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It is encouraging to report the outcome of a study that looked at the impact a pharmacist can have in reconciling and optimising medicines as part of a ‘rapid response’ team established to maintain patients in out-of-hospital care settings. It was assessed that the pharmacist’s intervention prevented moderate to severe harm in 30% of patients. This is an important finding in terms of the impact on quality of care and patient well-being.

The prescribing of gluten-free foods can result in a considerable cost-pressure. Restricting such supplies can, however, be a controversial issue. This edition carries a report of the outcome of a consultation process involving healthcare professionals, the general public and those with a gluten enteropathy. Although there was some mix of views, the outcome was an agreement to change policy and limit the amount of gluten-free bread and flour supplied to a maximum of eight units per patient, per month. This report will be of particular interest to those who wish to review the amount of gluten-free foods issued on prescription in their own area.

Continuing on the dietetics theme, our Face2Face considers the role of a dietetic project manager. This came about following a spiralling of costs for oral nutritional support products. What is happening to your costs and do you have such a role locally? Is the post described one that would be helpful on your patch?

The establishment of pharmacists in GP practices could prove to be a seminal initiative in improving patient care. It will certainly augment the long-established role to improve the cost and effectiveness of prescribing - but the real gain will come from direct patient contact and management, including prescribing, of specific therapeutic conditions. The vision is clear but much needs to be done to develop the infrastructure to support this development. An article in the Best Practice section is most helpful in setting out the background to the development and the steps that need to be done to capitalise on the opportunity for patients and the profession. If grasped, it will further impel pharmacy towards becoming a ‘patient-facing’ profession. The paper is an essential read for most pharmacists, but particularly for those who have a key role in leading the way forward - the future for the profession and better patient care is in your hands.

You can replace a post, but you can’t replace the member of staff. How, then, do you proceed when a pharmacist who has acquired extensive experience and is highly regarded by medical and nursing staff moves on in their career or retires in the post? It could be quite daunting for a less experienced person to take over. They may well become highly experienced and valued in the course of time – but how do you address the gap that exists in the meantime? This is a real-life situation that you may have experienced already but, if not, may do so in the future. The Management Conundrum section provides some very helpful advice.

Do you take everything in your stride and never get ‘phased’? If not, the Leadership section is just for you! It contains some useful guidance on how you can develop ‘bouncebackability’!
Working Better Together
How to build multidisciplinary and multiagency teams to improve patient care

The Spring 2017 series of Pharmacy Management Academy meetings is now open for booking, but places are limited so please act quickly!

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28 March  Manchester  23 May  Belfast
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Contribution Of A Pharmacist To The Rapid Response Service In Prevention Of Medicines-related Admissions

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Abstract

Title
Contribution Of A Pharmacist To The Rapid Response Service In Prevention Of Medicines-Related Admissions

Author List
Barnett N, Patel A, Kalsi D

Introduction
The Rapid Response Service (RRS) at London North West Healthcare (LNWH) NHS Trust uses a multidisciplinary team to maintain patients in their out-of-hospital care settings where possible. The objective of this study was to describe the contribution of a pharmacist within the Rapid Response Team (RRT) in reducing medicines-related admissions.

Method
The RRT pharmacist completed medicines reconciliation and medicines optimisation for patients referred to the RRT from December 2015 to March 2016. A locally developed tool (PREVENT) was used by the pharmacist to identify patients at risk of preventable medicines-related problems. Pharmacist interventions were categorised according to severity of potential risk of harm.

Results
The pharmacist completed a medication review for 229 patients during the study period. The most common risk factor for potential medication-related problems was ‘Risk from specific medications/medications-related admissions’.

For 52% of all patients a primary healthcare professional (HCP) was contacted to discuss medication-related problems. 30% of patients had an incident/error with their medication that had the potential for moderate or severe harm to be caused to the patient.

Discussion
In this study, the most common cause of admission was a fall. The average number of regular medications taken on admission was 9. Polypharmacy can lead to non-adherence, drug interactions, an increased number of side-effects and a pill burden. It is an independent risk factor for falls. Certain medications pose a significant fall risk (e.g. psychotropic drugs, benzodiazepines, hypnotics), hence the importance of medicines optimisation. The results of this study showed that a primary HCP was contacted in over half of the patients reviewed, which was essential to reducing this risk.

Conclusion
A pharmacist in the RRT improves safety through medicines optimisation/reconciliation, identifying adherence issues and reducing risks associated with medications.

Keywords: Medicines reconciliation, medicines optimisation, pharmacist intervention, hospital admissions.

Introduction
The Rapid Response Service (RRS) was established to maintain patients in their out-of-hospital care settings where possible and to achieve an earlier discharge for those who were admitted. The RRS uses a multidisciplinary team of nurses, physiotherapists, occupational therapists, paramedics, consultant physicians, speech and language therapists (SALT), dieticians and healthcare support workers as well as an administration team to provide a single point of access. During the time of the study, the service was commissioned by Brent and Harrow Clinical Commissioning Groups (CCGs) and managed by the London North West Healthcare (LNWH) NHS Trust, operating for 12.5 hours per day 7 days per week (14.5 hours per day in A&E).

The Rapid Response Team (RRT) in the community visits patients at home within two hours of a telephone referral to provide clinical, rehabilitation and social support. Another part of the RRT services the Accident & Emergency (A&E) department at Northwick Park Hospital, part of LNWH NHS Trust. The A&E team comprises of two to three clinicians who assess patients considered medically fit by the A&E physicians but who may require further clinical, rehabilitation and/or social support. This service operates between 8am to 10.30pm daily, including weekends.

Following a RRT assessment there are three possible outcomes. The patient may be considered as safe for discharge or to
remain at home with no follow-up, requires further support at home and will need to be visited by RRT at home post discharge or requires hospital admission for further medical input.

Medicines-related activities

Medicines reconciliation is being increasingly recognised as an essential means of improving patient safety. In 2006, the World Health Organization (WHO) launched their ‘High 5s’ project to address major patient safety concerns worldwide, in which medicines reconciliation was identified as a means of reducing medication errors during patient admission and discharge from hospitals. Medicines reconciliation is not routinely carried out as part of a rapid response assessment. A pilot at the Northwick Park Hospital found an average of 5 medicines reconciliation discrepancies per patient seen by the RRT in the absence of a pharmacist, with 40% of these discrepancies identified as moderate to high risk of causing potential harm to the patient.

The literature suggests that 5-8% of unplanned hospital admissions have a medicines-related contribution. With an increasingly ageing population, polypharmacy and medicines review have become an important consideration. Another local study at Northwick Park Hospital showed a reduction in preventable medicines-related readmissions due to a medication review of hospital inpatients with follow-up via the integrated medicines management service. In addition, a significant number of medicines-related incidents occur when patients are transferred between care settings, with between 30-70% of patients having an error or unintentional change to their medicine. A pharmacist post was therefore established within the RRT to complete medication reconciliation and review as part of medicines optimisation. This post aims to address these issues by ensuring that medication-related changes are relayed to HCPs in a timely and accurate manner.

Aim

To describe the contribution of a pharmacist within the RRT in relation to medicines reconciliation and review as part of medicines optimisation.

Objectives

- To describe the medicines-related risk factors in patients referred to the RRT pharmacist.
- To quantify the number of medicines reviews (including medicines reconciliation) completed by the RRT pharmacist between 14th December 2015 to 31st March 2016.
- To describe the interventions related to pharmacist liaison with primary care healthcare professionals regarding medications at point of discharge.
- To classify interventions undertaken by the RRT pharmacist according to risk.

Method

The RRT pharmacist reviewed patients referred to the RRS between 9am and 5pm Monday-Friday at Northwick Park Hospital Emergency Department (A&E) between 14th December 2015 to 31st March 2016.

The following was completed for each patient seen by the RRT pharmacist in A&E:

- medicines reconciliation and full drug history documentation on the Generic Clinical Information System (GCIS)

“... 5-8% of unplanned hospital admissions have a medicines-related contribution.”
medicines optimisation and recommendations documented on GCIS and discussed with relevant physicians in A&E or patient’s GP

• patient consultation to discuss medicines issues where appropriate

• full documentation of medicines changes on GCIS

• medicines compliance aid assessment where appropriate to support safe and effective management of medication

• communication and documentation of agreed actions with health and social care in secondary care regarding pharmaceutical management requirements

• referral to primary health and social care professionals as well as carers where necessary to ensure continuity of pharmaceutical care

• arranging rapid response home visits to ensure safe and effective management of medication where appropriate

• follow-up telephone calls to patient/carer where appropriate.

