

PM Healthcare

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PM Healthcare Journal

Editorial

It has been four months since the Health and Social Care Act 2022 became law, creating in England a new structure – integrated care systems (ICSs) – radically restructuring the way the NHS is paid for and provided for the vast majority of the UK's citizens.

In these few months there has already been a huge amount of activity as the new system beds in, with organisations in all sectors busily engaged in creating the delivery plans and strategies that will bring into reality the aspirations underlying the change.

It is too early at present to describe the final effect of what has been put in motion, and at PM we are busily engaged with healthcare professionals in all sectors and at all levels of the new system to understand what is happening, where examples of success and best practice can be found, and sharing these with you.

If it were not enough that the NHS in England is experiencing its most thorough restructuring for a decade, there is much else across the UK to give us pause. In Northern Ireland, in the absence of the restoration of devolved government, the NHS is still having to cope without the leadership of the Northern Ireland Assembly.

All parts of the UK are struggling with the relentless demands of the Covid pandemic backlog, an ongoing staffing crisis and challenges in healthcare delivery in all care settings (including social care). We are in the midst of an intractable cost-of-living and fuel crisis, both of which will impact upon health, and winter is coming, with all of its attendant pressures upon the NHS.

We are also experiencing a time of political and social upheaval that is (to coin a too well-used phrase) without precedent.

It almost escaped notice that the previous Secretary of State for Health and Social Care, Thérèse Coffey, served less than 50 days, making her the shortest-serving Health Secretary in history (succeeded by Steve Barclay, who was also her predecessor).

Perhaps all of this was missable when at the same time Liz Truss became our shortest-serving Prime Minister, resigning after 49 days in office, and Kwasi Kwarteng became the second shortest-serving post-war Chancellor of the Exchequer, in post for only 38 days.

Writing as someone who has worked with and in the NHS for some decades, these are indeed the strangest of times, and it is difficult to adequately describe the enormity of the challenge facing us without falling into cliché or hackneyed phrases.

In our autumn PM Healthcare Journal, Jas Khambh provides a fascinating insight into her career pathway, how ICSs are changing the London NHS landscape, and also some valuable advice for pharmacy's next generation.

From Wales, we see how the new community pharmacy contractual framework is making a difference to frontline services.

And perhaps appropriately (considering the above), we have a special focus on the importance of mental health, for patients and healthcare professionals alike.

Finally, Mohammed Asghar describes Frimley's experience of reshaping prescribing governance in the changing NHS environment as precipitated by ICSs.

Considering the situation that we find ourselves in, both in the NHS and wider, it is so important that we keep talking to each other, sharing what works as we meet the challenges ahead.

So please come forward with any ideas that you think will be of interest to those working in the NHS, pharmacy and wider, especially examples of best practice that you think will help colleagues meet the demands being placed upon them by an exceptional set of circumstances at a very difficult time.

We need to rely on each other.

John Chater, *Editor – PM Healthcare Journal*

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An interview with Jas Khambh



Author

Jas Khambh, *Chief Pharmacist & Clinical Director, Medicines Optimisation & Pharmacy Procurement, NHS London Procurement Partnership.*

Jas Khambh talks to PM Chair Ted Butler about her career, pharmacy services in London, how Integrated Care Systems (ICSs) are changing the NHS landscape, and also offers some valuable advice to pharmacy's next generation.

Can you tell us the history of NHS London Procurement Partnership?

NHS London Procurement Partnership (NHS LPP) is one of four national procurement hubs serving the health community in London and beyond. Our members extend across the acute, community and mental health sectors, as well as primary care and clinical commissioning.

"Having launched in 2006, NHS LPP is uniquely owned collectively by all our members, as opposed to one NHS organisation. This affords our members the benefit of equal status and input into our vision, structure, products and services through a series of membership forums and the governance of a member-led Steering Board."

As a trusted advisor, NHS LPP aligns priorities with national and regional agendas, including the NHS Long-Term Plan, the Central Commercial Function (CCF) and the move to Integrated Care Boards (ICBs) and ICSs. We collaborate with our members to provide local, regional and pan-London opportunities that bring rewards in the sharing of good practice, leveraging common

needs and spending power and working together towards shared aims, all of which develops relationships, knowledge, and ultimately supports the whole health system and economy.

NHS LPP delivers the services that help hospitals to run efficiently including workforce, digital systems, medicines, estates, facilities and corporate services and professional services. We support our members and other trusts to make sustainable decisions that help keep our money in the NHS and invested where it matters – on our valuable frontline staff, services and most importantly, patients.

How did you get involved in NHS LPP and what has been your career progression to become Chief Pharmacist?

