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**EDITORIAL**

**Best Practice**

Despite the best efforts of pharmacists working in hospitals, medicines still cause unwanted incidents that could perhaps be avoided. The time taken to dispense TTOs can be a cause of complaint and it is generally accepted that patients are not counselled about their medication and its side-effects as fully as would be liked. Can this situation be improved? This edition carries a report from a hospital in which the aim was to fully use an electronic prescribing and administration system and get closer to ward staff and patients by the establishment of ward-based teams. The new service was found to result in significant benefits. Hospital pharmacy managers will no doubt wish to review this article to determine the extent to which the approaches taken would be appropriate to their local situation.

What difference will the next five years make to community pharmacy and the services provided? The answer to that question can be illuminated by the article that summarises outcomes from focus groups consisting of a mix of community pharmacists. There has been significant change within community pharmacy in recent years but there remains some way to go in the transition from a practitioner working in isolation to someone who is a fully integrated member of the healthcare team. The need for policy change at a national level and further movement away from a business model that revolves around the supply role were seen to be key aspects if community pharmacy is to realise its full potential. Perhaps we need to revisit this in five years to see how far down the path things have gone?

What benefit would offering a work experience placement bring to your service? Do you have a corporate social responsibility to help people secure paid employment? This edition carries an interesting and heartwarming article from a mental health trust where a work placement was provided for a person with learning disabilities. It is uplifting to read about the benefits that this brought to the organisation and the individual concerned. Pharmacy managers, whether in hospital or other settings, may wish to consider whether the benefits described could also be derived from other work experience placements.

**Clarion Call**

Nurses need to undergo community placements during their pre-registration education. This section describes the experience of using community pharmacies to provide placements, with a period of three days being considered the most suitable.

Another article in this section describes the workings of the South East London APC with a view to obtaining feedback from others and further developing best practice.

**Face2Face**

This section describes the introduction of a new role working on medicines management within GP practices. No special training or experience is required to be a Medicines Management Facilitator beyond an ability to do the job intended. Suitable administrative or receptionist staff can, for example, fulfil the requirements when supported by appropriate in-house training. This is a development that others will no doubt follow with interest and consider the extent to which it could apply locally.

**Management Conundrum**

The introduction of independent prescribing by pharmacists is, debatably, one of the most important developments to have occurred within the profession - but has that opportunity been fully realised? Do you know of pharmacists who have the qualification but do not use it in any significant way in practice? Are you one of those pharmacists? Our Management Conundrum recognises that this is a real issue within the profession and comes up with some suggestions on how to go forward.

**Leadership**

Have you ever ‘lost it’ in the workplace? If so, the chances are that your chimp has taken over! Find out how to feed and control your chimp for better experiences at work and socially.
BEST PRACTICE IN PHARMACY MANAGEMENT

Introduction Of Ward-Based Pharmacy Teams At Harrogate And District NHS Foundation Trust

Janet Hobson, Chief Pharmacy Technician, Harrogate and District NHS Foundation Trust
Email: janet.hobson@hdft.nhs.uk

Summary
This paper:
- outlines how ward-based pharmacy teams were introduced
- describes the operation of an electronic prescribing and administration system
- identifies the benefits of the new system
- summarises the reduction in time that occurred when dispensing TTOs.

Introduction
Harrogate and District NHS Foundation Trust (HDFT) is the principal provider of hospital services to the population of Harrogate, the surrounding district and north Leeds. In addition, a wide range of community-based services covering the Harrogate and District locality are also provided, with some services covering the whole of North Yorkshire. The Trust’s overall catchment population is approximately 900,000.

Further to a review of processes, including feedback from patients, the department decided to change working practices to provide reliable and effective ward-based pharmacy teams.

Medicines are an integral component of delivering care at HDFT, which spends approximately £10m per annum on medicines with the wards administering 1.7 million doses per annum. Whilst medicines management across HDFT is relatively good, further improvements can be made:
- Medicine incidents are around 10% of the total incidents reported across HDFT and feature in the top 5 most common HDFT reported incidents.
- HDFT has recently had several high profile cases of security breaches relating to medicines.
- NHS inpatient surveys recognise that only 60% of patients are adequately counselled and informed about the side effects of their medication.
- The slow supply of medicines at discharge (i.e. ‘To Take Outs’ or TTOs) is a regularly reported concern/complaint by patients.

Aim
The HDFT pharmacy seeks to build on established and integrated ward-based services to develop dedicated ward-based pharmacy teams for inpatient areas. This is being achieved through service improvement, process redesign, devolvement of the resource for inpatient areas and the employment of remote technology and mobile dispensing units.

HDFT operates an electronic prescribing and medicines administration system (ePMA), which consists of:
- an electronic form of a patient’s medicine chart
- a pharmacy dispensing and labelling system (Ascribe), which communicates with the ARX robot within the dispensary
- the Integrated Clinical Environment (ICE) electronic discharge system for the dispensing of TTOs.

There is also access to ‘SystmOne’, which links into patient medicine records and four mobile pharmacy dispensing units situated on two surgical and two medical wards. The aim is to ensure that each element of this technology is used to its best advantage.

Each ward-based pharmacy team includes a pharmacist, pharmacy technician and pharmacy support worker.

“. . . only 60% of patients are adequately counselled and informed about the side effects of their medication.”
The team is responsible for medicines management issues on that ward and works seamlessly with nursing and medical staff.

Benefits
The new service endeavours to:

● supply all medicines (discharge prescriptions, stocks and inpatient supply) in a timely manner
● improve the counselling and provision of advice and education to our patients
● provide front line clinical/pharmaceutical advice to clinicians
● further develop the clinical review of medicines at admission, during the inpatient stay and at discharge
● improve the safe and secure handling of medicines
● develop medicines self-administration programmes for our patients
● reduce medicines waste in clinical areas.

Feasibility

The project initially required a sound business case to obtain support and commitment from stakeholders, including the Executive Board, to drive the plan forward.

Areas on the wards regarding where the mobile pharmacy dispensing units could be placed were identified and ward staff were consulted about the new service.

Pharmacy staff were introduced to the new way of working in a presentation and the opportunity was provided to enable any concerns to be addressed. The expertise of existing staff was used to introduce and develop extended roles. A medicines management training and competency programme for the pharmacy support worker was written and the pharmacy technicians undertook training in drug history taking.

A pilot scheme was undertaken on a surgical/trauma ward. The audits undertaken before and after included:

● the time taken for medicines to be ordered, dispensed, checked and put into a patient's locker
● the time taken for discharge prescriptions to be dispensed, checked and ready for discharge
● the adjustment in stock holding and any cost saving made through recycling
● feedback of nursing and patient experience by means of a questionnaire.

Further data was gathered and processed as the project advanced.

Timescale

The roll-out of the new service began shortly after five additional mobile pharmacy dispensing units had been purchased.

The project commenced on two wards (one surgical and one medical). The next medical ward followed a month later and it was then planned to introduce subsequent wards over the...
next 6 months with the program being
determined by the time taken to train
staff and annual/summer leave.

It was anticipated that a full roll-out to
all the wards would be completed within
a year.

The Experience

The transition from working in the
dispensary to being fully active on the
wards was welcomed by the pharmacy
team and their level of job satisfaction
increased accordingly.

The pharmacy team concentrated on
providing a familiar service to the ward,
with the pharmacist focusing on
medicine reconciliation, the pharmacy
technician undertaking the medicine
supply and checking patients’ own
medicines and the pharmacy support
worker providing a ‘top-up’ service for
the ward’s stock.

Discharge prescriptions started to be
dispensed from the mobile dispensing unit
by the pharmacy support worker and
be accuracy checked by the pharmacy
technician within the first week. This
progressed to include inpatient medicines. By
using the ePMA system it was possible for
the pharmacy technician to produce
worksheets for the pharmacy support
worker to use when dispensing. By checking
the drugs immediately and placing them in
the patient’s locker, they were available for
the patient either to self-administer, if
enrolled on the self-administration scheme,
or for the nurse to administer.

The pharmacy team could be more
selective regarding which medicines to
dispense into the patient’s locker as
adjustments could be made quickly and
easily using the mobile dispensing unit.
Pre-packs were used more at discharge if
the patient required them rather than
issuing a range of medication that may
not be needed.

The pharmacy support worker began
taking responsibility for all the stock,
including bulk fluids and dietary feeds.
Stock levels became leaner with recycling
and waste management becoming more
efficient as the pharmacy support worker
became aware of medicine usage
patterns.

As the patients’ medicines were put
directly into the bedside lockers, having them
ready for discharge was straightforward. Any
additional supply or relabelling was
carried out on the mobile dispensing unit.

The need to re-dispense medicines
when patients transferred wards was
avoided by also transferring the patients’
medicines. The security of medicines was
much improved as the pharmacy team
put the stock orders and the inpatient
medicines away.

Members of the pharmacy team spent
more time discussing medication with
patients, who became more aware of the
pharmacy team being part of the general
workforce.

Results

Stock ‘top-up’ figures have been reduced
by 10%. By allowing the ward-based
team to take responsibility for the ward
medicines service, savings have been
made by a decrease in the amount of
stock kept and by careful consideration of
what should be included on the stock list.
Savings by recycling medicines are almost
£1,000 a month per ward and waste has
been considerably reduced.

The number of TTOs provided at ward
level increased to almost 100%, with the
only exceptions being if it was necessary
to dispense a controlled drug or a
compliance aid, in which case the team
would return back to base for
completion.

Table 1 shows that, on the surgical
ward where 64 prescriptions were
audited over a four week period, almost
all the TTOs were dispensed at ward level
with 63% of medicines coming from the
patient’s locker, 31% being dispensed
from the mobile dispensing unit and 6%
of the medicines not being required by
the patient. On the medical ward, where
18 prescriptions were audited over a four
week period, all the TTOs were dispensed
at ward level with 82% of medicines
coming from the patient’s locker and
18% being dispensed from the mobile
dispensing unit.

The time taken for patients to receive
their medicines for discharge was
significantly reduced. The time measured
was from when the pharmacist had
clinically checked the TTO to having the medicines dispensed, checked and ready for the patient to take home.

Table 2 shows that, on the surgical ward where 23 prescriptions were audited over a one week period, the turnaround time for a TTO varied from 25% completed in less than 5 minutes (all medicines ready in the locker) to 82.5% taking less than 90 minutes. On the medical ward, where 9 prescriptions were audited over a one week period, the TTO prescriptions took an average of 45 minutes to prepare with 7 minutes being the fastest turnaround time.

Medicines were placed into patients’ lockers earlier than when the worksheet had been dispensed and checked within the department and the porter had been responsible for delivery.

Table 3 shows that, for both wards where between 13 and 22 worksheets were audited over a two week period, on average 76% of inpatient dispensing was taking under 90 minutes for a worksheet (consisting of up to 10 items) to be dispensed, checked and put into patient lockers in comparison to only 5% before this new way of working.

Comments from staff

Nurses commented that they had noticed the pharmacy team were spending longer on the ward and were available to give advice. They were happy that medicines were being put into the lockers. They rarely had to do this themselves and only when a patient was admitted out-of-hours. They also did not need to spend time putting stock away, which generally took between 30 minutes to 1 hour for two members of nursing staff.

An e-mail from a ward sister indicated:

“Just a quick note to express the staff’s gratitude for the exemplary job . . . have done on . . . ward. The additional role of unpacking pharmacy deliveries has made an immediate improvement to the running of the ward. This week alone it has allowed the Nurse in Charge (NIC)/Sister to attend MDTs for long-term patients, greatly improving the patients’ and families’ faith in the Nursing and Medical teams as well as contributing to a clear management plan. It has also freed staff to provide basic nursing care, demonstrate a greater presence on the ward and speed up our discharge process. Not to mention the improvement in medicines safety and ward tidiness.
... has always been very conscientious in her work. Our stock levels are always accurate and appropriate and she is often aware of TTOs before the NIC! I have never known TTOs be processed or delivered as quickly or with as little fuss. In addition to this ... has streamlined and tidied the ward medicine cupboards, removing any non-stock items and generally organising us. I understand the IV fluid cupboard is next on the hit list.

