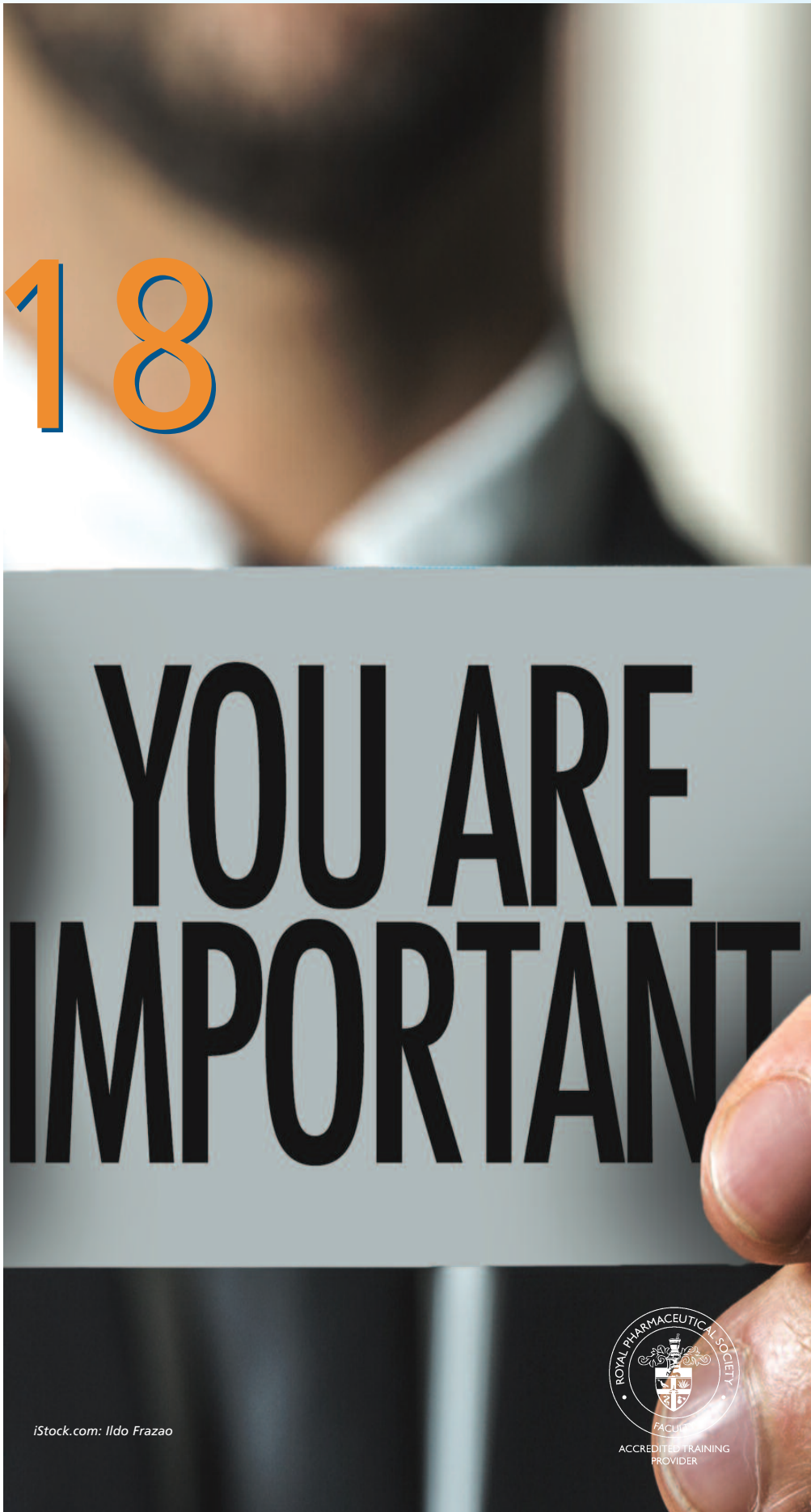
ISSN 2052-6415 (Online)
ISSN 1354-0912 (Print)

Journal of Pharmacy Management



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Oct 18

Volume Thirtyfour
Number Four

IN THIS ISSUE:

AIM OF THE JoPM

The aim of the JoPM is to play an influential and key part in shaping pharmacy practice and the role that medicines can play. The JoPM provides a vehicle to enable healthcare professionals to stimulate ideas in colleagues and/or disseminate good practice that others can adapt or develop to suit their local circumstances.

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The JoPM is made available on a controlled circulation basis to senior pharmacists in primary and secondary care and industry colleagues who work with them.

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Tel: 01371 874478

Homepage: see under the 'Journals' tab at: www.pharman.co.uk .

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BEST PRACTICE IN PHARMACY MANAGEMENT

EDITORIAL

Are care homes in your locality disposing of buprenorphine and fentanyl patches safely? Have you checked? Do you provide information and training on safe disposal practices? There may be sufficient amount of drug in a discarded patch to cause harm. The case of a 2 year old who died after placing a discarded patch in the mouth is saddening – safe disposal is necessary to avoid such a thing ever happening again. A study in Bradford has shown a significant variation in disposal practices and a lack of specific working policies. This is a helpful 'wake up' call for those who have a responsibility for medicines in nursing homes. It provides an opportunity to review and, as necessary, update and reinforce appropriate local practice for the safe disposal of transdermal opioid patches.

This edition carries a report on the outcome of a training need analysis with respect to diabetes and the provision of a multi-disciplinary diabetes workshop in primary care. The aim was to provide information on the current situation regarding diabetes care and to improve skills in planning and delivering effective diabetes education to patients. A key point to emerge was that all parties should give out a consistent message. The results indicate that the workshops were successful in improving knowledge and confidence regarding the management of diabetes care.

Pharmacists need good clinical and practical management skills. Education and training for the former has long been ingrained in the profession. Although the acquisition of management skills has been more varied, there has been an increasing emphasis on the need to do this in recent years. Is that, however, where things should rest? The development of an Integrated Care System, which is a partnership of NHS organisations, local government and the third sector, presents new challenges and an opportunity for pharmacy leaders to reflect on any additional skills, knowledge or experience they need to acquire. An article in this edition suggests that a heightened awareness of the 'softer' skills associated with group dynamics would be helpful and the experience of attending a course to develop such skills is outlined.

The 'Au Courant' section brings you up-to-date with some key aspects:

- The UKCPA has served the profession well in supporting and developing the specialties within the profession. The UKCPA's initial focus was in secondary care but this has broadened in the wake of the development of clinical roles in primary care. If you are not already a member then perhaps this is something you should consider?
- Pharmacy Management's Clinical Leadership in Pharmacy Programme (CLIP) has been well received in Scotland and Northern Ireland, as testified by attendees. It is also being run in Wales and England. Have a look and see if CLIP is something that would be useful to you or your staff.
- When asked to give a presentation or workshop, you may initially think of a lecture with slides. An article in this edition will, however, open up your thinking to alternative approaches that may be helpful and provide variety.

Our Face2Face section describes the role of a Doctoral Training Fellow. This involves scoping out research ideas, networking with key stakeholders and preparing grant applications. Is that something you would wish to implement locally?

The Management Conundrum looks at appraisal systems and our Commentators give some helpful advice on how to ensure that both the appraiser and appraisee get as much as possible from the experience.

Finally, the Leadership section stresses the need for you to look after yourself and gives some good tips on how best to do that.

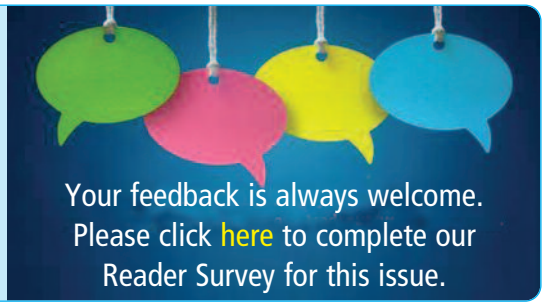
Successful submission of annual update for Royal Pharmaceutical Society (RPS) accreditation of Pharmacy Management as a Faculty Accredited Training Provider.

Pharmacy Management submitted a report to the RPS to demonstrate the progress, delivery and changes made to ensure that Faculty accredited initiatives were up to date, reflected current practice and that information was in line with a bespoke training provider action plan. The RPS subsequently confirmed that Pharmacy Management successfully met the requirements to be a Faculty Accredited Training Provider.

Pharmacy Management look forward to continuing to collaborate with the RPS in providing further support to develop the pharmacy workforce to meet the needs of patients and the public.

READERSHIP FEEDBACK

If the JoPM is to continue to publish material that you would find interesting and helpful in your practice, it is clearly important that readers feedback their views. There are various ways in which feedback is currently obtained but, with effect from this edition, a short SurveyMonkey questionnaire that will take just a couple of minutes to complete will be available for each edition.



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JPM

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THINK JOURNAL OF PHARMACY MANAGEMENT (JoPM)!

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Is it about good practice in medicines optimisation with a focus on **'optimisation'**, which relates to quality and improving patient care, rather than cost aspects?

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BEST PRACTICE IN PHARMACY MANAGEMENT

DOOP Kit, Domestic Bin Or Watery Grave? A Study Investigating Disposal Practices Of Transdermal Drug Delivery Products In Care Homes

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Dr Liz Breen


Hadar Zaman

Abstract

Title
DOOP Kit, Domestic Bin Or Watery Grave? A Study Investigating Disposal Practices Of Transdermal Drug Delivery Products In Care Homes

Author List
Breen L, Zaman H, McCulloch E and Isaq S.

Background
The issue of opioid use and misuse is current and topical at present with reports of opioid epidemics in the USA and the increasing use of opioids in other parts of the world. The New Scientist asserted that America was in the throes of an opioid epidemic with reports of fatalities linked to physical contact with fentanyl. Discussions have progressed from an American focus to speculating on the spread of this issue to UK cities, Glasgow in particular. Safety issues have more recently come to light regarding the physical application and management of specific drug forms e.g. opioid transdermal patches (OTPs). The prescribing, application and safe disposal of OTPs within both healthcare settings and personal dwellings is critical to the effective use of these products. Healthcare professionals have a duty of care and responsibility to ensure the safe application and disposal of OTPs.

Aims
The aims of this study were to 1) gain insight into current practices of healthcare professionals regarding OTPs (fentanyl and buprenorphine) disposal practices and 2) identify knowledge and system awareness surrounding the disposal of these products in care home settings.

Methods
We decided to focus on care homes due to the estimated high prevalence of prescribing of OTPs in these care settings. The study was undertaken by the University of Bradford School of Pharmacy in 2015 and the participant sample focussed on the North of England (UK).

Results
The findings (based on 56 survey responses) displayed a significant variation in current disposal practices and a lack of specific working policies. We unearthed anomalies in the participants' knowledge of the active ingredient volume held in depleted patches which, if not disposed of correctly, can lead to harm. This has highlighted the need for more thorough training and education on the safe and effective management of OTPs.

Conclusions
Further education and training is needed regarding safe disposal practices of OTPs, with the suggestion of pharmacist-led interventions. This will minimise confusion and reinforce safe disposal practices (denaturing products) and support the reduction of unsafe disposal practices (domestic waste or flushing).

Keywords: opioid transdermal patches, care homes, disposal practice, training.

Introduction

Background

The issue of opioid use and misuse is current and topical at present with reports of opioid epidemics in the USA and the increasing use of opioids in other parts of the world. The New Scientist asserted that America was in the throes of an opioid epidemic[1] with reports of fatalities linked to physical contact with fentanyl. Discussions have progressed from an American focus to speculating on the spread of this issue to UK cities, Glasgow in particular.[2,3] Safety issues have more recently come to light (June 2018) regarding the physical application and management of specific drug forms e.g. opioid transdermal patches (OTPs).[4] The prescribing, application and safe disposal of opioid transdermal patches (OTPs) within both healthcare settings and personal dwellings is critical to the effective use of these products.

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THE SAFE DISPOSAL OF FENTANYL PATCHES IN CARE HOMES IS MOST IMPORTANT: Remove backing, fold over on itself and place in a waste disposal or sharps bin - or use a CD denaturing kit.

Healthcare professionals have a duty of care and responsibility to ensure the safe application and disposal of OTPs.

There has been a steady increase in the prescribing and use of transdermal patches, especially in the elderly population who maybe dependent on caregivers to manage their medications in particular for chronic conditions.[5] Research by Rene et al found that 94.3% of caregivers preferred the administration of a transdermal patch over oral rivastigmine for the treatment of Alzheimer's disease due to ease of application of the patch over administering oral medication and reduced interference with the caregivers' daily routine.[6] Patient compliance and acceptance were also increased when using transdermal patches over other routes of administration.[7] Whilst the transdermal delivery system has many benefits, it has also been the source of numerous patient safety incidents often relating to their unsafe application and disposal.[8,9,10,11,12]

The main focus in this study was to investigate disposal practices of transdermal opioid patches, which have been subject to numerous Medicines Healthcare products Regulatory Agency (MHRA) medication safety alerts. Particularly concerning have been reports of accidental exposure to fentanyl patches where cases have been reported of patients swallowing patches or the risk of them being transferred to other individuals because they have not been disposed of safely. The incorrect disposal of patches by patients or healthcare professionals has the potential for patches to be diverted for misuse. Reports are emerging where active ingredients from OTPs have been extracted and used by individuals with substance misuse problems. This highlights the importance of raising awareness about the safe and effective disposal practices in both the patient and healthcare professional communities.

