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SP7 7AX
Tel: **01747 829501**
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Email: **pharm@pharman.co.uk**
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BEST PRACTICE IN PHARMACY MANAGEMENT

* The competencies listed above only relate to General/Generic Competencies, Competencies for Community Practice, Competencies for Hospital Practice, Competencies for Primary Care Practice and Competencies for Pharmacists involved in Medicines Management.

EDITORIAL

Adverse Drug Reactions Causing Hospital Admissions – Helping GPs Through Shared Learning

This article reports on a study that found that 35 (63%) of 56 instances of ADR causing a hospital admission were thought to be possibly preventable. That's right – 63% of admissions due to an ADR could be prevented! The main drugs implicated are shown, with diuretics and drugs affecting the renin-angiotensin system topping the list. Possible approaches to raise awareness amongst GPs and reduce the incidence of ADR admissions are noted. The findings provide a clear steer for targeted work in other locations and, given the current focus on admissions avoidance generally, will no doubt provide a spur to further work needed to quantify the consequences of ADR related hospital admissions in cost and quality terms.

Using Behavioural Insights: The Power Of 'Nudge'

People may not, for various reasons, make decisions that would give them the most benefit. Indeed, they may make decisions that are likely to cause them great harm – think of smoking and obesity. Welcome to nudge theory! With this approach, people are 'nudged', rather than forced, to change their behaviour. This approach has been adopted by the Government through a 'Behavioural Insights Team'. The article outlines the how the approach can be applied to achieve better outcomes within a pharmacy setting.

Changing The Prescribing Responsibility For Stoma Appliances Can Improve Patient Care And Reduce Costs

GPs commonly prescribe stoma appliances but the choice of product is often determined by other healthcare professionals. The article in this edition reports on an approach to remove prescribing and budgetary responsibility from GPs and place it with the healthcare professional who recommended the intervention. The new service identified a number of problems that patients were experiencing as well as situations where stoma products were being overstocked. In addition to improvements in the quality of care for patients, the potential saving through improvements in the management of prescriptions for stoma products was £279,039 (27%). These impressive results will be of much interest to those who are considering priorities for medicine management.

Face2Face: Head Of Pharmacy Development, CPNI

Community Pharmacy Northern Ireland (CPNI) represents Northern Ireland's community pharmacy contractors regarding negotiations on services, the pharmacy contract and remuneration/ reimbursement. The Face2Face describes a role formed two years ago to work collaboratively with commissioners and policy makers to support service development and implementation within community pharmacy.

Management Conundrum: A Balancing Act?

It has been well recognised for many years that the skills and experience of Community Pharmacists need to be harnessed to help improve the health of local populations. It is encouraging that the traditional role of dispensing is now giving way to new roles but there can be situations where, without appropriate changes being made, workload increases to unacceptable levels. Our commentators suggest potential ways forward to ensure that new services are appropriately incorporated within Community Pharmacy.

Leadership

Effective management requires effective delegation. This section provides a helpful checklist to ensure that you are delegating - not abdicating or dictating!

Adverse Drug Reactions Causing Hospital Admissions – Helping GPs Through Shared Learning

Beth Hodgson, Medication Safety Pharmacist; Susie Matthews, Medication Safety Pharmacist; Mike Wilcock, Head of Prescribing Support Unit, Pharmacy Department, Royal Cornwall Hospitals NHS Trust, Truro, Cornwall; Dr Nick Gibson, GP Prescribing Lead, NHS Kernow.
Email: mike.wilcock@rcht.cornwall.nhs.uk


Beth Hodgson

Summary

This paper:

- summarises data collected on ADR-related admissions deemed as arising from primary care prescribing
- categorises the ADR-related admissions as 'known knowns', 'known unknowns' and 'unknown unknowns'
- identifies the main categories of drugs associated with ADR-related admissions
- outlines how GPs were advised of the findings and potential ways in which ADR-related admissions might be reduced.

Introduction

The World Health Organisation defines an adverse drug reaction (ADR) as 'any response to a drug which is noxious, unintended, and that occurs at doses normally used in man for the prophylaxis, diagnosis, or therapy of disease'.[1] This definition excludes non-adherence with prescribed medication, drug abuse, overdose (intentional or unintentional), treatment failure and errors in drug administration. ADRs cause significant morbidity and mortality. One systematic review[2] suggested that approximately 5.3% of hospital admissions are associated with ADRs. A more recent systematic review, using a broader definition of adverse drug event (any medication related harm), noted a range of reported prevalence of medication-related admissions of 0.1% to 54%, with the authors noting that a higher prevalence was reported in studies that examined all hospital admissions compared with those only in acute hospitals.[3]

The majority of hospital admissions caused by ADRs are viewed as preventable and suggested simple improvements in prescribing include increased awareness of warning prompts of possible drug interactions in high-risk patient groups, and prescribing a drug at the lowest dose necessary to achieve the therapeutic target.[4] However, effective strategies to assist prescribers in preventing 'common' ADRs causing admission remain poorly implemented, and there is no clear strategy to encourage prescribers to learn from opportunities for prevention.[5]

Donald Rumsfeld is quoted as saying '….there are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things that we do not know. But there are also unknown unknowns – the ones we don't know we don't know.' We use this categorisation to help GPs understand those common causes of ADR-related hospital admission as a means of providing awareness and education to primary care. Hence our objectives were to collect data on ADR-related admissions deemed as arising from primary care prescribing and to advise GPs on those categorised as 'known knowns' and 'known unknowns' to ascertain if this feedback information would be valuable.

Method

The study was conducted in a 650 bed teaching hospital over a 5 month period in 2012 during which all patient records containing the ICD-10 diagnostic code Y40-Y59 (drugs, medicaments and biological substances causing adverse effects in therapeutic use) were scrutinised. Details of the suspected ADR, suspected causative drug, and

"The majority of hospital admissions caused by ADRs are viewed as preventable . . ."

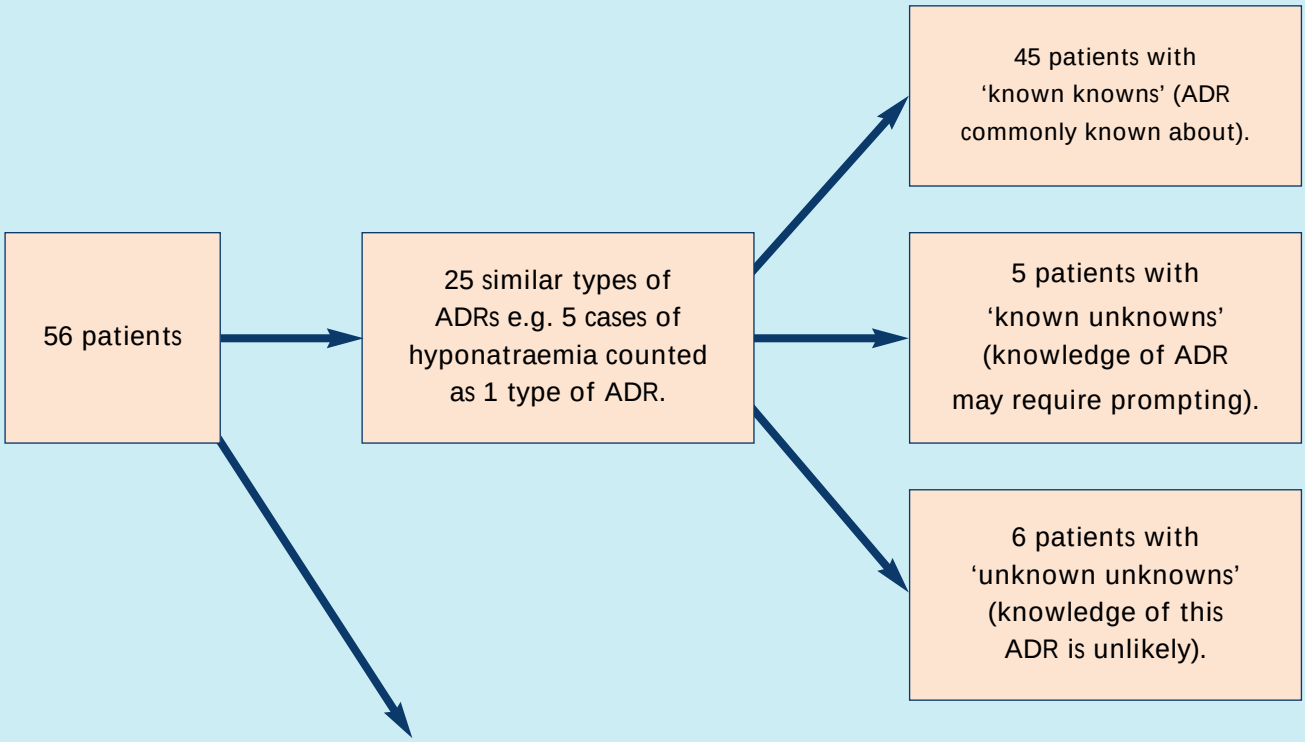
patient demographics were noted. The ADR was categorised by agreement amongst the authors as though from a GP's perspective as: commonly known ('known knowns' e.g. ACEI and angioedema); an ADR that a GP should have some knowledge of if prompted ('known unknowns' e.g. hyponatraemia and SSRI); or one that the average GP would be unlikely to know ('unknown unknowns' e.g. mirtazapine and neutropenic sepsis). This was deemed service improvement performed to meet specific local needs and ethics approval was not sought.

Results

Data were obtained for 70 patients. Fourteen were excluded as the associated drug had been given in hospital but caused admission once the patient was home e.g. chemotherapy-induced neutropenia. Of the 56 patients, 20 were male, 36 female and average age was 74 (range 28 to 99). Overall, 87 drugs were implicated (for some patients more than one drug was deemed the possible cause). The types of drug implicated and the ADR 'Rumsfeld' categorisation are shown in Figure 1. Overall, 35 (63%) of 56 instances of ADR causing a hospital admission were thought to be possibly preventable.