The daily roles of the RRT pharmacist are shown in Table 1.

---

### Table 1: Rapid Response Pharmacist - daily roles

| 1. | Patients in A&E are referred to the RRT by A&E clinicians. |
| 2. | The RRT pharmacist completes medicines reconciliation for these referred patients, the outcome of which is documented on the RRT pharmacist data collection form. |
| 3. | The RRT pharmacist assesses patient for PREVENT risk factors based on patient consultation, collateral history and discussion with rapid response/other HCPs where appropriate. These are documented on the data collection form. |
| 4. | Depending on risk factors identified, various interventions are carried out by the RRT pharmacist which are recorded according to the corresponding audit code on the data collection form. For example, contacting GPs to discuss review points, liaising with Rapid Response clinicians/HCP, social services, providing a medicines compliance aid (MCA), etc. |
| 5. | The following information is then documented on GCIS: |
| | • drug history |
| | • allergy status |
| | • sources of information used |
| | • date patient seen |
| | • where patient was seen – A&E/A&E Obs |
| | • any medicines review points |
| | • any compliance issues |
| | • other relevant information |
| | • interventions carried out and their outcomes. |
| 6. | Patients admitted to rapid response from A&E are then added to the electronic rapid response ‘whiteboard’ to be discussed in the daily rapid response virtual ward round with rapid response consultants at 3pm in the Harrow team and 2.30pm in the Brent team. |
| 7. | A&E patients admitted to rapid response are discussed/seen daily by the rapid response team virtual ward round and notes are documented on GCIS in a chronological order. |
| 8. | Once a patient is deemed fit for discharge from rapid response they are removed from the electronic whiteboard. |
### Table 2: PREVENT tool

#### PREVENT TOOL: “High Risk” patient REFERRAL FORM

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical impairment [PHY]</strong></td>
<td>Patient has difficulties with swallowing, impaired dexterity, poor vision, hard of hearing or poor mobility which will impact them taking medication</td>
</tr>
<tr>
<td><strong>Risk from specific med/medicines-related admission [RIS]</strong></td>
<td>Patient is taking a high risk medicine (anticoagulants/antiplatelets, insulin/oral hypoglycaemics, NSAIDs, benzodiazepine, antihypertensives, beta blockers, opioids, methotrexate, injectable medicines, drugs requiring therapeutic drug monitoring esp. with no monitoring, steroids) which the patient is unable to manage</td>
</tr>
<tr>
<td><strong>adhErence issues [ADH]</strong></td>
<td>Patient has not been taking their medicines e.g. various dispensing dates on medicines, no recent dispensing of medication, newly started on all medicines or cannot give names of medicines they are taking. Patient has decided to stop taking all or some of their medicines which has lead or will lead to worsening of their clinical condition</td>
</tr>
<tr>
<td><strong>cognitive impairment [COG]</strong></td>
<td>Patient is unable to take medication regularly without support as they have a condition which affects their memory e.g. delirium, dementia</td>
</tr>
<tr>
<td><strong>new diagnosis/exacerbation disease/ [EEC]</strong></td>
<td>Admission is related to poor management of medication for a long term of clinical condition or deterioration of organ system function eg renal, cardiac Previous admission or A&amp;E attendance within 30 days</td>
</tr>
<tr>
<td><strong>compliance support [COS]</strong></td>
<td>Refer all new requests</td>
</tr>
<tr>
<td><strong>social [SOC]</strong></td>
<td>Patient cannot manage daily activities independently or has carers to help with daily activities but not medicines. Patient has social issues such as no fixed abode, unkempt, etc which impacts on them taking medication Smoker</td>
</tr>
</tbody>
</table>

This guide supports identification of patients with **unmanaged** complex pharmaceutical issues, at risk of preventable medicines-related readmission where the risk is **modifiable** through pharmaceutical care.

The PREVENT tool was used by the RRT pharmacist to identify risk factors for potential medication-related problems in the patients reviewed (Table 2).

All pharmacist interventions were recorded during this period and were grouped per patient and then assessed for potential harm categorised by the NPSA definitions of harm scale. There are various other tools such as the RIO tool which can be used to assess interventions, the one used in this Trust is the NPSA definition of harm scale.

Results
The RRT pharmacist was referred to 229 patients between 14th December 2015 to 31st March 2016, all of whom received a completed medication review including medicine reconciliation. Of the 229 patients reviewed by the RRT pharmacist, the most common cause of admission was a fall (n=96, 42%) as shown in Table 3.

The average age of patients seen was 82 years. The average number of regular medications taken on admission was 9. The average time taken for the RRT pharmacist to review a patient was 1 hour 28 minutes, this includes taking a complete drug history from a minimum of two sources and any interventions/ follow-up that was required.

Identifying risk factors for readmission

The total number of PREVENT risk factors identified in all patients seen was 176 (more than one risk factor may be identified per patient). Figure 1 shows the risk factors that were identified. The most common risk factor for a potential medication-related problem was ‘Risk from specific medications/medications-related admissions’ (n=95, 55%). This is where a patient is taking a high risk medication or the patient has a complex medication regimen which they are unable to manage (e.g. an older patient taking sedating antihistamine and where falls risk is high) and has the potential to lead to a medicines-related readmission.

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exacerbation of COPD/asthma or new diagnosis</td>
<td>5</td>
</tr>
<tr>
<td>Exacerbation of heart failure or new diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>0</td>
</tr>
<tr>
<td>Hypoglycaemia or hyperglycaemia</td>
<td>3</td>
</tr>
<tr>
<td>Falls</td>
<td>96</td>
</tr>
<tr>
<td>A physical impairment has caused an admission e.g. reduced mobility</td>
<td>24</td>
</tr>
<tr>
<td>Patient has a cognitive impairment</td>
<td>10</td>
</tr>
<tr>
<td>A ‘high risk’ medicine</td>
<td>4</td>
</tr>
<tr>
<td>Lack of social support</td>
<td>4</td>
</tr>
<tr>
<td>Poor/non-adherence to medication</td>
<td>0</td>
</tr>
<tr>
<td>Other cause for admission e.g. infection, cardiovascular, symptoms, gastrointestinal, symptoms, renal, impairment/failure, pulmonary embolism/deep vein thrombosis (PE/DVT)</td>
<td>87</td>
</tr>
</tbody>
</table>

Note: a patient may have had more than one reason for admission

Liaison with HCPs
A total of 476 interventions were made by the RRT pharmacist (Figure 2). A patient may have had more than one intervention. For 52% of all patients (n=118), a primary HCP (GP, community pharmacist, specialist community nurse) was contacted to discuss medication-related problems. 32% of all patients (n=74) had changes made to their medication as a result of the pharmacist’s intervention (there may have been more than one change per patient). 8% of patients (n=19) had medication recommendations that were handed over to a primary healthcare professional to review.
Adherence issues were identified in 18% of patients (n=41). To help patients improve both unintentional and intentional adherence, interventions were made by the Rapid Response Pharmacist (Table 4). The most common adherence intervention was counselling patients/family on the patient’s current medication.

Interventions and risk assessment

Risk assessment of the incident/error is shown in Figure 3. 30% (n=68) of incidents/errors had the potential for moderate or severe harm to be caused to the patient. Definitions of risk categories, with examples of interventions, are shown in Table 5. No interventions carried out were considered as having the potential to prevent death.