In December 2015, NHS Wales issued a patient safety notice to all healthcare professionals highlighting reports of ineffective application, removal and disposal practices with fentanyl patches. The alert made specific recommendations advising healthcare professionals, including those in nursing homes, to ensure that patients and/or carers were advised about safe disposal practices.[13] The Care Quality Commission (CQC), in 2012, recommended that healthcare professionals needed further training and education around safe prescribing, administration and, importantly, disposal of fentanyl patches.[14] The literature demonstrates that the use of fentanyl patches is high on the agenda of medicines and health regulatory bodies and has been for the past ten years with the consistent theme of patient harm emerging due to many factors, one being inappropriate disposal of these products. The introduction of Controlled Drug Accountable Officers into healthcare settings has reinforced the priority of good and managed practice relating to the use and safe disposal of these products.[15] Internationally, in 2012, the US Food and Drug Administration (FDA) reinforced the quality of information provided to patients and caregivers regarding disposal of fentanyl patches after 26 case reports of paediatric accidental exposure to fentanyl over the past 15 years have resulted in 10 deaths and 12 hospitalisations.[16]

Incorrect disposal of OTPs has led to paediatric fatalities due to accidental exposure via ingestion and application of patches. Alarms have been triggered regarding these products based on incidents such as OTPs being disposed in a general waste bin within the home[17] and poor disposal practices in a care home which led to the death of a 2 year old boy, Blake, who placed a discarded fentanyl patch in his mouth during a visit to his great grandmother.[11] In June 2018 a further case of a 15 month old child dying from accidental exposure to fentanyl was reported widely in the media.[4] Although not directly a disposal issue it does highlight the importance of correct disposal practices, which can

prevent further such cases. A recent study by Breen et al regarding disposal practices in UK care homes reported a need for the implementation of training materials and standardisation of guidelines across the healthcare sector.[18]

Due to toxicity associated with OTPs their effective disposal is essential for the prevention of accidental exposure as used patches still contain a high proportion of active pharmaceutical ingredient. Research has shown that there can be up to 80% of residual drug remaining in a fentanyl patch after three days continuous use.[19] The current practice for the disposal of OTPs as reported in multiple healthcare settings is, once removed from the patient, to fold the patch with the adhesive side inwards, place the OTP back inside the original sachet and dispose of it via clinical waste or return it to the supplying pharmacy. A reported variation on this is that the folded patch should then be placed back inside the original sachet and disposed of via domestic waste.

Within care homes the expected practice is to remove the backing and fold the patch over on itself. The patch would then be placed into a waste disposal bin or a CD denaturing kit[20] or a yellow sharps bin.[21] This is contrary to FDA guidance in the home which recommends disposing of used patches by folding them in half with the sticky sides together, and then flushing them down a toilet. They should not be placed in the domestic waste where children or pets can find them.[22]

Despite many safety alerts issued by MHRA and FDA advising healthcare professionals and patients on the safe disposal of OTPs, there is a critical need to safeguard patients/carers against accidental pharmacological exposure with these products through raising awareness around correct disposal practices, which will also limit the inadvertent diversion of these products for misuse purposes. The focus of this study was to examine opioid transdermal patch disposal in care homes and gain a detailed understanding of systems, knowledge and practices in relation to disposal of OTPs. To our knowledge, we are not aware of any study that has specifically looked at OTP disposal practices in the UK or internationally despite numerous studies looking at disposal of medicines broadly.[23]

Methods

We approached participants for this study and asked them to share their views on OTP application, disposal and education between September 2015 and December 2015. The participants who contributed to this study were healthcare professionals working within a care home setting who were involved with medicines administration. Potential care homes with or without nursing were identified through the website 'www.carehomes.co.uk' in the following areas: Bradford, Leeds, Manchester. This yielded a very large number of care home contacts; Bradford 79 leads, Leeds 172 leads and Manchester 185 leads, which totalled 336 potential care homes that could be included in this study. The authors (EM and SI) then telephoned each care home to ascertain willingness to participate and this yielded an interest of 85 care homes. Interested parties were then sent out study information documentation and consent forms based on personal preferences (electronic or paper). Once consent documents were received the questionnaire was released to the individuals based on personal preference either electronically through Google forms or a paper version posted out. Two weeks after receiving the questionnaires care homes were followed up by telephone by EM and SI to check on progress with completing the questionnaire.

To ensure that all the information gathered was of high quality a mixture of qualitative and quantitative research methods for the development of the questionnaire were used, which enabled a broader and deeper understanding of the project and provided scope for a more detailed analysis. A variety of both closed-format and open-format question types were used to encapsulate both methodologies such as Guttman scaling, Likert scaling, multi-choice and single option questions. Thematic analysis was undertaken to determine common areas of focus as per the respondents' responses.

The questionnaire was piloted by healthcare professionals (5 individuals) including both nurses and pharmacists. The feedback included improving the clarity of answers and the appropriate wording of questions. The pilot was used to further develop the questionnaire before being finalised and sent out to care homes.

Ethical approval was granted by the University of Bradford ethics committee (Ref: EC2172).

Results

The number of respondents who participated in the study is shown in Table 1. The respondents were all healthcare professionals with the responsibility of administering OTPs within their role in care homes. It is not possible to

". . . there is a critical need to safeguard patients/carers against accidental pharmacological exposure with these products through raising awareness around correct disposal practices . . ."

accurately note the response rate for the online surveys therefore only the completed online numbers are mentioned in Table 1.

OTP Disposal Practice

The care home staff were asked a number of questions pertaining to their knowledge of current disposal practice of OTPs (specifically fentanyl and buprenorphine patches) and product related characteristics that impacted on safe and risk averse disposal. Following patch removal from a patient's skin, participants were asked what their initial course of action would be. Responses provided indicated that:

1) 63% of the staff fold the patch inwards:
2) 30% immediately dispose of the patch through clinical waste
3) 4% place the patch back into its original packaging
4) 3% cut the patch in half or immediately dispose of it through general waste.

Table 1: Surveys completed

Survey Format	Number of Responses
Online	36
Paper	20
Total	**56**

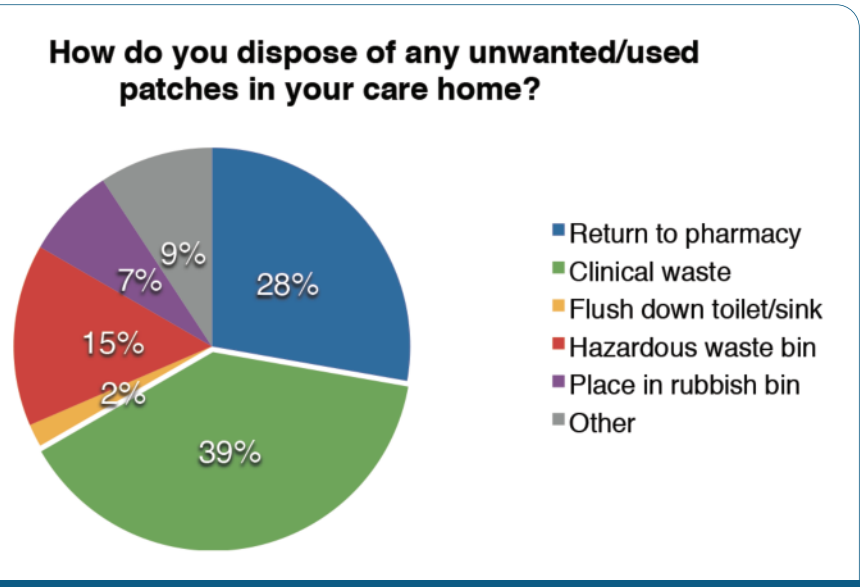

Figure 1: OTP Disposal profile as determined by participant responses

Table 2: Participants' views on active drug levels in used OTPs

Amount of residual drug in OTP once removed for disposal	Percentage of participants who agreed to the residual figure
0-9%	65%
10-30%	21%
31-50%	8%
51-80%	2%
80-100%	4%

Folding was not reported in options 2 and 3 - but that is not to say that it did not happen.

Participants were asked how they disposed of unwanted and used OTPs within their care homes. Responses are indicated in Figure 1. Responses listed as 'Other' were disposal via a DOOP Kit.

Participants were asked to select the percentage range of residual drug remaining in a patch once used for full duration of treatment to check their knowledge and understanding of OTP product characteristics. The responses are shown in Table 2.

On the subject of ongoing training, participants were asked if their care home provided training relating to disposal of medicines, and more explicitly relating to OTPs, which informed the staff of correct OTP disposal procedure. The majority (66.7%) of participants said that within their workplace they did not undergo training in order to safely dispose of patches as part of their continuous professional development.

Participants were asked if they were aware of the MHRA safety update issued in 2014. The results showed that only 47.2% of the respondents were aware of the update, with 52.8% unaware.

The questionnaire further explored the views of participants to see if they were aware of any policies or procedures within the care home setting for OTP disposal. 58.2% of participants stated they were aware of specific policies, with 41.8% unaware of any policies in place. When asked if there was a designated lead person within the healthcare team responsible for the disposal of unwanted medicines, 53.7% of participants said 'no', while 46.3% of participants were aware of a staff member tasked with safely disposing of medicines. When discussing final collection of OTP waste, the practice reported again varied: 69% of respondents stated that collections took place on a monthly basis, 17% on a weekly basis, 4% on a daily basis and

10% said that these waste products were not collected at all.

Discussion

Although this study is small scale it does provide a brief snapshot of activity in UK care homes relating to fentanyl and buprenorphine patch disposal practices. The results of this study yielded the following insights, which are discussed below in the five key themes shown.

1) OTP disposal – practice and process

The correct disposal of OTPs is vital in preventing patient safety incidents from occurring. Participants in this study were asked to comment on how they dispose of unwanted/used patches in their care setting. A variety of responses were recorded. The results showed that 39% of respondents disposed of patches through clinical waste and 28% disposed of patches by returning them to the pharmacy. The diverse responses in disposal practice is not surprising considering, as mentioned above, the lack of guidance health care professionals have in terms of disposing OTPs.

Of particular concern within this study was how divided respondents were regarding their knowledge of the quantity of residual active ingredients once an OTP was removed for disposal. This is an issue as previous research has demonstrated that the amount of drug remaining in a patch following three days of continuous use can fall within the range of 28.84% to 84.4% of the original drug content.[23] In this study, 86.6% of respondents believed there was less than 30% of drug remaining in a patch after use. There is a possibility that healthcare professionals may perceive OTPs as obsolete products after use and not give due care and attention to disposal because they do not perceive that harm can occur. This aspect of the OTP raises another 'red flag' concerning not only the risk of harm of ineffective OTP disposal to the patients/carers or family but the magnitude of this risk (e.g. the adverse impact to a patient or child or patch ingestion or adhesion) and increases the urgency within the NHS to ensure that safe disposal procedures are formulated and effective practice is utilised in all care homes and healthcare settings.

2) OTP disposal – system knowledge and awareness

A number of points raised within this study are a cause for concern. Healthcare professionals who are not aware of the considerable amount of drug remaining in a patch once it has been used may register these products as lower risk and hence take less safety precautions. This, coupled with the fact that used/discarded OTPs are stored by the majority of healthcare sites for a month prior to collection (which appears to be the industry norm), can carry additional risk.

The professionals' responses were split equally on the employment of a lead staff member responsible for OTP disposal. If this person was in post they would ensure that the risk attached to the product use, retention/storage, disposal/collection was managed and reduced (akin to the role of a Controlled Drugs Accountable Officer). However, care home providers at times are resource deprived and therefore the more practical solution may be to train and upskill all, or at least the majority of staff, in OTP safe disposal as a standard element of their job.

At the time of collecting this data (September to December 2015) only 7.5% of respondents were aware of any adverse incidents regarding the application and disposal of these products (as an aside to the MHRA alert in 2014). This again reinforces the need for accurate and timely provision of information that informs health professionals, patients and carers of the risks attached to OTPs and the correct method of opioid patch disposal to avoid personal risk and environmental pollution.

3) Communication

The results of the study indicated that 52.8% of care staff were unaware of the recent safety update issued in July 2014 by the MHRA in regards to fentanyl patches, which highlights a gap in communication between healthcare professionals and external governing bodies, a weakness in in-company communication strategies or both. Healthcare providers should have systems in place and procedures where medicine alerts which come through the Central Alerting System can be accessed by all healthcare professionals within the organisation and appropriate action can be taken within a timely manner. The MHRA alerts are released to practicing healthcare professionals, including pharmacists. A strong emphasis is placed on pharmacists to remind carers and patients of the potential risk of accidental patch transfer if patches are not disposed of safely. As the majority of respondents were unaware of this update, it indicates room for improvement for this information to cascade through the different healthcare settings and may support a case for the use of community or practice pharmacists to go into healthcare settings to reinforce this message.

"Of particular concern . . . was how divided respondents were regarding their knowledge of the quantity of residual active ingredients once an OTP was removed for disposal."

The wider implication of this finding is twofold: 1) the results have shown the deficiency and inaccessibility of medicines or patient safety alerts to healthcare providers/professionals resulting in potential patient harm and 2) the question of accountability and responsibility to ensure the alerts are acted up on and whether support is required through a pharmacist to ensure implementation. From a regulatory perspective the Care Quality Commission core standards of inspection require healthcare providers to have systems in place that ensure patient safety notices, alerts and other communications concerning patient safety that require action are acted upon within required timescales.

4) Training

Staff training regarding how to effectively dispose of OTPs (fentanyl and buprenorphine) was also raised as a potential area of focus to reduce risk of harm not only to patients but carers and family members. The importance of safe disposal of patches within care homes and the wider impact on family was highlighted through the tragic case of Blake who died 2 days after visiting his great grandmother.[11] The design of good procedures and protocols, and compliance with these, would reduce any risk of harm and therefore all used patches could be accounted for and signed to say they have been safely disposed. Tools to support OTP application and disposal (recording of the date, time and site of application, removal and disposal of the OTP by a healthcare professional) will significantly reduce the risk around unaccounted patches that have the potential to cause harm.