I believe this duo technician/support worker approach is part of a trial process and I just felt that you should know that on ... ward at least it is extremely effective. Please pass mine and the rest of the staff’s gratitude to ...”

Doctors were also appreciative of the service. An e-mail captured their opinions as follows:

“I have certainly noticed a much greater presence on the ward, which is incredibly useful to doctors of all grades, with problems and queries being sorted out straight away face-to-face. The admissions meds are being completed much more reliably and more quickly, which obviously improves patient care and safety.”

Patients were undoubtedly having more contact with the pharmacy team and were benefitting from counselling throughout their hospital admission.

When patients were questioned prior to the scheme commencing a number of negative responses were reported e.g.

Q: Have you met a pharmacy person today?
A: “No”

Q: How many times have the pharmacy team spoken to you?
A: “Not sure.”

Q: What have they spoken to you about and what did they do?
A: “Someone in uniform put my medicines in the locker.”

After the introduction of the ward-based teams, the feedback obtained was more promising. For example, when asked “Have you met and spoken to a pharmacy member of staff?”, patients answered affirmatively. Other comments made included “Pharmacy has been very helpful” and “Can’t fault anyone here - you are doing an excellent job”. More importantly, patients could give examples of conversations about their medicines with reference to inhaler counselling, new and changed doses.

Future Work

For the wards that have been involved, the project has proved to be a success for both the pharmacy team and patients, with all objectives being achieved. However, the completion of a full ward-based team service will take longer than anticipated.

The department is committed to build on what has already been achieved to ensure that pharmacy delivers an efficient and effective service as part of the multi-disciplinary team.

Declaration of interests
• None

“... on average 76% of inpatient dispensing was taking under 90 minutes for a worksheet (consisting of up to 10 items) to be dispensed, checked and put into patient lockers in comparison to only 5% before this new way of working.”

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Full prescribing information is available from Alliance Pharmaceuticals Ltd, Avonbridge House, Bath Road, Chippenham, Wiltshire, SN15 2BB.

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How Do Community Pharmacists Envisage Their Future In Five Years Time?

Michael Wilcock, Pharmacy Department, Royal Cornwall Hospitals NHS Trust, Truro, Cornwall and Geoff Harding, Honorary Senior Research Fellow, School of Medicine, University of Exeter
Email: mike.wilcock@rcht.comwall.nhs.uk

Summary
This paper:
● describes a study to assess how community pharmacists view the future development of the profession
● identifies the tensions that exist between the business model currently sustaining community pharmacy and the wish to implement additional cognitive services
● indicates how pharmacists perceive the changes needed to move towards the vision as outlined in recent policy documents.

Introduction
There is continuing discussion around expanding the role of community pharmacists within health systems, with the adoption of national policies that move community pharmacy from a supply-driven ‘industry’ to one encompassing a broader view of the individual patient as well as population health gains.1-3 Such reviews have concluded that community pharmacists could adopt an expanded, patient-centred role and contribute to safe, effective and economic use of drugs, recognising the important role pharmacists play in helping patients manage their own conditions. In particular, the 2013 report commissioned by the Royal Pharmaceutical Society concluded that:

‘Despite its potential, pharmacy - and particularly community pharmacy - is marginalised in the health and social care system at both local and national level. It is seen by others as a rather insular profession, busy with its own concerns...’ and ‘...there will be a need for a significant rethink of the models of care through which pharmacy is delivered...’

These reports identify and recommend the need to change the culture within which pharmacy is practised. As community pharmacists will have a significant role to play in the future development of their profession, their beliefs and expectations of how the profession is anticipated to evolve within the next five years will have a marked impact on how change is played out. A cultural ‘temperature check’ was therefore undertaken.

Method
Two focus groups were convened in late 2013, attracting sixteen attendees comprising three independent proprietor community pharmacists, eleven employee community pharmacists, one area manager and one locum. A topic guide was constructed to provide structure to the proceedings. Proceedings for both groups, which lasted an hour and a half, were digitally audio-recorded and contemporaneous notes were taken. Proceedings were transcribed and, together with the contemporaneous notes, formed the basis for a thematic analysis. Proceedings were coded and explored for emergent themes pertinent to the project’s aim. Before addressing the participants’ views on the future of pharmacy, the initial discussion focussed on the existing perception of the context of community pharmacy. This enabled participants to evaluate factors that have previously impacted on pharmacy and their influence on the profession as it goes forward. Findings are organised around participants’ views of how pharmacists are perceived in the wider community, how they perceive their current role and factors considered to hamper the future development of pharmacy, including the contractual basis of pharmacy core services and additional services offered. These issues provide a backdrop against which participants speculated on the future of pharmacy five years hence.

Results
Theme One: How do pharmacists think they are perceived by others?
It was evident that participants did not all share a common perception of how their role was viewed in the wider community. When asked to nominate which
Do the public perceive pharmacists as pill counters?

statements best represented how they thought pharmacists were perceived by the public, six considered pharmacists were regarded as largely unskilled professionals:

“If you ask most people out there, hand on heart I think it would be pill counters and bottle labellers.”

This negative perception reflects a sense of how pharmacy has not succeeded in promoting its services. However, six participants were more optimistic regarding the public’s perception of them as medicines experts – endorsing the view that the perception of pharmacy has developed more positively in recent years. Moreover, it was acknowledged that the public’s perception of pharmacy is evolving though at a slower rate than that of pharmacists themselves:

“I suspect our perception is growing …but the public haven’t grown with our intention in terms of professionalism.”

There was a sense that there was more to be done in order to increase the profile of pharmacy:

“...it is people’s positive experiences of pharmacy that count - ‘Oh, a pharmacist can do this...’ but that takes time. No matter how fast we want it (perception) to move it takes time...it takes positive patient response to realise what we can do - ‘Oh, I never realised you could do this.’”

Perhaps the greatest influence on the public’s perception of pharmacy was considered to be the notion of the pharmacy as a commercial, as much as a service, operation:

“Because we are a private business that lends out some of our skills [author’s emphasis] to the NHS then we are not perceived as professional as the GPs are...”

The greater concern, however, was less with the public’s perception of community pharmacy as it was with the perceptions of their fellow health professionals. It was this perception that was considered key to promoting pharmacists’ professional public image as they were instrumental in signposting patients to pharmacy services:

“If (others, opticians, etc) could see us (pharmacists) in a more clinical way and signpost them (patients) to the pharmacy for advice and they (others) had more respect for us then I think the general public will perceive us in a more professional clinical caring way.”

Theme Two: How do pharmacists themselves perceive their role?

Notwithstanding the fact that some community pharmacists believed they were perceived less as health professionals but more as commercial retailers, their self-perception was altogether more realistic, reflecting their knowledge and skills base. Five participants perceived their professional role as medicines advisor, five as clinical practitioner and one as a manager.

There were, however, concerns among the participants that their role as skilled health professionals was being undermined on two fronts: the decreasing...
opportunities for compounding medicines with an increasing emphasis on their capacity to provide health related advice and the basis of their remuneration as professionals – with payment based on piece rate.

**Theme Three: Barriers currently preventing development of pharmacy**

There was an inherent tension between embracing activities that deviate from the core activities of pharmacists (e.g. dispensing) and the need to secure an appropriate funding model which acknowledges the importance and value of non-core activities. In some sense, pharmacists considered themselves caught in a ‘double bind’ by existing regulations governing their activities:

“You can’t deviate from core (prescriptions) because that’s where your funding comes from ...until we can show outcomes that show we are worth investing in, who’s going to give us the money for it...”

Despite a willingness to develop their professional role, it has at its core a supply model i.e. medicines are supplied to patients in accordance with the prescriber’s instructions. Elements of these core activities, which form the basis of the remuneration, are increasingly being undertaken (albeit under supervision) by dispensing technicians, technically leaving the pharmacists with the capacity to develop their advisory role. However, regulations prevent a wholesale change to undertaking different roles vis:

“There is something regulatory that holds us back – having to dispense what the GP prescribes.”

Indeed, many participants regarded the current regulations governing their activities, particularly the associated remuneration structure, as not supporting an advisory role for pharmacists:

“The stumbling block is the payment model – who wants to do x items a week if you are paid for advice? Currently we are not paid to give advice.”

“Dispensing boxes out the door gives us income but giving advice doesn’t give us much.”

The fact that the pharmacy funding model is based primarily on its core business and that the majority of large national pharmacy chains require ongoing financial investment impacts directly on the opportunities for development beyond the core elements of the pharmacists’ role. However, the issue was not simply one of wanting payment for service, but more broadly a sense of a lack of acknowledgement of the value of advice offered – a situation which the profession itself had brought about:

“I think one of the things we as a profession need to do is stop doing things for free. There’s been far too much...we’ll throw this in as part of the service. If we don’t value the service no one else will .”

There was also a concern that the advisory role enshrined in Medicine Use Reviews (MURs) was itself ill-conceived by potentially blurring the boundaries between pharmacists and GPs with regard to advising on prescribing:

“When MURs first came out I thought that’s what we were supposed to do - advise on prescribing - but when you go back to the GP they say ‘that’s what we do’."

Nor was concern over regulations restricted to remuneration issues. For some the regulations inhibited the development of closer contact with users of pharmaceutical services:

“I think the model I’m looking at is to try and get back in contact with patients but under the current funding model this is constrained...I’d much rather go to somebody’s home and discuss their discharge medication ...I’d make much more use of my professional knowledge.”

Regulatory issues aside, there was a perception that the context of community pharmacy – functioning essentially as a ‘for-profit’ service – presented a significant barrier to their professional development. Lack of time to devote to other than core remunerated activities within a commercial business characterised the perceptions of many participants, who otherwise would wish for greater involvement in pharmaceutical services to patients. In addition to perceptions of regulatory barriers to professional development, there was also a clear undercurrent among participants of frustration emerging from their desires to develop a distinct identity apart from that of simply dispenser of prepackaged medication and proffering advice opportunistically vis:

“It is a frustration that you know you could do a better thing.”

In this regard the frustration is because the pharmacists’ role is often shaped by the demands for their core services:

“What is compromised is the opportunity to offer other services because you are so bogged down with hundreds of prescriptions that are waiting to be checked, unless you have another pharmacist to help.”

“...many participants regarded the current regulations governing their activities, particularly the associated remuneration structure, as not supporting an advisory role for pharmacists.”
Underscoring concerns about barriers preventing the development of pharmacy was a sense of their professional wish to establish a consensual and clear sense of direction:

“From my view I think we are still trying to define our future - there’s still so much internal conflict about what that looks like…”

In the perceived absence of such a direction, one pharmacist was of the opinion this had left the profession vulnerable to being considered a ‘jack of all trades’ with predictable consequences:

“We can’t be everything to everyone ...with every new role you have such a range of things...you sign up to do something and then generally as a profession we don’t deliver what we promise ...those services which have been decommissioned ...if we had delivered on them we would have a really strong case for them to continue. The fee for dispensing is cut and we are remunerated for other services and therefore are expected to do more and more and the prescription volume increases 4-5% every year.”

Theme Four: Patient registration versus unplanned services

A concern for participants was a desire to have greater direct involvement with patients by offering a valued advisory and support service but this was considered to be undermined by pharmacists offering a range of unplanned services. This was particularly an issue with regard to the introduction of Healthy Living Pharmacies. While it has been acknowledged that pharmacists broadly welcome this initiative it was considered something of a double edged sword:

“Healthy Living Pharmacy - it’s a badge which recognises what we are already doing...”

However, because it encouraged the uptake of unplanned services such as advice and information, and because the initial contact with patients was often by support staff, this potentially could facilitate the pharmacist to continue with their core activities (e.g. dispensing), rather than begin to establish the delivery of planned services (which by their nature might be more valued by patients):

“You hear the counter assistant saying go to your GP and you think ‘phew, thank goodness I’m really busy’ and, at the same time, we are offering a service and we are telling the PCT we’re doing a lot.”

This promoted a degree of ambivalence about the concept of pharmacies having a patient list with which to manage and deliver planned services:

“With a patient list it would undermine the idea of the pharmacy being openly accessible - a patient list goes against the grain of wanting to help straight away.”