Discussion

In this small study, most of the ADRs thought to be causing hospital admission were well recognised and considered theoretically preventable though some common ADRs were not preventable (e.g. 5 cases of renin-induced angioedema). A number of scenarios require reinforcement back to primary care e.g. acute kidney injury with ACE-I



BNF section	Number of drugs
Diuretics	17
Drugs affecting the renin-angiotensin system	12
Opioid analgesics	8
Antidepressants	7
Calcium channel blockers	7
Anticoagulants	5
Antiplatelets	3
Other	28

Figure 1: Types of drug implicated and the ADR 'Rumsfeld' categorisation

63% of ADRs causing a hospital admission might be preventable

and diuretic (3 instances), GI bleed in very elderly patients on aspirin but no covering PPI (2 instances), opioid-induced constipation (5 instances).

However, for some common scenarios it is expected that GPs may require further clarification on what action is possible and practical. For example, there were five cases of drug-induced hyponatraemia resulting in hospital admission. These were all in older females (a recognised at risk group) and were associated with commonly known causative drugs (diuretics, antidepressants, alone or in combination)[6,7]. Measuring sodium levels prior to commencing these drugs in this patient population and repeat sodium measurements at periodic intervals may seem intuitively sensible, precautionary steps but general practice may feel it is not able to deliver this routinely. In addition, GPs may question the absolute risk of this type of ADR-related admission i.e. how many elderly females need to be monitored to prevent one admission. Medication monitoring is recognised as a risk area but is one which remains poorly investigated and, therefore, lacks an evidence base.[8]

We note that a Dutch multidisciplinary task force, which was assigned to reduce the number of prescriber-related hospital admissions related to medications, developed a mixture of evidence and expert-based risk-reducing strategies.[9] Their drug-specific recommendations cover some of the instances we observed – electrolyte disturbances from thiazides, severe constipation associated with opioids, gastroprotection in very elderly patients on low dose aspirin.

Limitations of this pilot include no strict definition of ADR causality other than the hospital doctor's judgement, though we note that the literature reports on the difficulties associated with assessing causality, recognising that discriminating information that would clearly rule a case in or out is often missing. We also recognise that identification of ADR-related admissions

"Medication monitoring is recognised as a risk area but is one which remains poorly investigated . . ."

from the ICD code may under-report their rate,[10] and that ADR-related diagnoses, and particularly their ICD-10 codes, may also be inaccurate. If physicians consider that such coding is used only for administrative purposes, they may be less concerned with accurate recording of ICD codes. The consequences of this may be that the clinical information about a specific patient is incomplete, and the physician may be less motivated to report the ADR to the Medicines and Healthcare products Regulatory Agency (MHRA).

As of yet we have not purposefully attempted to gain wider GP consensus on whether our categorisation of ADRs as preventable or their Rumsfeld classification are correct. Currently, we have been unable to explore opportunities for measuring other outcomes e.g. the rate of YellowCard reporting from our organisation, the extent to which these ADRs increased length of hospital stay, and any actions taken by the GPs to prevent further episodes.

This project and some of these specific instances have been presented to approximately 60 GPs over a series of three meetings to ascertain if there are any general key principles to be learnt, or if there is specific feedback that they would welcome for reflective purposes. In general, the wish was to have selected examples of ADRs that contribute to hospital admissions described in the regular prescribing newsletter (circulated to GPs, community pharmacies and non-medical prescribers) together with potential, practical, preventative solutions. We will also emphasise the MHRA campaign to raise awareness of the YellowCard scheme and professionals' responsibilities in reporting ADRs.[11]

There is a potential role to involve pharmacists, both community and hospital-based, in uncovering, aiding the diagnosis of, and reporting ADRs, as well as suggesting treatment alternatives and future preventative strategies. In addition, use of web-based systems that interrogate GP records in real time such as Eclipse Live may be a future development.

Declaration of interests

- None

"There is a potential role to involve pharmacists, both community and hospital-based, in uncovering, aiding the diagnosis of, and reporting ADRs, as well as suggesting treatment alternatives and future preventative strategies."

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A masterclass in skills necessary to achieve successful outcomes for pharmacy.

Wednesday 23 April 2014	London
Thursday 24 April 2014	Stansted Airport
Wednesday 7 May 2014	East Midlands
Thursday 8 May 2014	Birmingham
Thursday 15 May 2014	Runcorn
Wednesday 21 May 2014	Gatwick Airport
Tuesday 3 June 2014	Newbury
Wednesday 4 June 2014	Taunton
Wednesday 11 June 2014	Leeds
Thursday 12 June 2014	Newcastle

National Forum

Tuesday, 18th November 2014
Novotel London West Hotel

Further information will be made available in due course.

Please make a note of these dates in your diary.

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Using Behavioural Insights: The Power Of 'Nudge'

Ewan Maule, Deputy Chief Pharmacist - Operational Services, Northumberland Tyne and Wear NHS Foundation Trust.
Email: ewan.maule@ntw.nhs.uk


Ewan Maule

Summary

- Behavioural insight, or 'nudge theory', uses an understanding of human psychology to gently influence people to make better choices.
- Nudge theory has been successfully used in a number of fields but is most prominent in public health and policy setting.
- The same principles can be scaled down and applied to managing groups of staff or influencing patients.
- Potential uses within the sphere of pharmacy management are proposed.

Introduction

If someone offered you free loft insulation that saved you several hundred pounds a year in heating costs, you would probably take it, wouldn't you? If they told you they would install it for free as well, you would definitely take it. But if they also told you that you had to clear out your loft in order for them to fit it and that they would tell you when they were coming to do it, rather than you deciding when was suitable for you, then you might start to think 'I can't really be bothered'.

What if the same person offered to clear your loft for you at a knock-down price of, say, £50. Decision made. Welcome to the world of 'nudge theory'.

The Government has embraced nudge theory by establishing a 'Behavioural Insights Team' (BIT - colloquially known as the 'Nudge Unit'). This is a team of thirteen employees with a 'remit to find innovative ways of encouraging, enabling and supporting people to make better choices for themselves'.

The BIT uses research on behaviour and influence to amend government policy to 'nudge' people into doing the 'right' thing, as opposed to being prescriptive and introducing policies to force people to change their behaviour. They are applying their expertise to a variety of government departments - but what is a nudge and is it more effective than a policy?

Hausman and Welch say 'nudges are ways of influencing choice without limiting the choice set or making alternatives appreciably more costly in terms of time, trouble, social sanctions, and so forth. They are called for because of flaws in individual decision-making, and they work by making use of those flaws.'[1]

This article details what behavioural insights and 'nudges' are and how understanding and applying the principles can help you both in managing and influencing staff and helping patients get the best out of their treatments.

Underpinning theory

The work is heavily influenced by Robert Cialdini's 6 Key Principles of Influence from the book 'Influence, the Science of Persuasion'.[2] These 6 principles are:

- **Reciprocity:** The very basic idea that someone will return a favour. This is why supermarkets give you free samples; you will subconsciously feel as though they gave you something for nothing so you should return the favour and buy more – even if it's not more of the product they gave you for free.
- **Commitment and Consistency:** Getting people to commit up front to an action will see them more likely to honour it. For example, requiring a signature at the start of a form induces more honest completion of the form than if the signature is at the end (research in America showed a 10% increase in declared mileage on insurance forms when this was done, even though it resulted in higher premiums).[3]

". . . nudges are ways of influencing choice without limiting the choice set or making alternatives appreciably more costly . . ."

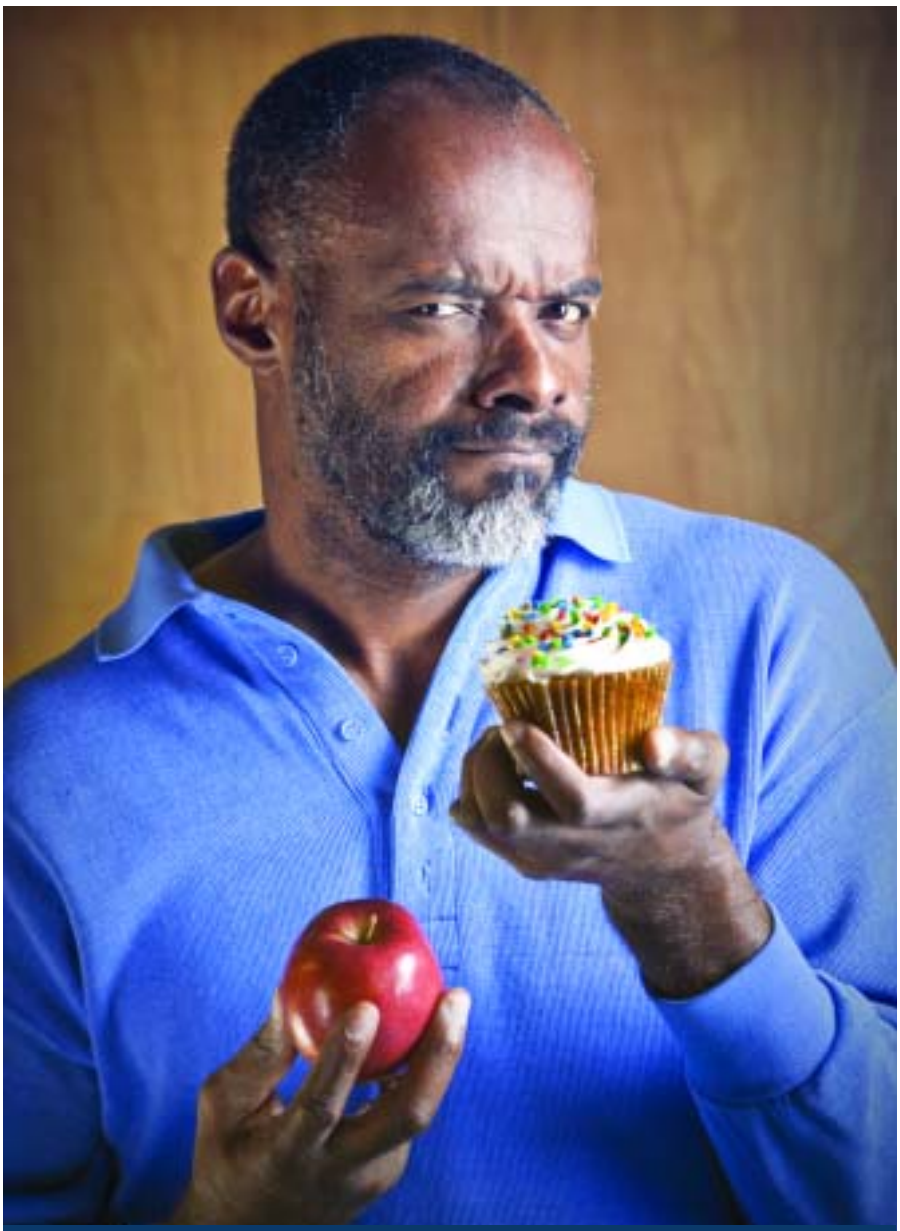
- **Social Proof:** People will want to conform, so will do what they see or know others are doing. The BIT have improved the quantity of tax self-assessment return forms by informing non-respondents how many other people in their geographical area have already responded (promoting a social norm).[4]
- **Authority:** People will respond to and obey a voice of authority. The Milgram experiments of the 60s and 70s (where people were instructed by an 'authority' to inflict pain on another person even though it conflicted with their conscience) demonstrates this.[5]
- **Liking:** We all respond better to someone we like than someone we do not. That is why advertisers use amiable celebrities to endorse their products.
- **Scarcity:** It is natural to want something more if you know it is in scant supply. Witness the annual scramble for 'must have' Christmas toys (people actually physically fought in shop aisles for Furbys!).