5) Pharmacists as experts in medicines management guidance and support

The findings of this study indicate that 61% of care staff would refer to pharmacists as their first port of call if they required any further information on application or disposal of patches. The role of a pharmacist can be described as an educator, particularly in care homes where better utilisation of the pharmacist's skills and knowledge can bring various benefits not only in improving medicines management processes but also medicines optimisation. Pharmacists can raise awareness of the impact of incorrect disposal methods/routes e.g. risk of soil and water contamination and/or risk of third parties accessing used OTPs and purposefully using them by extracting their active ingredients for subsequent injection or reusing patches. Furthermore, the results from this study indicate that care homes have no adequate guidance or systems in place for staff to follow in relation to OTP disposal. Pharmacists can be used to develop robust systems around the safe and effective disposal of OTPs.

The value of a pharmacist's knowledge and skills is further supported by the new plans set out by the NHS in employing pharmacists in local GP surgeries in patient-facing roles highlighting the potential pharmacists have in providing additional support as well as delivering advice to patients. This has been reinforced by the introduction of pharmacists into care homes to support medicines optimisation and advise on better medicines systems for care homes to reduce waste and inefficiency.[24]

Conclusions

This study and subsequent analysis was done in response to risks identified as a result of poor OTP management within the healthcare environment e.g. accidental paediatric exposure and patch transfer from elderly patients have been reported by the MHRA (2008 and 2014) and Greater Manchester Combined Authority (2017). This study is by no means comprehensive but aims to highlight a significant risk attached to the disposal of transdermal opioid patches.

The results indicate the diversity in current policies across different healthcare settings as well as the disjointed knowledge concerning the practices currently being used when disposing of patches. Only 9% of respondents used the denaturing process (DOOP Kit) to safely dispose of OTPs. Other practices such as disposal via flushing and domestic waste are totally unacceptable and cause potential harm to patients, the environment and society. The returns to pharmacy and disposal via clinical and hazardous waste were all favoured disposal methods but the disparity of practice exhibited is of concern.

The study also indicated that there is awareness of the level of residual active ingredients in OTPs at the point of disposal, and there is limited mandatory guidance provided regarding product use and disposal. From a system perspective there does not appear to be consistent training and practice regarding the safe disposal of this product range and the information channels whereby alerts and vital information regarding these products are passed to healthcare professionals are underdeveloped.

This study presents preliminary but cautionary findings, and on this basis the authors recommend that the following elements be considered when effectively managing OTP products (fentanyl and buprenorphine):

- The main tool that can educate patient/carers and healthcare professionals on the correct and most effective method of patch disposal is the Patient Information Leaflet (PIL). Manufacturers should ensure that the information needed to dispose of such products is clear and can be acted upon by carers and staff and should make this a separate document to the PIL.
- There is a need for a guidance document which can be used in all healthcare settings dictating the mandatory practice to be followed regarding OTP disposal.
- As part of the medicines management training all healthcare professionals receive, particular focus should be placed on the disposal of transdermal opioid patches. This training could be delivered by pharmacists who have

expert knowledge about safe disposal practices of medicines.

- A tool should be developed which fully audits the stages of application, removal and most importantly disposal of the patch. This will ensure unaccounted patches are located and thus disposed of safely.
- We suggest that further research be undertaken by Central Alerting System to look at the best channel of communication to ensure these alerts reach all healthcare professionals, not just managers, and, most importantly, that they are acted upon. Several alerts issued identified healthcare professionals who were best positioned to remind patient/carers of safe disposal practices and this information is not being cascaded down. This study has identified this from an OTP perspective but the finding is generalisable to all alerts concerning medicines and their implementation.
- More research needs to be undertaken into the prevalence of OTP safety incidents, incident recording mechanisms, root cause analysis and prevention mechanisms. This data can be used to inform guidance and process design.
- Improved knowledge and understanding, coupled with training and education of OTP disposal, should be considered to mitigate and reduce the risk of harm from these products. Pharmacists can play a key role, working with other healthcare professionals, to create essential guidance and training materials regarding the safe disposal of OTPs in care home and other healthcare settings.

Declaration of interests

The authors have nothing to declare.

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- **Stephen Brown**, Senior Delivery & Improvement Lead, NHS Improvement
- **Richard Goodwin**, Paediatric Integrated Care Pharmacist, Evelina London Children's Hospital
- **Lelly Oboh**, Consultant Pharmacist, Care of Older People at Guy's & St Thomas Community Healthcare NHS Foundation Trust
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- **Stephen Doherty**, Chief Pharmaceutical Officer's Clinical Fellow, Health Education England

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Multidisciplinary Blended Learning – Diabetes Management In The Black Country

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Dr Hana Morrissey


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Abstract

Title
Multidisciplinary Blended Learning – Diabetes Management In The Black Country

Author List
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Summary
One in 17 people in the UK are affected by diabetes. This paper presents the results from a training need analysis collected prior to a 'primary care interdisciplinary diabetes management workshop'.

All participants were from the West Midlands. There were 23 primary care pharmacists, three nurses and two GPs. The highest level of diabetes education was based on CPD e-learning (n=16) and the lowest was reading National Institute of Health and Clinical Excellence (NICE) guidelines (n=1). The highest confidence was in referring patients to specialist diabetes services due to cardiovascular risk followed by discussing the management of modifiable lifestyle factors. The areas listed by participants as being involved in their practice were general diabetes review, medication reviews and optimisation, foot check, intensifying treatment in type 2 diabetes and lipid management. Also, introduction of treatment post diagnosis and referral to lifestyle advice, running long-term chronic condition clinics and annual review. Regarding insulin therapy management, the highest confidence was in reviewing HbA1c levels and agreeing on appropriate targets with patients (n=2), the lowest was the identification of lipohypertrophy/lipodystrophy. Participants indicated that they are confident in initiating insulin therapy, but the majority indicated that they never initiated the therapy (n=16). Regarding the confidence in 'Initiation of GLP-1 receptor agonists injectable agents' the majority selected 'never' (n=15). More community pharmacists training is required on diabetes management to improve patient continuity of care and quality of life.

Keywords: BMI, risk reduction, smoking, HbA1c, training needs analysis.

Introduction

Diabetes mellitus is a global epidemic. According to the World Health Organization (2011), it is one of the most important chronic metabolic disturbances.[1] There are 3.2 million people diagnosed with type 2 diabetes in the UK (2012).[2] Its severe chronic complications with elevated morbidity and mortality destroy lives and escalate healthcare costs. Diabetics have increased risk of long-term damage to various organs, including eyes, kidneys, nerves, heart and blood vessels.[3] Consequently, diabetes treatment should aim to prevent complications through maintaining ongoing control of the blood glucose level. In type 1 diabetes (DM1), exogenous insulin treatment is essential whilst most type 2 (DM2) patients can be managed with non-insulin medications, dietary changes and exercise.[4]

Modifiable risk factors and Diabetes

Eating a balanced diet, maintaining consistency in quantity and time of food intake, preventing hypoglycaemia with appropriate snacks, avoiding simple refined sugars, consuming dietary fibre, reducing cholesterol and saturated fat intake, all help to control blood glucose level.[5] Low glycaemic index (GI) carbohydrate use reduces fluctuations in blood glucose and insulin levels and promotes long-term health including reduction in diabetes and heart disease risks.[6] Studies demonstrate that a 5-7% bodyweight reduction reduces the risk of developing pre-diabetes by half. Data from a cross-sectional study by Diaz et al (2007) looking at eight different ethnic groups from England, showed the lowest incidence among those who had normal body mass index (BMI).[7] Observational and meta-analysis studies have demonstrated risk reduction of up to 30% in moderate alcohol consumption compared to those who regularly drink larger amounts.[8] Smoking increases oxidative stress, causes inflammation and reduces the flow of blood to muscles, resulting in insulin resistance and impaired glucose tolerance.[9] Consequently, changing drinking and smoking habits may decrease the risk of developing or worsening diabetes.[10]

Monitoring

Glycated Haemoglobin (HbA1C) is considered as a reliable marker of long term glycaemic status. Fructosamine as a marker was also reviewed, but is currently recommended 'if HbA1c monitoring is invalid because of disturbed erythrocyte

turnover or abnormal haemoglobin type'.[11] Intervention studies have suggested that a low carbohydrate diet[12] and a fibre-rich low glycaemic diet[13] have clinical benefits in DM2 patients. A prospective observational study by Stratton et al (2000) reported diabetic complications strongly correlated with previous hyperglycaemia and any reduction in HbA1c is likely to reduce the risk of complications.[14]

Design

The aims of this project were, by applying the above approach, to identify the training needs of local health professionals in the primary care setting and to deliver a pilot education workshop in a multidisciplinary environment that would inform them of the current situation of diabetes care in England and improve their skills in planning and delivering effective diabetes education to patients. This should help to develop strategies to improve their patients' adherence to treatment, to reflect on their own professional development needs, to practice the use of diabetes medication devices and enable them to demonstrate their use. Also, to inform them of materials to empower patient self-management using resources such as Dr David Cavan's 'Reverse your Diabetes' and 'Reverse your Diabetes Diet' books.[15] Participants completed an online anonymous training needs analysis questionnaire before, and submitted a reflective piece after, the 2-day workshop. Additionally, competency on the use of the devices was assessed by an advanced diabetes nurse practitioner at the end of day 2.

The results from the Training Needs Analysis (TNA) and the participants' feedback are presented.

Ethical clearance was granted by the University of Wolverhampton Human Ethics Research Committee on 18/1/2018.

Sample

All participants were from the West Midlands, primarily the Black Country. The 2-day workshop was advertised to all local practitioners in primary care in the area: general practitioners (GP), nurses and pharmacists. Thirty-four local practitioners completed the TNA but only 30 attended the workshops.

Method

A TNA was conducted as an online survey to establish the individual participants' needs and knowledge and skill gaps. A 2-day multidisciplinary workshop was designed and delivered. The course material was delivered by pharmacists, doctors and nurses and sessions covered revision of basic concepts in diabetes therapeutics, followed by four simulated cases, where avatars were used to present the scenarios between patients and health practitioners. It concluded with a hands-on training and skills assessment on devices used in the management of diabetes (Figure 1).

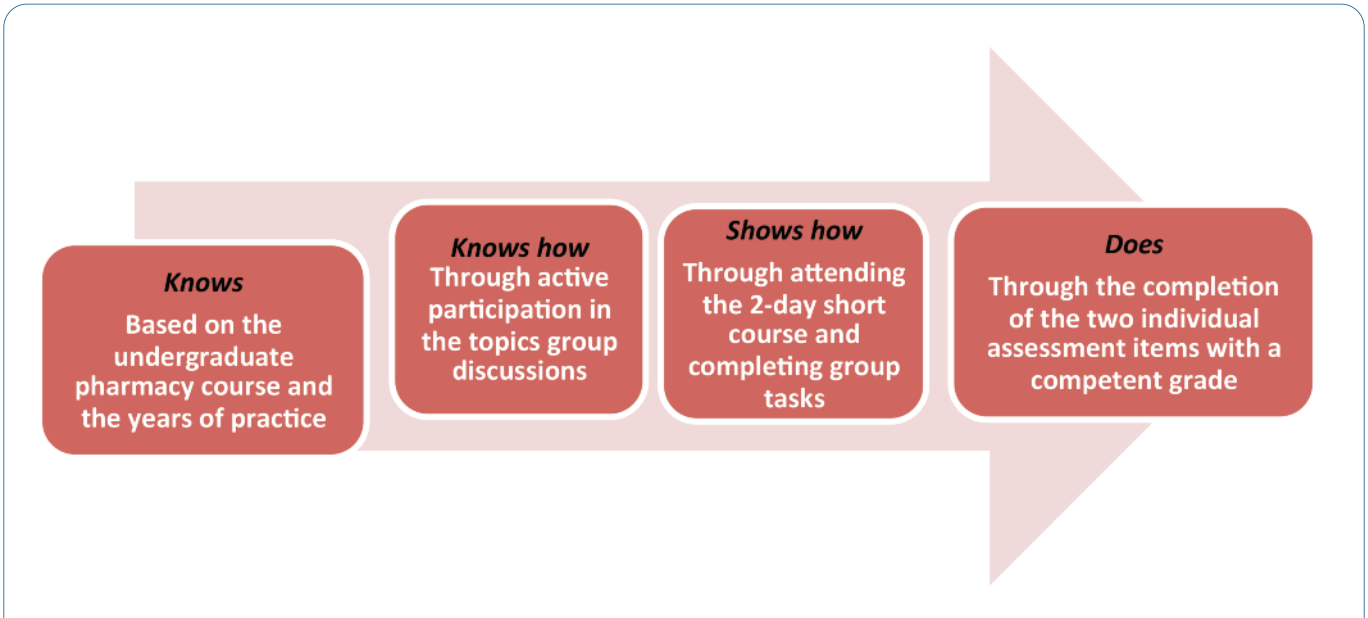

Figure 1: Concept of the training design

". . . competency on the use of the devices was assessed by an advanced diabetes nurse practitioner . . ."

Table 1 shows more detail regarding the program topics and competencies assessed.

Participants consented to the use of the TNA data in this publication and some indicated their wish for names to be acknowledged.

Results

The majority of attendees were primary care pharmacists (n=23) with valuable participation by nurses (n= 3) and GPs (n=2).

When participants were asked about the level of diabetes education they had completed, the highest source was CPD e-learning (n=16) and the lowest was reading National Institute of Health and Clinical Excellence (NICE) guidelines (n=1). Regarding how confident they feel in disease management, the highest number of participants (n=9) who selected 'very confident' was in 'identifying the signs and symptoms of type 2 diabetes'. The lowest confidence was in 'knowledge and implementation of NICE guidance and local guidance for type 2 diabetes.' Asked how often they perform those activities, the majority selected 'weekly' (n=15) followed by 'monthly' (n=9) whist 'daily' and 'hardly ever' were equally selected (n=4 each) and two selected 'never'.