I did my pre-registration training in hospital, after which I did what they called basic grade rotations for nine or so months. Then in the late 1990s to early 2000s, I was offered the role of clinical audit and procurement pharmacist.

I did that for a while and then saw a post advertised for an interface pharmacist, one of the first in the country, I think. That was in 2001, between City and Hackney Primary Care Trust (PCT) and Homerton Hospital. It interested me because it was a really innovative role, working across interfaces between primary and secondary care. This happens quite openly now, but some twenty years ago it would have still been a sort of a panacea. I successfully applied for that role and then led the production of an interface prescribing policy and formulary across primary and secondary care in East London for a number of years.

I then met one of the senior leads from NHS LPP at a meeting and he said that he was looking for project pharmacists to come and work for him. I was called for an interview, and he offered me a secondment to work at NHS LPP. That was in 2011.



Have you been at NHS LPP since then?

No, because I did approximately two and a half years at NHS England, where I was the National Pharmacy Advisor for NHS RightCare, which I did from 2016 to 2018.

NHS LPP was undergoing a restructure at that time and had a new managing director who was trying to establish more director level posts (for example, chief pharmacists). This was when the roles of clinical director and chief pharmacist were established. I applied to be chief pharmacist and have worked in this role for the past three years.

Is NHS LPP staffed totally by pharmacists?

As well as pharmacists, there are four main categories of work. There is medicines optimisation and pharmacy procurement, that's the team I lead. Then there is workforce, estates and facilities, and clinical digital solutions. We also have some new arms at work that we've introduced recently, for example sustainability and social value, and other parts such as business intelligence solutions and Programme Management Office (PMO) services that we offer as well. My team is currently the only clinical team here because it is a heavily procurement and finance-led organisation.

My team is reasonably small with around seven or eight staff. That can go up and down because we do secondments, depending on what we are working on when we need different specialists. We also now have a medical director, to whom I report. And this is fantastic because he really gets our work. I think we are one of the first procurement hubs to do this.

What is your current relationship with the newly established ICSs in London?

We are a membership organisation, so our work plan is very much determined by our stakeholders, namely the ICSs in London and also beyond if we are doing something outside of London.

If we talk about London, the five ICSs previously would have been NHS trusts and Clinical Commissioning Groups (CCGs) and we would have worked in collaboration with them. We are continuing to do that, the only difference now being is that we are liaising more with what you might call the ICS footprint, their chief pharmacists and finance chiefs, etc. In a way, it does make our life a little easier because what we would have had to do thirty-odd times, liaising with each individual trust and CCG, we can now do with the five ICSs.



Do all of the five London ICSs now have a chief pharmacist?

Not all of them, no, but a few of them do. But in the others, there is somebody acting up into that position. I anticipate that all will have a chief pharmacist in the near future.

Is it correct that NHS LPP is working on a London-wide formulary in conjunction with the ICSs?

Yes, that is true. We decided to pilot a pan-London formulary, but unfortunately this project started just before Covid, so it has been quite slow getting it off the ground. Obviously, this was challenging, but it taught us that we could probably do some things better and also where the gaps were. One of the things that we have always been aware of is the unwarranted variation that exists across systems, and especially in relation to access to treatments.

We decided to pilot the formulary in two areas – ophthalmology and hospital only Red List drugs. These projects are now coming to an end, and they are being uploaded onto net formulary for access by NHS trusts and NHS organisations in London. Because they have been successful, the London health economies agreed that this approach is useful, and they want us to continue building the pan-London formulary. So the other area we are looking at now is respiratory, and we will prioritise different clinical areas as dictated by our stakeholders year-on-year.

We are currently trying to work out the governance model for the pan-London formulary, because even though we have been working on this for a year and a half it is still in its infancy in the sense that nobody has attempted anything at this scale in a health-economy like London. There are also other areas to think about: for example, how do you introduce new drugs and how do you maintain governance? We will work on these areas over the next six months.

Over the next 6-12 months and then you will move onto something else?

Yes. Respiratory is quite a broad area to look at, so we are focusing just on inhalant medicines for COPD and asthma at the moment. Anything that is more complex we will look at later.

As you go through the process, how do you work with the ICSs?

We have something called the Medicines Optimisation and Pharmacy Procurement (MOPP) Board, which is chaired by our regional chief pharmacist, and all of the five ICSs from primary and secondary care are represented on it.

There are a number of ways in which we prioritise our work. We look at what the priorities are within the local ICSs and other systems, and we may put suggestions forward to them based on what we know, but ultimately the decision is made by that board. And what we want to see is buy-in from the majority of ICSs. For example, at least three out of the five ICSs would have to support something before we went ahead with it.