Interestingly, people are known to value losses more than gains.[6] This is one of the reasons governments around the world are increasingly taxing plastic bag use, rather than offering bonuses for re-use.

The Behavioural Insights Team

One of the most memorable mnemonics from the BIT is the EAST framework. In order to influence someone do something, make it Easy, Attractive, Social and Timely:

- **Easy:** The removal of multiple small frictions. If someone has to find a form, rather than being provided with it, they are considerably less likely to complete it.
- **Attractive:** Make something more attractive by invoking curiosity about it or providing some personal benefit for doing it.



Nudge theory encourages people to make a decision that benefits them most but which they may not make naturally

Prompted Choice

Historically, deciding whether or not to be on an organ donor register has been either 'opt in' or 'opt out' i.e. there is always a default. If you wish to choose the option other than the default, this requires active decision making. Consequently, rates of 'opt in' where the default is 'opt out' have been low. Countries where the default is 'opt-in' have had higher rates of organ donation, but with accompanying concerns about freedom of choice.

Prompted choice addresses this. It presents the two options without a default, requiring an individual to make a choice that is personal and acceptable to them.

This has been recently introduced into organ donor register consent by the DVLA; new applicants will have to state whether they wish to be on the register or not. A similar approach in Illinois, USA increased the declarations of consent to join the organ donor register from 38% to 60%.[7]

Box 1: Prompted choice

No single approach will be a 'silver bullet' - success will come from a variety of approaches.

- **Social:** Linked to social norms (as Social Proof above).
- **Timely:** Asking the right questions at the right times e.g. when is a decision being made?

The work of the unit represents a view that governments have, in the past, been guilty of believing the only way to manage behaviour was by rules and regulation, rather than encouragement. One of their highest profile interventions was to introduce 'prompted choice' into organ donation consent. (see Box 1).

With specific regard to health issues, the BIT published a paper in 2010 detailing how behavioural insights could be used in managing public health and describing how policy and practice should reflect what people actually do, rather than what we will assume they do.[8] The paper covered areas such as teenage pregnancy and organ donation (see Box 1) as well as proposing a wide number of simple, evidence-based approaches, from introducing a 'fruit and veg only' section to supermarket trolleys to showing the Icelandic fitness and exercise-promoting TV programme 'LazyTown' in nurseries. Iceland, where this show is mainstream, is one of the only countries to demonstrate a fall in children's obesity. Supermarkets in Iceland promote fruit and vegetables as 'Sports Candy', which is the terminology used in the show.

The report makes it clear that no single approach will be a 'silver bullet' and that success will come from a variety of approaches and experimentation at a local level. Successes include:

- A collaboration with a pharmacy chain to develop a smoking cessation regime based on the principles of Ego, Incentive, Commitment and Salience:

  Ego: We underestimate the likelihood of bad things happening to us and overestimate the likelihood of good things happening (attributional bias), which makes us feel better about our choices. Being honest about these perceptions is vital to success.

  Incentive: Small incentives are more successful than medium or large ones. This is because they create dissonance – we believe we are giving up smoking for the 'right' reasons and not just because we expect to get something out of it. Irregular incentives, such as lottery tickets awarded for negative breath CO tests, also prevent us from disengaging – the uncertainty holds our interest.

  Commitment: If we make an active verbal or written commitment or promise to ourselves or someone we care about at the beginning of a programme, we are less likely to break that commitment than if it is unexpressed.

  Salience: Profiling incentives to likely intervals of greatest impact. For example recognising that the most difficult time in smoking cessation is during the first two or three days when withdrawal symptoms are at their worst.

- Improving blood testing rates in people with diabetes: We naturally discount the future; we will prefer a smaller immediate reward to a greater

long term alternative. Blood testing involves a short term pain for long term gain and this can be a difficult choice, particularly for children who do not value the incentive. Emphasising the long term gain can go some way towards influencing behaviour, but creating salience (in this case a Nintendo device which generates game 'rewards' for blood testing) brings the incentive within reach.

- Reducing the burden of binge drinking: We all 'normalise' ourselves – we will moderate our behaviour based on our perceptions of what those around us are doing (see 'Social Proof' above) but, sometimes, those perceptions can be distorted; students tend to overestimate how much their peers drink. In 1994 the University of Arizona placed publicity material around the campus stating real student alcohol consumption figures. Consequently, they realised significant reductions in the rate of heavy drinking in their students.[8]

Differences between Persuasion and Nudging

Persuasion is about changing somebody's perspective, opinion or viewpoint. While it is relatively easy to change someone's stated or expressed opinion, it can be more difficult to change their internally held opinion. Persuasion can be used to encourage people to do things that are not in their best interests, for example in sales.

Nudge theory encourages people to make the 'right' decision i.e. the one that benefits them most but that they may not naturally make for a variety of reasons. It alters the choice architecture (i.e. the way that choices are presented). This is why it is such an interesting area for social marketers and policy makers.

How can this work be translated into a pharmacy manager's role?

The published work on nudge theory relates to public policy and social marketing, so how can these principles be applied to management?

Pharmacy departments come in all shapes and sizes but one of the consistent roles of a pharmacy manager's job will be to motivate staff to do things which may be new, intimidating, uncomfortable, inconvenient or just different. Understanding the science (and art) of nudging will enable staff to be appropriately engaged in such situations.

In the public sector, managers are constrained by a lack of incentivisation options that are available in the private sector e.g. bonuses. Consequently, managers in the public sector must be more imaginative to gain active staff participation and engagement. Some simple examples of how these theories could be used in pharmacy management are given below.

Dispensary error reporting

Dispensary errors are usually reported as an absolute number and as a percentage of total items dispensed. This results in a paradox; greater reporting results in a more open and safer culture but self reporting high levels of 'mistakes' feels uncomfortable.

A change to the way dispensary errors are reported can result in a significant improvement in both culture and reporting levels. For example, reporting errors as the proportion detected before leaving the dispensary (i.e. near misses) versus the proportion that did leave the dispensary (i.e. were not detected at the checking stage) results in a high (and therefore seemingly positive) number. For example:

- Dispensed items: 20,000
- Near misses (dispensing errors detected at the checking stage): 600
- Errors leaving the dispensary: 15

This can be reported as an error rate of 3% (near misses) and 0.075% (errors). Alternatively, you could say that 97% of dispensing errors were detected at the checking stage, which provides greater 'reward' and, when benchmarked against different sites or trusts, provides greater incentive to report those dispensing errors which were detected at checking.

The behavioural insights used here are:

- Social proof - knowing other sites or trusts are getting greater results encourages greater reporting.
- Attractive - Reporting something as a high number (and aiming for 100%) is more positive, rewarding and attractive than aiming for zero.

Recording clinical interventions or audit data

If staff are being encouraged to record clinical interventions or audit data but are suffering from poor reporting levels, some of the following approaches could be considered:

- Make recording as easy as possible.
- Provide the means to collect the data (including a new pen if necessary).
- Reduce the post-collection effort level by having one individual collate the data, rather than everyone doing their own.

"Nudge theory encourages people to make the 'right' decision i.e. the one that benefits them most but that they may not naturally make for a variety of reasons."

- Give a prompt when data collection is due:
  - Rather than saying 'you must collect this data' asking 'Will you please collect this data?', encourages a 'yes' response.
  - Draw upon an individual's previous reporting levels – 'you have been one of our highest reporters in the past'.
  - Ask people to sign, not just write, their name on the form.
- Tell them: 'the whole team is collecting this information' and 'the medical director 'Dr Smith' is personally interested in seeing the results of this data collection'.
- Include the names of all the data collectors in the final report.