Participants were then asked how confident they feel when referring patients to specialist diabetes services. The highest level of confidence was in providing information about cardiovascular risk and discussing management of modifiable lifestyle factors (smoking, diet, weight, etc) (n=8). One person did not answer. Asked how often they perform the activities, the majority selected 'weekly' (n=13) followed by 'monthly' (n=9), 'hardly ever' (n=5); 'daily' and 'never' were equally rated (n=3). The majority answered 'yes' for smoking cessation (n=24); however, 24 participants selected 'no' for mental health problems related to diabetes.

When asked to list any other areas that they are involved with, mention was made of general diabetes review, medication reviews and optimisation, foot checks, intensifying treatment in type 2 diabetes, lipid management (primary and secondary prophylaxis), introduction of treatment post diagnosis and referral to lifestyle advice, running long term chronic condition clinics and annual review.

Participants were asked how confident they are in 'pre-insulin' glycaemic management. The highest level of confidence was in understanding when referral is required for glycaemic control (to GP/specialist team) (n=6). One person did not answer. When they were asked how often they perform those activities, the majority selected 'monthly' (n=13) followed by 'weekly' (n=8), 'hardly ever' (n=6), 'never' (n=5) and one response was 'daily' (n=1).

On insulin therapy management, the highest confidence was in reviewing HbA1c and agreeing appropriate targets with patients on insulin (n=2), the lowest was in identification of lipohypertrophy / lipodystrophy and provision of appropriate advice; one person did not answer. When asked how often they

Table 1: General Pharmaceutical Council - pharmacist national standard achieved in this session in context of diabetes management

Able to discuss the requirement for gaining patient consent prior to provision of one-on-one education session.
Able to differentiate and identify patients' personal and general information and the required level of security for each type in the context of the provision of patient education and reflective practice.
Being able to apply the code in case-based patient education.
Able to prioritise aspects of patient education based on their patients' needs.
Able to use reflective theories to complete a reflection on the 2-day course and their learning objectivity.
Able to actively communicate therapy issues to patients when providing counselling or education.
Able to actively communicate therapy issues to the patients' carer during counselling or education.
Able to actively communicate the rational regarding therapy changes, maintaining objectivity.
Able to read laboratory reports and explain to patient or carer during an education session.
Able to read diagnostics reports such as microbiology, lipids profile and blood pressure and explain to patient or carer during education session.
Able to include expected targets to improve outcomes into patient education and relate patients' current complaints to their laboratory results.
Participate in the hands-on training and achieve competency in the final assessment.
Collect the required patient information from GP, pharmacy records and the patient or carer.
Assessing learning needs. Developing learning objectives – for example, who does what, how, when?
Planning and implementing patient education. Evaluating patient learning. Documenting patient teaching and learning.

perform those activities, the majority selected 'hardly ever' (n=10) followed by 'never' (n=9), 'monthly' (n=8), 'weekly' (n=6) and none answered 'daily'(n=0).

On initiating insulin therapy, nobody selected the 'very confident' option. One person did not answer. When they were asked how often they perform those activities, the majority selected 'never' (n=16) followed by 'hardly ever' (n=9), where 'weekly' and 'monthly' were equally reported (n=4) and none answered 'daily' (n=0).

On confidence in advanced insulin management, the highest confidence was in 'Initiation of GLP-1 receptor agonists injectable agents' (n=1). One person did not answer. When they were asked how often they perform those activities, the majority selected 'never' (n=15) followed by 'hardly ever' (n=9), where 'weekly' and 'monthly' were equally reported (n=4) and none answered 'daily' (n=0).

Discussion

Most participants reported their knowledge came from previous undergraduate studies or continuous professional development sessions, not postgraduate qualifications. Most of the sessions had been on aspects of diabetes management other than Insulin use. It was surprising that participants were least confident in early management, and in knowing when to initiate therapy, which recently was acknowledged globally to be one of the key issues to reduce complications and their cost.[16] Participants were also not confident regarding knowledge and implementation of NICE guidance, local guidance or discussing legal principles of type 2 diabetes in regard to driving and insurance. These are intrinsic parts of the duty of care to provide best health practice and ensure patients' and public safety.

The difference between the perception of knowledge or confidence and the frequency of performing the activity was large, especially when the task was not within the scope of the employment of the respondent. However, when the workshops were conducted, all participants, with no difference in confidence, demonstrated ability to use devices and to make decisions regarding patient treatment, including initiation of 3rd line treatment and insulin (Table 2). Most participants had 1-5 years seniority in prescribing, with the exception of one person with 10 years or more. This may have affected the frequencies of managing or initiating insulin therapy and in managing patients with type 2 diabetes complications.

Participants demonstrated more confidence in lifestyle and referral advice (Table 3) than in treatment management. However, the SD was 9.24% between 'yes' and 'no' answers. This might be a result of the participants' previous background as community pharmacists prior to becoming independent prescribers, as patient education was part of everyday activities.

Three application activities allowed the sharing of skills and experience between professions. Participants' feedback indicated that the skill workshop was the most enjoyable part, followed by the application activities and the networking opportunities. At the end of the second day two assessments took place, one reflective and one skill based (Table 4).

Participants' reflection included a question on what aspects of the workshop they would include in their practice. The following are some of their comments:

- *'It is important to understand the patient and appreciate who they are.'*
- *'The concept of clinical inertia and watching and waiting before treating.'*
- *'Education provided at the time of diagnosis has great effect long term.'*
- *'Having a unified pathway in which the patient hears the same advice from all members of the health care team.'*
- *'Became more aware of type of knowledge to pass to the patient during conversation.'*
- *'I will definitely confirm and check injection technique.'*
- *'I will check the storage and preparation of insulin with the patient.'*
- *'Use the idea of treatment goals to ensure patients adhere to treatment and celebrate with them when they achieve them.'*
- *'It is important to timely escalate treatment when required to prevent complications.'*
- *'Understanding the diabetes ominous octet approach: 'Decreased insulin secretion, decreased incretin effect, increased lipolysis, increased glucagon secretion, increased glucose reabsorption, decreased glucose uptake, neurotransmission dysfunction, increased hepatic glucose production'.*[17]

Conclusion and Recommendations

This workshop demonstrated the effectiveness of inter-professional continuous education, where health practitioners from different professions complemented each other's knowledge and skills, whilst gaining familiarity with each other's specialist skills.

The major message coming from the program was the need for a team approach, with all members of the team playing their part and reinforcing messages, but also stressing the damage that can be done when the messages are confusing. The best results are obtained when the whole team sticks to what is known from reliable evidence and guidelines and reinforces what others have said. Start from what the patient has been told, or believes they have been told (acknowledging that these are not always the same thing) and build forward on a common platform of instruction, firmly based on evidence. It is intended to continue this type of workshop in the future.

Table 2: Standard Deviations

GENERAL DIABETES REVIEW	AVDEV
Knowledge of which investigations required at annual review	3.42
Reviewing the individual's and carer's knowledge of diabetes and offer appropriate education	3.18
Identifying the individual's and carer's ongoing support needs and agree how they will be met	2.94
Reinforcing lifestyle advice and provision of more individualised advice and support and referral as appropriate	3.3
Providing information about cardiovascular risk and discussing management of modifiable lifestyle factors (smoking, diet, weight, etc)	3.7
Explaining the risks and benefits of introducing/changing antihypertensive therapies	3.52
Explaining the risks and benefits of introducing/changing lipid lowering therapies	3.45
Recognise and discuss the psychological implications of diabetes and assess for signs of depression	2.58
Ability to discuss erectile dysfunction and appropriate treatment options with patients	2.48
Diabetes foot check and risk stratification	2.58
Recording details using template and specific READ codes	2.61
Reviewing diabetes management and setting targets and goals with patients	2.79
24% never performed those activities	
PRE-INSULIN GLYCAEMIC MANAGEMENT	
Reviewing HbA1c target and understanding of individualised targets	2.91
Explaining HbA1c to the patient/carer and agreeing individualised target together with them	2.82
Understanding when referral is required for glycaemic control (to GP/specialist team)	2.97
Reviewing the progression of diabetes and choosing appropriate treatment options in collaboration with patient/carer	2.78
Initiation and optimisation of metformin	3.03
Understanding when to discontinue metformin	2.88
Understanding most appropriate second line treatment choices in accordance with NICE guidance/local guidance/individual patient	3
Explaining the risks and benefits of sulfonylureas (patient outcome benefits, patient risks, hypo risks)	2.91
Initiation and optimisation of sulfonylurea and when to discontinue	2.52
Understanding of when blood glucose monitoring is relevant with sulfonylureas	2.82
Explaining the risks and benefits of pioglitazone and prandial glucose regulator therapies (glinides) e.g. patient outcome benefits, patient risks, hypos risks	2.58
Explaining the risks and benefits of DPP-4 inhibitors (patient outcome benefits, patient risks)	2.79
Initiation and optimisation of DPP-4 inhibitors and when to discontinue	2.64
Explaining the risks and benefits of GLP-1 receptor agonists (patient outcome benefits, patient risks)	2.61
Initiation and optimisation of GLP-1 receptor agonists and when to discontinue	2.48
Explaining the risks and benefits of SGLT-2 inhibitors (patient outcome benefits, patients risks)	2.58
Initiation and optimisation of SGLT-2 inhibitors and when to discontinue	2.55
Understanding most appropriate third line treatment choices in accordance with NICE guidance/local guidance/individual patient	2.76
Choosing appropriate treatment choices in collaboration with the patient	2.79
33.5% never performed those activities	

Table 2: Standard Deviations (continued)

INSULIN MANAGEMENT	AVDEV
Reviewing HbA1c and agreeing appropriate targets with patients on insulin	2.3
Understanding the time action profile of insulins and the relevance to blood glucose control	2.09
Reviewing insulin practicalities with the patient including timing of injection, technique, site rotation, needle length and changing of needles, storage of insulin, disposal of sharps	2.09
Identification of lipohypertrophy/lipodystrophy and provision of appropriate advice	1.79
Troubleshooting variable glycaemic control, in particular hypoglycaemia, and appropriate advice/referral	1.97
Providing information and supporting the individual with prevention, recognition and treatment of hypoglycaemia and all safety aspects surrounding hypoglycaemia including DVLA regulations	2.36
Recognising hypo unawareness in individuals; discussing and recording individual's hypoglycaemic episodes in line with DVLA guidance	2.27
Providing education for useful and relevant self-monitoring of blood glucose, ensuring patient understanding and agreement to test appropriate to insulin regimen	2.39
Teaching and supporting patients to interpret their blood glucose results and make safe and appropriate changes to their insulin as relevant	2.24
Advising individual and carer of the effects of illness on insulin requirements and sick day rules	2.18
Knowing when further optimisation of insulin management is required and appropriate referral	2.15
58% never performed those activities	
INSULIN INITIATION	
Initiation of GLP-1 receptor agonists injectable agents	1.82
Identifying the appropriate time to discuss the need for insulin initiation in partnership with the individual/carer	1.76
Explaining the risks and benefits of insulin	2.21
Choosing the appropriate insulin regimen for initiation in partnership with the individual, taking into account target HbA1c, lifestyle, employment, safety, etc	1.76
Teaching the patient to start insulin, including all practical elements of insulin initiation, issues surrounding hypoglycaemia, DVLA advice, appropriate, timely and beneficial blood glucose monitoring	1.79
Teaching and supporting the patient/carer with simple, safe self-titration of insulin, in relation to agreed targets and agreement of appropriate review intervals (face-to-face/telephone)	1.73
Advising individual and carer of the effects of illness on insulin requirements and sick day rules	1.91
76% never performed those activities	
ADVANCED INSULIN MANAGEMENT	
Changing or altering the insulin type or regimen in response to persistently raised HbA1c above target	1.7
Identifying and acting on 'swinging' blood glucose readings in partnership with the individual	1.67
Understanding the implications of deteriorating renal function on the action and safety of pre-insulin and insulin therapies	1.7
76% never performed those activities	

Table 3: Assessment of negative risk

Do you know how and when to refer to specialist diabetes services for the following areas of diabetes care?	Yes	No	AVDEV
Structured patient education (type 1, type 2, carbohydrate awareness/carbohydrate counting, etc.)	27.27	72.73	22.73
Dietary advice	69.7	30.3	19.7
Smoking cessation	72.73	27.27	22.73
Podiatry	42.42	57.58	7.58
Emergency foot care	27.27	72.73	22.73
General podiatry	39.39	60.61	10.61
Renal clinic	27.27	72.73	22.73
Retinal Screening	51.52	48.48	1.52
Erectile Dysfunction	33.33	66.67	16.67
Pre- conception and pregnancy care	21.21	78.79	28.79
Poor glycaemic control	45.45	54.55	4.55
Mental health problems related to diabetes	21.21	78.79	28.79

Table 4: Activities and Assessments

Item	Learning Objectives
Assessment 1: Reflective learning	1. Understand the value and importance of reflection and reflective practice 2. Learn the method and understand the tools of reflection 3. The value and importance of record keeping 4. The importance of objective setting 5. The use of record-keeping in ongoing development and fitness to practice
Activity 1: Treat or wait and watch?	1. Develop a structured, approach to information gathering 2. Understand what information a pharmacist must gather to advise effectively and safely 3. Understand the importance of asking the patient's own knowledge, beliefs and priorities 4. Understand the concept of red flag symptoms and findings 5. Learn the red flag signs and symptoms for some common conditions
Activity 2: Patient adherence	1. Understand the importance of therapy adherence in non-communicable disease 2. Understand the terms adherence, compliance and concordance 3. Introduce the general level of adherence found in research studies 4. Understand the concepts of intentional and non-intentional non-adherence 5. Introduce some of the drivers to non-adherence 6. Introduce some of the approaches used to increase adherence
Activity 3: Patient education	1. Develop a structured, method approach to information gathering 2. Understand what information a pharmacist must gather to advise effectively and safely 3. Understand the importance of asking the patient's own knowledge, beliefs and priorities 4. Develop a plan based upon a firm foundation of accurate information and the patient's own knowledge and priorities 5. Prioritise a plan into manageable, achievable steps for staged delivery to the patient 6. Plan to communicate the plan at an appropriate level for the patient and support with additional printed resource 7. Include modifiable risk factors in patient consultation including diet, activity, alcohol intake and smoking cessation.
Assessment 2: Skill	1. Develop a working knowledge of a range of common devices that a pharmacist would be expected to know and to demonstrate 2. Learn the importance of revising the key points yourself before attempting to demonstrate to someone else 3. Learn the principles of demonstrating a device; storage, preparation, usage, cleaning and maintenance, replacement. 4. Competently demonstrate three different commonly used devices to a potential user

Funding

The two one-day workshops were sponsored by Novo Nordisk. The sponsorship covered the venue hire, subsistence costs and speaker fees for this meeting, without controlling or stipulating any of the content delivered or the speaker recruitment. No Novo Nordisk brands were discussed or advertised. Novo Nordisk has not sponsored and has had no involvement in this publication.