Regulations and funding issues impair progress to develop new roles
This concept also raised the issue of whether pharmacies have the necessary resources to manage a pharmacist-led unplanned service. Notwithstanding issues of how unplanned services are to be resourced, the development of planned services are also challenged in part by the ageing population and implications this has for how pharmaceutical services will be utilised by older people:

“I used to have face-to-face contact with 80% of my patients. Getting advice to the patient is increasingly difficult as an increasing number of patients are not physically seen by the pharmacist - they have carers, we have delivery services and the distance from the patient - you are relying on the telephone... That’s why it’s important for us to get out and actually do more domiciliary visits.”

**Theme Five: Speculation about the future of pharmacy**

It was evident that the perceived changes to the nature of community pharmacy over recent years would continue and pharmaceutical services would need to continually adapt accordingly. It is from this historical perspective that it was possible not only to consider the negative developments i.e. the dilemma of having to protect their remunerated core activities at the expense of establishing the value of their often non-remunerated advisory role, but also the opportunities afforded by other developments such as the increasing need for vigilance over the supply of ever potent medicines:

“We need to recognise that in the 60s there were only three drugs that did anything and that today there’s an enormous array of potent drugs that do something and the confusion around these complex regimen means there’s a need for an advisor and I find GPs access that and certainly the practice nurses more than the patients. I think the medical profession now realise they can’t know everything in a way they never did. I think the fundamental change over the last 20 years is that GPs will readily accept advice from pharmacists now ...I feel part of the entire team.”

Reflecting the view that pharmacy services are continually developing, one participant considered the recent changes indicated an agenda for change that continues at a breakneck pace:

“It has changed in the last twenty years and the pace of change is exponential...we are on a journey but we have to make sure all the profession is on that journey because things are going to change ...things like robotics...”

Indeed, it was the possibility of increased mechanisation and future technological innovation that figured largely among participants' considerations, and there was an associated recognition that pharmacy as a profession needs to prepare for such eventualities in order to protect its continued existence:

“When the NHS finally gets IT lined up I think there’s a real possibility ...you’ll get the big companies that will have ...warehouses with dispensing robots that will pull prescriptions out electronically ...pharmacists then become an expensive resource ...we are vulnerable to that in five years’ time.”

Though increased mechanisation may pose a threat to pharmacists’ core activities, by undermining their input into the supply chain there was recognition that such developments might potentially work to the advantage of future pharmacists, as portrayed by one participant’s scenario:

“If and when mechanised dispensing comes along what that does for the professional without the shackles of needing to be close to the dispensing operation ...if that is removed physically and operationally from the pharmacy... what that does is unlock some of the potential for what we are aspiring to deliver professionally ..”.

However, in order to realise this potential pharmacists require a major shift in the nature of the services they provide – a shift requiring that they relinquish their primary core supply service to technological systems and in its place capitalise on their skills and knowledge to assist in the safe and effective consumption of prescribed medication:

“The pharmacist will be part of a triage between the patient, the drug and the pharmacist...call it medicines optimisation...supporting the patient to ensure they get the best from that drug is where I see the fundamental way the profession goes forward.”

This brave new world scenario is, however, predicated on pharmacy services being fundamentally redefined:

“We need to reinvent ourselves based on cognitive service not supply. It is the fragile management of that transition that will determine the existence of the profession in something akin to its current format as opposed to de-professionalisation - in 10 to 15 years’ time.”

A somewhat more pessimistic perspective questioned the potential for the very existence of pharmacy in the future:

“...pharmacists require a major shift in the nature of the services they provide - a shift requiring that they relinquish their primary core supply service to technological systems . . .”
"We don’t have a ‘God given right’ to exist. Technology and the world will move around us and we have to make some choices about whether we are going to move with it or attempt to live in the historical past...I think we are at a low ebb at the moment with the fragility of our relationship with the commercial world in terms of the value we add to that particular circumstance and that is only held together by regulation and our dispensing skills. It wouldn’t surprise me if the larger commercial organisations might have a vision of providing drugs without the cost of pharmacists.”

In a similar, although perhaps less pessimistic, vein was the perceived role of large chain pharmacies in shaping the future of community pharmacy – with the supply role being delivered via technology - leaving the pharmacist to focus on ‘cognitive’ services. However, it was broadly agreed that to secure the future of pharmacy in the face of technological changes, there was a pressing need to shape policy. This needs to be done on the basis of quantifying exactly what pharmacists do and offer, together with providing an element of quality assurance of their services which have demonstrable value. However, one participant felt such change would take time:

“... in five years not much will change - five years is optimistic - the contract will change in three years time - elements of quality will come in and I think patient registration will become more prevalent and you will be paid for providing services in the NHS.”

The reorganisation of the Royal Pharmaceutical Society, which separated its regulatory function with the General Pharmaceutical Council from its representative function with the Royal Pharmaceutical Society, was considered potentially instrumental in facilitating such change. What participants did all concur on was the imperative for community pharmacists of the future to develop a distinct identity which extended beyond their core dispensing activities.

Discussion and Conclusion

The findings reported here have obvious limitations - not least because they are based on self-selecting groups of pharmacists and other key stakeholders (GPs, commissioners, patients, etc) were not involved. However, the beliefs and expectations for pharmacy services five years hence have been captured from pharmacists in a variety of positions - including employee pharmacists working within large corporate organisations, locum pharmacists and pharmacists working in primarily management roles. As such, the views have been garnered from individuals with a range of professional experiences and set out a benchmark for strategic development. While the nature of focus groups (and qualitative research) makes no claims to generating generalisable findings, nonetheless the issues illuminated here well may be transferable to other experiences of pharmacists in other geographical regions.

The profession of pharmacy has undergone significant changes, most notably within community pharmacy settings within recent years. These changes might best be characterised as a response to challenges to pharmacists’ core supply function from a number of sources, including other members of the pharmacy team (such as dispensing technicians), technological innovations and so forth. Indeed, these challenges are perceived as on-going for the foreseeable future; challenges which require to be addressed in order for pharmacists to ensure a sustained role in health care. This is a role that will see the pharmacist as a fully integrated member of the healthcare team engaged in collaborative working with healthcare colleagues, rather than that of a practitioner working
in isolation. Other research has noted the isolated working practices and environment of the community pharmacy and is something that, professionally, community pharmacists themselves can do little to alter.

Just as the traditional role of extemporaneous preparation of medicines was challenged by pre-formulated and packaged medicines, so too the dispensing and supply function is being challenged. Hence cognitive services such as MURs and the New Medicines Service were being delivered at the time of our survey, whilst other bodies have a vision for increased clinical and therapeutic services through the pharmacy team in collaborative partnerships with medical practitioners. Our participants acknowledged the need to challenge their own traditional role, perceptions and the traditional business model that accompanies this role. A reliance on the need for a policy change at a national level was key to their view on the future of community pharmacy. This was considered to rest on the successful management of a redefined identity for community pharmacists away from a core dispensing and supply model to one in which pharmacists traded on their expertise and knowledge as medicines advisors, though recent research shows that the dispensing of prescriptions continues to dominate practice despite the desire within the profession for role change. However, as others have identified, one barrier to negotiating a new role is that of supporting the role change while still operating a business model that revolves around the supply role. Other studies have described difficulties and slowness surrounding the undertaking of patient-centred services by community pharmacists.

We have described the views of a small selection of pharmacists as of late 2013, but implementing any change requires other social and health care agencies the general public and policy makers to sign up to the new roles for pharmacists, and to recognise the value - quantifiably and qualitatively - that advice and support for medicines use can offer.

**Declaration of interests**

- This study was funded by an unrestricted educational grant from Pfizer.

"A reliance on the need for a policy change at a national level was key to their view on the future of community pharmacy.”

**REFERENCES**

**Pharmacy Management**

**Forthcoming Events**

### Diary Dates for 2015

#### 8th Academy Workshop Programme

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<tr>
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#### 9th Academy Workshop Programme

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#### Pharmacy Management National Forum: Regional Roadshows

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#### Pharmacy Management National Seminars

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#### Pharmacy Management National Forum Workshop

Right Medicines In The Right Place: Homecare, Out of Hospital Care and Medicines Optimisation - Friday 20 November 2015 at the Radisson Blu Portman Hotel (22 Portman Square, London W1H 7BG)

Further information will be made available in due course. Please make a note of these dates in your diary.

Pharmaceutical companies and others who wish to sponsor any of these events should contact jgriffiths@pmmarketaccess.com.
Supporting Work Placements For Young People With Learning Disabilities Or Autism – A Case Study

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

Summary
This paper:
● indicates what is meant by Corporate Social Responsibility
● outlines the benefits of Corporate Social Responsibility to an employer and to an individual
● summarises the benefits of employing people with learning disabilities
● outlines the experience of a work placement with someone who has learning disabilities
● explains Project Choice and its role in facilitating work experience placements.

Corporate Social Responsibility (CSR)

In recognition of their impact on local or global populations, large organisations often go above and beyond what is required of them by legislators or regulators by supporting schemes which aid social welfare. This is termed Corporate Social Responsibility (or Corporate Citizenship).

As a public organisation of over 6,000 employees and covering a large geographical area (over 2000m²), Northumberland, Tyne and Wear NHS Foundation Trust (NTW) recognises its place in the local communities it serves and undertakes a number of schemes to engage with and support them.

As a mental health and disabilities Trust, NTW has more capacity, capability and responsibility than most to undertake CSR that is aimed at individuals with some form of disability and whose opportunities elsewhere may be limited.

Offering a work placement

Offering a work placement is one of the most accessible ways to engage with the local community and demonstrate a positive attitude to CSR. Offering an opportunity to a young person is not simply an altruistic ‘good thing to do’; they can bring a whole new dimension and dynamic to a workplace with their enthusiasm and different perspective.

In addition, there is an obvious wider social benefit; unemployment, particularly at an early age, not only affects future employment prospects but also results in other social problems such as poverty and ill-health. A work placement can provide a springboard for a young person to make the often difficult transition from school to employment in a measured, controlled and supported environment.

Benefits to the employer
● Risk free trial of a new member of staff.
● Little or no financial cost.
● Development opportunity for mentors.
● Development of supervisory and management skills of a number of staff members.
● Promotes diversity and understanding amongst the wider staff group.
● Enhanced public profile.

Benefits to the individual
● An understanding of the relevance of education in the workplace.
● Introduction to the workplace and opportunities available for career development.
● Developed employability skills.
● Increased self-esteem, confidence, independence and satisfaction.
● Introduction to an adult role model.

Work Placements for people with learning disabilities

Whilst a range of opportunities exist through government backed schemes, charities and advocacy organisations for training programmes for people with learning disabilities, employment opportunities are much harder to come by.

There are 1.5 million people with a learning disability in the UK. People with a learning disability are more excluded from the workplace than any other group of disabled people. Only 10% of people with a learning disability known to social services are currently in paid work,¹ and even then it is often for part-time hours and low pay.

The benefits of employing people with learning disabilities¹
● Some 77% of the public think more highly of organisations that make an extra effort to employ people with a disability. The organisation will be more representative of the community.
● Staff will overcome any misconceptions about learning disabilities by getting to know a colleague with a learning disability.

● Staff are likely to respond well to a more diverse team, particularly if they are given the chance to ‘buddy’ or line manage the person.

● Many people with a learning disability have been excluded from the workplace for a long time and are very keen to work hard. Their enthusiasm can improve team dynamics and overall performance.

● Candidates with a learning disability can undertake, willingly and very well, jobs that are hard to recruit to or tasks that staff struggle to fit in to their workload.

● There is evidence to suggest that employees with a learning disability stay with one employer for a longer time than most other employees and take less time off work.

● By welcoming candidates with a learning disability, employers are accessing a part of the workforce that they may not have reached before and are therefore more likely to recruit the right person to the right job.

The NTW experience

Project Choice (see below) contacted NTW Pharmacy in early 2012 to discuss the possibility of introducing some short-term, unpaid work placements. The Project had experienced success with placements at another pharmacy department in a local hospital (City Hospitals Sunderland NHS Foundation Trust) and had identified that pharmacy was an area that carried out a number of functions to which their students were well matched.