The behavioural insights used here are:

- Reciprocity – providing a new pen subconsciously encourages the individual to participate.
- Commitment – asking, rather than telling, them to collect the data and prompting a positive response encourages commitment, as does signing the form rather than writing their name.
- Consistency – telling people they have collected significant amounts of data in the past. People will tend towards consistency.
- Social Proofing – 'everyone else is doing it as well'.
- Authority – personalising the authority gives it greater significance. It also draws a direct line between the actions of the individual, and the greater collective output.
- Personal benefit – including the name of the data collector in the final report provides the incentive to be a willing participant.

Making Standard Operating Procedures (SOPs) available on a touch-screen computer in the dispensary

SOPs are the bedrock of consistent and reliable high quality dispensing activity but how often are they consigned to a dusty shelf in an adjoining office, gradually but inexorably going out of date? Making SOPs available on a touch-screen computer at a workstation will make them more accessible and more likely that they will be read and followed.

The behavioural insights used here are:

- Reciprocity – by putting an expensive and intuitive piece of equipment at a work station, people feel valued and are encouraged to use it.
- Social proof – by making SOP reading a visible and 'normal' activity, others are encouraged to follow suit.
- Authority – SOPs are written in an authoritative tone and are promoted by management. Staff feel like they are doing 'the right thing' by checking these on a regular basis.
- Make it easy – by enabling the access to SOPs, it is easier to access them and the 'tipping point' swings in favour of using them.

Personalised mobile technology

Providing mobile technology (in the form of tablets, laptops, smartphones, etc.) for pharmacy staff to use when not in the department for recording interventions, collecting audit data, etc. can be much more successful if individuals are given a device with their name on it, rather than taking one from a pool of devices.

The behavioural insights used here are:

- Reciprocity – feeling that you personally have been 'given' something makes you more likely to use it.

Conclusion

These are just a few simple examples of how the principles of influence can be applied and how they may affect the actions of an individual or team. As you can see, there is nothing groundbreaking about it – some may perceive it as simple 'good management'. I believe there is, however, a real benefit to understanding and applying the theories to practice and enabling greater influence on others, as well as understanding why people sometimes make bad choices. After all, who would not want their staff doing 'the right thing' all the time?

There is relatively little published data on the direct influence of behavioural insights on outcomes, be they patient care or management of staff. I would be keen to hear your examples of where simple adjustments based on the principles above have encouraged behaviour change, and would like to share them in a future article if possible.

Declaration of interests

- None

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Changing The Prescribing Responsibility For Stoma Appliances Can Improve Patient Care And Reduce Costs

Stuart Lakin, Head of Medicines Management, NHS Rotherham CCG;
Joanne Mangnall, Continence Advisor, Rotherham Foundation Trust;
Kate Midgely, Medicine Management Pharmacy Technician, NHS Rotherham CCG;
Laura Shepherd, Continence/Stoma Prescribing Service Manager/Support Worker, Rotherham Foundation Trust;
Michelle Gibson, Stoma Prescribing Support Worker, Rotherham Foundation Trust.
Email: stuart.lakin@rotherham.nhs.uk


Stuart Lakin

Summary

This article:

- explains how experience gained with nutritional products and continence appliances provided the basis of a new prescribing model for stoma products
- outlines the significant level of expenditure and growth that was occurring for stoma care products
- describes how the service was redesigned so that stoma care products were prescribed by nurses rather than GPs
- indicates that patient care was improved and a cost avoidance of £279,039 (27%) was achieved on stoma products.

Introduction

The NHS is challenged to deliver 20 billion of efficacy savings by 2015 and prescribing, which typically accounts for between 15-20% of a Clinical Commissioning Group's (CCG) expenditure, is an area constantly challenged to ensure that value for money is delivered.

Contained within a CCG's prescribing budget will be expenditure on a range of appliances and nutritional products. These are areas that Medicine Management teams and GPs have found challenging to control.

This paper describes a project within Rotherham NHS that changed the way stoma appliances were prescribed and, through joint ownership of the issues and partnership working between healthcare professionals, resulted in significant efficiencies and improvements to patient care.

Experience with conditions other than stoma care

NHS Rotherham has a population of 255,000, 38 GP practices ranging in size from 771 - 20,801 and 70 community pharmacies. The deprivation value (percentage of people in the locality living in the 20% most deprived areas in England) is 33.4, which is above the average for England of 19.8.

In 2006, the former Rotherham Primary Care Trust (PCT) Medicine Management team identified that there were some situations where GPs considered that they had little influence over the choice of product although they were ultimately responsible for the products prescribed and the associated costs. In the opinion of GPs, they were requested by dietitians, nurses and appliance companies to provide prescriptions for items that they were unable to assess as appropriate for the patient. GPs were only the mechanism of supply as they rarely initiated or made alterations to the choice of product requested and felt that they were being pressured into prescribing the products.

Five specific areas of concern were identified i.e. enteral nutrition, continence appliances, gluten-free and low protein products, stoma appliances, wound care products. The vision was to remove prescribing and budgetary responsibility from GPs and place it with the healthcare professional who recommended the intervention. Any efficiencies were to be shared between NHS Rotherham and the service that had taken over the prescribing. This investment would allow that service to develop, thereby improving patient care.

A model had been tried and tested with the prescribing of nutrition supplements, gluten free products and continence equipment (see Table 1).

"... partnership working between healthcare professionals, resulted in significant efficiencies and improvements to patient care."

The management of nutritional products by dietitians had delivered real savings to NHS Rotherham whilst allowing 5.5 whole time equivalent (WTE) dietetic posts to be funded. Similarly, savings made against the prescribing of continence appliances funded a community continence team consisting of two nurses and a support worker and delivered a saving against the NHS Rotherham prescribing budget. The patient experience was improved as demonstrated on the Patient Opinion Website and the number of hospital attendances and admissions for blocked feeding tubes and catheters that were prevented.

A redesigned prescribing service for stoma patients

In 2011/12, NHS Rotherham spent £964,687 on stoma appliances, which amounts to 2.3% of Rotherham's prescribing costs and appears to match the expenditure pattern reported in other CCGs.[1]

Following the success of the previous projects, it was decided in 2012 to review the prescribing, supply and management of stoma appliances. The vision was, as before, to improve the patient experience by reinvesting any associated prescribing cost efficiencies into developing the service.

GPs and practice staff acknowledged that they had a poor understanding of stoma products and GPs regularly reported to the Medicines Management Team that producing prescriptions was problematic. Furthermore, many Rotherham practices had expressed enthusiasm for a service redesign solution similar to the continence model for stoma appliances. The established continence service had also received requests directly from stoma patients for them to manage their prescriptions.

An initial questionnaire was sent to 300 stoma patients across Rotherham. This identified a number of common problems that patients were encountering:

- making practice staff understand what was required following product changes or if a product had been discontinued
- having to order products weeks in advance of when products were required to accommodate the time taken to request a prescription from their practice and then to post it to an appliance contractor or for a community pharmacy to order the products
- getting stoma products put on a separate prescription to regular medication so that the stoma prescription can be posted to an appliance contractor
- quantities being altered on their prescriptions such that patients were constantly running short of some products whilst being over-stocked on others. Communication between the patient, GP practice, and appliance contractor/community pharmacy was a common problem.

There was already an established colorectal service provided at local hospitals that was delivered by a mix of NHS employed and appliance contractor sponsored nursing staff. Further community support was also being provided by stoma nurses working for appliance contractors. However, a significant proportion of those on the community caseload were not known to the local colorectal services, typically because they had received their initial operation out of the area or were using an appliance contractor that did not provide nursing support.

The new service needed to ensure that all patients had access to on-going support when required whilst ensuring that there was no duplication or confusion of service provision.

The initial pilot

It was decided to run a 12 month pilot project to ascertain the ongoing needs of patients. This would then provide a basis to determine how a service should be commissioned in the future.

Funding was secured for two band 3 support workers and the services of a stoma nurse were purchased from an appliance contractor for a period of 12 months. The stoma nurse was funded entirely by NHS Rotherham CCG and was not under any obligation to use any particular products or place patient prescriptions with a particular company.

All patients, and any who reported a problem, were offered the opportunity for a review.

The project did not encompass initial product choices. Patients remained on the products they were receiving post-discharge and changes only occurred if the patient reported a problem and,

Prescribing area	Management transferred to:	Date
Nutrition supplements and tube feeds	Dietitians	April 2006
Continence appliances	Continence advisor	April 2009
Gluten free/low protein products	Dietitians	September 2009
Stoma appliances	Expanded continence service	April 2012
Wound Care	District Nursing	April 2014

Table 1: Experience gained with conditions other than stoma care

Patients were offered the opportunity for a review.

thereby, participated in a product review. The aim of the service was to manage their ongoing requirements; patients were not switched solely on grounds of cost-effectiveness and the service did not operate a stoma appliance formulary.

Prior to the start of the service, all appliance contractors who were receiving prescriptions from Rotherham practices were contacted and invited to attend a meeting explaining how the new Stoma Prescribing Service was going to operate. Colorectal nurses from two local hospitals and stoma nurses employed by appliance contractors, who were already supporting Rotherham patients, were invited to attend a separate meeting. This ensured that all appliance contractors, colorectal departments and company stoma nurses received the same message and had the same opportunity to ask questions.

Stoma Prescribing Service

The Stoma Prescribing Service started operating on 1st April 2012. The operational model mirrored that of the Rotherham continence service, which had been operating since April 2009.

A total of 90 patients were initially managed by the new service with all patients being transferred across to the new service by 1st October 2012. The service was managing a caseload of 694 patients in July 2013.

The use of SystmOne®, a centralised clinical management system used by the majority of GP practices in Rotherham, enabled prescriptions for required products to be issued by the Stoma Prescribing Service but still be charged against the GP practice's prescribing budget.

Once management of the patient had been transferred to the Stoma Prescribing Service, all stoma products were removed from the patient's list for GP prescription. The GP practice could view the patient's records and see what stoma products the patient was using prescriptions for those products could only be issued by the Stoma Prescribing Service.

"Once management of the patient had been transferred to the Stoma Prescribing Service, all stoma products were removed from the patient's list for GP prescription."