Declaration of interests

Dr Hana Morrissey reports grants from Novo Nordisk, non-financial support from the University of Wolverhampton, during the conduct of the study.

Professor Patrick Ball reports grants from Novo Nordisk, non-financial support from the University of Wolverhampton, during the conduct of the study.

Acknowledgments

Raj Jain, Hemal Gohel, Vik Sharma, Afzal Imran, Furzana Begum, Gurjit Dhadday, Ahsan Bhatti Mandeep Rana, all participants, all presenters, Novo Nordisk and the FSE Dean UoW.

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Pharmacy Management
Progress through partnership

CLARION CALL

A section for passionate calls for action to further develop the contribution that pharmacy can make to healthcare

The Pharmacy Profession And Integrated Care Systems: Are Your Soft Skills Up To The Mark?

One pharmacist's passion for pharmacy professionals in senior leadership positions to review their skills and knowledge to further improve systems and patient care.

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Sally Bower

Abstract

Title
The Pharmacy Profession And Integrated Care Systems: Are Your Soft Skills Up To The Mark? One pharmacist's passion for pharmacy professionals in senior leadership positions to review their skills and knowledge to further improve systems and patient care.

Author List
Bower S.

Summary
This article recognises that clinical skill training is embedded within the profession and that structured management and leadership training is available. However, particularly at senior levels, there is considered to be a lack of awareness of what additional skills, knowledge and experience, including 'soft' skills, could be gained and how these would be of benefit within pharmacy roles and to a greater extent if considering a role outside pharmacy.

Many of the pharmacy profession have demonstrated an ability to undertake wider roles but there is potential to do more, particularly given the Integrated Care Systems initiative.

This call is about a personal experience on one course but the aim is to encourage the pharmacy profession to consider and extend their leadership role, particularly into Integrated Care Systems.

Keywords: emotional, authority, integrity, power, conflict, difference, change, transition, complexity, uncertainty

Integrated Care Systems – are new skills needed?

An Integrated Care System (ICS) is a partnership of NHS organisations, local government and the third sector that applies in some areas of England with the aim of integrating health care to deliver high quality services for the local population.

The following information about an ICS may be helpful:

- 'How does the NHS in England work? An alternative guide'.[1]
- Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England – The King's Fund, February 2018.[2]

With this in mind the time is right for senior leaders in the pharmacy profession to consider what additional skills, knowledge and experience might be appropriate to enable them to operate effectively and seize opportunities in this new way of working.

This article outlines the potential benefits of a course offered by the King's Fund and suggests that senior pharmacy managers review its applicability and that of other appropriate courses and approaches to ensure they are ready to face the challenges posed by the ICS approach.

A personal experience

During a '1:1' with my manager it was suggested that I should consider a future role that was not solely pharmacy focussed, and that I look into what leadership training was available that would excite me and would be beneficial for my current and future roles. Whilst passionate about pharmacy my thought process about 'what next' was stimulated!

Having had a career pathway clearly set out in hospital pharmacy and then primary care, it became clear that there is potential to explore further leadership training that would also provide an exposure for potential development into wider areas that involved more multi-disciplinary and multi-agency working.

Several options were seen to be available (e.g. NHS Leadership Academy, Pharmacy Management Clinical Leadership in Pharmacy Programme, Institute of Leadership and Management). Having looked into all options, however, I decided that the King's Fund Top Manager Programme (TMP) was the one for me. Health and Social Care services continue to face increasing economic pressures, changing demographics and increasing public expectations, whilst all the time health inequalities are widening. The TMP has a 30-year history of developing and supporting senior leaders to meet the challenges of this changing environment. It stood out for me from other structured development programmes. Whilst right for me it is not for everyone - it is important to reflect and identify what is appropriate individually so that the knowledge and experience gained is beneficial for current and future roles.

In March 2017 I completed an application form for the TMP but, with hindsight, I was not fully aware of the positive influence the course would make to my work and home life. The total duration of the course, which was five weeks at five different locations across the UK, and was completed in January 2018.

About the course

The King's Fund continue to learn more and more about the kind of leadership challenges and opportunities that new ways of working bring, and about the type of leadership practices needed now and into the future. Drawing on the best available evidence, TMP enables individuals to develop, test and embed these leadership practices.

Group work provides the core learning approach in TMP. For the duration of the programme the TMP community creates a temporary system of leaders coming together, with all of its inherent dynamics. This provides a live system in which to study, learn, practice and experiment. Through your active participation in the different study groups you develop your self-awareness and explore how you relate to others and them to you, how you take up and use your authority with integrity and authenticity and what happens between different parts of a system. Issues of power, authority, conflict, role, difference, change and transition are examined in depth.

In addition to the study groups you participate in experiential workshops, visit different organisations (including those that create policy and frontline community services), debate ideas with guest speakers and apply your learning to the changes you want to lead in your workplace and system.

The learning continues beyond the programme. There are alumni events and many TMP alumni remain in contact with fellow participants throughout their careers, calling on each other for ideas, support and challenge. I found the networking that resulted with senior people in different specialties and roles to be particularly beneficial

As an experiential learning programme it is somewhat difficult to adequately describe but the crux of the learning I got from it was - if it doesn't challenge you it won't change you.

TMP was a journey of self-discovery which made me more aware of my behaviour and interactions with others. To give just one example, I now recognise that, when you feel something emotionally, that is the right time to consider how you might bring about a change and whether you should speak out.

Whilst I felt I had learnt and changed during the programme I wanted to know how others had perceived me on my journey. I asked three fellow course delegates, whilst writing this article, for their perceptions of my behaviour and development during the course as I considered that their comments would be insightful, constructive and illuminating.

This was indeed the case and it was helpful to have this reality check - and reassuring that the comments were positive!

But - so what? How has the learning has been used?

Writing articles and producing posters on projects demonstrating outcome benefits that the pharmacy profession working across sectors can achieve is an accepted part of pharmacy practice. Without the experience gained on the course, however, I would have found it too challenging and would not have contemplated writing about the need for softer skills such as group dynamics and self-awareness, far less exhort senior colleagues to review their skill needs in the light of the development of changes in NHS systems!

TMP really helps you, as a leader, to learn about yourself, how others see you and group dynamics. It enables you to better understand the dynamics that arise within systems and organisations and how to lead well in times of uncertainty and complexity.

The course allows you to test your own levels of self-belief and resilience, to believe in them and to know that they are key to your role and how this relates to your organisation. It also allows you to explore, within a group of senior leaders, the level of doubt inherent at all levels; the group were ready and willing to provide mutual support where an answer was not readily apparent.

The learning is translated into practice during and after the course. I have been given opportunities to chair meetings that are not solely pharmacy related, including the serious incident review panel and provider quality performance meetings. The benefit of a better understanding of how to handle change and uncertainty has meant this was less challenging than it might have been.

At meetings, I have been more conscious about group dynamics and

have been able to recognise and articulate when we need to discuss the hidden agenda before moving on with what we are trying to achieve.

For me, I now realise that it's not simply about chairing a meeting or getting results that is important. Understanding the system dynamics at play and having the confidence to challenge them when appropriate are equally important. People matter the most and they need to be engaged and enthused.

Having confidence in what and how you do it is important. I recognise the need to have challenging conversations on occasions but now have more confidence and feel more comfortable in doing so.

With the support of managers within my organisation I have been given a broader portfolio with aspects that are not just pharmacy focussed. I now sit within the Quality Directorate and my role is Head of Patient Safety and Medicines Optimisation Commissioning. My portfolio also now includes STP lead for Care Home Integration work and Leeds lead for co-ordination of all care home work streams.

So what's next?

Having been through this experience and in the face of changes towards an ICS approach, which brings increased working across a range of organisations and significant change management challenges, it has become clearer than ever that the time is right for senior pharmacy managers to review the skills requirements and personal development needs of themselves and their staff. This should not just be about clinical skills and management training but about the softer skills that are important for leadership roles, particularly when working across different organisations.

The development of the ICS approach means change, and change is by its nature both uncertain and an opportunity. The profession has the ability to drive forward a patient-centred focus, using what we know about our experiences with patients in communities, to be a vital part of the new partnerships and systems being formed. These partnerships will break down the barriers between GPs and hospitals, physical and mental health, social care and the NHS. The unique training and skills within the profession has often enabled pharmacists to confidently expand their role on a wider basis in Care Systems and take up leadership positions ICS is the vehicle to do this on an even wider basis….. but we need to want to be involved.

I will certainly be drawing on the learning from the TMP about the ability to lead in a networked structure and how to be open across all health and care sectors with a focus on systems leadership.

Conclusion

Pharmacy professionals in senior leader positions need review their skills and knowledge so we are all ready to seize opportunities in the ICS approach to improve systems and patient care.

The pharmacy profession and its senior leaders in particular, can become a significant part of the best available solutions to some of health and social care's most difficult problems. Opportunities to use current and newly acquired skills outside the profession should be eagerly pursued.

Declaration of interests

None, other than being attendee on a recent King's Fund TMP programme!

Acknowledgments

It is wished to thank my manager for her support, the King's Fund course leaders and my fellow course participants.

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Prescribing information can be found overleaf

CHTRI20170962h(1) Oct 2017

AU COURANT

UKCPA: Supporting You To Support Your Patients

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Sarah Carter

For over 35 years the UK Clinical Pharmacy Association (UKCPA) has been supporting the pharmacy workforce to share best practice, network, collaborate, innovate and flourish (see www.ukclinicalpharmacy.org). Our goal is to foster and support excellence in clinical pharmacy practice so that practitioners can provide outstanding patient care.

UKCPA was first founded at a time when pharmacists who provided significant clinical input into patient care in the UK were few and far between. Because of their isolation, those first 'clinical pharmacists' identified a need for a support network and a forum to share their experiences and pass on their knowledge to others coming through into this growing area of practice.

UKCPA has continued to support clinical pharmacists since then and has grown in parallel with the advancement of clinical pharmacy in the UK and overseas.

Leaders in clinical pharmacy

As clinical pharmacy has flourished, so has the expertise of our members. We are proud to have the most experienced and knowledgeable pharmacy practitioners amongst our membership. As such, they are sought as experts by the government, professional bodies and the media to advise on aspects of pharmaceutical care. The UKCPA is regularly called on to provide expertise and contribute to national and international consultations, guideline developments, and health policy and agenda setting.

The UKCPA has always been at the forefront of pioneering national initiatives for pharmacy. In the early 2000s we were involved in the development of what are now known as the Foundation Pharmacy Framework[1] and the Advanced Pharmacy Framework[2] competency frameworks for the pharmacy workforce, which fed into the creation of consultant posts in pharmacy. We were, and still are, involved in the formation and maintenance of professional curricula,[3] and were instrumental in advising on the process for professional recognition of advanced practice (now part of the Royal Pharmaceutical Society Faculty programme).[4]

The UKCPA Critical Care Group, for example, has been so central in the advocation of pharmacists in intensive care that pharmacists can now be identified on 98.6 percent of critical care units across the UK.[5] Similarly, the UKCPA Surgery & Theatres Group recently published a Handbook of Perioperative Medicines,[6] which was endorsed by three professional bodies and commended throughout the medical community. It has just had its third print run.

Clinical pharmacy: at the core of the whole workforce

UKCPA is celebrated for our practitioner-led educational events. Members of UKCPA, who work at the leading edge of their practice area, are committed to sharing their expertise with the pharmacy profession. Their knowledge and experience is shared with others so that best practice can be spread more widely. The quality of this education is highly respected and is reflected by the Royal Pharmaceutical Society's accreditation as a training provider for Foundation and Faculty level.

Historically, UKCPA membership tended to encompass those who work in secondary care. However, as clinical services expand within community pharmacies, with the growth of

"We are proud to have the most experienced and knowledgeable pharmacy practitioners amongst our membership."

pharmacists practicing in GP surgeries, with pharmacy technicians developing clinical roles, and as the importance of continuity of care between sectors is promoted, it is now acknowledged that clinical pharmacy is at the core of the whole pharmacy workforce.

UKCPA has partnered with organisations such as the Royal Pharmaceutical Society and Pharmacy Management to share good practice with pharmacists in all sectors. Over the last two years UKCPA and Pharmacy Management have jointly delivered several successful medicines optimisation events in the areas of diabetes, respiratory and cardiovascular. These clinically focussed workshops, delivered by expert members of UKCPA, have been attended by hundreds of pharmacists and pharmacy technicians from both primary and secondary care.