Discussion

In this study, the most common cause of admission was a fall (n=96, 42%). The majority of patients were over 65 years with the average age of patients seen being 82 years. The average number of regular medications taken on admission was 9. It is well established that polypharmacy is an independent risk factor for falls, with psychotropic drugs such as tricyclic antidepressants, antipsychotics and benzodiazepines being clearly associated with a significant increased risk. Furthermore, benzodiazepines and hypnotics pose a clear dose-dependent risk. The National Institute for Health and Care Excellence (NICE) recommend that older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling.6

Older patients with multiple co-morbidities are the highest risk patient group for falls. Research has demonstrated that patients on multiple medications are more likely to suffer drug side effects and are at higher risk of hospital admissions.7,8 In addition, polypharmacy is associated with potential problems with adherence, drug interactions, increased number of side-effects and pill burden. It should be noted that appropriate polypharmacy is needed to meet the needs of complex patients and there is some concern older patients are often under-treated and are
Table 5: Definitions of each grade of incident prevented by pharmacist’s intervention

<table>
<thead>
<tr>
<th>Grade of Incident prevented by Rapid Response Pharmacist intervention*</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>No harm to the patient. Clinical intervention only (e.g. medicines reconciliation and medicines review).</td>
</tr>
</tbody>
</table>
| Low harm | Minimal harm to the patient whereby the patient required extra observation or minor treatment, including minimising fracture risk, addressing electrolyte imbalance, addressing deficiency, low risk changes to medication therapy.  
Patient example: Adcal D3 changed to caplets to aid compliance as the patient was unable to take ‘chewtabs’ because they were considered too large. |
| Moderate harm | Significant but not permanent harm which resulted in a moderate increase in treatment, including minimising falls risk, addressing non-adherence or adverse effect to a medication which may result in hospital admission or exacerbation of condition.  
Patient example: Patient with a risk of falls prescribed aspirin with no apparent indication together with two anti-muscarinics for urinary urge incontinence. This was discussed with GP and highlighted for review as both medications had a potentially adverse effect on falls. |
| Severe Harm | Permanent harm to the patient, including poor management of a high risk drug (such as an anticoagulant or immunosuppressant drug) that may lead to physical or cognitive permanent harm to the patient.  
Patient example: patient on azathioprine which was scheduled for discontinuation 3 years ago and no apparent clinician monitoring patient’s blood test: pharmacist advised that medication should be discontinued. |
| Death | Death caused as a result of a patient safety incident. |

*The NPSA 2011 definition of harm scale
often not involved in decisions about their care.9

The study found that approximately half of all patients admitted to the RRS had an unmanaged, modifiable, complex pharmaceutical issue, which puts them at risk of a preventable medicines-related admission. The study also found that, for 30% of all patients, the pharmacist’s intervention had the potential to prevent moderate to severe harm being caused to the patient.

There is considerable risk that patients’ medications will be unintentionally altered when moving between care settings. Liaising with GPs, community pharmacists and other HCPs in the community is essential to reduce this risk.

The results of this study showed that a primary HCP was contacted in over half of the patients reviewed by the RRT pharmacist. In some cases this involved the handover of important medications-related information. For example, medications that were identified as being the cause of admission (e.g. blood pressure medications in patients admitted with postural hypotension) were stopped in A&E. The RRT pharmacist contacted the GP and community pharmacy to ensure that the appropriate medication was omitted from the multi-compartment compliance aid. Without this intervention from the RRT pharmacist, these patients may have continued to take these medications with potential worsening of their condition and/or readmission to hospital.

**Limitations**

The number of patients reviewed by the RRT pharmacist was limited to the availability of the RRT pharmacist, taking into account annual leave, sickness, additional ward cover, medicines management pharmacist cover and other work commitments over the 3 month data collection period.

Patients assessed by the A&E RRT after RRT pharmacist working hours (5pm to 10.30pm) and at weekends and bank holidays were not accounted for in this study.

The RRT pharmacist was unable to review all patients seen by the A&E RRT as the team comprised of two or three clinicians and only one pharmacist was available.

Due to the dynamic environment of the A&E department, if the pharmacist was reviewing a patient in the A&E observations ward, they may have missed a patient in A&E who had left the department over the same time period.

**Conclusion**

This study confirms that having a pharmacist in the RRT provides improved safety and quality of service through medicines reconciliation, identifying adherence issues and reducing risks associated with medications. In addition, liaison with HCPs in the community promotes the safe and effective transfer of medication-related information.

The RRS prides itself on multidisciplinary team working and having a pharmacist in the skill mix provides medicines-related expertise and supports evidence-based decision making.

With an increasingly ageing population, and older frail patients being the fastest growing segment of the population, the work of the RRT in managing these patients will inevitably increase. In turn, the complexity and needs of the service will mean an increase in demand for medicines review and optimisation, which a pharmacist brings to the RRT.

**Declaration of interests**

The authors have nothing to disclose.

**REFERENCES**


Consultation On Changes To Gluten-free Prescribing Guidance In Buckinghamshire

Correspondence to: alison.smith47@nhs.net

Abstract

Title
Consultation On Changes To Gluten-free Prescribing Guidance In Buckinghamshire

Author list
Smith A

Introduction
Restricting the amount and type of gluten-free food prescribed was suggested by Buckinghamshire’s Clinical Commissioning Groups Medicines Management Team following similar restrictions being proposed at border CCGs. Consuming a diet free from gluten is essential for those with a diagnosed gluten enteropathy, therefore consultation with both healthcare professionals and the general public was essential.

Method
A survey of healthcare professionals was undertaken, followed by a public consultation. Both were undertaken in partnership with the local Communications and Engagement team.

Results
74% of healthcare professionals indicated support for some form of prescribing restriction, with 51% indicating that they considered gluten-free food prescribing should be limited to 8 units per month. 54% of members of the public who responded indicated that they were in favour of some form of gluten-free food prescribing restriction with the majority favouring a restriction to 8 units of gluten-free food per month, comprising bread, flour and pasta.

Discussion
The same preferred option was identified in both the public consultation and the healthcare professional survey. Therefore, in line with the survey outcomes, Buckinghamshire’s CCGs chose to change gluten-free prescribing guidance away from Coeliac UK National Prescribing Guidelines to a maximum of units per patient per month, comprising bread, flour and pasta. New local guidance was produced, including guidance on the most cost-effective prescribed gluten-free foods. This is published on the Buckinghamshire Formulary, which is available on the internet.

Conclusion
Buckinghamshire’s CCGs did not consider that stopping all gluten-free prescribing was appropriate. The cost of gluten-free staple foods remains significantly higher than the cost of equivalent gluten containing foods, and so a system where the NHS contributes towards these costs but the patient also contributes seems to be a fair compromise. We consulted with those who will be affected, as well as the wider public, to establish the local consensus on the best overall approach. In the current difficult financial climate, we feel that publishing the results of these two surveys may help others to consider a similar restriction of gluten-free foods on prescription in their localities.

Keywords: gluten-free, consultation, coeliac, restriction.

Introduction
Tough decisions are needed on how to best use NHS resources. We have a statutory responsibility to involve the public with these difficult decisions but, more than that, involving people who are affected by changes helps to ensure that sound decisions are made.

In Buckinghamshire we conducted two surveys (presented below) which demonstrate that both healthcare professionals and the majority of our population, including patients with coeliac disease, support restricting the use of gluten-free foods on prescription to 8 units per patient per month.

The need for gluten-free food
Gluten-free food may be prescribed for patients who meet the Advisory Committee on Borderline Substances (ACBS) criterion ‘established gluten enteropathy with or without co-existing established wheat sensitivity’. The conditions to which this applies are coeliac disease and dermatitis herpetiformis. Both are autoimmune conditions caused by the body reacting to the presence of gluten in the diet and, as a consequence of this reaction, the immune system causes damage to the gut.
Coeliac disease is common, it may affect as many as 1 in 100 people in the UK, but there is concern that, for many, coeliac disease remains undiagnosed. Consumption of a diet free from gluten is the required treatment for both coeliac disease and dermatitis herpetiformis, and should be continued lifelong.

A change to local prescribing guidance

In 2014, following consultation with the public, Oxfordshire CCG’s gluten-free food prescribing guidance was changed to advise prescribing a maximum of 8 units of gluten-free bread and flour per patient, per month. This guidance was intended to ensure equity and it was also intended to be simpler for GPs to implement than the county’s previous guidance.

Aylesbury Vale CCG and Chiltern CCG (Buckinghamshire’s CCGs) began to consider changing their own gluten-free prescribing guidance. At this time guidance in Buckinghamshire followed that issued by Coeliac UK (Figure 1), which recommends different allowances of gluten-free foods based on patients’ age, gender, level of physical activity and, for women, whether they are pregnant or breastfeeding. This is hard to audit because requirements are different for different patients, and it is also difficult for GP practices to monitor.

The Buckinghamshire’s CCG guidance at this time recommended avoiding the prescription of non-essential gluten-free foods such as biscuits and cakes.