It was agreed that Project Choice would come to the department to present the work that they do to generate some publicity and discuss the sorts of roles the students undertake but also to identify any potential mentors. The resultant presentation was one of the most memorable and uplifting events the department has had the benefit of hosting. As well as the project organisers, four of the students with a range of disabilities who had undertaken placements discussed the roles they had performed and how they had benefitted. All of the pharmacy staff who attended discussed afterwards how uplifting it was to see these incredibly able and confident young people standing up in a room full of people they did not know and discussing their personal experiences so eloquently and with such passion.

From that presentation, a significant number of pharmacy staff members expressed their interest in becoming mentors and the department began working with Project Choice to create suitable work placement opportunities. This involved identifying suitable tasks and roles that contributed to the functioning of the department. It was agreed that a post working into both the dispensary/stores and procurement team would be the most appropriate. There was also a careful selection process...
undertaken by Project Choice to select a suitable student for the workplace, tasks and roles that were to be undertaken.

Jacques Reid (a 19 year old with autism) was selected and came to meet the department. Following lengthy consideration, two mentors were selected; a Pharmacy Dispensing Assistant and a Pharmacy Technician. These two individuals not only had the attributes, attitude and communication skills required, but were also working in the appropriate areas to be able to closely supervise Jacques. The placement was also overseen by the Specialist Pharmacy Technician - Training Manager and the Specialist Pharmacy Technician - Procurement and Informatics.

Jacques started working at NTW in September 2013, initially two days a week with a view to a three month placement. His initial duties were limited to tidying and facing up shelves in the dispensary, topping up bottle/carton stocks and other simple tasks. It quickly became apparent however that not only was he able and competent to complete more demanding tasks, he also benefitted from more varied work.

He progressed quickly on to processing medication returned from wards (assessing them for re-use, disposal, processing all necessary paper and computer work), transferring stocks from stores to dispensary shelves and adding standard warning labels to stock (e.g. ‘date opened’ stickers).

His introduction to the department was supported by all pharmacy staff, and he quickly became another valued member of the team.

His initial placement came to an end in December 2013, however by this time Jacques had made such impressive progress that both he and the department were keen to extend this. In addition, his career ambition was to pursue paid work in pharmacy (rather than a laboratory, which had always been his dream).

He returned to the department in January 2014 and quickly increased to three working days. This then ran until the end of the academic term. His role further developed in line with his confidence and competence to progress to picking stock from stores and raising and issuing picking tickets from the pharmacy computer system. As his confidence grew he provided extremely useful support for both the storekeepers and dispensary staff.

In July 2014 Jacques’ placement with Project Choice came to an end. It was clear, however, that he had more potential to fulfil and whilst the project may have given him employability skills and confidence, he still had untapped ability. Consequently, the Trust supported the department in creating a 12 month apprenticeship position for him. This position allowed him to continue his development in a paid position in an environment he knows and enjoys and with the support of his trusted colleagues. Towards the end of this apprenticeship Jacques was truly ready to enter the world of work and stand proudly on his own two feet. He has now been successful in securing a full-time, fixed-term post as a Pharmacy Assistant.
and others) his growing independence and confidence. The department also has another competent member of staff to support its daily functions and staff have another valued colleague.

“When I first started I didn’t know how I would fit in. Everyone has been great at helping me though and I really enjoy working here. I am really pleased to have a paid apprenticeship because I love my job!” Jacques Reid – Project Choice student/Pharmacy Apprentice

Benefits to the mentors

Jacques’ mentors have rightly taken a phenomenal amount of pride and satisfaction from their work with him. Whilst there have been challenges (see below) it has been a richly rewarding experience and one that will stand them in good stead for supporting other placements and taking on other career challenges in the future.

“Mentoring Jacques has been a great experience. It has been a challenge at times and required patience to explain things in an appropriate manner; however it has allowed me to see my role from a new perspective. Watching Jacques develop from his first day to the way he is now has been so rewarding. He has really grown in confidence and ability. The department has also benefitted - there were a lot of tasks that previously we struggled to keep on top of, now Jacques keeps a close eye on things and he is very thorough and precise.” Pharmacy Dispensing Assistant/Mentor

“Project Choice has given me the opportunity to undertake a mentor role that I have thoroughly enjoyed. This has allowed me to develop and improve my communication skills in such a capacity. From a professional point of view, it has been a privilege to provide support to a new member of our team and to see them flourish and grow in confidence in their role.” Pharmacy Technician/Mentor

Challenges

Welcoming Jacques into the department has been a rewarding process, but it has been challenging at times as well. Whilst the department was keen to support Project Choice, there was some trepidation that the student we received may need more support than we could provide without impacting on operational effectiveness. Whilst there have been times Jacques has needed a significant time investment, notably when preparing to undertake new tasks, this has always been recouped once he is ‘up to speed’ and confident.

When supervising or training any person with learning disabilities, it is vital that their condition is considered since this affects how they are managed. On occasions, Jacques was quick to become frustrated if a solution or course of action was not immediately apparent or if a change of plan was required. It was through the patience and communication skills of his mentors and colleagues that he came to understand how to react to this frustration in a manner which is appropriate for the workplace; this will be one of the key skills he will take away from his time with us.

Project Choice

Project Choice is a scheme established by City Hospitals Sunderland NHS Foundation Trust to provide work based placements for young people (aged 16-24) with learning difficulties or autism. The project is designed to:

1) Work experience

Half a day a week for a six week period (one school term). The students work one-to-one with a mentor to help develop an understanding of work expectations and behaviours. This stage offers young people a variety of personal skills.

2) Internship

The internship programme lasts one academic year and is unpaid. Interns have a named mentor (any member of staff can be a mentor; no qualifications are needed) but aim ultimately to work independently offering a positive supportive introduction to working life. Interns spend 4 days a week in work placement and one day in college undertaking an Edexcel work skills qualification. Interns may undertake up to three placements in the year.

3) Exit strategy

Potential to progress into an apprenticeship, job or further learning supported by existing systems/ agencies. The placements are tailored to meet individual needs and supported by Project Choice staff.

How to support a work placement for an individual with learning disabilities

Although a person with a learning disability may learn more slowly than some people, they will often learn more carefully and may perform tasks...
better than others over time.

- People with a learning disability often need support to learn new tasks or to understand new situations. It may be possible for a team member to provide this support, taking on a ‘buddy’ role until the person has settled in.

- The vast majority of people with a learning disability have little or no experience of paid work and so may lack confidence and need a little extra attention at the start. It is wise to let the team know that a person with a learning disability is joining and make sure that everyone is positive and welcoming.

- People with a learning disability are all individuals with different skills so they will be able to do many different kinds of jobs. However, Mencap offers some general guidelines about the sort of jobs that could most easily be made accessible to people with a learning disability. These include jobs that:
  - require practical skills that can be learned through practice and repetition
  - do not require high-level qualifications
  - do not require a driving licence
  - have fixed elements and only require a little multi-tasking
  - are within teams where tasks can be shared and support can be offered.

- ’Job carving’ often proves helpful in employing people with a learning disability. This comprises identifying different tasks that a person with a learning disability can do, and ‘carving’ out a job from these different tasks. For example, freeing up the receptionist from doing the mail distribution or freeing up the office manager from ‘stuffing’ envelopes and data entry. All of the tasks should be genuine business needs for the employer.

- Once people with a learning disability are confident performing one task, they can go on to learn the next. Once the individual has developed their skills in a number of particular areas, they can then be supported to gain promotion and extend those skills.

**Conclusion**

Offering a work based placement is a rewarding and efficient way of enhancing the makeup and capabilities of the workforce, whilst also providing a valuable opportunity for a young person to demonstrate and develop their skills, confidence and self-esteem. In particular, placements for people with learning disabilities support the people who struggle most to achieve paid employment. This brings benefits not only to the individual involved but also the staff members around them, the employer and the local community and society as a whole.

There are a number of organisations that can offer support to employers wishing to offer work based placements. Details of some of these are listed below:

- **BASE** are a UK network of supported employment agencies. You can find details of all the member organisations on the BASE website. Website: www.base-uk.org.

- **Mencap** offers a range of education and employment services for people with a learning disability through all stages of training and development. There are a number of different services, including Mencap’s supported employment service – Mencap Pathway. This provides employers with potential candidates matched to job requirements, and ongoing support from a job coach. Website: www.mencap.org.uk. Telephone: 01709 830 956.

- **Remploy** can refer disabled candidates to employers. Website: www.reemploi.co.uk. Telephone: 0845 900 0031.

- **Shaw Trust** provide a supported employment service. Website: www.shaw-trust.org.uk Telephone: 01225 716 300.

- **United Response** provide a supported employment service. Website: www.unitedresponse.org.uk Telephone: 020 8246 5200.

**Declaration of interests**

- None.

**Acknowledgements**

- Jacques Reid and his family.

- Lorna Harasymiuk and Stephanie Smith (Project Choice) for their support in developing and maintaining the placements, as well as contributing to this article.

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- Steven Routledge (Specialist Pharmacy Technician – Procurement and Informatics), Caroline Gerrard, Richard Moffat, Tracey Buglass-Burge and the rest of the pharmacy department for supporting Jacques and helping him integrate and become part of the pharmacy team.

- Gayle Hennessy for assisting in developing the apprenticeship scheme in which Jacques enrolled.

**REFERENCES**


Introduction

The following provides an Executive Summary of presentations given at a workshop held in early 2015 with a group of senior pharmacists who had responsibility for the development of medicines optimisation.

The medicines management era was heavily cost driven but the focus of medicines optimisation is on value. Pharmacists are ideally placed to be the healthcare professional with the holistic view of the patient. They can validate whether the number of medicines and interventions to which the patient is exposed is appropriate.

Medicines optimisation was seen to be a driver for innovation.

Medicines optimisation and coordinating the patient treatment pathway

A key challenge is to ensure that the principles of medicines optimisation are fully integrated into guidelines - particularly for long-term conditions. Case studies were presented to demonstrate how each of four principles for medicines optimisation had been used to steer development:

**Principle 1: Aim to understand the patient’s experience**

An Area Prescribing Committee had re-defined the therapeutic pathway for patients with inflammatory bowel disease. The journey from diagnosis through advice and access to specialist care fell short of patient expectations but patients were satisfied with their treatment once they were initiated on a monoclonal antibody.

**Principle 2: Evidence based choice of medicines**

A value-based approach, rather than one based solely on cost, had been shown to result in benefits related to quality/outcome measures and patient experience as well as financial parameters. NICE quality standards are a good reference point and provide a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. An analysis of value assessment in the area of COPD had indicated that the most money is sometimes spent on the least-valuable intervention.

**Principle 3: Ensure medicines use is as safe as possible**

This was considered in the context of multi-morbidities and polypharmacy. Many guidelines, whilst clinically correct, rarely take into account the fact that patients often have co-morbidities. Guidelines often focus on one condition rather than multiple conditions and do not address the ‘whole patient’. For example, if a patient is diabetic and also suffers from depression, HbA1c levels are more likely to be controlled if the mental health problem is appropriately treated.

It is only at the patient level that all guidelines converge.

**Communicating effectively across the interface between secondary care and primary care to improve the use of biologics**

Biologics are responsible for a high level of expenditure within some Clinical Commissioning Groups (CCGs). Implementing recommendations relating to biologics would result in benefits for all stakeholders (e.g. patients, CCGs, Acute Trusts).

From a CCG’s perspective, aspects such as a high-growth rate of expenditure on biologics, NICE guidance and clinician feedback regarding inefficiencies in the current system provide a stimulus guideline development. These factors can be assessed against opportunities for service improvement, the evidence base and ensuring access to cost-effective treatments.

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The over-arching objectives for the development of new guidelines from a CCG perspective are to prioritise patient needs, improve efficiency and deliver on outcomes measures.

The engagement of pharmacists with rheumatologists is pivotal to the development of new guidelines. The aim is to transfer patients from IV to sub-cutaneous formulations of biologics products, if appropriate for the patient. The Acute Trust may lose some direct income from fewer IV infusions within the hospital but the principle of ‘gain-share’ incentivises an Acute Trust to adopt the new guideline and share in the savings achieved by the CCG.

By employing a dual approach of appropriate financial incentives together with effective communication between primary and secondary care, outcomes for patients can be improved.

