
- How would you like to resolve this issue?

FOR: These give the other party free rein to put over their point of view.

AGAINST: You can lose your control of the process and/or make it look like you are not prepared.

Leading Open Questions
These are questions such as:

- Where do you think the best place to save money would be?

FOR: These give you more control by directing the conversation in the way you want it to go.

AGAINST: You may not get the answer you want. The other party does not get a free chance to give you extra information.

Confirming Agreement

Summarise your understanding of what has been agreed. Deal in facts only, not opinions.

It is important to check that the other party agrees with your summary and all the conclusions that it contains.

Now is a very good time to ask if the other party if they are happy with the deal. Many negotiators would be afraid of asking that question as it may open up a ‘can of worms’. An unhappy opponent who feels bad about the deal may, however, spend a considerable amount of time and effort undermining the deal afterwards. Far better to check what they are unhappy about now and resolve it - but don’t give anything away without getting something in exchange!

Then consider what needs to be put in writing. It’s probably best for you to do this. Confirm exactly what you would summarise, i.e:

- All the salient points
- List them exactly as they were agreed
- No opinions, only facts
- Remember that it may be read by people who weren’t there.

What Has to be Done? (WHTBD?)

So many negotiations fail to complete because everyone agrees, goes away smiling, and then waits for the deal to take place. That isn’t going to happen unless someone takes some action.

Along with your confirmation of the agreement must come a list of action points and who has to do them. This can be laid out in a fairly simple format:

<table>
<thead>
<tr>
<th>Action (WHTBD)</th>
<th>Who is Responsible</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remember – negotiation is not about confrontation. It’s about mutual respect and understanding of each party’s requirements.

“It is important to check that the other party agrees with your summary and all the conclusions that it contains.”

REFERENCES
2. WOBL. Created by Hilary Shields, Ascensys. Date unknown. Personal communication. 2019.

Further reading
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