How frequently does the MOPP Board meet, is it quite a regular thing?

Every quarter or so. Obviously, there are other things that we look at as well, like the NHS Long-Term Plan, and planning priorities and prescribing trends for example. So it is not just any one thing that decides what we prioritise.

From what you are saying, it seems as if your team works closely with the senior pharmacists in all five ICSs.

Yes. We also attend the Local Medicines Committee or equivalent within each ICS. I have a member of my team assigned to a different ICS, and it is the role of that person to build relationships, attend their medicines committee or equivalent and find out what is happening locally. Feeding things back is important, but equally so is feeding things in from NHS LPP, to share our work and make sure that it is implemented. This is an important part of our role, doing this kind of engagement and collaboration.

What opportunities do you see at the moment developing for pharmacists in the NHS as a result of the restructuring, and do you see a very positive environment for the development further of pharmacy?

Yes, I do because I think what happened with my generation of pharmacists and before is that you started working in one area and then you became

quite niche. So for example if you were in hospital, you specialised in hospital and then your career would follow that path. You would either become a specialist, a consultant pharmacist, or you might go on to be a chief pharmacist and it would very much be focused on that.

The same would happen with primary care in a PCT or CCG. You would become very much focused on that area. I think the creation of ICSs gives a newer generation of pharmacists a lot more opportunity for some of that portfolio working and cross-system working, because that is the way it is going now.

“If we are thinking of the ICS as one organisation, and they are meant to be working in collaboration and partnership with all the organisations within the ICS, then it really does provide an opportunity for people to try and get that breadth of experience from across the system before they decide in which area they might want to settle down.”

And that was not as open probably twenty years ago when you either went to one place or the other. I was lucky because I ended up in the interface post that I did at the time, so I think that is a really big advantage for pharmacists now.

Do you see examples now of what you are talking about, of posts and functions looking across secondary and primary care? Do we start to see that happen?

Yes definitely. Before the pandemic, I had rotations of pharmacists from one of the London trusts, allowing some junior pharmacists to gain regional experience. But then we were hit by COVID, and this came to an end, because you cannot really teach junior pharmacists as you would like when you are working remotely.

I have had conversations with other teams of pharmacists from across London and they are interested in introducing something like this again, because regional exposure is something not many people get at the moment. These are very niche roles, the ones that my team and I do, and it is very unlikely you would get exposure to this in any sort of rotation because it is not established in that way unless you end up in a post.

If you were to give a piece of advice to anybody in pharmacy who is wishing to progress their career is there one thing you would say?

I would say that before you settle down in any one area you ought to try and get some breadth of experience before you decide where you want to go.

The other piece of advice I would give to people is that I think our future pharmacist leaders should try and maintain some level of clinical practice, even if it is only doing one session every couple of weeks. Because I think that this really makes you stronger when you are in a leadership role. If you are clinically sound and you have kept in touch with what is happening in terms of patient care on the frontline, and you maintain your clinical practice, I think it makes you much more credible as a leader.

If I could turn back the clock, this is something I would have done, but these opportunities were not available then – you only went one way or the other. I think if I could have done something different, this is something I would have done. Because we all get sucked into these leadership roles and then there is not the time to think. But if we had this commitment to maintain clinical practice built into job descriptions, for example having to do one session every two weeks, then it does not take too much time out of your leadership role.

Thank you Jas for this fascinating insight into your career and role.



The new Community Pharmacy Contract in Wales

From April 2022, NHS Wales adopted a new community pharmacy contractual framework. In this article, Aled Roberts (Associate Director Contractor Engagement, Community Pharmacy Wales), Jonathan LLOYD-Jones (Community pharmacist and superintendent, Caerau Pharmacy), and Steffan John (Superintendent Pharmacist for Fferyllwyr) share their experience of the new contract, and what it will mean for community pharmacy services in Wales.

The new contract

By Aled Roberts MRPharmS IPresc

Associate Director Contractor Engagement (Cyfarwyddyd Cysylltiol Ymgysylltu Contractwyr).

Announced in December 2021 and beginning in April of 2022, the new community pharmacy contractual framework in Wales brought wide-ranging reforms including a commitment to clinical service delivery, workforce development, improving quality and safety and integrating community pharmacy within primary care clusters.

“Since 2016, when Welsh Ministers confirmed the intent to see continued investment in the sector, Welsh Government, health boards and Community Pharmacy Wales (CPW) had been working to agree contract reforms to deliver a community pharmacy service able to meet the needs of citizens in Wales, underpinned by significant reform of funding to incentivise and reward pharmacies.”