UKCPA and Pharmacy Management are further cementing this successful formula to reach all sectors of the workforce by jointly delivering a national conference on 2nd November 2018. The Pharmacy Together conference has a simple aim: to deliver exceptional quality education and skills development to the whole pharmacy workforce, bringing the sectors together to improve patient care.

Understanding the challenges of pharmacists' working lives

We understand that the working lives of pharmacists are as busy as they have ever been, and that budgets for professional development are not as full as they once were.

The UKCPA has been mindful of these conditions whilst developing our strategic plans for the future. Although we know that face-to-face events are extremely valuable and can offer unrivalled opportunity for networking and sharing information, we also know that it is not always easy or affordable to travel to, and attend, an event.

It is with this in mind that we are offering our Pharmacy Together conference at no charge for delegates. In addition, over the coming years UKCPA will be developing a library of education and training which can be accessed online, saving you time and money and bringing a flexibility to your professional development in which you can choose where and when to learn depending on what is best for you.

We have also invested in our website technology, and will continue to do so, in order to provide our members with a user friendly online support network. Our online forums have always been highly valued amongst our members for their ability to connect with the wider UKCPA community. The forums enable our members to support each other every day of the year, regardless of where they are practising. You can post a message, ask advice, respond to a query, upload a document to share, promote good practice, or share important information. We know that this virtual support network is a lifeline for practitioners, particularly those who are working in new areas or in isolation.

Supporting you to support your patients

Everyone can benefit from the expertise and experience of the UKCPA community. Everyone has something to share and everyone has an opportunity to learn. As a member of UKCPA you have access to a community of supportive and stimulating like-minded pharmacy practitioners, sharing information and benefitting from collective strength. There are thousands of supportive practitioners available to you, whether that is at our educational events, through our online forums, or by getting involved in our activities. All our members have the opportunity to become involved in all that we do. And everything we do is with the aim of supporting you so that you can better support your patients.

Declaration of interests

None, other than UKCPA Secretary as indicated above.

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"UKCPA has partnered with organisations such as the Royal Pharmaceutical Society and Pharmacy Management to share good practice with pharmacists in all sectors."

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Pharmacy Management National Forum/ UKCPA Annual Conference

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Understanding the Challenges and Opportunities to develop pharmacy and the profession

See the separate page in this edition for full details of dates and venues for the Academy.

And coming in 2019 . . .

See the separate page in this edition for full details of dates and venues for events during the 2019 year.

Further information relating to these events will be added onto the Pharmacy Management website events page which can be found using the QR code.

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Diary Dates with Pharmacy Management in 2019

JoMO-UKCPA Respiratory Workshop

Date: **Thursday 14 March 2019**

Venue: The MacDonald Burlington Hotel, Burlington Arcade, 126 New Street, Birmingham B2 4JQ.

PM Celtic Conference

Date: **Tuesday 26 March 2019**

Venue: The Edinburgh International Conference Centre, The Exchange Edinburgh, 150 Morrison Street, Edinburgh EH3 8EE.

JoMO-UKCPA Diabetes Workshop

Date: **Tuesday 14 May 2019**

Venue: The Midland Manchester Hotel, 16 Peter Street, Manchester, M60 2DS.

Pharmacy Management National Forum for Scotland

Date: **Thursday 29 August 2019**

Venue: DoubleTree by Hilton Glasgow Glasgow Central Hotel, 36 Cambridge Street, Glasgow G2 3HN.

JoMO-UKCPA Cardiovascular Workshop

Date: **Wednesday 2 October 2019**

Venue: Radisson Blu Portman Hotel, 22 Portman Square, London W1H 7BG.

Pharmacy Together Conference

Date: **Friday 8 November 2019**

Venue: London (to be confirmed)

Pharmacy Management National Forums are being planned for Northern Ireland and Wales - dates and venues to be confirmed.

To view further information, please go to www.pharman.co.uk/events

Pharmacy Management
Progress through partnership

CLIP Experience

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Ted Butler,

Chairman, Pharmacy Management

As all Western democracies seek solutions for the delivery of healthcare to an ageing population the door of opportunity opens for pharmacy. There is, however, a need to ensure that the profession (in all disciplines) has the tools to open that door and to keep it open.

In 2016, the modular programme **'Clinical Leadership in Pharmacy'** (CLIP), was created by Pharmacy Management to provide those tools that enable leadership and the skills to become a leader to be developed and sustained by pharmacists and pharmacy technicians within primary care, secondary care and community pharmacy.

The programme, which is funded by educational grants from several pharmaceutical companies, is delivered through Pharmacy Management which is an Accredited Provider of Education for the Faculty of the Royal Pharmaceutical Society.

10 separate modules, which are all a day in length, are delivered in the programme which runs for twelve months:

- Day One: 'Leading with Colleagues - Getting to know you'
- Day Two: 'Leading with Flexibility - How to 'work' your leadership style'
- Days Three and Four: 'Leading with My Team - Developing yourself and others'
- Day Five: 'Leading with Focus - Project leadership for project success'
- Day Six: 'Leading with Impact - Making a personal impact'
- Day Seven: 'Leading without Conflict - Conflict management and resolution'
- Day Eight: 'Leading with Negotiations - Negotiating for success'
- Day Nine: 'Leading with Me - Maximising effectiveness and impact in the workplace'
- Day Ten: 'Leading within Health Systems - Why are we doing this? Leaders of today talk to leaders of tomorrow'

CLIP has received support from a high level in pharmacy, particularly in Scotland, Ireland and Wales where Chief Pharmaceutical Officers have endorsed it by being present at launch meetings and presenting Completion Certificates to delegates.

The programme is available to all pharmacists with the only financial contribution being £100 upon successful application.

Applications for the course are always reviewed by an independent panel of senior pharmacists from within the country where CLIP is being delivered. The CLIP Application Form is shown in Figure 1.

Karen Miller and Heather Dalrymple, CLIP attendees from Northern Ireland and Scotland respectively, provide their perspectives on the CLIP programme below.

Plans are in process to deliver the second CLIP programmes in Scotland, Ireland and Wales. 24 Pharmacists from different sectors of the healthcare system of each of these countries will benefit from this year-long exposure to skills and their interpretation in to action.

"Karen Miller and Heather Dalrymple, CLIP attendees from Northern Ireland and Scotland respectively, provide their perspectives on the CLIP programme below."

Figure 1: CLIP Application Form

Jill Cruickshank

As a result of the success of CLIP in both Scotland and Ireland plus the initial reaction to the programme in Wales, Pharmacy Management realised the significant development potential for this programme within the Celtic Nations. In June 2018, Ted Butler asked me to come on board and support the programme as the CLIP Communications Coordinator.

I was delighted to take on this role as I am passionate about my own and others development.

I was a CLIP delegate in Scotland, and have considerable pharmacy experience gained from key leadership roles in community pharmacy in the early part of my career. I now combine working as a community pharmacist and a community pharmacy champion along with running my own coaching and development consultancy.

Looking back over my CLIP experience, one of the main benefits was meeting and building relationships with a group of like-minded pharmacy professionals. In Scotland, we have set up a steering group to support the Scottish cohort but also to ensure that, as a cohort, we use our skills and experience to influence the profession nationally.

In the role of CLIP Communications Coordinator I am working with Pharmacy Management to create communication platforms for the current and future delegates across the three countries and build relationships across the expanding CLIP family.

I am looking forward to the Celtic Conference in Edinburgh on 26 March 2019, which will allow CLIP delegates from Scotland, Ireland and Wales to meet in person for the first time.

If anyone is interested in any aspect of the CLIP programme please contact me at jill.cruickshank@pharman.co.uk

Karen Miller

What was your role and position when you applied to join the Clinical Leadership in Pharmacy (CLIP) programme?

I was an Intermediate Care Pharmacist working on a NHS consultant-led rehab unit based in a private care home. The rehab unit has a Trust team comprising a care of the elderly consultant, physiotherapists, occupational therapists, a pharmacist and social workers. My role was to ensure accurate medication histories and medicines reconciliation on admission, medication review, bone health assessment and medicines optimisation, patient education and the onward transfer of accurate pharmaceutical information at discharge.

What was your motivation for applying?

At the time that CLIP applications were open I was in the process for applying for a new post of Consultant Pharmacist for Older People, which would lead one of five new teams of Medicines Optimisation in Older People pharmacists within each of the five Trusts in the region. This was a regional roll-out of evidenced-based medicines optimisation work undertaken in pilot sites in Northern Ireland during 2012-2016. I was successful at interview and took up post in July 2017.

I'm passionate about the impact that pharmacists can make in helping patients get the most out of their medication, improving health outcomes and in reducing the risks of inappropriate polypharmacy. I'm also a strong advocate that patients should be helped to make their own choices through providing balanced evidence-based information and by respecting individuals' beliefs and values influencing those choices. This new role presented me with a fantastic opportunity to make a real difference through regional team working and strategic influencing to shape a better healthcare landscape for older people by rolling out the case managed pharmaceutical care pathways already tested (Intermediate Care and Care Homes) and by piloting and testing new models of pharmaceutical care such as supporting patients with medicines adherence issues and targeting medication review in patients admitted to secondary care with frailty.

Karen Miller receives her Completion Certificate from Mark Timoney, Chief Pharmaceutical Officer, Northern Ireland

Although this was an exciting opportunity I was aware of my limitations as my current role didn't involve any leadership or team management roles and I only had limited experience with service development at local level. CLIP was the perfect opportunity to learn some new skills around leading and inspiring a team and managing successful projects.

How was the application process - was it straightforward?

The application process was straightforward and easy to complete. I

". . . the light bulb moment for me during the programme was, without doubt, the module on 'Leading with Impact'."

needed support from my line manager and two sponsors. Even though attending CLIP would mean 12 days away from work in the current pressurised NHS my line manager was very positive and encouraged me to apply and agreed to be one of my sponsors. I asked the consultant lead for the Intermediate Care rehab unit to be my other sponsor and he was fantastic in supporting the project I decided to undertake for the CLIP programme and encouraging me throughout the year.

The application was completed online and involved answering a few structured questions such as what was my current role, where I saw myself in five years and what challenges and opportunities existed in the healthcare landscape.

Looking back over the programme, what have been the key learnings and highlights for you?

I have learned so much by undertaking the CLIP programme on so many topics such as what are the different leadership styles and which one reflects my preferred style, how to deal with conflict, negotiation skills, building resilience and much more; however the light bulb moment for me during the programme was, without doubt, the module on 'Leading with Impact'. This module was about how you could be an effective communicator and what I didn't know before this workshop was that people have preferred communication styles that are essentially driven by their personality types.

We all know that communication involves much more than just speech but what I didn't appreciate was that different people respond better to certain types and style of both written and oral communication. I gained a practical insight into effective communication by learning about the 'Colours' model, which describes four preferred communication styles. Through the application of this model it is easy to increase the impact of your message through the use of the style and language which best suits the colleague who you are communicating with. I have found this an extremely effective tool in engaging with others and understanding how they might be responding and processing information and how it is best to present ideas, gain co-operation, initiate useful discussion and, ultimately, 'buy in'.

The work we engaged on around project management has also been invaluable by illuminating the benefits of careful planning, setting SMARTER goals and anticipating potential problems. Although we all know we want to get from A to B on any project journey, in reality we usually have to detour through C, D and E and sometimes the plane just gets grounded! The project management modules take you through various tools to manage each step and the obstacles that may present along the way, such as project planning, stakeholder mapping, risk and contingency planning, negotiating skills and managing conflict.

How have you been able to translate your CLIP experience into practical actions that have supported your personal and professional development?

One of the key messages of the CLIP programme is that anyone in an organisation at any level can be a leader. We can all promote positive change, service development and improvement through our ability to inspire others with a shared vision, commitment, enthusiasm and resilience. The only reliable constant in the NHS is that it is constantly changing, evolving and adapting to the different healthcare challenges that arise such as new innovations and shifts in population demographics. The CLIP experience allowed me to explore how I could adapt to this changing arena to be a vector for positive change. By understanding and applying how effective teams operate in addition to project planning I am considerably better equipped and more confident to highlight areas that need improvement or changes that will enhance patient experience and safety. CLIP does push you out of your comfort zone but guess what I found - it wasn't actually uncomfortable at all, rather it was empowering.

". . . we had heaps of fun and laughed a lot together while absorbing and developing our leadership skills."

How have you used CLIP learnings to contribute to the development of local pharmacy services?

I've had a very busy and rewarding year and I can definitely credit the CLIP programme for some of my wins. I project managed introducing a regional long stay kardex into a Trust intermediate care (IC) unit that is based in a private care home. This has seen medicines-related incidents reduce and now all patients admitted for rehab have a VTE risk assessment completed, which has also improved patient safety. As the improvements have been realised, the long-stay kardex has been rolled out to other IC units in neighbouring Trusts. We are now exploring how we can streamline the medication supply to the IC unit to reduce workload on

our increasingly busy dispensary by piloting an over- labelled top-up, which will also be a first for the region.

The coaching skills I learnt have been put to good use with my team as we have extended our reach into another IC unit and have also introduced a medicines adherence pilot, which we are testing and refining. I've also been mentoring a pharmacy technician in a new clinical role that involves her taking over the role of drug histories, patient counselling and assisting with the bone health assessments we carry out. This extended technical role frees up a clinical pharmacist for medicines optimisation and medication review work helping to improve healthcare outcomes for our patients by optimising skill mix. I'm very proud that my pharmacy technician passed all the modules in the Medicines Management Accredited Programme (MAPP) in under a year as she is the first technician to achieve this in the region. Of course, none of this can be achieved without the enthusiasm, dedication and commitment of my whole team, so thank you guys!