### Rheumatoid arthritis biologics guidelines - an example of medicines optimisation

NICE guidance supports the use of biological therapies in inflammatory arthritis. Despite the biologic drugs being funded, an acute Trust had no funds available for the infrastructure required to deliver the service and ensure NICE compliance.

The aim of the service redesign was to review all patients being treated with a biologic agent, assess continued benefit, drive implementation of NICE guidance, improve quality of care, identify eligible patients for research and achieve savings. A ‘gain-share’ agreement facilitated the commissioners and providers to work closely together in order to achieve these goals. CCG funding of extended biologic appointments was agreed.

Prioritising patients to ensure they receive the highest standard of care was the overall driver; all patients were to be transferred to a dedicated biologic clinic with one dedicated rheumatology consultant, a biologics pharmacist, a specialist nurse and a trained musculoskeletal ultrasonographer.

In the biologic clinics patients received a longer appointment time to enable education messages to be reinforced, to address patient concerns regarding their disease and to assess co-morbidities (e.g. cardiovascular and fracture risk). In addition to the clinical assessment all patients with peripheral arthritis also undergo musculoskeletal ultrasound of their hands and feet to provide an objective measure of disease activity alongside the more conventional Disease Activity Score (DAS). Non-responders are rapidly identified and switched to more effective and potentially less expensive medications. Each patient assessment is recorded in the biologic database, in addition to the patient’s medication history, smoking and employment status and co-morbidities.

A patient contract was implemented in which patients accepted responsibility for their treatment; if they do not attend a clinic appointment or do not attend to have their blood checked as required, their medication is suspended.

The homecare service was also revised to maximise efficiency; the quantity of drug delivered was reduced to a maximum of one month’s supply, patients were telephoned pre-delivery to check if they actually needed additional drugs and patient training visits were increased to limit waste. Finally, in line with the Hackett report, all of the electronic homecare biologic prescriptions go through the pharmacy department.

The Acute Trust can now access a detailed report of patients currently on biologic therapy, including details of compliance with NICE Guidance, and can provide accurate, quarterly reports to commissioners.

Date prepared: June 2015 Reference: RCUKACTE01204k

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2. NICE TA 130. Adalimumab, etanercept and infliximab for the treatment of rheumatoid arthritis - Includes a review of technology appraisal guidance 36. Published October 2007
3. NICE TA 186. Rheumatoid arthritis - Certolizumab pegol for the treatment of rheumatoid arthritis. Published February 2010
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6. NICE TA 225. Golimumab for the treatment of rheumatoid arthritis after the failure of previous disease-modifying anti-rheumatic drugs. Published June 2011
7. NICE TA 280. Abatacept for treating rheumatoid arthritis after the failure of conventional disease-modifying anti-rheumatic drugs (rapid review of technology appraisal guidance 234). Published April 2013
Prescribing Information RoActemra® (tocilizumab) in Rheumatoid Arthritis (RA): Please refer to RoActemra SPC for full prescribing information.

Indication: RoActemra, in combination with methotrexate (MTX), is indicated for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have either responded inadequately to, or who were intolerant to, previous therapy with one or more disease-modifying anti-rheumatic drugs (DMARDs) or tumour necrosis factor (TNF) antagonists. In these patients, RoActemra can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate. RoActemra has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function when given in combination with MTX.

Dosage and Administration: Patients should be given the Patient Alert Card. IV: 8mg/kg IV infusion given once every 4 weeks. Doses exceeding 800mg per infusion are not recommended. Sub cut: 162mg once every week.

Dose Adjustments: In the event of raised liver enzymes, low absolute neutrophil count (ANC) or low platelet count: IV: reduce dose to 4mg/kg or interrupt. Sub cut: reduce dosing to once every other week or interrupt. RoActemra should not be initiated in patients with ANC count below 2x10^9/L.

Contraindications: Hypersensitivity to any component of the product; active, severe infections.

Precautions: Infections: Cases of serious and sometimes fatal infections have been reported; interrupt therapy until controlled. Caution in patients with recurring/chronic infections, or other conditions which may predispose to infection. Tuberculosis (TB): Screen for and treat latent TB prior to starting therapy. There is a risk of false negative tuberculin skin and interferon-gamma TB blood test results, especially in patients who are severely ill or immunocompromised. Patients should be instructed to seek medical advice if signs/symptoms of a tuberculosis infection occur during or after therapy with RoActemra.

Hypersensitivity reactions: Serious hypersensitivity reactions have been reported and may be more severe and potentially fatal in patients who have experienced hypersensitivity reactions with previous treatment even if they have received premedication with steroids and antihistamines. Appropriate treatment should be available for immediate use if an anaphylaxis occurs during IV treatment. If an anaphylactic reaction or other serious hypersensitivity/serious infusion related reaction occurs, permanently discontinue RoActemra. Hepatic disease/impairment: Use with caution in patients with active hepatic disease/impairment. Transaminase elevations: Not recommended in patients with ALT or AST >5xULN; caution in patients with ALT or AST >1.5xULN. Haematological abnormalities: Caution in patients with platelet count <100x10^3/µL. Continued treatment not recommended in patients with ANC <0.5 x 10^9/L or platelet count <50 x 10^9/L. Lipid parameters: If elevated, follow local guidelines for managing hyperlipidaemia. Vaccinations: Live and live attenuated vaccines should not be given concurrently. Combined with other biologic treatments: Not recommended. Viral reactivation: Has been reported with biologics. Diverticulitis: Caution in patients with a history of intestinal ulceration or diverticulitis. Patients with symptoms of complicated diverticulitis should be evaluated promptly.

Interactions: Patients taking other medicines which are individually adjusted and metabolised via CYP450 3A4, 1A2, or 2C9 should be monitored as doses may need to be increased.

Pregnancy and Lactation: The potential risk for humans is unknown. Should not be used during pregnancy unless clearly necessary. Women should use contraception during and for 3 months after treatment. A decision on whether to continue/discontinue breastfeeding should take into account relative benefits to mother and child.

Undesirable Effects: Prescribers should consult SPC for full details of ADRs. IV: Very common ADRs (> 1/10): URTI, hypercholesterolaemia. Common ADRs (≥ 1/100 to < 1/10): cellulitis, pneumonia, oral herpes simplex, herpes zoster, abdominal pain, mouth ulceration, gastritis, rash, pruritus, urticaria, headache, dizziness, increased hepatic transaminases, increased weight and increased total bilirubin, hypertension, leukopenia, neutropenia, peripheral oedema, hypersensitivity reactions, conjunctivitis, cough, dyspnoea. Medically significant events: Infections: Opportunistic and serious infections have been reported, some serious infections had a fatal outcome. Impaired lung function may increase the risk of developing infections. There have been post-marketing reports of intestinal lung disease, some of which had a fatal outcome. GI perforations: Primarily reported as complications of diverticulitis. Infusion reactions: Clinically significant hypersensitivity reactions requiring treatment discontinuation were reported and were generally observed during the 2nd – 5th infusions. Fatal anaphylaxis has been reported. Other: Decreased neutrophil count, decreased platelet count, hepatic transaminase elevations, lipid parameter increases, very rare cases reports of pancytopenia and Stevens-Johnson Syndrome in the post marketing setting. Sub cut: The safety and immunogenicity was consistent with the known safety profile of IV. Injection site reactions (including erythema, pruritus, pain and haematoma) were mild to moderate in severity.

Legal Category: POM
Presentations and Basic NHS Costs:
IV: (per vial) 80mg in 4mL, £102.40, 200mg in 10mL, £256.00, 400mg in 20mL, £512.00. Sub Cut: (per pack of 4 pre-filled syringes) £913.12.
Marketing Authorisation Numbers:
IV: EU/1/08/492/01 (80mg), EU/1/08/492/03 (200mg), EU/1/08/492/05 (400mg).
Sub Cut: EU/1/08/492/07 (prefilled syringe).
Marketing Authorisation Holder: Roche Registration Limited, 6 Falcon Way, Welwyn Garden City, Herts, AL7 1TW.
RoActemra is a registered trade mark.
Date of Preparation: August 2014 RCUKMED00027

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Adverse events should be reported.

Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Roche Products Ltd. Please contact Roche Drug Safety Centre by emailing welwyn.uk_dsc@roche.com or calling +44(0)1707 367554.

As RoActemra is a biological medicine, healthcare professionals should report adverse reactions by brand name and batch number.

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Background

The primary purpose of pre-registration nurse education is to prepare the future nursing workforce. Nurse education is therefore driven by decisions and predictions about what future health services could and should be like, and the knowledge and skills that nurses will need to meet individual and population needs.

The major factors affecting the health of the population and of individual people include:

- demographic change (ageing population and higher birth rate)
- changing patterns of health and disease
- rising expectations of the public and health service users
- increased access and choice
- the shift to delivery of more care in community settings
- continuing social inequality
- advances in care and treatment
- advances in technology for communications and care.1

These changing needs are reflected in the modification of nursing curricula and programme design. The Nursing and Midwifery Council guidance recommends a community placement in all three years of pre-registration nurse education.2 This has put increased pressure on existing community services (e.g. health visiting and district nursing) and has highlighted the need to continually source and sustain new placements to meet demand. To maximise practice learning opportunities, Higher Education Institutions (HEI) are reviewing their practice placement models so that student nurses can experience a wider variety of community placements.

With the nationally recognised concept for Healthy Living Pharmacies, enabling pharmacies to help reduce health inequalities within the local community by delivering high quality health and well-being services, promoting health and providing proactive health advice, combined with their role of helping to provide better quality and more resilient urgent care, community pharmacies were identified by the HEIs in Leeds as having the potential to be an excellent learning environment for student nurses.

The Pilot

Two pilot studies took place. The first was in March 2014, utilising twenty three community pharmacies (Healthy Living Pharmacies) as two week (six days) practice learning opportunities for twenty-two 3rd year pre-registration nursing students from the University of Leeds. Feedback from the first pilot suggested that the length of the placement should be reduced and the timing of the placement should occur earlier in the education programme. A second pilot took place in November 2014 with twenty-one 2nd year pre-registration nurses and thirteen community pharmacies; placements were reduced to one week (3 days).

Both pharmacists and student nurses were provided with a briefing sheet with suggested learning outcomes and information was provided via face-to-face contact. Pharmacies were happy to participate in the pilot even though there was no funding available to support them.

Findings

Combining the data for both pilots provided a response rate of 77% (34 responses) for the students and 49% (17 responses) for the pharmacies. The responses from the pharmacy evaluation may have been low as many of the pharmacies took part in both pilots and may have already provided an evaluation. As the surveys were anonymous there was no way of verifying this assumption.

Two of the key findings of the pilots related to the students’ knowledge of the role of community pharmacies and the application of this learning to practice.
Knowledge of the role of the community pharmacy

Prior to starting the placement 59% (20) of the students who responded said that they had a thorough understanding of the role of the community pharmacy; this figure increased significantly to 91% (31) by the end of the placement. As two students commented:

“I have experienced the complexities of the community pharmacy, how they manage medicines for people and how they use concordance aids. Also their partnerships/communication with linking surgeries. Delivery systems. Ordering prescriptions. Health promotion projects: new medicines service, medication reviews, diabetes reviews, skin reviews, BP monitoring, smoking cessation programs, minor ailments schemes, home visits and more. I did not realise the breadth of their services.”

“I did not know about some of the additional services they provided such as prescribing particular medications without a prescription from the doctor.”

A small minority of students (3) commented that they did not feel that the placement added any value.

Application of learning to practice

When the students were asked how this knowledge would be applied to practice they identified that it would help them in terms of making appropriate referral of patients to the community pharmacist, discharge planning, gaining support from the community pharmacist for themselves, greater knowledge of pharmacology, medicines reviews, health promotion advice and multidisciplinary team working.

This greater understanding of each other’s roles and responsibilities provides the potential for closer collaboration and integration between the different professions, leading to being better able to support self-care and the ability to deliver care closer to home. Effective collaboration has been shown to create teams that work together better and improve patient experience.

Wider learning

The majority of respondents felt that the ideal length of placement should be for a day, dependent upon the student’s individual needs. This flexibility could be built in if the placement was part of a wider community placement where their learning needs could be assessed and the placement learning opportunity utilised appropriately.