Method

Healthcare professional survey

We knew that the Oxfordshire CCG’s proposal resulted in a large number of patient queries and, from this, we surmised that proposing a restriction of gluten-free food prescribing could be extremely contentious. Buckinghamshire’s CCGs decided to initially survey the views of local healthcare professionals across Buckinghamshire’s CCGs and the local combined acute and community NHS

<table>
<thead>
<tr>
<th>Age and sex</th>
<th>Number of units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 1-3 years</td>
<td>10</td>
</tr>
<tr>
<td>Child 4-6 years</td>
<td>11</td>
</tr>
<tr>
<td>Child 7-10 years</td>
<td>13</td>
</tr>
<tr>
<td>Child 11-14 years</td>
<td>15</td>
</tr>
<tr>
<td>Child 15-18 years</td>
<td>18</td>
</tr>
<tr>
<td>Male 19-59 years</td>
<td>18</td>
</tr>
<tr>
<td>Male 60-74 years</td>
<td>16</td>
</tr>
<tr>
<td>male 75+ years</td>
<td>14</td>
</tr>
<tr>
<td>Female 19-74 years</td>
<td>14</td>
</tr>
<tr>
<td>Female 75+ years</td>
<td>12</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Add 4</td>
</tr>
<tr>
<td>3rd trimester pregnancy</td>
<td>Add 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Food item</th>
<th>Number of units</th>
</tr>
</thead>
<tbody>
<tr>
<td>400g bread/rolls/baguettes</td>
<td>1</td>
</tr>
<tr>
<td>500g bread/flour mix</td>
<td>2</td>
</tr>
<tr>
<td>200g savoury biscuits/crackers</td>
<td>1</td>
</tr>
<tr>
<td>200g pasta</td>
<td>1</td>
</tr>
<tr>
<td>500g oats</td>
<td>1.5</td>
</tr>
<tr>
<td>300g breakfast cereal</td>
<td>1.5</td>
</tr>
<tr>
<td>2 x 110-180g pizza bases</td>
<td>1</td>
</tr>
<tr>
<td>100 - 170g xanthan gum</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 1 - Coeliac UK National Prescribing Guidelines
Trust to establish if there was a desire to change the prescribing guidance that was current at the time. This exercise was undertaken with the local Communications and Engagement team.

The survey comprised an explanation of the reason for undertaking the survey together with a comparison between the existing prescribing guidance in Buckinghamshire’s CCGs and Oxfordshire CCG where:

- Buckinghamshire’s CCGs’ guidance recommended following Coeliac UK guidance
- Oxfordshire CCG guidance recommended restriction to 8 units gluten-free food per patient per month, comprising bread and flour only.

The survey asked respondents to choose one of 4 options as their preferred model for future gluten-free food prescribing, which were:

1) Stop prescribing of gluten-free foods completely.
2) Change the current model so that each patient with gluten enteropathy receives 8 units per month regardless of age, gender or activity level and limit products prescribed to bread and flour only (as per the Oxfordshire CCG model).
3) Change the current model so that each patient with gluten enteropathy receives 8 units per month regardless of age, gender or activity level and limit products prescribed to bread, flour and pasta.
4) No change to the current model (follow Coeliac UK guidance on quantities to prescribe based on age, gender and physical activity level).

We were aware that some CCGs were considering stopping gluten-free prescribing entirely and hence that option was included. We deemed that pasta is a healthy, staple food for many people, and together with purchased gluten-free bread and flour, purchased gluten-free pasta remains more expensive than gluten containing options. For these reasons, we included an option where an allowed 8 units included pasta as well as bread and flour.

Public consultation

Working together with the local Communications and Engagement team, a public consultation was set up through ‘Let’s Talk Health Bucks’. This is an online public and patient forum supporting Buckinghamshire’s CCGs to run engagement, consultations and surveys. We were keen to hear the views of the general public, as well as those of people with a gluten enteropathy, and to enable this to happen the 12 week survey was run in two stages. For the first 6 weeks the survey was only open to those who, prior to the survey start date, were already registered on the ‘Let’s Talk Health Bucks’ website, thus giving a cross section of the views of the general public. For the remaining 6 weeks the survey was advertised widely, including to Coeliac UK, and the survey was opened to all who wished to answer it.

Results

Healthcare professional survey

In total, 100 responses were received. The profession and employing organisation of respondents is shown in Figure 2.

Respondents indicated which of the four options for future gluten-free food prescribing they most agreed with (Figure 3).

In total, 74% of respondents indicated support for some form of prescribing restriction, with 51% indicating that they considered gluten-free food prescribing should be limited to 8 units per month. 4% of respondents also volunteered the information that either they or a close relative had coeliac disease.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Employed by:</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aylesbury Vale CCG</td>
<td>Chiltern CCG</td>
</tr>
<tr>
<td>GP</td>
<td>22</td>
<td>39</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Practice manager</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Practice nurse</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Dispensary staff</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Dietitian</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Consultant</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Other (profession not stated)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>29</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>

*Figure 2: Healthcare professional survey - respondent organisations*
As 74% of respondents indicated support for a more restricted option than the current Buckinghamshire’s CCGs’ guidance, the survey results from healthcare professionals made it clear that there was an appetite to restrict gluten-free prescribing in Buckinghamshire. The results of the survey were taken to our local prescribing decision making forum along with draft documents suggesting restricted quantities. At this meeting it was suggested that a public consultation was also required.

Public consultation

Coeliac UK’s action in encouraging their members to respond to the public consultation significantly boosted the number of respondents (Figure 4).

For those who identified themselves as having coeliac disease or having a close relative with coeliac disease, 84% reported current receipt of gluten-free food on prescription. Of those who did not receive gluten-free food on prescription, only one stated that they were unaware that gluten-free food was available on prescription, with the majority identifying that they found the range of food available on prescription limited or that they bought the gluten-free food that they preferred. Two people with coeliac disease stated that they did not agree that gluten-free food should be available on prescription.

When asked to identify why they obtained gluten-free food on prescription, 62% of respondents stated that gluten-free food available in supermarkets or on the high street is too expensive, and 41% stated that they were eligible for free prescriptions.

Respondents also indicated how strongly they agreed or disagreed with several statements (Figure 6).

A number of respondents also offered comments on the consultation, of which 44% were in support of some restriction on gluten-free food prescribing. Nearly two thirds of these respondents had identified themselves as someone with a gluten enteropathy. These comments mainly indicated that they thought the NHS had other higher priorities, or that 8 units per month was a fair compromise when there was improved provision of gluten-free food on the high street, albeit at a higher price than gluten containing food.

Comments that challenged the proposed restrictions mainly focussed on the high cost of gluten-free food on the high street/in supermarkets (with prices three or four times the cost of equivalent gluten containing food quoted). There was also concern that further restrictions may lead to people with a gluten enteropathy not following a gluten-free diet and that 8 units of gluten-free food per month would not be enough for some people. There was a sense from some of these comments that those with a gluten enteropathy had a ‘right’ to receive all their gluten-free food on prescription, and some comments pointed to other ‘inappropriate’ use of NHS resources as areas that should be tackled rather than restricting gluten-free food prescribing.

Overall, 54% of respondents indicated that they were in favour of some form of gluten-free food prescribing restriction with the majority favouring a restriction to 8 units of gluten-free food per month comprising bread, flour and pasta.

Decision reached

The same preferred option was identified in both the public consultation and the healthcare professional survey. Therefore, Buckinghamshire’s CCGs chose to change

<table>
<thead>
<tr>
<th>Survey option</th>
<th>% response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop prescribing of gluten-free foods completely</td>
<td>23%</td>
</tr>
<tr>
<td>8 units per month regardless of age, gender or activity level and limit products prescribed to bread and flour only</td>
<td>25%</td>
</tr>
<tr>
<td>8 units per month regardless of age, gender or activity level and limit products prescribed to bread, flour and pasta</td>
<td>26%</td>
</tr>
<tr>
<td>No change to current model</td>
<td>18%</td>
</tr>
<tr>
<td>Other (option to add free text)</td>
<td>8%</td>
</tr>
</tbody>
</table>

Figure 3: Preference for options

<table>
<thead>
<tr>
<th>Survey period</th>
<th>Total number of respondents</th>
<th>Respondents with coeliac disease</th>
<th>Respondents with close relative with coeliac disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>After 6 weeks</td>
<td>25</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>After 12 weeks</td>
<td>125</td>
<td>59%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Figure 4: number of respondents
gluten-free prescribing guidance away from Coeliac UK National Prescribing Guidelines to a maximum of 8 units per patient per month, comprising bread, flour and pasta.

Discussion

Following the consultation outcomes, the following documents were developed to support the change:

- Local patient friendly resource: Gluten-free foods on prescription - Patient information leaflet.
- Healthcare professional resources: Gluten-free foods - Health care professional (HCP) guide and Most cost effective prescribed gluten-free foods - HCP guide.