The way the service operates in practice is illustrated in Figure 1.

Registration details

Case load

The case load, as at 1st October 2013, was 609 patients (311, 51% male 298 female 49%).

Type of ostomies

The type of ostomies involved is shown in Figure 2.

Registration information

The following applied at the time of registration:

- Patients held an average of between 1-6 weeks supply of products as buffer stock. One patient reported holding 6 months supply, other patients reporting holding 'loads' but were unable to quantify the amount.
- It was difficult to ascertain how much buffer stock was held if the patient resided in a care home. However, the project stoma nurse reported at least two patients reviewed in care homes had stock in excess of two months.
- A number of patients did not realise

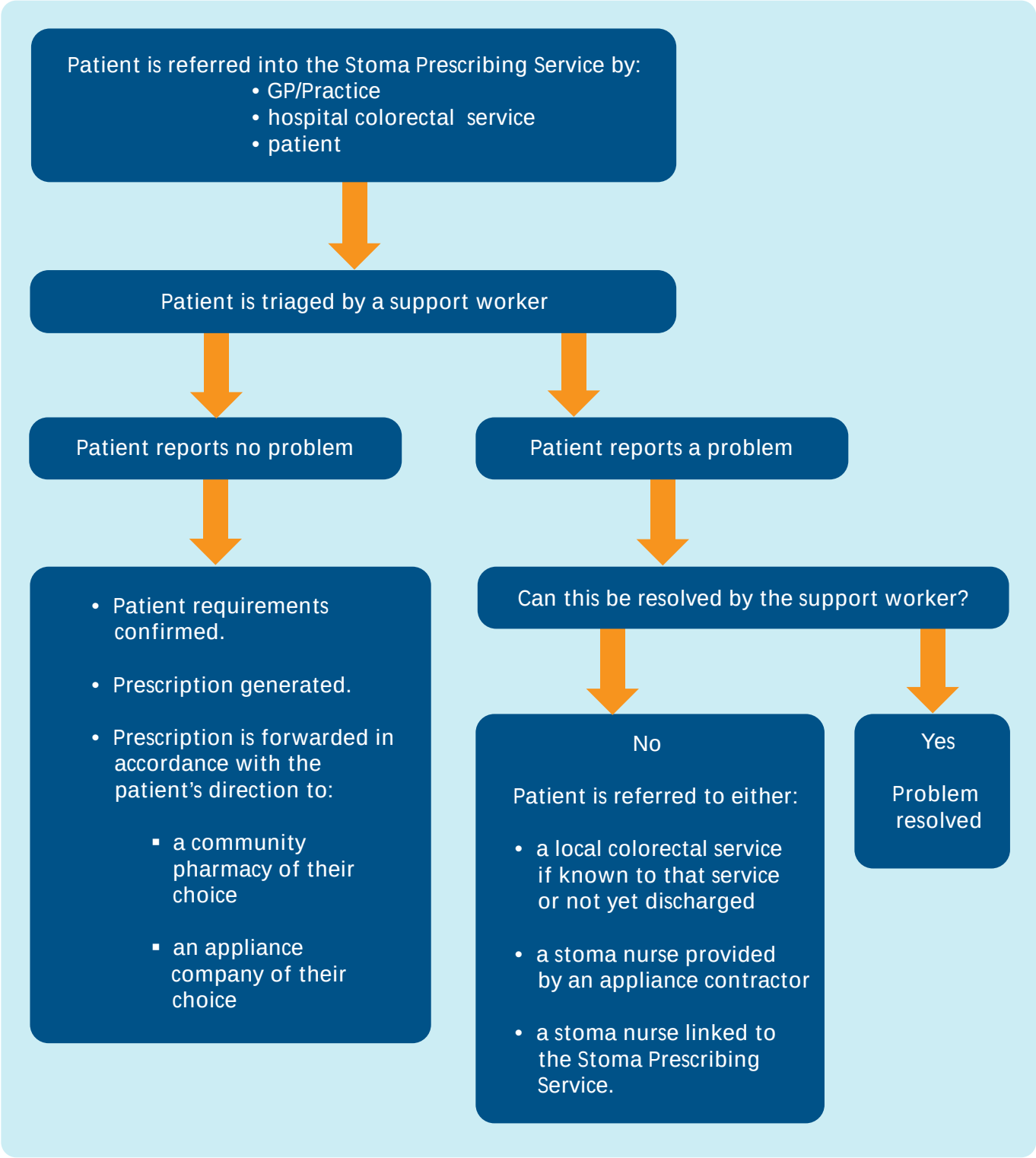

Figure 1: Stoma Prescribing Service Operational Diagram

that stoma products were prescription items - they thought the appliance contractor supplied the products when they requested them.

- 26% of patients had been living with their stoma for more than 10 years, with 5% having had a stoma for more than 30 years. Our oldest case had received their stoma in 1936 (i.e. 77 years ago).

Age profile of caseload

69% were aged over 60, 15% were over 80 with 10 patients (1.64%) being over 90 (see Figure 3).

Prescription dispensing

88% of patients were having their prescriptions sent to one of eight appliance contractors with 46% of patients using the appliance contractor that provided sponsored colorectal nursing posts at the two local hospitals where 87% of patients had received their surgery (see Figure 4).

Stoma related problems reported on registration

Details of problems reported by patients at the time of registration (some patients reported two or more issues) are shown in Figure 5.

Appliance Reviews and Advice

On registering to the caseload, 305 (50%) patients reported that they had

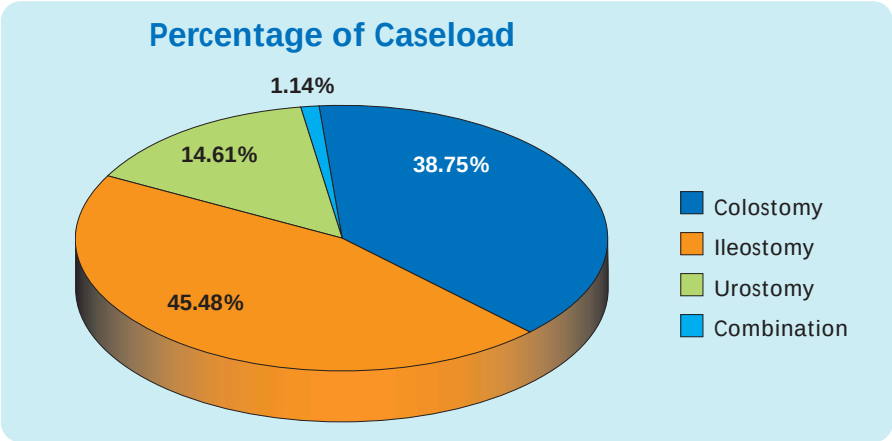

Figure 2: Types of ostomy in caseload

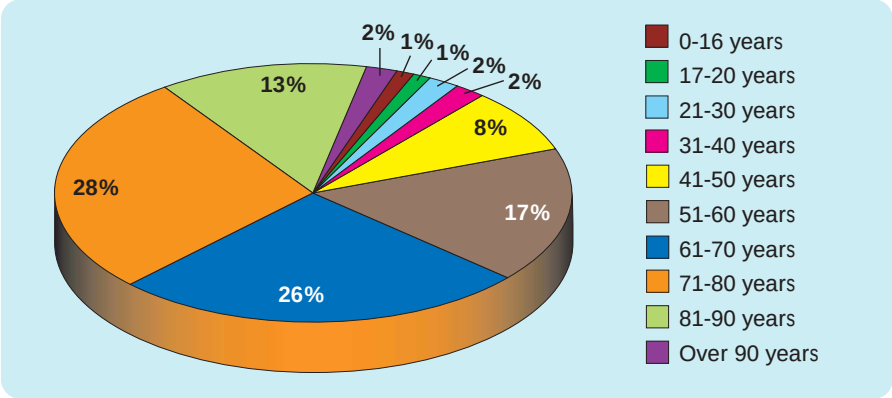

Figure 3: Age profile of caseload

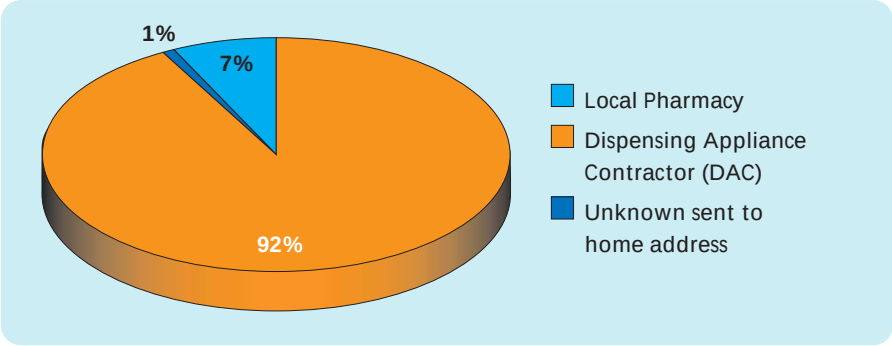

Figure 4: Prescription dispensing point

Problem*	Number of patients	% caseload
No reported problems	454	74.54%
Skin problems – includes occasional soreness	102	16.74%
Don't know	13	2.13%
Leakage	11	1.80%
Product related problems	11	1.80%
Odour	6	0.98%
Multiple problems - being already being reviewed	6	0.98%
Hernia	4	0.65%
Over-granulation	1	0.16%
Infection	1	0.16%

* some patients reported two or more problems

Figure 5: Stoma related problems reported on registration

never been reviewed by a stoma nurse and 3 did not know if they had ever been reviewed.

Patients were asked who they would contact for advice (see Figure 6). Only 5.6% of patients would contact their GP for advice regarding stoma products. Although patients did not have any experience of the Stoma Prescribing Service at the time of registration, 8.7% said they would contact the service for advice.