Between pilots there was a noteworthy changeover of personnel in the pharmacies, which meant that a significant amount of time was invested in briefing new staff. This would not be an easily sustainable model for the future.

Next steps

Be proactive and consider approaching your local HEI, district nurse or practice nurse to explore your options and consider offering a practice learning experience as part of a wider community placement.

REFERENCES


Is Our South East London Area Prescribing Committee Working To Best Practice, Or Could We Be Even Better?

Vanessa Burgess, Assistant Director, Medicines & LTCs, NHS Lambeth Clinical Commissioning Group; Devika Sennik, Area Prescribing Committee Pharmacist, Lambeth Clinical Commissioning Group/Senior Pharmaceutical Advisor, Medicines Optimisation Team, NHS Southwark Clinical Commissioning Group

Email: vanessa.burgess@nhs.net

Summary

This paper:
- outlines our collaborative partnership across all local stakeholders
- describes the formal annual work plan
- summarises our funded resources that are available to support the groups
- offers our model of a safe, consistent approach to medicines use in South East London
- seeks view on whether the model could be improved.

Introduction

As in all health communities, there has been considerable change in the NHS in South East London (SEL) in recent years, but alongside the transformation of services there remains the need to continually ensure medicine use is both clinically and cost effective. The primary care spend on medicines across the six boroughs in SEL is approximately £200m, with an estimated additional Clinical Commissioning Group (CCG) cost of approximately £17m for high cost drugs (i.e. ‘Payment by Results’ excluded drugs) for 2015/16.

At times of reorganisation, personnel move on, often taking with them organisational memory. The SEL Area Prescribing Committee (APC) ensures that there is an ongoing consistency for decision making at times of such change. It is the result of a commitment from all CCG clinicians and medicines optimisation teams, as well as from colleagues in provider organisations, to ensure medicine use remains safe and consistent across the area covered, despite the significant changes in the NHS locally. Attendance at all meetings is good and clinicians have prioritised their involvement. The SEL APC aims to provide a consistent, high quality approach to clinical decision making about medicines across the local health economy.

The aim of this article is to explain our current SEL APC model and to understand if we are providing and implementing best practice for our patients and clinicians, compared to other APCs across the country. Pharmacy Management have offered to assist in this by conducting a survey of local APC arrangements and disseminating the outcomes so that additional ideas can be incorporated as appropriate at a local level. The outcomes from the survey could also contribute to a new document showcasing current best practice for APCs.

The South East London Area Prescribing Committee

This was established in February 2013. It is a forum where each CCG, Acute Trust and Mental Health Trust in SEL has signed up to jointly discuss and agree pertinent medicines issues. The Committee represents a partnership of NHS organisations involving six CCGs, three Acute Trusts and two Mental Health Trusts in SEL, with a nominated Lead Clinician and Lead Chief Officer identified from within the SEL CCGs.

There are strong links with the Health Innovation Network (South London) to support work in the medicines elements of diabetes.

Support and leadership from the Chairs and Vice-Chairs and the Chief
The APC is a partnership of local organisations

Officer (from a variety of SEL organisations) has been invaluable. Although membership of the committee is large and varied, commitment to making it successful is high across both commissioners and providers. Many members describe their enjoyment at participating in the APC. GPs are positive about the outputs of the APC, reporting that it offers consistency and reduces inappropriate requests.

The Committee has the following remit:

- To provide a collective clinical leadership committee to ensure cooperation and consistency of approach to medicines optimisation across SEL.
- To enable clinicians, providers and commissioners to work together to ensure that patients have safe and consistent access to medicines in the context of care pathways which cross multiple providers.
- To advise on implementation of best practice around medicines, including NICE guidelines and technology appraisals, to encourage rapid and consistent implementation.
- To enable local NHS stakeholders and clinicians to exert a population approach to the prioritisation, improvement and development of healthcare delivery related to medicines.

The SEL APC uses a prioritisation approach, taking account of the financial position of its constituent organisations, when considering any new application that is outside of the NICE Technology Appraisal (TA) process. Any decision for change from the APC needs consideration of where funding will be found; this may be from new money, the need to disinvest or a change to the current pathway.

National guidance on APCs

In 2000, the National Prescribing Centre produced a document entitled ‘Area Prescribing Committees - maintaining effectiveness in the modern NHS’ but, with the national NHS transformation, this is no longer current or readily available.

In 2003, following another NHS reorganisation, an article was published in the Pharmaceutical Journal, in which the author asked: ‘Area Prescribing Committees - what is their role in the new NHS?’ He went on to discuss how one APC was adapting to the changing National Health Service, similar to what the SEL APC describes here.

In 2012, NICE published ‘Developing and updating local formularies (MPG1)’ which provides good practice recommendations for the systems and
processes needed to ensure that NHS organisations develop and update local formularies effectively and in accordance with statutory requirements.\(^2\) This goes some way to advising on the membership, governance and outputs of an APC.

The remit of our SEL APC is far wider than just formulary inclusion. Along with clinical effectiveness, we also consider funding, commissioning of both drugs and services and the overall budgetary impact across our whole health economy.

Current SEL Prescribing Committees

In SEL we have two main committees - the APC and New Drugs Panel (NDP). These are supported by a set of time-limited subcommittees, together with other prescribing groups.

Area Prescribing Committee (APC)

This strategic committee meets every 12 weeks. It reports and is accountable to the SEL Commissioning Strategy Committee (CSC). It is advisory to the SEL CCGs, who have agreed inclusion of its recommendations into the SEL collaborative commissioning agreement, which will uphold the APC recommendations, unless very exceptional circumstances prevail.

The committee has Terms of Reference (ToR) which are reviewed, agreed and updated annually and presented as part of the APC Annual Report to the SEL (CSC). These ToR set out the governance and remit of the SEL APC (including the NDP, see below). The ToR are included in the SEL collaborative commissioning agreement.

Our APC continually reviews its decision making processes based on the DH guiding principles and best practice as defined by NICE.

The APC is the single point of entry for new medicines or new indications for medicines (i.e. not devices or interventions) in all the following situations where:

- the cost impact assessment (including both medicines and activity costs) is likely to be significant to our local health economy
- the intervention is likely to have a high impact for the needs of the population
- a major change in the care pathway or model of care is required
- there is likely to be a high risk of challenge to decision making and a SEL wide approach would reduce this risk.

The APC also advises on best adoption and implementation in line with NICE where primary care or commissioned medicines are subject to a new NICE technology appraisal.

Core membership and partner organisations

Nominated representatives are responsible for ensuring two way reporting, implementation and feedback to the APC via relevant committees such as the Drugs and Therapeutics Committees in the member organisations.

The Chair of the SEL APC is currently a CCG chair (GP) and is nominated by the CSC; the tenure of the Chair is two years with the possibility of a further two years.

A Chief Officer, who is a manager not a clinician, regularly attends meetings, broadening the discussions but also closing protracted deliberations thus ensuring that the meetings remain focussed. He brings a different dimension compared to the clinicians and provides a valuable link to other SEL work (e.g. health innovation and transformation work), which otherwise may not be apparent to the members.

Each of the partnership organisations nominates one GP/Consultant and one Pharmacist member; a consultant in Public Health and the Director of Medicines Information from Guy’s and St Thomas’ NHS Foundation Trust (GSTT) complete our core membership. The CCG Chief Pharmacists have regular teleconferences; it is their responsibility to ensure we have a collaborative APC.

Each member is the representative of a ‘constituency’ (e.g. organisation) and is accountable to the constituency for ensuring that their representation reflects their view. Members are responsible for ensuring representation - if they cannot attend a deputy must be arranged or comments given to the Chair in advance of the meeting. An attendance rate of below 50% is flagged to the Chair for consideration of any action to be taken.

Any potential conflicts of interest are declared and recorded. A report is made available for public scrutiny. In the case of committee members, if appropriate, they may be asked to leave the room during the decision making process if a potential conflict of interest arises.

Where appropriate the committee invites and actively seeks the views of appropriate consultant and/or service leads for specific issues in order that decisions are made with full acknowledgement of specialist expertise and reflect the need of the local health economy.

Engagement with clinical groups and networks, especially if a formulary decision needs specific knowledge and expertise or has direct implications for a clinical practice area, is undertaken as required with:

- patients or patient representative groups e.g. for our diabetes and inflammatory bowel disease pathways
- local people and communities
- local clinical specialists
- relevant manufacturers of medicines, for example, when the company can offer additional evidence and insight that can assist with decision-making
- other relevant decision-making groups.

It is ensured that stakeholder engagement is proportionate to the type of decision being made and the medicine being considered.
The SEL APC is fortunate to have local input and membership from the Regional Medicines Information Centre, based at GSTT, which is one of the core member Trusts. They provide active support to the APC’s horizon scanning, NICE implementation and the NDP new medicines evaluation processes.

In attendance at our APC

The following are in attendance:

- NHS England (NHSE) London Area Team has membership of the Committee to provide communication and alignment on the management of the specialist drugs they commission. Attendance has been challenging, due to their small team, but with the recent recruitment of an embedded Medicines Optimisation Pharmacist it is hoped this will be addressed going forwards.
- South East London Commissioning Support Unit (CSU)
- Specialised commissioning, NHSE
- Consultant Pharmacist, cardiovascular disease
- A Community Pharmacist, nominated by South London Local Education and Training Board (LETB)
- A Lay Member nominated by Healthwatch, the consumer champion for health and social care.

Other key relationships

These are:

- CCG Medicines Management Committees (formal receipt of minutes)
- Provider Trust Drug and Therapeutics Committees and Formulary Committees (formal receipt of minutes)
- Community Health Services in SEL
- Other London APCs
- SEL Individual Funding request (IFR) Panels.
- Local Medical Committee (LMCs)
- Local Pharmaceutical Committees (LPCs)

APC Resources

The SEL APC resources and leadership required across the partner organisations are reviewed on a regular basis by our member organisations, with the SEL CSC retaining oversight.

All six CCGs in SEL contribute to 0.4WTE business management and 0.4WTE pharmacist leadership and support time for the APC; these roles are hosted by Lambeth CCG. The pharmacist is currently seconded from one of the Acute Trusts.

Electronic papers are distributed to the members seven days before each meeting. Minutes and outputs of the Committee are published to the APC website; this is hosted by Lambeth CCG. All SEL APC partner organisations either already signpost or have committed to signposting users of their websites to the SEL APC website.

All of our member CCGs have signed up to sharing the workload of delivering and leading pieces of work on behalf of the SEL APC; this ensures every partner CCG is fully engaged in the APC’s work. The SEL APC work plan ensures engagement and leadership opportunities for all of our CCGs on a rolling basis. For each work area one CCG is designated as the lead CCG and is then responsible for ensuring the agreed timescales are achieved. A supporting CCG is also identified. An update on progress against the work plan is noted as a standing item on each APC agenda. Our work plan is divided into broad pathway reviews and narrower therapeutic or project areas.

Outputs of the SEL APC in 2014/2015

- Reviewed, consulted on and approved 17 guidelines/pathways.
- Consulted on, agreed and published a red list for SEL (drugs suitable for hospital only prescribing).
- Reviewed, consulted on and approved four shared care/transfer of care guidelines.
- Received and resolved one appeal against a ‘grey’ (not for prescribing) decision.
- Regularly forward planned for NICE technology appraisals.
- Withdrew one shared care guideline following publication of NICE clinical guideline not supporting the treatment.
- Undertook a horizon scanning exercise with SEL Trusts to assist with planning for the APCs 2015/16 work plan.
- Consulted on, agreed and issued a position statement on the commissioning of the biosimilar infliximab.
- The SEL APC co-ordinated a response on behalf of six SEL CCGs to a national campaign, led by NHS Clinical Commissioners, seeking support for a national solution to the use of unlicensed intravitreal bevacizumab for wet age-related macular degeneration. The process used to reach a consensus decision across SEL to support the campaign demonstrated just how well engaged SEL APC members are.
- The NDP considered and made decisions for 18 new medicine submissions and issued 17 recommendations for these medicines, with only one deferred. Of the 18 submissions, approximately 80% resulted in recommendations for approval (categorised as either red or amber or green).
New Drugs Panel
The NDP meets every four weeks as an active working group of the APC. It provides a strong focus on quality and prioritisation and reporting to and advising the APC on the entry of new medicines into our local health economy, in line with the principles outlined in the APC ToR. The Panel assesses new medicines for prescribing within SEL where these are intended to be prescribed in primary care or commissioned by CCGs. NDP recommendations require ratification by the APC; this is usually via Chair’s action when a full consensus has been reached; otherwise (or if a decision is likely to have significant implications) a full circulation to the APC for ratification is undertaken.