The new Buckinghamshire CCGs’ guidance came into effect on the 1st December 2015.

The Buckinghamshire Formulary (http://www.bucksformulary.nhs.uk/) was also updated with all current ACBS listed gluten-free foods (Chapter 25), and the most cost-effective products were clearly identified. Cost-effectiveness was calculated based on a comparison of cost per 100g of similar foods, as comparable products from different manufacturers are often a different weight or contain different quantities and cannot, therefore, simply be compared one with another. The number of units per item prescribed was also added to the formulary so that the formulary could be used to easily ascertain how 8 units could be made up using different products.

Following the public consultation, there have been few concerns raised about the new guidance either by patients or healthcare professionals.

Coeliac UK made Buckinghamshire’s CCGs aware that they strongly agreed with the statement ‘it is difficult to find gluten-free food on the high street’ and cited research conducted in 2010 which...

<table>
<thead>
<tr>
<th>Consultation question</th>
<th>Agree or strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand the reasons for reviewing the guidelines</td>
<td>77%</td>
</tr>
<tr>
<td>It is right that the NHS provides some gluten-free food on prescription to those who need it</td>
<td>84%</td>
</tr>
<tr>
<td>People who need gluten-free food should buy some of it themselves</td>
<td>69%</td>
</tr>
<tr>
<td>It is difficult to find gluten-free food on the high street</td>
<td>29%</td>
</tr>
</tbody>
</table>

Figure 6: Views about statements
demonstrated that, at the time it was conducted, gluten-free food was not widely available in corner shops and budget supermarkets. However, in the six years since that research was conducted, gluten-free diets have become more widely chosen by those who do not have a gluten enteropathy. This trend has seen a significant rise in the availability of gluten-free foods even in smaller shops. For those with a gluten enteropathy the by-product of this trend has been greater accessibility of the gluten-free food that they require.

The change to Buckinghamshire’s CCGs’ guidance was also supported by the results of the public consultation survey in which only 29% of respondents with a gluten enteropathy indicated that it is difficult to find gluten-free food on the high street.

Coeliac UK has since released this statement:

‘Chiltern and Aylesbury Vale Clinical Commissioning Groups’ (CCGs) consultation on gluten-free prescribing ended on 28 September 2015. We’ve now had confirmation that the CCG will prescribe eight units a month from a choice of gluten-free bread, bread rolls, bread mixes, flour and pasta.

Although this new policy moves away from National Prescribing Guidelines, we’re pleased to see that the CCG has listened to the patient voice and has not opted to completely remove gluten-free food on prescription, one of the options considered. We are also pleased to see that pasta is being prescribed alongside other important staples.’

Conclusion

Gluten-free food prescribing can be a contentious subject but, nonetheless, is an area in which many CCGs are considering some restrictions, including some areas proposing a blanket ban on the prescribing of gluten-free foods.

Buckinghamshire’s CCGs did not consider that stopping all gluten-free prescribing was appropriate. The cost of gluten-free staple foods remains significantly higher than the cost of the equivalent gluten containing foods, and so a system where the NHS contributes towards these costs but the patient also contributes seems to be a fair compromise. If patients wish to buy extra gluten-free foods, the cost of this extra food should not be more than the cost of one month’s supply of gluten containing foods from the same food groups. In line with the outcomes of both surveys, the CCGs considered that it is appropriate for people with a gluten enteropathy to provide some of their gluten-free food requirements themselves. Overall, the healthcare professional survey and public consultation both demonstrated broad agreement with this view.

Declaration of interests

Alison Smith has nothing to disclose.

REFERENCES

COMING TO A TOWN NEAR YOU IN 2017 - A PHARMACY MANAGEMENT EVENT FOR MEDICINES

JoMO-UKCPA National Respiratory Workshop
1 February 2017, Birmingham

National Forum for Northern Ireland
April 2017 (day to be confirmed), Belfast

JoMO-UKCPA National Diabetes Workshop
9 May 2017, Manchester

PM National Forum for Scotland
30 August 2017, Dunblane

JoMO-UKCPA National Cardiovascular Workshop
13 September 2017, Leicester

JoMO-UKCPA National Diabetes Workshop
10 October 2017, London

Pharmacy Management National Forum Workshop
24 November 2017, London

Pharmacy Management Academy
See details for the next programme elsewhere in the Journal.

Details from katie.fraser@pharman.co.uk
or jgriffiths@pmmarketaccess.com
75c High Street, Great Dunmow, Essex CM6 1AE
Tel: 01747 829501
Homepage: www.pharman.co.uk
Email: pharm@pharman.co.uk

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

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Correspondence to: finlay.royle@nhs.net

Abstract

Title
Pharmacists In General Practice

Author list
Royle F

Summary
Practice-based pharmacists will play a central role in delivering medicines optimisation in an integrated care approach to healthcare delivery. The NHS Five Year Forward View has outlined the need for a more integrated and holistic healthcare system and highlights the potential for pharmacists to deliver more direct patient care. Medicines optimisation is a central component of this vision and whilst pharmacists are not the only professionals involved in medicines and prescribing, they should be leading the implementation of medicines optimisation and delivering it on the ground.

It is essential that the pharmacist workforce is equipped to work in general practice and that it delivers high-value interventions. Pharmacists will be required to prescribe for defined groups of patients with long-term conditions (LTCs), undertake medication reviews, provide leadership and assurance around safe systems for medicines reconciliation, undertake repeat prescribing, deliver education and training and engage with multidisciplinary teams across the NHS.

Providing capacity to support these individuals and creating leadership in practice will be important to ensure that peer-led clinical supervision, local training and research is robust and effective. These roles will need to be established in the face of decreasing budgets for education and training.

In short, practice-based pharmacists have the potential to drive the medicines optimisation agenda forward by addressing complex adherence and polypharmacy issues and providing ongoing management for patients with LTCs. However, this will only be effective if pharmacists with the correct skills and experience are working with effective professional leadership to support education, training and clinical supervision.

Keywords: practice-based, medicines optimisation, patient-facing, prescribing, pilot.

Introduction

Following NHS reorganisation in England in 2013 and the publication of the Five Year Forward View,1 there has been increased interest in the role of the practice-based pharmacist. The medicines optimisation agenda, along with the focus on the management of long-term conditions (LTCs), has put patient-centred, integrated care at the forefront of healthcare strategy in the NHS.

Workforce concerns are also driving innovative solutions to the growing numbers of GPs and practice nurses who are leaving primary care or retiring. Pharmacists will be required to fill the gap in providing direct, patient-facing care in the general practice and community pharmacy setting. They will be joined alongside physicians’ associates and other healthcare professionals.

To support this, NHS England announced the ‘Clinical Pharmacists working in General Practice’ pilot scheme, funded to the tune of £31 million, in summer 2015. This scheme, developed jointly by the Royal College of General Practitioners (RCGP) and the Royal Pharmaceutical Society (RPS),2,3 is funding up to 400 patient-facing practice-based pharmacists to work in General Practices during a 3-year pilot. Practices part-contribute to the funding of these posts, with the intention that the posts will be mainstreamed by the end of the 3 year pilot. The aim of the pilot is to improve patient safety and reduce waiting times for appointments in GP practices.

Such is NHS England’s belief in this scheme that the pilot is to be extended, providing funding for pharmacists to work in all areas of England, with one pharmacist funded for every 30,000 population.

Of course, the concept of pharmacists working in GP practices is not a new one and, indeed, those who already work in these settings have demonstrated the effectiveness and importance of the role.4 In Scotland, Wales and Northern Ireland, integrated care is already embedded and the NHS in Scotland, for example, is already taking advantage of pharmacists’ skills through caseload management of patients in both general practice and community pharmacy settings.5 However, it will be important to establish a broader evidence base to demonstrate the benefits of pharmacists working in this healthcare setting.
The practice-based pharmacist and integrated care

The Five Year Forward View in England clearly outlines the growing funding gap that faces the NHS (Figure 1). The NHS in England will need to rapidly integrate care across the primary, secondary and community care settings in a patient-centred approach that puts the patient at the heart of the decision-making process. This integrated care concept will reduce the demand on the health system by identifying, treating and preventing many LTCs earlier to reduce morbidity. A multi-disciplinary team approach will deliver a patient-centred holistic approach to treating and preventing ill health. The Five Year Forward View explicitly states that a ‘far greater use of pharmacists’ forms part of the solution to these issues.