If you had to describe CLIP and its benefits, how would you summarise?

The CLIP programme covers a series of leadership models, behaviours and leadership tools over a 12 month period via fun interactive group activities to challenge, investigate and develop the delegate's leadership skills. The aim of the programme is to encourage delegates to identify their personal leadership styles and to learn how to apply and adapt these to work effectively with their colleagues to help deliver service improvement. During the year each delegate undertakes a project within their sphere of work, which provides the opportunity to apply and embed the skills and tools that are explored during the programme. The whole programme is delivered in a friendly environment and, as delegates, we had heaps of fun and laughed a lot together while absorbing and developing our leadership skills.

After completing the programme and seeing how it has changed my approach and confidence to having a meaningful impact in my work area, I'll definitely be encouraging other members in my team to undertake the next CLIP Ireland programme - bring it on!

Heather Dalrymple

What was your role and position when you applied to join the Clinical Leadership in Pharmacy (CLIP) programme?

I was working in the same role I now have – as the Lead Cancer Care Pharmacist for adult services in NHS Lothian.

What were your motivations for applying?

I'm responsible for the pharmacy cancer service delivered in the Edinburgh Cancer Centre (ECC). At the time the initial CLIP course was advertised, the environment for cancer services was one where rapid

Heather Dalrymple receives her Completion Certificate from Professor Rose Marie Parr, Chief Pharmaceutical Officer, Scotland

". . . the CLIP course seemed like a great opportunity to help ensure I had the necessary skills to successfully lead the cancer pharmacy service . . ."

change was taking place in terms of new treatment options becoming available for patients and new delivery pathways being developed.

There were (and still are) a great many challenges and opportunities as a result of this to the cancer pharmacy service, alongside the multidisciplinary team. It was necessary for all the services to evolve and adapt as we continued to see an exponential increase in the number and lines of treatment available to cancer patients, with the service demands increasing accordingly.

With all this in mind the CLIP course seemed like a great opportunity to help ensure I had the necessary skills to successfully lead the cancer pharmacy service and most effectively support my team in this high-pressured environment.

How was the application process - was it straightforward?

The application process was straightforward – it just required some self-reflection to consider how such a course might help me to achieve personal and professional objectives.

Looking back over the programme, what have been the key learnings and highlights for you?

The course provided the opportunity to learn and improve on a variety of management and leadership tools and techniques. One of the most positive things about the course was the enthusiasm of both the trainer and the participants throughout the course, which ensured maximum collaboration and participation throughout.

The parts of the course focussing on interpersonal skills were of particular interest and having the time out of practice to enable self-reflection around these was useful. In particular, use of coaching featured quite early on in the course and was an extremely helpful tool to enable self-reflection.

The project management skills learnt on the course have also been invaluable, and I am practising regularly!

The 'skill will' matrix has helped to identify how to manage particular behaviours within a group, and the coaching side of things has also been useful when encouraging individual members of my team to seek their own solutions when a challenge arises.

". . . the CLIP course offered an opportunity to step out of my usual working environment and find some time to develop myself personally and professionally."

How have you been able to translate your CLIP experience into practical actions that have supported your personal and professional development?

A number of areas addressed in the course around how we understand and most effectively work with other people have been extremely helpful when considering group and individual interactions in my everyday practice. Having knowledge of areas such as the 'Circle of Concern' and the 'Circle of Influence' has helped me focus where it is best to concentrate efforts as a group, and individually as a chair of a group.

The learning around communication styles (e.g. understanding that different people have different communication styles and the need to flex my own preferred communication style to best interact with others) has been useful as I interact with all levels of staff across the organisation (and nationally) throughout my working week.

Techniques to deal with conflict and challenging behaviours have been helpful to refer back to generally.

In particular, project management skills and some of the learning around teams have been really helpful in everyday practice.

How have you used your CLIP learnings to contribute to the development of local pharmacy services?

There has been, and there continues to be, a large number of service development projects in my area of practice. We are striving towards new means of delivering treatments for cancer patients and exploring new models for delivery of care including closer working with community pharmacy and primary care and role extension of the highly specialised pharmacy workforce through the use of prescribing and clinical skills. All this is going on alongside continued extension of treatment options available and the service working with the multi-disciplinary team (MDT) to ensure we

continue to deliver treatments to required governance and safety standards.

A specific example around use of my CLIP learning is the successful establishment of a local Systemic Anti-Cancer Treatment (SACT) management group within the ECC to enable oversight of operational and governance issues around the use of SACT. The project management side of leadership was effective in helping me to focus on getting the group formed. I followed the over-riding principles of considering the project planning cycles when planning the establishment of the group from the initiation and planning phase through to implementation, monitoring and review. In addition, at the outset I reflected on Kouze and Posner's leadership challenge - having an insight into what effective leaders do was helpful when considering the approach to leading within this group. I believe this has significantly contributed to the success of this group, which is now well established and has a key role in the management, review and planning of

18 months on from Scottish CLIP cohort group completing the course, I continue to chair this group and am part of many others currently, where I hope my learning from the course has translated into effective leadership skills being demonstrated on a regular basis.

If you had to describe CLIP and its benefits, how would you summarise?

After 20 plus years working for hospital pharmacy services, and quite a few years working as a manager, the CLIP course offered an opportunity to step out of my usual working environment and find some time to develop myself personally and professionally. There was an opportunity to gain some headspace to consider how I work and interact with colleagues and how I could perhaps improve my practice.

The areas of the course focussing on people management, such as work on communication styles, understanding others' working styles and motivations and using these to ensure successful working relationships, has been of great benefit. In addition, anyone working as a manager and being responsible for leading on change cannot fail to benefit from the project management skills side of the course.

One of the biggest positives for me personally has been the exposure to different areas of pharmacy services through the networking opportunities afforded by the breadth of areas from which participants in the course came. This has offered insight into other areas of pharmacy practice to which I had not previously had exposure. The ability to work collaboratively with new colleagues and to have a network across Scotland of colleagues, from all areas of pharmacy practice, who might be able to offer advice and assistance has been of great benefit.

The CLIP group in Scotland continues to communicate regularly and within Edinburgh we have set up a small group, which meets regularly, to support each other – although it goes without saying that what happens in CLIP club stays in CLIP club.

Declaration of interests

Ted Butler: CLIP is funded by sponsorship from pharmaceutical companies.
Karen Miller: Nothing to declare.
Heather Dalrymple: Nothing to declare.

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THE CURRENT NHS AGENDA AND HOW IT AFFECTS YOUR FUTURE

Understanding the challenges and opportunities to develop the pharmacy profession

If you would like to:-

- Understand the changing NHS environment and what it means for your professional development
- Hear more about the NHS direction of travel and its impact on the future for pharmacy
- Listen to speakers who understand the environment of the NHS and have been successful in promoting pharmacy
- Meet colleagues who have the same challenges as yourself and want to discuss and share learnings
- Talk with pharmacy professionals from other sectors of the service and grow closer in understanding each other's needs
- Learn how to create messages to develop your professional and personal agenda
- Take part in a highly interactive day which is facilitated by experienced pharmacists who speak the same language as yourself

YOU OWE IT TO YOURSELF AND THE PROFESSION TO BOOK A PLACE AT THE PHARMACY MANAGEMENT ACADEMY THIS AUTUMN.
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The dates and locations for the Academy Workshops are:-

- Wednesday 3 October 2018 - Leeds
- Wednesday 17 October 2018 – Bristol
- Wednesday 7 November 2018 – London
- Tuesday 11 December 2018 – Glasgow
- Thursday 4 October 2018 - Manchester
- Thursday 18 October 2018 - Cardiff
- Thursday 8 November 2018 - Birmingham
- Wednesday 12 December 2018 - Belfast

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Presentation Skills

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Dr Glenda Fleming


Rachael Lemon

Abstract

Title
Presentation Skills

Author List
Fleming G, Lemon R.

Summary
This article summaries basic presentations tips, ideas for presentation styles and various presentation software that is available.

Keywords: campfire, Hakathon, Prexi, HaikuDeck, SlideDog, Keynote, Swipe.

Introduction

So, you've been asked to present your award-winning project or showcase your pioneering work - an exciting opportunity to share what you are passionate about with peers and colleagues. Even the most experienced professionals still get nervous, but good presentation skills are important to possess when it comes to succeeding in professional or academic life.

An impressive presentation can win over an audience and effectively showcase your work. Few people are born with the gift of public speaking; most people must work at preparing an effective speech or presentation.

This article will provide a recap of some basic presentations tips and ideas for presentation styles and indicate software that is available as an alternative to the more traditional PowerPoint slide show.

Presentation Tips

Effective Communication

Effective and compelling communication is the key to any successful presentation. Without an authoritative tone or an air of confidence (not arrogance!), a presenter's main points will be lost on the audience. During a presentation it is important for the presenter to make eye contact, speak clearly and project, engage the audience by fielding questions and, most importantly, stay calm. A presenter must adapt to the audience and be prepared for disagreement or even confrontation. A presenter must also make the setting more comfortable by engaging in anecdotes and humor when appropriate. If you become overwhelmed or lose your train of thought, take a moment or two to compose yourself.

Building a Presentation

An important feature of an engaging presentation is the use of visual aids. In most instances, a visual aid should highlight and clarify points rather than forming the basis for the presentation — the audience should be more focused on what the presenter is speaking about than what is on the visual aids. Common visual aids include PowerPoint slides, handouts, charts, tables and graphs.

Presentation Design

When it comes to designing a presentation, it is best to keep visual aids as simple as possible. If the presenter is using slides, they should appear uncluttered with minimal text. The use of bullet points and titles help the audience to focus on the presenter's most important points. It is also important to keep design and backgrounds plain and simple and not too flashy or overbearing. To ensure that the entire audience can

"If the presenter is using slides, they should appear uncluttered with minimal text."

Consider the style of presentation that you wish to give

view the slides, consider the font size and colour to ensure your slides can be easily read from the back of a room.

Planning a Presentation

When planning a presentation, preparation is a must. The presenter should know their material well and should be prepared for debate from any angle. Also, it is imperative that a presenter takes the venue and audience into consideration when planning the presentation. Visit in advance if you can, or at least arrive early, and find out about the presentation venue prior to the actual presentation to get a feel for the environment and make any necessary changes to the setup of the room. Not all presentation types are the same. Demonstrating to students is different from offering a proposal to a corporate board of directors. Other types of presentations include training demonstrations, business proposals, professional negotiations, or even job interviews. Learn who your audience will be so you can effectively engage with them.

Presentation styles

For delegates to get the most out of your presentation you might like to make it as interactive as possible. Lecture style presentations should be a maximum of 40 minutes, with an interactive activity of at least 20 minutes.

When attending a study day, delegates will be more engaged if they have the opportunity to attend varying styles of presentations throughout the day since this will allow them to have a wider and greater experience.

Presentation plus case study or small group discussion	Example 1: 10 minute speaker presentation + 10 minute case study/small group discussion + 5 minute case study feedback. Example 2: 40 minute speaker presentation + 20 minute case study/small group discussion. Example 3: 30 minute speaker presentation + 20 minute case study/small group discussion + 10 minute Q&A.
Campfire	A safe and secure environment to share challenges and hot topics. No set agenda - delegates decide the direction.
Dare to ask	An intimate Q&A with the expert speaker and a facilitator in which the delegates are given the opportunity to ask any questions they dare.
The following methods may be more suited to longer sessions:	
Clinic	Hosted by an expert, delegates bring their challenges and the expert helps work through them.
Hackathon	A dynamic group working together to solve a given task with real, valuable and actionable outputs. Group facilitator sets the task.
Lab	Experiment with new ideas, test out theories and shape new practices and processes with experts.
Masterclass	Learn from the best - a masterclass session in a very specific skill or technique.

FIGURE 1: Ideas on how you could deliver your presentation

Different speakers are talented in delivering information in different ways. Ultimately, it is up to you to decide how to deliver your workshop as you need to feel confident.

Figure 1 provides some ideas on how you could deliver your presentation. The methods shown may suit both shorter and longer presentation slots.

Some Available Presentation Software

What do you think of when you hear the word 'presentation'? If the first thing that comes to mind is Microsoft's PowerPoint, the grandfather of presentation software, you're not alone - for the last twenty years, the presentation software has dominated the market. It remains an effective method of presenting your slides but you might want to look at the alternatives that have become available - see Box 1. Many allow you to create and store your presentations in the 'cloud'.

PREZI	www.prezi.com
HaikuDeck	www.haikudeck.com
Google Slides	www.google.com/slides
SlideDog	www.slidedog.com
Keynote	www.apple.com/keynote
Swipe	www.swipe.to

Box 1: Potential alternatives to PowerPoint

Summary

When asked next time to give a presentation, it is hoped that the tips above will be found to be useful and that you will have a good basis to consider alternative tools that could be used for your presentation. Please also be aware that this is a developing area and other alternatives may become available.

Declaration of interests

The authors have nothing to declare.

FACE2FACE

Doctoral Training Fellow

Justine Tomlinson, Leeds Teaching Hospitals NHS Trust.
Correspondence to: justine.tomlinson@nhs.net


Justine Tomlinson

Question:

What is your job title?

Answer:

Doctoral Training Fellow; Clinical Pharmacist; Lecturer.

What are your main responsibilities/ duties?

My week is split into 4 days research, 0.5 days clinical practice at Leeds Teaching Hospitals Trust and 0.5 days teaching at the University of Bradford.

This is a 4-year collaborative post where I am responsible for carrying out research in the field of medicines safety alongside practice.

My duties involve developing research ideas, questions and projects, applying for grant funding, managing the day-to-day research activities and disseminating the findings so that they can inform practice.

To whom do you report and where does the post fit in the management structure?