The NDP has Joint Chairs - a CCG GP Lead and a Trust Consultant, who are recruited from the membership of the APC.

The NDP liaises closely with the local Acute Trust Joint Formulary Committee via its membership.

The NDP is supported by Formulary Pharmacists in the member Acute and Mental Health Trusts, member CCG Medicines Management Teams and GSTfT Medicines Information, who provide triage and horizon scanning.

APC Subcommittees
Pathway Groups
These take between 6-12 months to fully develop a pathway, ensuring all stakeholders are involved. An example completed in 14/15 is the Inflammatory Bowel Disease (IBD) pathway group. This was a short-life working group of the APC, which brought together key stakeholders across SEL to develop comprehensive disease management pathways for IBD (Crohn’s disease and ulcerative colitis). The pathways cover the treatment of IBD from diagnosis to the use of the more complex biologic agents.

The final pathways are an example of real clinical commitment and engagement with all partners working together to achieve consistency and improve the patient experience. As part of the development process, the working group held a valuable and successful patient engagement event to identify where in the pathway quality improvements could be made. A second event is being planned to present the finalised pathway to patients.

This work resulted in a potential increase in cost (~£158K/100,000 population) relating to two recommendations arising from the IBD biologics pathway. However, these costs have been offset locally by efficiencies in the pathway such as the use of dose banding, dose optimisation and cost effective choices of medicines across the pathway. Contract monitoring will be agreed with the Trusts and implemented for this pathway with support from the SEL CSU.

The rheumatology pathway group is about to be reconvened in anticipation of the NICE MTA publication in 2015.

Task and Finish Groups
These work to a set timetable.

A number of cardiovascular guidelines were approved by the SEL APC in 2014/15. These were co-ordinated by the Consultant Cardiovascular Pharmacist for South London and provide common guidance across SEL for a number of indications, including:
- a position statement on stroke prevention in atrial fibrillation
- an algorithm to guide choice of novel anticoagulant agents for stroke prevention in AF
- a summary of the available antiplatelet options in cardiovascular disease
- guidance for managing uncomplicated hypertension.

Other prescribing groups
Trust Prescribing Committees
The local Trusts retain a Joint Formulary Committee which considers new drugs and changes of use of existing drugs which are used only within hospitals and are not subject to any specific commissioning arrangements. Individual Trusts also maintain Drug and Therapeutics Committees/Prescribing Committees within their organisations.

Borough Committees
These six committees consider local CCG priority items and most have Local Authority and Community Pharmacy membership; these do not formally work collaboratively but aim to avoid postcode prescribing and APC minutes are ratified by these committees.

Work Plan for the SEL APC and its subcommittees
The APC develops a work plan with specific objectives which is reviewed regularly and formally on a 12 monthly basis; this assesses the outputs of the APC against the benefits identified during a scoping exercise we undertook in 2012, which were:

“The NDP . . . provides a strong focus on quality and prioritisation . . . advising the APC on the entry of new medicines into our local health economy . . .”
an ability to assess medicines use across the whole care pathway and move beyond a simple assessment of one drug against another

- a forum where a decision can be made about appropriateness of prescribing in different settings so that prescribing can take place in the right place. Shared care guidelines would be included in this

- the costs of medicines can be assessed as part of the managed entry process, which can also incorporate a local reality check on NICE drugs and possible phased implementation of new medicines

- the APC would be able to work in the ‘grey areas’ i.e. clinical consensus can be gained where there may not be strong evidence for a medicine or there is a complex risk vs. benefits balance to be struck

- reduce bureaucracy associated with management of Payment by Results excluded (PBRe) drugs and IFRs

- transparency of Quality, Innovation, Productivity and Prevention (QIPP) savings – the APC could be explicit about potential shifts between medicines spend and subsequent investment or disinvestment in services/activity

- mapping of local need – using public health expertise we would be able to determine likely uptake of national guidelines locally and prioritise based on our local population

- consistency of access to medicines - we would enable Trusts to ensure consistency between clinicians in prescribing or recommendations to GPs to prescribe

- forecasting local spend on drugs and potential QIPP initiatives (using our local Medicines Information expertise to distil national horizon scanning information)

- management of new drugs or indications ‘pre-NICE’ and implementation planning

- monitoring of usage data and spend on medicines – highlighting where local uptake is higher or lower than expected.

What is the SEL APC planning for 15/16?

As part of the drug service development process for 2015/16, the APC requested local Trusts to submit horizon scanning requests for anticipated new medicines using an agreed template. Based on this exercise, the 2015/16 forecast cost pressures for SEL CCGs are likely to be around £1.3 million across SEL, although there are many large caveats on these costings and they exclude the impact from NICE technology appraisal guidance anticipated in year.

There is a section within the work plan to support the development of the APC around collaborative working to ensure that all constituent groups are given full opportunity to be aware of and be involved in pathway/therapeutic area developments.

The SEL APC has identified the following key priority areas for 2015/16:

- Continuing to manage the introduction of new medicines into our local health economy – including formulary submissions and horizon scanning.

- Development and implementation of a SEL Respiratory Prescribing Group to inform the APCs decision making process around respiratory medicines

- Improved collaborative working around the medicines optimisation mental health agenda.

- To continue to progress expert patient involvement and engagement in decision making around pathway development.

Appeals Process

Our APC received its first appeal in 2014, offering us an opportunity to review our methodology. It was resolved through a ‘resubmission with further information’ process rather than a formal appeal. The appeal resulted in some important learning for our Committee:

- The ToR for the SEL APC have now been updated to include grounds for appealing against decisions made by the Committee.

- The outcome letters that are sent to applicants following a new drug submission now detail the grounds for appeal and who these should be directed to.

ToRs have been developed for the appeals panel by the secretariat of the SEL Clinical Strategy Committee (CSC). The appeal panel will be supported to discharge its responsibilities administratively by the secretariat of the SEL CSC.

Any appeals against APC decisions should be directed to the CSC Chair. Appeal requests must be submitted in writing to the chair of the CSC within 30 days of the date of the decision. The appeals process gives applicants the right to appeal an APC decision if they feel that the process leading to the decision being made was not followed correctly. The Appeal Panel does not consider whether the decision was clinically right or wrong and cannot change the assessment criteria agreed by all six SEL CCGs. There are three grounds for appeal that can be considered:

- Illegality: the refusal of the request was not an option that could lawfully have been taken by the APC.

- Procedural impropriety: there were substantial and/or serious procedural errors in the way in which the process of reaching a decision was conducted.

- Irrationality: the decision was irrational in light of the information available to the Committee e.g.

  - There were any material shortcomings in the consideration of the request.
  - There was consideration of relevant factors only and no irrelevant factors.
The decision was not reasonable taking into account all the available information and evidence.

The appeal panel will assess if the APC has followed its own processes accurately. The results of the appeal will be communicated directly to the appealing clinician and the APC who will review the decision if required. The review panel will be set up by the SEL secretariat of the CSC as required.

Proactive reviews of the APCs decision making processes will be carried out on an annual basis via scrutiny of individual examples.

Weakness/Challenges

Although we feel our SEL model has lots to offer, there is no national document to guide practice. It is difficult to understand if we are covering everything other APCs do. We would like to understand what other healthcare communities provide locally so that we could add to our work to improve our process.

Not all participants attend our meetings on a regular basis; we are currently exploring the use of teleconferencing facilities to understand if this would encourage attendance or promote agreement to become a member of one of the groups.

GPs can request a new addition to the Formulary, but this is very uncommon.

Lay/patient/public members are currently recruited from Healthwatch - is there an alternative?

How do we keep all participants involved e.g. Mental Health and the smaller Acute Trust?

There is a place on the committee for a nominated Community Pharmacist, but currently there is no member - how do we get engagement from this sector?

Bordering CCGs - we know there are inconsistencies which could result in postcode prescribing.

We do not provide training for our members but this may be particularly useful for lay/patient members.

Are the recommendations and guidelines we develop helpful and are they being used? We have developed a local survey which will hopefully provide an answer.

Succession planning for members and Chairs needs to be more robust.

What next?

The benefits of the local Primary Care investment in a Consultant Cardiovascular Pharmacist are evident from the outputs achieved in this therapeutic area. The appointment to a Consultant Respiratory Pharmacist post will allow similar achievements going forwards and the recent work to develop a diabetes post should provide similar benefits.

Our SEL APC is dynamic and continuously evolving to support the needs of an ever changing NHS, but we would welcome constructive comments on how we can make it even better and some help with the weaknesses/challenges we have identified.

We have developed a local survey to send to committee members and other interested parties to understand their opinions of the current SEL APC and how we can make it better. It is hoped to publish the results and to use it to benchmark with other APCs.

It is intended to participate in the proposed Pharmacy Management survey to understand the national picture for APCs and to determine how they might have changed since 2013 and development of an updated document to demonstrate what makes an effective APC.

Declaration of interests

● None

Acknowledgment

We would like to acknowledge the work of Kath Mcpherson, Area Prescribing Committee Support Officer/Medicines Optimisation Intelligence Officer, for the collation of data to support the article, Val Shaw for her assistance in preparing the article and committee members/chairs for their support.

REFERENCES


“We would like to understand what other healthcare communities provide locally so that we could add to our work to improve our process.”
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Do you have a colleague who has moved on to another organisation?

If so, please let us know or pass this to them so they can let us have their contact details.
**Question:**
What is your job title?

**Answer:**
Medicine Management Facilitator

**What qualifications/experiences are required for the role?**
None. The expectation is that practices will promote receptionist or administrative staff who would be suitable for the role. The CCG provides supportive training and the scope of the role is expanded as the post holder gains experience.

**What are your main responsibilities/duties?**
These are to:
- Liaise with partners, practice managers and health professionals to develop and implement systems and protocols to improve safety, quality and reduce waste
- Liaise with other organisations and agencies across Mid Mersey involved with Medicine Management, including Commissioning Support Services (CSS) teams, private organisations, CCG leads, etc
- Supervise and train practice staff dealing in medicine management systems, making best use of their skills e.g. repeat prescribing
- Promote better use of medicines by developing and improving patient information
- Collect monthly data to monitor improvements in line with core medicine management objectives
- Conduct patient surveys to measure and improve patient satisfaction
- Encourage joint working and facilitate the integration of all staff towards common practice prescribing aims
- Keep abreast of all medicine management issues and ensure practice protocols are updated
- Help the practice prescribing team in the implementation of formularies and treatment guidelines
- Assist in the medicine management audit process at practice and CCG level
- Act as the main point of contact for community pharmacies
- Manage discharge letters from secondary care, with particular attention to changes in medication following inpatient stay (and escalating as appropriate to the appropriate GP).

**To whom do you report and where does the post fit in the management structure?**
I report to the Practice Manager for administrative issues and the General Practitioners for medication issues.

**How is the post funded and is it on a non-recurring or recurring basis?**
The post is funded by the practice on a recurring basis.

**When was the post first established?**
The post was first established in 2012 with training support from Interface Clinical Systems, a private provider of medicine management solutions.

**Are you the first post holder? If not, how long have you been in post?**
I am the first post holder and was the first in Liverpool to hold this role. I am still undertaking the role and have been doing so for the past 2.5 years.

**What were the main drivers for the establishment of the post and how did it come about?**
To enhance patient safety, quality and reduce waste.
What have been the main difficulties in establishing/developing the post to its current level?
Re-educating pharmacists and patients to promote better use of medicines and pharmaceutical companies in all aspects of ordering and monitoring of medication.

What have been the main achievements/successes of the post?
The main achievements of this post are improvements made to enhance patient safety. Also, a great deal of cost saving has been achieved.

What are the main challenges/priorities for future development within the post which you currently face?
The main priorities within this job role are to further improve patient safety and to further reduce waste.