The medicines optimisation concept aims to address these issues by focussing on maximising value and reducing waste in relation to the use of medicines. Primary care spends over £9 billion per annum on prescribing and that spend is rising at 4% per year, not including specialist and hospital prescribing costs. With a funding shortfall in the overall NHS budget, there is significant pressure to find efficiencies in the prescribing budget. Relying on dwindling numbers of patent expiries and the resultant generic windfalls will not be sufficient to balance the prescribing budget.

Treating LTCs accounts for 70% of the NHS budget, and this treatment includes a significant spend on medicines, many of which are not used as intended. An integrated care approach, which brings specialists, patients, GPs, nurses, pharmacists into a multi-morbidity, multi-disciplinary way of working, can bring about significant benefits. Pharmacists, as coordinators of the prescribing elements of patient care, can ensure safe, timely and optimal drug therapy for patients and address the adherence issues that are often complex and multifactorial (Figure 2).

Pharmacists should, however, be patient-facing. Running medication review clinics to address adherence and polypharmacy issues and de-prescribing where appropriate will have a higher impact than focussing on administrative functions relating to medicines management. Maximum value can be achieved through the prescribing function; by taking appropriate workload away from GPs in a structured and supported way, pharmacists can ease workload and recruitment issues, provide an additional layer of expertise and bring real value to the general practice team.

Patient care should be tailored around the needs of individuals, not the needs of the system. This means addressing multi-morbidity as a joint effort, led by the generalist. Silo working led by the specialist is no longer helpful when patients with LTCs have several specialists involved in their increasingly complex care. Pharmacists, who are trained as generalists, are key to supporting this approach. By bringing a specialism (medicines and prescribing expertise) to a generalist setting with an understanding of the generalist’s way of working, pharmacists are well placed to facilitate medicines optimisation in the general practice setting.

The practice-based pharmacist role

Since the reorganisation of the NHS in 2013, ‘Medicines Management’ teams have supported their GPs by providing strategic leadership around the use of medicines by setting and managing prescribing budgets, providing clinical
leadership around the introduction of new medicines, developing local guidelines and responding to patient-specific queries. Our experience in Lambeth, with around 15% of practices employing an in-house pharmacist, has demonstrated that there is still a need for strategic planning around medicines optimisation. The practice-based role has allowed us to have further ‘reach’ into practices thereby helping to improve relationships between GPs and Community Pharmacists and deliver our local medicines and prescribing priorities.

However, in addition to the practice-based role, pharmacists are already working in primary care; Community Pharmacists, Clinical Commissioning Group (CCG) and Clinical Support Unit (CSU) employed pharmacists, community health services pharmacists and hospital pharmacists are all working directly in, or supporting, general practices to varying degrees. One of the roles of the practice-based pharmacist will be to coordinate medicines and prescribing issues across the interface; they will need to develop effective working relationships with pharmacists and other healthcare professionals in optimising the use of medicines (Figure 3).

Pharmacists can work in and for GP practices in a number of different ways and these have been described elsewhere. The key challenge is ensuring maximum value. The RPS advocates that pharmacists should have a minimum of two years experience as a practising pharmacist before taking on such roles. Although not all roles require a prescribing qualification, most practices who seek advice in recruiting a pharmacist want a prescribing pharmacist when they become aware of the vast array of skills and benefits a pharmacist can bring to their team. However, the reality is that only 3% of pharmacists are currently qualified as prescribers. Strategic workforce planning is critical to ensure that any planned increase in practice-based pharmacist capacity is accompanied by appropriate training in therapeutics and access to non-medical prescribing qualifications. The Centre for

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**Figure 2: The practice-based pharmacist is central to coordinating and optimising medicines across multi-providers and others involved in a patient’s use of medicines.**

**Figure 3: Examples of activity that a practice-based pharmacist can provide**

- Medication review to support complex adherence and polypharmacy issues
- Clinics focusing on specific LTCs
- Formulary adherence and local prescribing cost-efficiencies
- Waste, including supervising repeat prescription processes
- Stakeholders and key relationships (Patient Participation Groups, Community Pharmacists, Hospital Pharmacists, CCG staff, NHS England (NHSE) staff)
- Medicines reconciliation
- Monitoring of high risk drugs (disease modifying anti-rheumatic drugs (DMARDs), warfarin, )
- Training of practice staff
- Local Incentive schemes relating to medicines and prescribing
- Support meeting of Care Quality Commission (CQC) standards
Pharmacy Postgraduate Education (CPPE) highlights the importance of obtaining a prescribing qualification as part of their training pathway for the NHS England pilot. The provision of funding and capacity is being coordinated at a local level in England (via Local Education and Training Boards) to ensure funding and capacity is provided to meet what will be a growing demand.

Education, training and development

Recruiting the right pharmacist for the role is critical in ensuring good outcomes for patients, the practice and the NHS. Whilst this decision resides with the employer, it is essential that practices are advised appropriately on the relevant skills, values and experience necessary for pharmacists to undertake such roles. Employing a newly qualified pharmacist, with lower salary expectations, may be an attractive option for practices looking to make a low-cost and immediate impact on repeat prescription processes and other ‘administrative’ functions relating to medicines and prescribing. Yet there is risk in such an approach.

Without effective pharmacist leadership in place, this first (mass) generation of practice-based pharmacists will be setting the tone and standards for the future development of the role, and it is important to get it right. Whilst there will be a need for such process-driven roles delivered by competent pharmacy professionals, higher-value, higher impact outcomes will be required to demonstrate the true potential of the practice-based pharmacist. Having a deeper understanding of a range of skills, experience and knowledge in areas as diverse as therapeutics, patient behaviour, negotiating skills, NHS structure and function are all important in being able to deliver patient-centred care in the general practice setting. Experience beyond the foundation years (the ‘first 1,000 days in practice’), at the point upon which pharmacists are able to undertake a prescribing course, is a good benchmark of the experience required for any type of practice-based role. The ability to recognise limitations of practice, to assess risk and to have maturity in decision-making is more critical as pharmacists move from a world of ‘safety-netting’ to one where they are active clinical decision-makers in the care of individual patients.

As the role of the practice-based pharmacist will be centred on caseload management (e.g. medicines optimisation in LTCs), some form of post-graduate clinical training will be desirable as well as local training and peer review. Post-graduate training could be in the form of an academic post-graduate qualification, or via completion of a specific training package such as that offered by CPPE. This type of training should be aligned to competency frameworks such as the RPS Faculty framework and the Prescribing...
Standards Framework,18 as well as standards required of the General Pharmaceutical Council.19 Local training needs will also need to be considered and addressed via local networks to ensure pharmacists are aware of local priorities in relation to medicines use, and any specialist area of practice.

Developing careers for practice-based pharmacists

What will become necessary in the medium term is a local leadership role to support pharmacists who may be working in relative isolation. As part of a wider general practice multidisciplinary team typically comprising of several doctors and nurses, pharmacists will usually be the only pharmacist. There will be varying skills, experience and confidence amongst pharmacists who will be working in general practices and, as the roles will be patient-facing and providing direct patient care, professional oversight and peer review will become necessary so that individual pharmacists can demonstrate quality, consistency and safety in their practice.

This role should be undertaken by a senior, experienced pharmacist who would be expected to provide leadership around education, training and development, clinical supervision, advocacy, peer review and mentoring, research and evaluation and also support development of career pathways in General Practice. There are already initiatives across London and the South East involving pre-registration pharmacist placements in general practice.

As the pharmacy workforce in General Practice develops, a comprehensive supporting structure for education, training and development, career development and research will be required. This should ultimately include pharmacy trainees at undergraduate level, pharmacy technicians and Foundation level pharmacists. The aim of such a structure would be to:

- identify training needs for pharmacy professionals working in practice-based roles
- develop an integrated training programme for pharmacy undergraduates and immediate postgraduate education and training
- raise awareness of the role of primary care healthcare professionals
- ensure primary care is seen as a rewarding and attractive place to work
- ensure robust evaluation of and research into the impact of practice-based pharmacists.

Measuring success

The traditional role of the pharmacist around ensuring safe and effective supply of medicines is still relevant in the role of the practice-based pharmacist, and the success of these pharmacist roles will need to be evaluated in this context. These pharmacists, who will have an important role in advising and influencing other prescribers, may sit on prescribing committees and will prescribe for patients themselves.