The patient experience

Patient feedback was obtained to establish if the service redesign was improving the patient experience. All patients were encouraged to use the Patient Opinion Website, thereby allowing the project team early feedback from the patient's perspective. The patient feedback via the Patient Opinion Website and over the phone was extremely positive (see Figure 7).

The feedback obtained indicated that the Stoma Prescribing Service had made life easier for patients and that they appreciated being able to speak to someone who understood the products and their needs. If a patient reported any issues they were referred to a stoma nurse whereas previously GPs reported that they were unclear how to access support for these patients.

A patient service users group has been convened and the feedback from the patients that attend these meetings has also been positive.

Rotherham/Sheffield Colorectal Nurses (Including Children Colorectal Services)	359	58.9%
Themselves – using the internet, patient forums, etc.	104	17.1%
The new pilot project team	53	8.7%
Appliance Contractor	52	8.5%
GP	34	5.6%
Don't Know	7	1.1%

Figure 6: Source for advice

- The care and help from all concerned was very good. I am very pleased with the excellent service that the prescription department gives.
- The Stoma Prescribing Service is excellent. They not only order the stoma bags immediately but the nurses are on hand to give any advice that one could need either on the phone or face to face.
- I've never experienced any problems. I order my stoma bags from the central prescription service. They then contact (name of appliance contractor) who deliver the bags to my house 2-3 days later. This is much better than getting the prescriptions from my GP which is what I used to do before.
- The Stoma Prescribing Service is very useful. I'm delighted with it. All I have to do is phone the central prescription service and they do the rest. I don't have problems with any of it. I've had a stoma for 28 years. Everyone has been wonderful.

Figure 7: Patient views

Financial aspects

Patients reported that they sometimes received products they did not require or were provided with excessive amounts. Community nurses also reported that care homes often appeared to have surplus stoma appliance stock. The provision of supplies in excess of patient requirements appears to be confirmed by the Colostomy Association as the 2013 Spring edition of their magazine contains reports of charities receiving donations of surplus stock and advising patients where to send such products.[2]

In the three years preceeding April 2012, stoma prescribing costs in Rotherham increased by 17.5% (England 18.7%), which was considerably greater than the total prescribing cost growth of 5.3%. There is nothing to indicate that there was a significant increase in the number of patients requiring stoma equipment.

During 2012/13, stoma prescribing costs in NHS Rotherham CCGs decreased from £964,687 in 2011/12 to £748,159 in 2012/13 i.e. a cost reduction £216,528 (22.45%) as indicated in Figure 8. The trend in average monthly expenditure remained downwards at the end of the project whereas across England ePACT data suggests costs increased by 6.48% over the same period (see Figure 9).

If Rotherham costs had increased in line with those of England then predicted expenditure for 2012/13 would have been £1,027,198 compared to the actual expenditure of £748,159, a potential saving of £279,039 (27%) as a result of the service redesign project. This saving was obtained by improvements in prescription management - patients were not changed to alternate products nor had their prescriptions switched to any particular appliance contractor.

Patient feedback demonstrates that these savings were made whilst improving the patient experience.

The Stoma Prescribing Service only started managing all Rotherham's stoma

patients part way through the financial year from October 2012 onwards. The effect of the new system of prescription management is demonstrated in Figure 10, which demonstrates how the monthly expenditure decreased as more patients moved across from GP management into being managed by the nurse-led service. 90 patients were transferred into the nurse-led service at the very beginning. For the patients that were managed for the complete 12 months of the pilot project, average monthly prescribing costs had decreased by 44% by the end of 2012/13 compared to 2011/12.

Commissioning the Service

The project demonstrated that improvements to the patient experience and care could be made whilst at the same time making substantial financial savings. The Stoma Prescribing Service was commissioned by NHS Rotherham CCG to continue to manage the prescribing of all stoma appliances from April 2013 onwards.

The nursing support to manage the patients was difficult to quantify but it was determined that it was not necessary to fund an additional full-time stoma nurse due to the improved links that had developed with the existing colorectal nursing services provided from the local hospitals and appliance contractors as well as the anticipated level of support required. An indication of the latter was summed up in a patient quote provided by the Stoma Patients Service User Group: 'We don't want to be constantly called for reviews when there is nothing wrong. We want to get on with our lives but, when we have problems, we want to see someone quickly.'

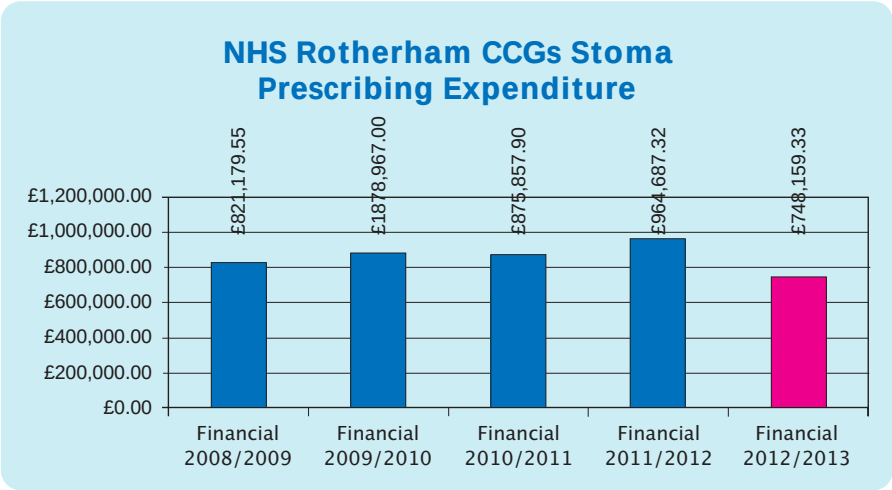

Figure 8: NHS Rotherham CCG stoma prescribing costs

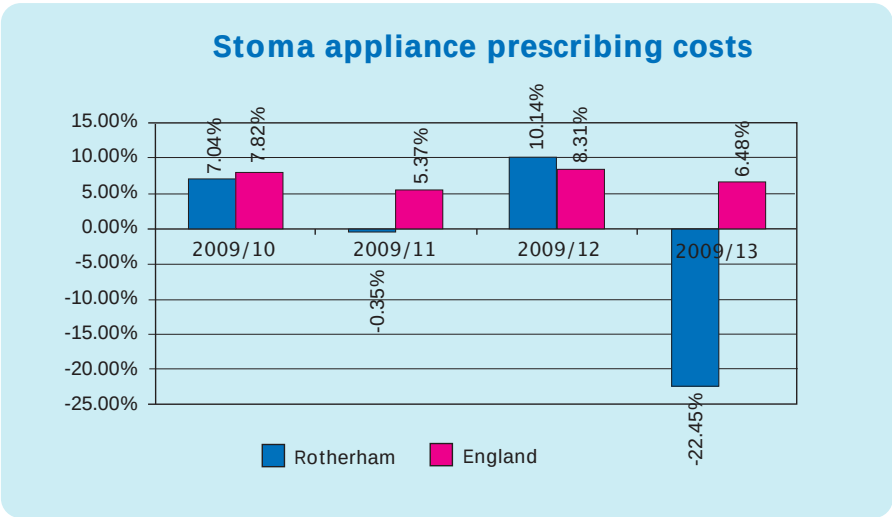

Figure 9: Stoma appliance prescribing costs

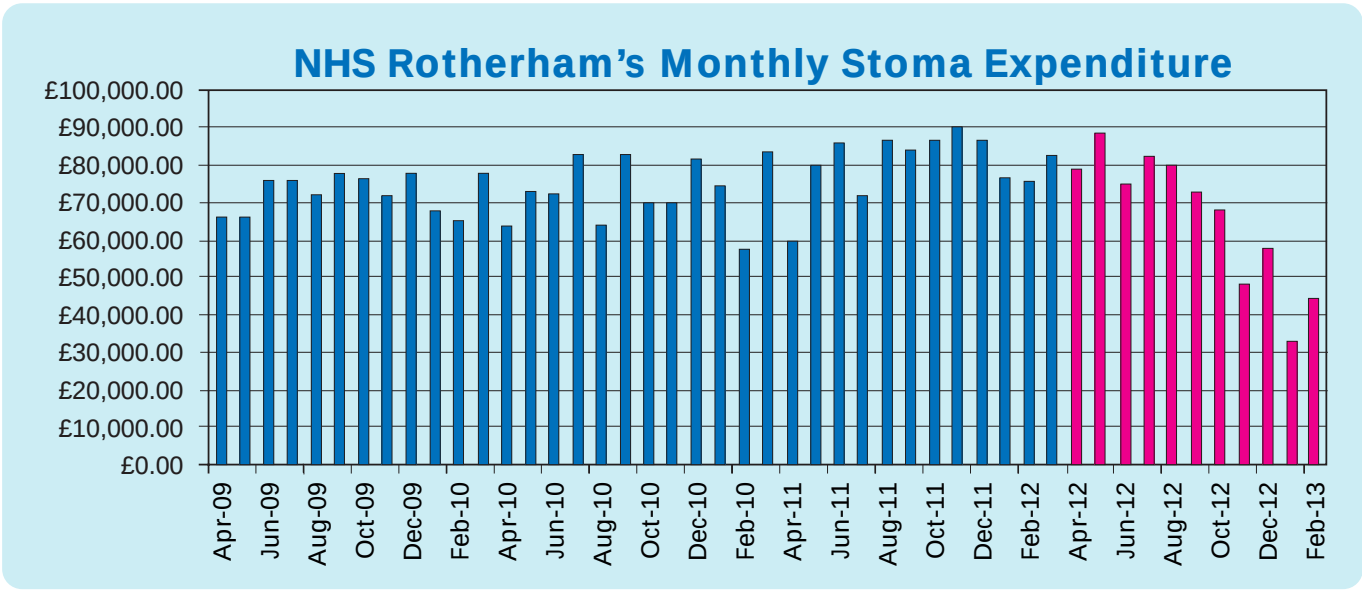

Figure 10: NHS Rotherham's monthly stoma expenditure

Staff	Cost
Prescribing Manager regrade from Band 3 to Band 4 (initially funded from savings made against continence prescribing)	£3,285
Ostomy Prescribing Co-ordinator Band 3 x 2	£42,200
Service Administrative Support Band 2 x 1	£18,500
Colorectal support Band 6-7 for 10 hours per week	£7,935-£9,474
Total investment	£73,459

Figure 11: Investment in staffing

After consideration of the patient feedback, and following discussions with the local colorectal nursing team, it was agreed to fund additional nursing time to enable a review clinic to operate for 2 hours a day to enable the Stoma Prescribing Service to offer any patients that were experiencing problems a speedy appointment with a colorectal nurse.