Within each role of my post I have a line manager or supervisor who supports me with my work. My research supervisors are a mix of academics from the University and a Consultant Pharmacist within the Trust's senior management team; however, I am ultimately responsible to the Deputy Chief Pharmacist.

How was/is the post funded? Is the post funded on a non-recurring or recurring basis?

The 4-year research post was initially funded by the Medicines Management and Pharmacy clinical service unit at the Trust. This enabled me to have dedicated time to scope out research ideas, network with key stakeholders and prepare grant applications. We have recently been awarded funding from the National Institute of Health Research (NIHR) for my current project, which will fund the study and my role within it for 30 months.

When was the post first established?

This collaborative post between the University of Bradford and Leeds Teaching Hospitals was established in 2016, following a successful trial of a similar model at Sheffield Teaching Hospitals.

Are you the first post holder?

My colleague and I are the first two post holders within our organisation.

What were the main drivers for the establishment of the post and how did it come about?

In a bid to increase evidence-based practice and to drive pharmacy research capacity within the Trust, the Medicines Management and Pharmacy clinical service unit developed this post. The combination of roles (research, clinical practice and teaching) and the associated access that I have to different healthcare settings ensure that the work that I do is truly translational to real life clinical practice.

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

Being the first post of its kind within my organisation there have been a lot of unknowns in terms of processes and procedures and we have had to work hard by trial and error to find the best way forward. Working in a collaborative post has great advantages but it also has its challenges, especially when you need to work out which organisation is responsible for what and who you need to speak to. Ensuring clear expectations and identifying who the key stakeholders are within each organisation is important, otherwise you spend a lot of time acting as a go-between!

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

Being able to bring brilliant academics and passionate clinicians together in a truly multidisciplinary way to make a difference for patients.

Working collaboratively to develop important, pragmatic research questions that are grounded in the experiences of front-line health care professionals and underpinned by quality academic principles.

Being involved in the non-medical research strategy launch at the Trust, increasing the profile of research and sharing my skills with other members of the Medicines Management and Pharmacy clinical service unit.

Our greatest success to date, however,

has to be successfully applying for NIHR funding as an early career researcher for this project.

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

My current priority is ensuring that the research is completed to time and target. We will also need to consider what our next steps are, ready for when the 4-year post comes to an end.

Another key priority of the post is to encourage others within the department to become more involved in research as part of their everyday role and to support dissemination of findings to wider audiences.

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

Be willing to build relationships with key stakeholders and act as a conduit between organisations.

Be able to listen to and consider multiple perspectives that surround an issue.

Have tenacity, passion and be motivated to get the job done.

Project management and organisational skills.

The training opportunities are genuinely endless. There's great support available from the University and I sit within the Medicines Optimisation Research Group, which holds skill and knowledge development sessions regularly.

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

This post has allowed me to develop skills and experience in three core areas of practice – research, clinical pharmacy and teaching. This allows me flexibility in my career and to keep my options open for the future.

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

I think it is likely that more of these posts will be developed as we start to see the positive impact of the work that we do.

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

Make sure you find out about all the different funding opportunities available from project grants to personal awards and familiarise yourself with their eligibility criteria. We originally anticipated applying for a doctoral fellowship but I did not meet all the funder's requirements. This set us back a little, so make sure that you plan carefully before setting out and don't be discouraged if your original funding plan doesn't work out as there are always other funding opportunities.

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.

MANAGEMENT CONUNDRUM

Effective Appraisal

Janet Donit, Chief Pharmacist at Metropolis NHS Trust, often used her weekly coffee break with Carey Whitecoat, Head of Medicines Management at Riverside Primary Care Organisation, to share concerns, compare notes and generally just 'bounce' ideas around.

"I had an interesting conversation the other day with one of my direct reports," said Janet. "He said that he wasn't sure that he or his staff were getting the best out of the appraisal system."

"Why was that?" asked Carey.

"Well, the feedback from one of his prescribing pharmacists was that the appraisal examined most of her role but not all of it. When I asked 'why not' he said he found it difficult to appraise the bits of the role that he did not do himself.'

'I can see where he is going with that one - but what about your own appraisal? Your line manager isn't even a pharmacist. How does she manage?'

'That's a fair point,' said Janet, 'but, to be honest, I'm just grateful when it's over! If she says I've done all right I don't feel like widening the conversation. I'll gladly take that!'

'Then you're not getting the most out of your appraisal either,' Carey pronounced. 'I may not be the best person to help but am happy to go over how I do things. It might be best, though, if you got some ideas from a couple of other colleagues.'

Carey's comments were helpful to Janet but she has asked if you could give her your views on what should be done to ensure appraisals are as effective as they can be for both parties.

Commentaries

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There should be no surprises in an appraisal. If there is a good line management structure, regular one-to-ones should allow for positive encouragement but also challenge on areas that are falling short before problems expand into something far more difficult to tackle.

The appraisal should be a review of the past year (or time-frame of focus), consolidated into some clear achievements and identification of areas for development that both parties knew were there. The appraisal is also about focusing the appraisee on goals in line with the leader's and team's strategy. A lack of regular quality appraisals will lead to staff being unclear as to how to do their job.

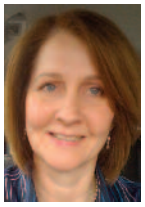
One of the big differences between regular one-to-ones and appraisals is that, in the appraisal, the appraisee has the opportunity to reflect and offer an opinion on their performance and this can be objectified and discussed. The appraisal then provides a safe environment where each party has permission to speak frankly regarding performance and feedback and, as part of this safety, there is mutual agreement to be honest and maintain confidentiality within the environment. The conversation should be focused on the individual, supporting change through feedback, planning for development and providing support to achieve objectives that contribute to a vision/strategy.

In terms of the appraiser's ability to appraise components in an individual's role that they do not possess themselves, the key is the appraiser's preparation and the fact that an appraisal should be in part about developing the partnership between appraiser and appraisee. The appraiser should already know how the appraisee is performing from the network they have with the appraisee's peers. If necessary, they should gather specific opinion and views from the appraisee's peers and use these in an anonymised way to have an appraisal conversation with the appraisee; these conversations can be

difficult sometimes, but if the background work is done the conversation should be constructive and enable reflection on the comments provided.

In my experience, preparation and structure is important. A number of templates are available to guide and document these conversations; however, these should not take away from the fact that it is important for a safe and constructive conversation to occur where both parties give each other permission to be honest. Paperwork and a huge list of appraisal questions can often put managers and staff off completing the appraisal; if this hurdle is overcome and the appraisal takes place the paperwork and questions can then still stifle free conversation. I always advise my team that the honest conversation is the most important thing and that the appraisee is given the opportunity, space and time to provide an honest account of their progress, reflections and future needs to achieve their objectives.

". . . it is important for a safe and constructive conversation to occur where both parties give each other permission to be honest."



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When asked, many people will say that they find appraisals are not very helpful at best, and very stressful at worst. Even though the organisation may say that performance appraisals are important it is often sadly evident that they do not take them very seriously. However, all that said, appraisals do have real value as they provide both the manager and staff member with allotted time to explore where an individual may want to go with their career, alongside an understanding what the options for that may be and how activities undertaken are aligned to organisational priorities. At a time of constant change within the NHS appraisals also provide an opportunity to redefine the responsibilities and priorities for staff to ensure that these match the organisation's requirements.

For the member of staff being appraised it is important that they prepare - whether your manager is prepared or not, you must be ready. To do this you should gather together relevant information, particularly anything that meets a specific objective or project that you were set. It is also important to identify any stumbling blocks that have caused you issues.

For the manager carrying out the appraisal it can be very useful to ask the staff member to reflect and give feedback on their own performance. This will give some insight as to how the person views their own performance, which can then be gauged against your own assessment. This can also provide the opportunity to open up areas for discussion that may have been harder if you were to raise them yourself. If there are areas that need improvement, encourage the staff member to come up with what they think are potential solutions. Listen without arguing or defending your point of view and be prepared to adjust your views, if appropriate. To avoid any miscommunication it is important to seek confirmation back from the employee, during the appraisal meeting, that they understand any performance issues highlighted; make sure they agree with your version of the discussion.

For both the manager and staff member, just because you have completed a formal appraisal doesn't mean you can ignore performance for the rest of the year. It is good practice to keep in contact and to discuss progress with against any goals you both set and to provide/seek support when required. This can be as simple as a catch-up chat with no documentation - which should mean that the next appraisal contain no surprises.

Declaration of interests

- **Luke Groves:** Member of the JoPM Editorial Board. Personal payment from Pharmacy Management for writing the commentary.
- **Christine Gilmour:** Member of the JoPM Editorial Board. Personal payment from Pharmacy Management for writing the commentary.

"To avoid any miscommunication it is important to seek confirmation back from the employee, during the appraisal meeting, that they understand any performance issues highlighted . . ."

Why It's Good To Be Selfish

By Tom Phillips, lead trainer at Pharmacy Management, who has enjoyed 20 years of working with both the private and public sector, during which time he has gained extensive experience and demonstrated considerable success in management, sales, marketing and training. Tom is an excellent communicator and motivator and has designed/ delivered training at all levels from trainees to directors at both a national and international level. Such is Tom's love of training and development that, in his personal life, he is also a qualified fitness and diving instructor.

Tom Phillips

Being selfish?

From an early age we are taught that selfishness is bad. Remember being told to share your sweets and your toys with others? Sharing is good, right? Of course it is but, if you give too much of yourself to others, the consequences can be devastating for you and possibly those closest to you.

If you have ever flown anywhere, you will be familiar with the following part of the safety briefing. "In the event of sudden cabin depressurisation, oxygen masks will drop from the panels above your heads. Please fit your own mask first before assisting others." I have often wondered what would happen in this situation to a lone adult traveling with more than one child. Which child's mask would you fit first, after fitting your own? The one nearest to you or your favourite? Only kidding!

A good friend of mine often does charity work in the Greek islands with the thousands of unfortunate refugees who have arrived there. I am sure she has seen some heart wrenching sights, but she always tells me that the hardest part of the day is when she and the other volunteers have to eat. Naturally, they want to give their meals to those people they are trying to help.

Both of the above stories highlight the fact that it is essential to look after yourself. In the first case you would be no good to anyone if you pass out from a lack of oxygen whilst trying to help others. In the volunteer's case, they are no good to the refugees they are trying to help if they become fatigued due to a lack of nourishment.

Some top tips

So, there are times when it pays to be selfish and look after number one. But how can you be selfish without upsetting others or making yourself feel guilty as a result?

- **Know your limitations**

  We all have limits to our physical and mental strength. An awareness of these and, more importantly, when they are being reached, is essential to knowing when to take time out for yourself. Even if you really love your job and rush in to work every day with gusto, you will still have a limited amount of energy that will become depleted over time. Knowing what the warning signs are and acting upon them is critical to your self-survival. Classic warning sign of someone who is reaching their limits include fatigue, irritability, headaches, lack of enthusiasm - and more.

- **Take time out for yourself**

  It is really important to make time for yourself during the day, even if it is just 5 minutes here and there. I personally take time in the morning before I start work, during the working day and at the end of the working day. Sometimes that means getting out of bed a little earlier, but I prefer to do that in order to avoid starting the day in a rush just because I wanted to hit the snooze button a few times. During the day I always find time to just sit down and clear my head of all work-related matters. If you have attended Pharmacy Management's Academy meetings or Clinical Leadership in Pharmacy (CLIP) programmes, you may have noticed that I tend to eat lunch on my own. This

"It is really important to make time for yourself during the day . . ."

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is not me wanting to be anti-social, this is simply me wanting to take time out to recharge my batteries. Find somewhere you can grab a few minutes to yourself, even if is just walking around outside the place where you work. At the end of the working day, take time to 'switch off'. One of my old managers used to stop her car on the way home at the same place every day. She would park up opposite a duck pond that was on the way to her house, switch her engine off, put her phone on silent and allow herself to unwind. That duck pond was her 'anchor'. A place where she could relax and unload any work-related thoughts or concerns that she was still carrying.

- **Don't be afraid to ask for help**

  If you do feel like you are reaching the limits of your ability to cope, ask for help. This is not a sign of weakness, it is a sign of someone who knows when and how to take appropriate action in order to prevent a small problem becoming a big one. You could ask a colleague, your manager, HR or occupational health if you have access to them. Any one of these individuals or groups would much rather intervene sooner rather than later. You would support a colleague who asked for help - wouldn't you?

- **Be prepared to say "no"**

  Saying no to the demands of others can be tough, especially if it is someone senior that is making the request. However, the consequences of not saying "no" when you need to are tougher. If your boss keeps adding to your workload and you take it all on the chin, then you initially appear like a willing team player or a good worker. But eventually your work will begin to suffer as you spread yourself too thinly. If your manager or another colleague asks for help, be honest with them about your current workload. If a colleague desperately needs your help with something, what could they help you with by way of reciprocation? If it is your boss, what could they take away from you and pass to someone else or what will they allow you to put on the back burner for a while? On previous academies and during the CLIP programme we talk about being NEAT when saying no. This stands for:

  No - say it up front, don't prevaricate.

  Explain - state why you are saying "no" on this occasion.

  Alternatives - be prepared to explore these, especially if it is someone senior that is making the request of you.

  Timeline - agree a timeline for what will happen next if you have agreed to help (if you haven't, then ignore this step).

Remember!

Remember, there is only one of you and you are no good to your colleagues, your manager or your loved ones if you get 'burned out'. Stress costs businesses all over the planet billions every year in lost productivity. You can help to avoid this by being selfish!

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Membership of the Editorial Board is an honorary appointment but a personal fee is offered for writing a Management Conundrum commentary, which is then declared in the journal, or for conducting peer review.

Oct18

Published by **Pharman Limited**
PO Box 2378, 39 Ridgeway Road, Salisbury, SP2 2PH
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