For the commissioner, a practice-based pharmacist offers expertise in medicines and prescribing, but with a generalist background, which is an important asset to have as the NHS develops a primary care-led model.1

For the practice-based pharmacist, they can demonstrate impact via their RPS Faculty portfolio, participating in and initiating audit, evaluation and research.

Challenges and barriers

A lack of inter-professional collaboration can be detrimental to health outcomes.20 The role of the practice-based pharmacist offers significant benefits in this regard and can aid good transfer of care across health settings in relation to medicines use and prescribing. However, these roles also need to be introduced carefully to ensure that capacity is delivered in a structured and sustainable way. New roles can often be perceived as threatening or challenging other roles, for example practice nurses. Careful explanation of the role of the practice-based pharmacist and the skills they bring is important to avoid potential tensions in the practice. Focus should be on building trust and how pharmacists complement, rather than replace, existing roles and skill sets.

Managing poor performance could be a tricky professional issue to address. Pharmacists are accountable for their...
actions as healthcare professionals, but clinical accountability and, usually, line management responsibility will ultimately rest with the practice-based pharmacist’s designated supervising GP. A clinical leadership role external to the practice will be important in managing any issues via clinical supervision. How that role relates to performance management and capability will need to be carefully considered.

Relative to this, none of the indemnity insurers for general practice currently offer insurance to cover the activities of practice-based pharmacists. It is critical for any pharmacist working in general practice to ensure their indemnity insurance arrangements cover their activities.

**Conclusion**

The emergence of the pharmacist as a direct provider of patient care has the power to be truly transformative in how medicines and prescribing issues are addressed in primary care, and can help deliver medicines optimisation on a mass scale. There continues to be significant system-wide medicines-related issues that can be tackled by practice-based pharmacists as part of wider pharmacist and multi-disciplinary teams across the NHS.

With the benefits practice-based pharmacists can add, comes significant risk, which will need to be carefully managed at both a local and national level. To mitigate some of these risks, pharmacists will need access to affordable and sensible employer-provided indemnity insurance, a supporting education and training infrastructure and career development opportunities.

**Declaration of interests**

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**“The emergence of the pharmacist as a direct provider of patient care has the power to be truly transformative in how medicines and prescribing issues are addressed in primary care . . .”**

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JoMO-UKCPA National Workshop

Medicines Optimisation in Respiratory Medicine

Macdonald Burlington Hotel
Birmingham
1st February 2017

See www.pharman.co.uk/events for details
What is your job title?
Answer: Dietetic Project Manager with the NHS London Procurement Partnership (LPP)

What are your main responsibilities/duties?
The main aim of the role is to provide strategic leadership to support the appropriate prescribing of nutritional products with the 32 London Clinical Commissioning Groups (CCGs). This includes nutritional products for adults, infants and children and also gluten-free foods.

By examining local trends of spend and population groups together with the resources available, positive initiatives and good practice can be shared in areas where spend may be increasing or is higher than expected.

Another element of the role is ensuring resources are available and up-to-date with the latest evidence base for local areas to adapt and use. These are updated on the website and available to London Procurement members. Other resources and communications are provided regarding new/changing products and updated prices for nutritional products so clinicians can make a reasoned judgement on which product to use, based on both price and appropriateness of each one.

Training and educating professionals and students on what appropriate prescribing is and what strategies can be adopted to help promote this is also key to the role.

To whom do you report and where does the post fit in the management structure?
Currently, as the only dietitian working within the LPP, the post directly reports to a previous post holder, also a dietitian by profession. This allowed good handover when I first came into post and a shared dietetic understanding of the workload and support of how to approach it. There are also strong links with the LPP Pharmacy Modernisation and Optimisation Team and with dietetic and medicine management colleagues in the CCGs.

How is the post funded?
The post is funded by the NHS Organisations that are members of the LPP.

When was the post first established?
The role was established in 2008 when two dietitians were seconded to address the increased use and spend on nutritional products across London. The post has been extended since then. In 2010 the role was expanded to include paediatric prescribing practices. Over time the amount of dietetic resource has changed depending on the needs and allocated funding.

Are you the first post holder? If not, how long have you been in post?
I came into this role in May 2015. The role was advertised as a part-time position and required someone with experience and knowledge of adult and paediatric dietetic practice and products.

What were the main drivers for the establishment of the post and how did it come about?
The LPP supports the NHS to make the most of its purchasing power helping organisations to deliver the highest quality services whilst also ensuring value for money. Prior to this role there were concerns regarding the screening and monitoring of malnourished patients together with spiralling costs of Oral Nutritional Support products.

“. . . there were concerns regarding the screening and monitoring of malnourished patients together with spiralling costs of Oral Nutritional Support products.”
The LPP, through the Pharmacy & Medicines Management Steering Group, commissioned the Clinical Oral Nutrition Support Project in 2008, leading to the secondment of the first post holders.

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

When the role was initiated, dietetic resource was variable and limited meaning prescribing practices were not consistent. Responsibility for prescribing and monitoring of patients taking nutritional products was unclear and proper assessments and screening was often lacking or incomplete. Addressing these issues in all areas was therefore difficult and required providing advice specific to the local areas needs and level of resources.

Providing advice and guidance which can be adapted locally allows it to be realistic and useable. Providing a quick, useable template for areas where resources are more limited is helpful.

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

Since the role was initiated there has been a much greater awareness of appropriate prescribing and, although still variable resources across London, an increase in prescribing posts, which allows patients on supplements more access to dietetic expertise.

There are now a range of resources available for CCGs to use as templates locally and a facilitated network of the prescribing posts across London to share good practice and discuss any challenges faced.

Linking in with universities has meant that appropriate prescribing is now part of the learning before starting clinical practice so in the future there will be greater awareness.

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

Malnutrition, in 2014, was estimated to effect 1 in 20 people in England and is predicted to increase due to an aging population (British Association of Parenteral and Enteral Nutrition – BAPEN). However, pressure on resources in the NHS is also mounting. Balancing these two factors is a huge challenge. Future developments need to be realistic about this and ensure resources continue to be evidence-based but adapted to local priorities and needs.

Ensuring the message of appropriate prescribing and not just stopping prescribing is key. It is important to focus not just on cutting spend but providing better outcomes for patients. Demonstrating areas where investing short-term into resources has benefited both reduction in spend and improved quality of care will help highlight the effectiveness of the previous work.

Continuing to engage students and hospital dietitians in what appropriate prescribing means in the community and in their area of work will continue to be necessary, especially as suppliers develop new and more innovative products in the future.

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

The post requires being a qualified dietitian with experience in an NHS clinical setting. In practice, having experience in a community setting is beneficial to have an understanding of the main objectives and potential challenges of the role.

A good knowledge and understanding of the products available and their clinical indications is valuable.

Continuing professional development is mandatory for professional registration as a dietitian to ensure clinical practice is safe and effective so it is important to ensure opportunities which are appropriate to keeping up-to-date with clinical practice are incorporated.

Additionally, support in analysing data and facilitation/training skills are also beneficial to develop within the role.
How does the post fit with general career development opportunities within the profession?

The role is very different to working as a dietitian clinically - it allows more insight to strategic decisions and rationale. Working with such a wide range of professionals and connecting with several organisations gives a broader view of the NHS and the opportunities within it.

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

There are many opportunities within the post. Looking at the current models of prescribing nutritional products and finding possible alternatives can further progress clinical outcomes for patients and increased value for money for organisations.

Training and support to dietetic colleagues will continue to be part of the role and, as more evidence emerges, guidelines can be updated and disseminated to those working in the profession and dietitians in training.

Product developments and new suppliers will also drive what is required for the post to continue to achieve its objectives. There are also opportunities to complete audits to assess the impact of the role or identify further work to be done.

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

This role is fairly unique, but there is plenty of opportunity for posts within Trusts to look at prescribing practice and move the dietetic profession to drive forward better patient outcomes and experiences as well as reduced cost.

Care should be taken when simply reducing spend or resources to patients on prescribed products to ensure that any potential risks are fully assessed first.

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

I have no declarations of interest.

“. . . there is plenty of opportunity for posts within Trusts to look at prescribing practice and move the dietetic profession to drive forward better patient outcomes and experiences as well as reduced cost.”
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MANAGEMENT CONUNDRUM

A Square Peg In A Round Hole?

“You can replace a post”, said Carey Whitecoat, Head of Medicines Optimisation at Riverdale Primary Care Organisation, “but you can’t replace the person.”

“I know what you mean,” responded Janet Donit, Chief Pharmacist at Metropolis NHS Trust, “but that doesn’t help when consultants and nurses are complaining that Colin isn’t delivering the sort of service that they had from Linda.”