The additional permanent staffing funded to take the project forward is shown in Figure 11. The investment in staffing will be reviewed after 12 months.

Conclusion

If all healthcare professionals acknowledge and take ownership and responsibility for both the clinical issues and the subsequent financial implications then, by working in partnership, improvements to patient care can be made whilst also reducing costs.

Declaration of interests

- Stuart Lakin and Joanne Mangnall have presented their work on the continence service redesign project at educational events sponsored by Astellas, Coloplast, and Rochester.

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"If all healthcare professionals acknowledge and take ownership and responsibility for both the clinical issues and the subsequent financial implications then, by working in partnership, improvements to patient care can be made whilst also reducing costs."

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FACE2FACE

Head of Pharmacy Development, Community Pharmacy Northern Ireland

Katherine Kidd, Head of Pharmacy Development, Community Pharmacy Northern Ireland.
Email: kkidd@communitypharmacyni.co.uk


Katherine Kidd

Question:

What is your job title?

Answer:

Head of Pharmacy Development with Community Pharmacy Northern Ireland (CPNI), which represents Northern Ireland's community pharmacy contractors regarding negotiations on services, the pharmacy contract and remuneration/ reimbursement.

What are your main responsibilities/ duties?

My role focuses on supporting service development and implementation within community pharmacy, working collaboratively with both commissioners and policy makers. This involves reviewing and seeking ways to improve existing pharmacy services, as well as identifying and developing new opportunities. I also support the Chief Executive in addressing professional pharmacy issues related to the work of CPNI. I have responsibility for CPNI's Margins Survey Unit, which seeks to understand the extent to which retained profits on medicines purchased contribute to community pharmacy funding, and deal with Drug Tariff issues.

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

I report directly to the Chief Executive, CPNI and Head of Policy and Development, CPNI. The organisation is governed by a Board of Directors to which I also report.

When was the post first established?

The post was established 1 November 2011.

Are you the first post holder?

Yes, I am the first post-holder and have held the position since the post was created over two years ago. Prior to this I was happily working as a community pharmacist when I saw my current job advertised and it immediately appealed to me. I was already actively involved in providing community pharmacy services, and was keen to expand this area as I could see huge potential for community pharmacists helping to improve the health of the 123,000 people that use pharmacies every day in Northern Ireland.

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

As the post was a new role, I was starting with a blank canvas. While this can initially be daunting and sometimes overwhelming, I found that the support and guidance of the CPNI team enabled me to quickly define and establish the post into its current format. The flexibility of being the first post-holder allowed me to put my own stamp on the direction of the role - which is really exciting.

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

One success which immediately springs to mind is the introduction of the Medicines Use Reviews (MURs) service in April 2013. The service is tailored towards patients with respiratory conditions (e.g. asthma) and seeks to improve outcomes for these patients by enhancing how their medicines are used. It was great to see so many pharmacists attending the training sessions required to deliver this important patient service and, most recently, to learn from the pharmacists the positive impact it is having on patient health. I would hope to see this service expanded to patients with other conditions.

On a personal level, it's working closely with community pharmacy contractors and building solid working relationships; this gives me a fresh perspective into issues that affect them. The majority of community pharmacists in Northern Ireland work independently and can at times feel isolated, so it is important to develop and offer a network of support.

"One of the main priorities for the future will be to assist in the roll out of the new pharmacy contract."

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

One of the main priorities for the future will be to assist in the roll out of the new pharmacy contract. Community pharmacy is currently operating within interim arrangements to allow time for key pieces of financial work to be carried out and these are progressing steadily. CPNI meanwhile is working collaboratively with the Health and Social Care Board and the Department of Health, Social Services and Public Safety, not only on these investigations but also on a service development plan which will see the continued implementation of new community pharmacy based services which will translate into a new contract framework. These developments will influence the direction of community pharmacy services and this presents significant possibilities for the future of community pharmacy. I am confident that, once a contract is in place, we can further develop opportunities which will offer an enhanced and diverse range of services, expertly delivered by community pharmacies across Northern Ireland.

I would also be keen to see IT developments within community pharmacy, such as linking community pharmacies electronically with other healthcare providers. It would undoubtedly enrich the level of service offered to patients.

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

Excellent organisation skills are a key part of the role as you need to manage a varied and often complex workload. You also need to be a good communicator as part of the job involves building working relationships with partner organisations, both at a local and national level. A sound knowledge of the profession is essential, as a clear understanding of the skills and expertise community pharmacists possess as healthcare professionals allows you to develop services which can be successfully delivered to meet patient needs. In terms of training opportunities, pharmacists in Northern Ireland are required to document thirty hours of Continual Professional Development (CPD) per year. I often undertake training to support any learning needs I have identified in my practice ranging from online training to workshops to distance learning courses.

IT developments to link community pharmacies electronically with other healthcare providers is essential.

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

Community pharmacists in Northern Ireland have access to first class education providers such as Northern Ireland Centre for Pharmacy Learning and Development (NICPLD). The training available from this institution helps to underpin the development of services such as MURs. My post supports my career development path as each year I engage in Continual Professional Development (CPD) to complete a variety of training programmes according to my needs ranging from computer to clinical training. My experience of being a community pharmacist and delivering services is a great asset when developing both new and existing services.

The development of a range of services offers community pharmacists the opportunity for additional training, development and competencies which undoubtedly will present career opportunities for ambitious and progressive pharmacists.

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

With two diverse and exciting years under my belt, I feel that the steady progress which has been made is ready to be built upon. With a contract in place, we could improve and develop new services which meet the needs of the changing population. Data suggests that 83% of the population in Northern Ireland currently use the same pharmacy. This presents pharmacy with opportunities such as providing a long-term conditions management service, which would greatly benefit the patient. It is still early days for the post and as both new services and Transforming Your Care are implemented with the support of Integrated Care Partnerships I believe the post will diversify and develop further with the likelihood of additional roles within the CPNI team to support service development.

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

Embrace the opportunity whole-heartedly as it is an exciting and ever-changing role.

Take the time to learn from those around you and never be afraid to seek advice. Also, never under-estimate the importance of looking at the role of community pharmacy from another perspective, as this can provide valuable insight into how a service could be developed and delivered.

MANAGEMENT CONUNDRUM

A Balancing Act?

Mr Silver, who represents Community Pharmacists in Riverdale Primary Care Organisation (PCO), was more agitated than usual. He shook his head from side to side.

'You can't just keep adding in more services, things are at breaking point in some pharmacies!'

'Community Pharmacy can't stand still,' said Carey Whitecoat, Riverdale PCO's Head of Medicines Management. 'They are an enormous untapped resource and what has happened to date is just scratching the surface. Everyone is under pressure. We need to keep costs down and keep people out of hospital. Community Pharmacy can really help by making sure patients with long term conditions take their medicines correctly.'

'I know, but it's not that simple,' sighed Mr Silver. 'Look,' he said, I was talking to Peter Pill just last week. He is one of the most innovative Community Pharmacists out there and has embraced all the new services. The problem is that he seems to be working at a furious pace and, on top of that, when he had some staff off sick the number of scripts he dispensed on his own that day was quite frightening. It's an accident waiting to happen.'

'It seems that dispensing still rules the roost in Community Pharmacy', replied Carey glumly. 'That needs to be changed if we are ever going to develop a truly clinical approach in Community Pharmacy.'

'I know,' said Mr Silver, 'but how can that be done?'

What advice would you give to Carey and/or Mr Silver?

Commentaries

Chris Howland-Harris, Medicines Optimisation Pharmacist & Independent Prescriber, Bristol Clinical Commissioning Group
Email: chris.howland-harris@nhs.net

There is no doubt that all contractors are feeling the pressure of increased workload. Independent contractors are conscious of their income being squeezed from falling counter sales and reduced buying margins, while employee pharmacists are under intense scrutiny to achieve Medicines Use Review (MUR) and New Medicines Service (NMS) service targets. Meanwhile, all community pharmacists have to do the day job with ever greater scrutiny from both Area Team Community Pharmacy Contract Framework reviews and General Pharmaceutical Council (GPhC) Standards inspections.

The Pharmaceutical Services Negotiating Committee (PSNC) is fully behind the future vision for pharmacy, so it is imperative to work with the Local Pharmaceutical Committee (LPC) who are the first contact for commissioners. They will understand that most important aspects to commissioners are consistency, reliability and quality of service - this is valued above provision or geographic spread. Already, some pharmacies are at risk of losing a place at the table because they are just not engaging with the services on offer. Such contractors may need support to improve their performance and helped to understand that it is better to perform well in just one service than to do several badly.

Another important source of support should be the Local Professional Network (LPN). The LPN Chair works across many boundaries including the Clinical Commissioning group (CCG) and Health & Wellbeing Boards and will have a good understanding of the priorities for the local health organisations and what training is available to help pharmacists.

Many LPCs are also encouraging their commissioners to make use of online reporting systems such as Quit Manager or PharmOutcomes. This cuts down the paperwork, speeds payment and reduces administrative burdens. Such systems help the commissioner and the LPC to see which providers are performing and which need some support.