What are the key competencies required to do the post and what options are available for training?
In-house training is a good opportunity and is available to staff who require learning this role. As part of this job role, staff training is regularly provided to keep knowledge and skills updated.

How does the post fit with general career development opportunities within the profession?
It is a good grounding to becoming a pharmacy technician. A three level Medicines Management/Medicines Optimisation model operates locally. Pharmacists undertake clinical medication reviews on complex patients with multiple morbidity, technicians conduct audit, systems and process work and single therapy medicines reviews and my role as Medicines Management Facilitator involves running the prescribing system in the practice. I resolve process issues and bring clinical/risk issues to the attention of the GP or Medicines Management team for resolution.

How do you think the post might be developed in the future?
I think this post will be rolled out across practices and into other neighbourhoods. The CCG would like such roles to be in place 5 days a week i.e. at the time prescribing happens. It doesn’t need to be full-time in smaller practices, but does need to be every day. There is the potential for several people to provide the service across several practices, being employed through the GP federation model rather than by a single practice.

What messages would you give to others who might be establishing/developing a similar post?
My advice would be that this job role is very rewarding and is of great benefit to the practice and its patients.

Potential for the role is more important than qualifications or experience
MANAGEMENT CONUNDRUM

Grasping The Nettle Of Independent Prescribing

Janet Donit, Chief Pharmacist at Metropolis NHS Trust, Carey Whitecoat, Head of Medicines Optimisation at Riverdale Primary Care Organisation (PCO) (PCO) and Mr Silver, who represents Community Pharmacists in the PCO, were having one of their regular, quarterly meetings to discuss issues of mutual interest.

“It would be good to have more Community Pharmacists who are Independent Prescribers”, said Mr Silver. “They could do a lot more in minor ailments and urgent care.”

“You’re not wrong,” interjected Janet, “but I’d like to see Independent Prescribing pharmacists working across the interface. They could facilitate the flow of patients out of hospital. It would be good if they could target complex patients and frequent flyers and sort out their prescribing needs a bit more.”

“The problem is”, said Carey, “that we already have people qualified as Independent Prescribers but they have really just dabbled at the edge and are not embedded in the service in any sustainable way. It really is difficult to make a case for funding, at least from the PCO, to support the development of Independent Prescribing.”

“Isn’t that just it,” said Mr Silver who was warming to his theme. “There doesn’t seem to be any clear strategy about where Independent Prescribers fit and how many would be needed. Universities are ploughing on with courses that pharmacists are taking under their own steam but it then all comes to a dead halt!”

“That’s right,” said Janet, “there is a huge potential here but we’re not tapping it properly. We do a little bit here and a little bit there but never really get to grips with things. We really need to grasp the nettle .”

“That’s something we can all agree on,” said Carey, “but what are we going to do about it?”

What advice would you give?

Commentaries

Graham Brack,
Pharmaceutical Adviser,
NHS Kernow Clinical Commissioning Group
Email: graham.brack1@nhs.net

I qualified as an independent prescriber in 2007. We still have not identified a budget and governance structure that will allow me to undertake the work that was originally envisaged!

That is a shame because community pharmacists have a lot to offer as independent prescribers. There is a school of thought, as championed by a speaker at a Pharmacy Management National Seminar, that doctors should diagnose and agree the drugs to be used, but that the dose titration and ongoing management should be in the hands of community pharmacists, freeing the GP to concentrate on more difficult cases. There are several examples of pharmacists who play a full part in medicines optimisation within practices, and recent encouragement to practices to employ pharmacists to improve their prescribing. All these are welcome, but as Janet notes there has been a failure to get to grips with independent pharmacist prescribing. Why is this?

First, some commissioners have had poor experiences of pharmacists operating (or failing to operate) services under Patient Group Directions. Too many pharmacies have not been able to ensure continuity of service and these commissioners say that if pharmacists cannot deliver under PGD, how could they possibly offer a reliable prescribing service? In fact, in one respect pharmacist prescribing gets over this problem. The barrier has usually been the result of a failure to accredit staff, but independent prescriber status avoids this need for accreditation – and it is national, rather than local. If every community pharmacist were to be an independent prescriber, we would not need the raft of PGDs that currently underpin services (and require accreditation processes).

Second, the old approach has usually been to specify services first, then think about how you might provide them. That will never justify the time and expense of developing independent prescribing.
Janet and Mr Silver both have ideas about how both have ideas about how independent prescribers could be used. If there were a pool of such prescribers, a large number of opportunities would present themselves – and NHS managers would save a lot of time currently spent writing PGDs and collecting accreditations.

I would suggest that they convene a meeting of interested parties to agree a plan to develop all pharmacists as independent prescribers within a challenging timeframe – perhaps three years. Community pharmacists cannot expect commissioners to meet the costs of doing this – those who seek work should equip themselves to take on that work – but there must be a commitment to commissioning services that will justify the expenditure involved. A plan to convert existing PGD-based services to prescriber services will be a start, but that involves no new income, so the meeting should be looking at all the possibilities. These will need costing, but if the considerable training costs do not need to be considered it is likely that a substantial number of patient-centred services could be offered within community pharmacy, and the PCO could have confidence that they would be delivered consistently.

A PCO that took a bold approach could negotiate with its local higher education partners to deliver training at a keen price, because currently HEIs do not know whether their next course will involve 5 or 55. An LPC that matched that boldness by persuading members to invest on the expectation of future commissioning would remove one of the big barriers. But as Janet notes, you cannot do a bit here and a bit there. Develop a big vision for the future, then think how you can get there.

“There are several examples of pharmacists who play a full part in medicines optimisation within practices, and recent encouragement to practices to employ pharmacists to improve their prescribing.”
roles are aligned to the delivery of local priorities and are clearly identified.

The three colleagues need to identify the specific needs and priorities of their organisations or local health economy that can be met by the deployment of their pharmacist independent prescribers. New independent prescriber roles need to be embedded and integrated with existing or new services to be sustainable.

The opportunities vary between settings; these could focus on a therapeutic area such as pain management, a chronic disease such as COPD or a generalist approach e.g. ‘in’ or ‘out’-of-hours services to support access to medicines, medicines optimisation or polypharmacy. Patients could be seen at home, in a care setting, at a hospital or at a GP surgery; or could be managed carefully across organisational boundaries. Where are the current work force gaps?

What is both necessary and achievable? Who will pay for, or commission, these services? It is necessary to consider some practicalities such as access to prescriptions or the patient’s record, using consulting rooms and who will book appointments and follow up patients when this is required.

There must be a clear governance and accountability framework in place for the independent prescribers to ensure they operate within clinical governance and financial parameters. There must a clear understanding of how the role fits with the roles of other pharmacists and the colleagues within the service in which they are working.

Currently, the number of independent prescribers is small and they have qualified with a competency in a defined disease area. They are not currently sufficient in numbers to deploy widely. To demonstrate success and embed these roles for the future, colleagues should evaluate the outcomes of using independent prescribers and should share their successes.

Declaration of interests

Graham Brack
- Professional Adviser to Pharmacy Management
- Member of the Editorial Board for the Pharmacy Management Journal
- Managing Director of Michael Meagher Ltd
- Director, TMS Pharmacy Ltd.

Anne Sprackling
- Member of the Editorial Board for the Pharmacy Management Journal

“New independent prescriber roles need to be embedded and integrated with existing or new services to be sustainable.”
LEADERSHIP

Do Not Forget To Feed Your Chimp!

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.

Have you ever ‘lost it’ in the workplace? A colleague or manager says or does something and that red mist descends over you. You then say or do something that you later regret but, at the time, it is almost like you have become a different person, someone who you don’t recognise as being yourself and certainly someone your colleagues will not recognise.

If you can relate to the above, there’s a good chance that in such a situation your chimp took over! The Chimp Paradox is a best selling book and self-management principle by Dr Steve Peters. Such eminent figures as Steven Gerrard and Sir Chris Hoy credit Peters and his theory for a huge part in their success. They have both worked with him at an individual level and, in 2015, Roy Hodgson famously invited Peters to work with the England squad.

In his book, Dr Peters talks about the fact that our brains can be divided into distinct regions:

- the limbic or ‘Chimp’ region that controls our emotions and provides emotional responses to the external world
- the human region that seeks to rationalise our experiences in the external world
- the computer region, which seeks to run systems and processes that simplify our lives by effectively automating our responses to certain situations based on how we responded to those situations previously.

In reality, chimps are very aggressive animals. They are faster and stronger than humans - and so it is with our brains. If we allow our chimp to take over, it will wreak havoc as its responses are primal, emotional and irrational. In the wild, chimps are concerned with two main things - survival and propagation of the species. Our ‘inner chimp’ gives us defence mechanisms that are essential, but not always necessary. Herein lies the paradox; we need our chimp, but only some of the time.

How do you know when your chimp is in charge?

Ask yourself the following questions when dealing with people or situations that make you feel uncomfortable:

- Do I want to be having these thoughts?
- Do I want to be having these emotions?

Don’t let your chimp take over!

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How do you know when your chimp is in charge?

Ask yourself the following questions when dealing with people or situations that make you feel uncomfortable:

- Do I want to be having these thoughts?
- Do I want to be having these emotions?
Do I want to behave in this way?

If the answer is ‘no’ to any or all of these questions, there is a good chance your simian is in control.

Dealing with your chimp

Dr. Peters (quite rightly) points out that you should not attempt to tackle your chimp head on. In a battle between a chimp and an unarmed human, the chimp would win easily. The results for the human would be bloody and bruising, possibly even fatal. Dr. Peters suggests the following strategy to deal with your chimp:

1) **Let the chimp out of its cage.** Every now and again, we need to let our chimp get out and let off steam. Find a private room and vent your spleen! Scream at the walls, stamp your feet and do whatever it takes to get rid of that pent-up frustration that another individual or situation is causing. Go to the gym and pound the living daylights out of the treadmill or slam the weights around like there is no tomorrow! In this environment, such behavior is normal and accepted. Your chimp will be in good company!

2) **Allow your human brain to work with your chimp.** Once you have vented, examine the facts of the situation objectively. This is what your human does extremely well. Did your colleague really mean to put you down with that throwaway comment during the team meeting or has your chimp just taken exception to an otherwise harmless comment? Does your boss always reject all of your ideas or have they just rejected this one idea? This is where a coach or mentor is a good idea. Someone who can help you analyse a situation objectively.

3) **Change your computer programmes.** Give some serious thought to the thoughts, feelings and behaviours you display when dealing with certain people or situations. If you ‘hate’ 1:1s with your boss, is it any wonder that you feel nervous about them and then act in a corresponding manner? Allow your human to identify what exactly it is that you find uncomfortable about 1:1s. It may be that you feel your boss does not give you enough autonomy. Once you have identified this fact, you can then start to develop a strategy to deal with it. You may want to discuss your need for greater autonomy with your boss. Once you realise this, you are effectively changing the computer programme called ‘I hate 1:1s’ to a programme called ‘I could find 1:1s more effective and enjoyable by changing my thought patterns and behaviours’.

4) **Reward your chimp.** Once you have gone through the previous steps, give yourself a pat on the back! This may involve a physical reward as well, but at the very least acknowledge that you have recognised a way in which your chimp gets riled and you have dealt with it. Your chimp is still alive and healthy, but it is now back in its cage, enjoying a well earned banana.

Dr. Peters also makes the following points that are worth considering here:

- **Chimps change behaviour when their old behaviours are ineffective.** A chimp will learn very quickly that trying to take bananas from a tree full of poisonous spiders is a painful experience. As humans, we need to take responsibility for changing ineffective behaviours, thoughts and feelings. We have evolved to a higher mental and emotional plan than our primate ancestors!

- **Chimps do not carry feelings of guilt.** Accept that, every now and again, your chimp will ‘play up’. If it does and you lose control of it, accept that it has happened, learn from the situation and move on. Learn how to control your chimp in similar situations in the future.

- **You are not responsible for the nature of your chimp.** Our chimp brain is genetically inherited. You are however, responsible for the actions of your chimp.

- **In any situation, there is a stimulus and a range of possible responses.** You may not be able to control the stimulus, but you can and should control your response.

Good luck in feeding your chimp!