Colin Cleverly had only joined the department recently. He was an able and ambitious pharmacist but a very different kettle of fish from Linda Longtime, who had been well known and liked by the medical and nursing staff. Her specialist interest was in respiratory medicine and her knowledge in this field was second to none; indeed, she had been something of a national authority and was well known in pharmacy circles. Linda had, however, recently retired and Colin had been appointed to step in to her shoes – except that things did not seem to be quite working out that way. He was less experienced and, although being competent, did not have Linda’s passion or interest in respiratory medicine.

“Does Colin have an area of special interest?” asked Carey.

“He seems very interested in pain management”, said Janet.

“I bet the clinical staff feel they’ve been sold a pup! Are you trying to put a square peg in a round hole?”

“There is something in that”, said Janet, “but I have a department to staff and have to recruit the most able pharmacists from the available pool. I didn’t really expect such a strong concern arising and am not sure what I can do at this stage.”

Janet needs some advice. What would you suggest she does at this stage?

What would you also suggest she does in future when making an appointment to avoid a similar situation arising?

Commentaries

Tim Hanlon, Chief Pharmacist & Clinical Director of Pharmacy and Medicines Optimisation, Guy’s & St Thomas' NHS Foundation Trust. Correspondence to: tim.hanlon@gstt.nhs.uk

At this stage, Janet has a few choices to navigate her way through this situation. I would advise her to have some honest discussions with Colin himself as well as other key stakeholders, including the respiratory team.

It is really important to always gather the facts as these matters are rarely as straightforward as they may seem. After all, human beings are involved! Colin may, for example, not be happy in this post even after this short time and may be only too keen to move into another post, take a secondment to a more relevant job in another Trust, develop a new specialist interest or rotate with another member of staff who does have an interest in respiratory medicine. None of this will be

“. . . getting the right person into a role is more important than simply filling a post . . .”
brought out into the open without an honest and supportive conversation. I would advise Janet to act quickly but sensitively as Colin may be vulnerable as a new member of staff stepping into the shoes of an experienced member of staff. Pace and tact are key here.

In terms of advice for the future, I would say that getting the right person into a role is more important than simply filling a post ‘come hell or high water’. Whilst this approach, which is debatable, may offer some short-term service pressure relief, it stores up issues for the downstream if the ‘fit’ is not right with the various teams (e.g. pharmacy and the front line clinical directorate, which is respiratory in this case). I would advise Janet to explore all options around filling the gap should there not be a clear candidate with the right ‘fit’, even if that means living with the gap until the right candidate is found.

The fit must be right with clinical teams.

Michael Pratt, Chief Pharmacists, NHS Dumfries and Galloway
Correspondence to: m.pratt@nhs.net

My advice to Janet is that she needs to carefully reflect on this situation, and as part of that reflection she needs to view things from Colin’s perspective. He is an able and ambitious pharmacist and his only fault seems to be that he is not Linda.

I think the first thing Janet needs to do is meet with medical and nursing colleagues who are expressing concerns, get a clear understanding of those concerns and manage their expectations.

Having understood their concerns, ensuring they are realistic, Janet needs to meet with Colin. This meeting should have two main objectives:

- Share the realistic concerns and work these through with Colin to agree a clear development plan.
- Ensure Colin is fully aware of the history and the abilities of Linda Longtime as a nationally recognised expert in her field. Colin needs to be absolutely clear that Linda’s expertise will not be held against him and he will be judged against his peers. If he is currently competent and ambitious, he will want to be the best he can be. Janet needs to support him in getting there.

The agreed action plan could usefully contain some training and development from the same medical and nursing colleagues raising the concerns. In my experience, these staff are often very keen to develop enthusiastic young professionals. This may also help overcome the problems in the longer term and develop a new clinical team dynamic that is different to the old team, but just as effective.

There are strategies Janet could have adopted to mitigate this problem, and she may wish to consider this in future. The most obvious strategy is to discuss the impending retirement of the ‘next Linda Longtime’ with medical, nursing and pharmacy colleagues long before the person leaves. She needs to be very clear
There should be an early meeting with medical and nursing colleagues. with them that a knowledge and experience gap may well be expected. They need to agree a plan to overcome this problem. Janet may also want to include representation from the wider team in the selection process. I have done this in the past and it has gained significant buy-in from the wider team.

Declaration of interests

- **Tim Hanlon**: member of the Editorial Board, Journal of Pharmacy Management
- **Mike Pratt**: member of the Editorial Board, Journal of Pharmacy Management

“. . . meet with medical and nursing colleagues who are expressing concerns, get a clear understanding of those concerns and manage their expectations.”
A new word for your lexicon!

Have you ever wondered how some people seem to take everything in their stride? How challenges and setbacks, no matter how big or small, never seem to phase them? Maybe you are one of those people yourself, but perhaps you have never really thought about it until now.

Numerous researchers have demonstrated that resilience can be considered both an art and a science. Some of us seem to be naturally resilient. The good news is that, for the rest of us, there are certain characteristics that resilient people all seem to share. These have been studied and can be learned and reproduced by all of us.

Common characteristics of resilient people

Below is a list of the most common characteristics identified by researchers and demonstrated consistently by resilient people.

1. Vision
Resilient people have a very clear vision of where they want to go in life. This could be a short, medium or long-term vision, or often all of these. If we know where we want to go, we will find a way to get there. We may discover setbacks along our planned route, but we can and do find ways around those setbacks.

2. Avoid a victim mentality
Resilient people do not sail through life without ever experiencing setbacks and disappointments. Instead, they accept that setbacks—both major and minor—are an inevitable part of life. However, rather than sit back and allow themselves to dwell on the setback, they take proactive steps, such as the ones discussed in this article, to take control of the situations in which they find themselves.

3. Think, feel and act positively
Having a positive mental attitude may sound like a cliché, but it is a common factor identified amongst resilient people. This does not mean they never experience negative thoughts and feelings but they are quick to identify and control them. Dr. Viktor Frankl, a Jewish survivor of Auschwitz, famously said that “Human beings can always choose that one last freedom that can never be taken away from them. The freedom to choose their attitude in any given circumstance.” This is very true in resilient people. They minimise their negative thoughts and feelings and look to take positive action to move toward their vision and goals.

4. Offer and seek advice
Resilient people are able to offer advice and support during times of adversity. This often has the benefit of improving their self-esteem as they are able to focus externally on others and not just themselves. Resilient people are also able to ask for advice and support. They are not too proud to seek help, even if it is just to discuss their ideas on how to overcome the specific challenge that they may be facing at the time.

“. . . there are certain characteristics that resilient people all seem to share.”
5. Use your support network

Connected to the last point above, resilient people always have a network of individuals who they can and do go to for advice. This may be in work and also amongst their family and friends. A professional coach or mentor is often a good idea. Such an individual will help you to assess a situation objectively and then help you to create solutions to the challenges you are facing.

6. Focus on solutions, not problems

Resilient people are good at looking for solutions rather than focusing on problems. They will brainstorm potential solutions, individually and with their teams, then assess the pros and cons of each possible solution before deciding upon the best way forward.

7. Look after yourself

Resilient people know when and how to take time out to recharge themselves and their batteries. I was talking recently to a friend of mine who had done some volunteer work with refugees arriving in Greece. She described to me how difficult she found it when she had to go and eat her own meals every day, knowing that many of the refugees she was helping had not eaten in days. However, foregoing her own meals was not an option. She and the other volunteers she was working with needed to keep their strength up to be able to help the refugees who so desperately needed their help. Resilient people will take regular timeout from a situation to do something that is a complete diversion from whatever challenge they are facing. This could involve going to the gym, going for a walk, watching a movie, reading a book or anything else that they enjoy. Mentally and physically, such diversionary tactics will enable you to recharge your batteries and stay focused on the challenge at hand.

8. Be resilient about your resilience!

From this article you will see that there is a range of skills involved in being resilient - and this list is by no means exhaustive. You may think you have some, all or none of these skills. Now would be a good time to start developing them or to gain an understanding of which ones you have and do well and which ones you need to develop. There are lots of free resilience questionnaires available online. Here are links to just a couple:


https://www.veryswell.com/quiz-how-resilient-are-you-4008851

A final thought

Remember, resilient people do face set backs and do have negative thoughts and feelings at times, just like the rest of us. But by using these skills (and more) they are able to overcome challenges and move forward with their lives.

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