Robbie Turner,
Chief Executive Officer,
Community Pharmacy
West Yorkshire
Email: robbie@cpwy.org

I'm sure this is a situation that many people working within community pharmacy will recognise and even the most innovative pharmacists such as Peter Pill sometimes find it difficult to provide more and more services whilst balancing the need to ensure a safe and efficient dispensing service.

Carey is correct in saying that pharmacy teams are an enormous, untapped resource. It is important not to confuse this, however, with an expectation that the pharmacy team has lots of (or any) free time to undertake new services in a sustainable way. Mr Silver has recognised that continuing to add new services without considering how they can be delivered effectively will cause problems.

So what needs to happen? Well, the expansion of services that pharmacies will be expected to offer is not going to stop. The services of the future are likely to put even greater demands on the pharmacy team if they are to be delivered in a way that gets the best possible patient outcomes.

I'm sure Peter Pill's pharmacy is doing great work but there is the opportunity to do even more to help support the health and wellbeing of their local community through delivering additional services. To do this Peter will need to review his staffing levels but, more importantly, the roles each of his team are undertaking and what more they may be capable of if developed and supported. He will need to use his whole team as effectively as possible whilst investing in increasing their skills so that he has the best mix possible. This will not happen by chance. He will need to work out what skill mix he needs and invest time and resources to achieve it.

New services need to be incorporated alongside traditional roles

If Peter is to spend time and resources in developing his team and employing more people (or flexing up the hours of his current staff) he needs to know that there is a good chance of a return on his investment. It is important for Carey to recognise this when developing services for community pharmacy.

Carey needs to give Peter and his colleagues in community pharmacy the confidence to invest in his team if she is to succeed in keeping costs down, keeping people out of hospital but, more importantly, improving the care and safety of patients. Confidence will come from a fairly funded service with as few obstacles to delivery as possible and a length of contract that allows every opportunity to recover the costs of investment and a level of return that recognises the risk taken.

The move to delivering more services through pharmacy will not be easy and can only happen if pharmacies are willing to take risks in investing in their teams. Commissioners must give them a good chance of making a return if they are to do this. Currently, the risks are high and the return is low. This needs to be balanced out urgently if we are to realise the full potential of community pharmacy.

Declaration of interests

Chris Howland-Harris

- Director, F.B. (Downham) Ltd
- Member of the Pharmacy management Advisory Board.

Robbie Turner

- See role above.

"Currently, the risks are high and the return is low. This needs to be balanced out urgently if we are to realise the full potential of community pharmacy."

LEADERSHIP

Effective Delegation

By Tom Phillips, Managing Director, TLP 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

Never put off until tomorrow, what someone else can do for you today!

Has your boss ever given you a project to oversee and then left you to get on with it, no matter how competent or confident you feel about handling that project? That's not delegation that's abdication! Conversely, have you ever been given a project and told exactly how to do it and when it needs to be done by? That's not delegation, it's dictation!

Delegation is an essential skill for all managers and organisations. Consider the benefits of getting delegation right:

- Development of the people being delegated to.
- Free time to focus on other challenges for the people doing the delegation.
- Motivation of the individual(s) being delegated to.
- Improved individual, team and organisational performance.

So the pay offs to effective delegation are immense. The skill of getting delegation right can be greatly enhanced by considering the following steps.

1. Define the task

What is the task? Is it suitable to delegate?

2. Select the individual or team

How will individual X or team Y benefit from having this task delegated to them?

3. Explain the reasons

You must explain why the job or responsibility is being delegated to that person or team. What is its importance and relevance? Where does it fit in the overall scheme of things

4. State required results

What must be achieved? Clarify understanding by getting feedback from the other person. How will the task be measured? Make sure they know how you intend to decide that the job is being successfully done.

5. Consider resources required

Discuss and agree what is required to get the job done. Consider people, location, premises, equipment, money, materials, other related activities and services.

6. Agree deadlines

When must the job be finished or, if an ongoing duty, when are the review dates? When are the reports due? If the task is complex and has parts or stages, what are the priorities?

"Delegation is an essential skill for all managers and organisations."

At this point you may need to confirm understanding with the other person of the previous points and get their ideas and interpretation. As well as showing you that the job can be done, this helps to reinforce commitment.

Methods of checking and controlling must be agreed with the other person. Failing to agree this in advance will cause this monitoring to seem like interference or lack of trust.

7. Support and communicate

Who else needs to know what is going on? Have you informed them? Involve the other person in considering this so they can see beyond the issue at hand. Do not leave the person to inform their peers of their new responsibility. Warn the person about any awkward matters of politics or protocol. Inform your own boss if the task is important and of sufficient profile.

8. Feedback on results

It is essential to let the person know how they are doing and whether they have achieved their aims. If not, you must review with them why things did not go to plan and deal with the problems. You must absorb the consequences of failure and pass on the credit for success.

Following the above steps turns delegation into an enjoyable and rewarding process for everyone involved but, remember, it is delegation NOT abdication or dictation!

Deadlines should be agreed

Declaration of interests

- None.

"It is essential to let the person know how they are doing and whether they have achieved their aims."

Don't miss

Tuesday 13 May 2014
Strirling Management Centre

NATIONAL SEMINAR - SCOTLAND

Pharmacy MANAGEMENT

13th May 2014 -
Stirling Management Centre

DELIVERING THE FUTURE OF PHARMACY

Building on Prescription for Excellence

A free event for all NHS Pharmacists takes place at the Stirling Management Centre

University of Stirling, Stirling, Scotland FK9 4LA

This seminar will be entirely funded by a limited number of pharmaceutical companies. These companies will have no input into the design or content of this meting.

THE DAY WILL INCLUDE:

Presentations in the morning

- **Keynote Presentation - Building on Prescription for Excellence**
  Professor John Cromarty, Chairman of Scottish Pharmacy Board
- **Planning for the future**
  Andrew Radley, Consultant in Public Health (Pharmacy), NHS Tayside and Sharon Pfleger, Consultant in Pharmaceutical Public Health at NHS Highland
- **Prescription for Prescribing**
  David Pfleger, Director of Pharmacy & Medicines, NHS Grampian
- **Delivering the Skills Necessary to Succeed**
  Dr RoseMarie Parr, Director of Pharmacy, NHS Education for Scotland

Workshops in the afternoon

1) **The Hospital Patient – Prescribing for Excellence in the Hospital**
   Christine Gilmour, Chief Pharmacist, NHS Lanarkshire
2) **Primary Care Prescribing**
   Emily Kennedy, LHP Prescribing Support Pharmacist, Dumfries & Nithsdale LHP
3) **Planning for the Future**
   Andrew Radley, Consultant in Public Health (Pharmacy), NHS Tayside and Sharon Pfleger, Consultant in Pharmaceutical Public Health at NHS Highland
4) **Delivering the Skills Necessary to Succeed**
   Members of the NES Team

Hurry to book your place by visiting the Pharmacy Management website at https://pharman.co.uk:8444/national-seminar-england-2014 where you will find a booking form or send an email to lorraine.hawes@pharman.co.uk (Project Manager, Pharmacy Management).

Pharmacy MANAGEMENT
www.pharman.co.uk

Takeda

"DIABETES MEDICINES OPTIMISATION – MAINTAINING QUALITY AND OUTPUTS IN THE MODERN NHS"

A Pharmacy Management Workshop Programme

...including the latest information and guidance on Primary Care Rebates Schemes

Pharmacy Management is coordinating, on behalf of Takeda UK Limited, a series of half-day RPS-accredited workshops to address the role of pharmacy in delivering improved patient care and medicines optimisation in diabetes. Additionally, the latest information and guidance on Primary Care Rebate Schemes will be delivered by Senior Commissioning Pharmacists.

Workshops will be of particular interest to:

- Members of Prescribing Teams in CCGs and CSUs
- Hospital Pharmacists
- Community Pharmacists

The need for the evolution of healthcare delivery to meet growing demands for care is continually prompting a review of services and it is against this backdrop that the opportunities for increased pharmacy involvement will be discussed and debated.

The accompanying agenda will give clear insight into the approach of this highly interactive afternoon meeting. The afternoon will include presentations and syndicate sessions exploring opportunities for creating savings to further enhance medicines optimisation in diabetes through pharmacy. These sessions will be followed by a presentation and group discussion outlining latest information and guidance on Primary Care Rebate Schemes.

Workshops will be chaired by Senior Pharmacist Jonathan Mason FRPharmS, Clinical Adviser (Medicines) at NHS England (London Region) or Richard Hey MRPharmS, Director of Pharmacy at Central Manchester University Hospitals NHS Foundation Trust. The syndicate sessions will be facilitated by highly experienced members of the Pharmacy Management Team.

Proceedings of all meetings will be written up and published in the accredited quarterly publication – Pharmacy Management.

The workshops will commence at 1pm (with a buffet lunch from 12noon) and will conclude at 5pm. Workshops will take place on the following dates and locations:

- **Tuesday 29 April 2014 – Manchester**
- **Wednesday 30 April 2014 – Birmingham**
- **Wednesday 14 May 2014 – Cambridge**
- **Tuesday 20 May 2014 – London**

To book your place at what are likely to be very popular workshops, please send an email to Katie Fraser (PA to Directors) at katie.fraser@pharman.co.uk stating your wish to attend the relevant geographical meeting and commence your email with *"I would like to reserve a place at the workshop on XXX April / May 2014 at XXX location".*

You will receive a prompt acknowledgement of your email from the offices of Pharmacy Management. More detail about the training afternoon will then follow in due course.

These workshops are organised and funded by Takeda UK Limited.
Promotional information will be presented at these workshops.

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PO Box 162, Shaftesbury, Dorset, England SP7 7AX
Tel: **01747 829501** Homepage: **www.pharman.co.uk** Email: **pharm@pharman.co.uk**