Priority services (Common Ailments Scheme, Flu vaccine provision, Emergency Medicines Supply and provision of emergency contraception) have been brought into national commissioning

under the Clinical Community Pharmacy Service. An additional Bridging and Quickstart contraception service will begin rollout from November 2022, and a nationally commissioned Pharmacy Independent Prescriber Service allows suitably qualified community pharmacists to prescribe for a range of acute minor illnesses and contraception, following on from the success of pathfinder sites situated across the country since 2016.

The response from contractors in Wales has been positive, the number of monthly common ailments consultations has doubled vs 2021, and the IP service has developed rapidly, with nearly one in five pharmacies in Wales already signed up to provide the service, and some pharmacies providing over 300 consultations in a single month. Early indications are that another record-breaking flu vaccination season is on the cards, and the number of pharmacies delivering the emergency medication service and provision of emergency contraception on a monthly basis is on the rise.

Other work is ongoing to release capacity for Welsh contractors to provide even further clinical services, as prescription numbers continue to rise. But early signs are encouraging that the collaborative approach between stakeholders in Wales will continue to support the community pharmacy network and the needs of the people of Wales for the foreseeable future.



In the community – Caerau Pharmacy, South Wales

By Jonathan LLOYD-Jones

Community pharmacist and superintendent at Caerau Pharmacy, South Wales.

In what is a hugely challenging time for everyone in healthcare I am feeling inspired and enthused by the changing role of community pharmacy. The new contract provides for a collaborative, innovative and progressive approach to the delivery of pharmaceutical care and maximises the impact of community pharmacy teams on the NHS and people in Wales, both now and for generations to come.

After a few enjoyable years working for the professional body, I have been struck by the changing landscape of working in community pharmacy in Wales. This new contract is increasingly clinically focused, with less emphasis on dispensing and more on providing advice and support for people to stay healthy.

I am especially enjoying supporting the local population through the introduction of the national independent prescribing service. This builds on the success of the long-standing common ailment service and it has really enabled me to play a greater role as part of the primary care team. We get fantastic feedback from patients and colleagues. I really feel that we are starting to be seen as the gateway to local primary care services.

It has also been helpful to have consistency of service commissioning through the combined national clinical community pharmacy service (emergency contraception, common ailments,

emergency medicines supply, seasonal influenza). This has created a new offer for all patients in Wales, and further promotes the appropriate use of NHS services. I am now able to tell people with confidence what they are able to access locally.

Of course to deliver these changes requires a change in how we have traditionally worked. It has been fantastic working with our team and supporting colleagues to take on more exciting roles. Just this month I have been able to work with our pharmacy technician to lead our flu vaccination and discharge medicines review services.

“I have been very fortunate that local care providers have really bought into our services. The funded collaborative visits have enabled me to spend time with GP colleagues and others to develop patient focused pathways.”

I am really excited about developing our role as a community pharmacy team. We are heading in the right direction, but the potential is limitless.



In the community – Fferyllwyr Llyn, North Wales

By Steffan John

Steffan John, Superintendent Pharmacist, Fferyllwyr Llyn Cyf, Blaenau Ffestiniog, North Wales.

The new pharmacy contract in Wales has provided an opportunity for community pharmacy as a profession but also for individuals within the profession (both pharmacist and support staff) to upskill and increase our offering to patients as an integral part of the primary care team. By providing extra funding and redistributing funding from volume dispensing to clinical services, the Welsh Government's vision is that community pharmacy becomes the first point of call for patients when seeking treatment for acute conditions.

For Fferyllwyr Llyn as an independent pharmacy contractor with five branches, the work force enabler funding has allowed us to upskill our support staff so that they can manage the day-to-day running of the dispensary. Further to this we have been able to employ additional accuracy technicians within the business, freeing up time for our pharmacists to spend with patients delivering clinical services.

Our pharmacies are at the heart of our communities and have always worked closely with local colleagues. However, the contract's funding for collaborative working has allowed us to build stronger relations with local healthcare providers (GPs, opticians, care homes, etc) to develop new services and ensure that patients are aware of and are referred into the services.

The clinical community pharmacy service compromises four elements:

- Emergency contraception
- Seasonal flu vaccine
- Common ailments service
- Emergency medicines supply

The funding available for this service not only ensures that we are able to train all our pharmacists to deliver the service, but also makes us as a company only want to employ accredited pharmacists. This in turn ensures that there is continuity of services for our patients and gives

local healthcare providers the piece of mind that they can confidently refer patients into our services. Since the introduction of the contract, we have seen a continual increase in the number of consultations for these services, particularly for the common ailments service.

The contract has given us the means to ensure that all our pharmacists have been given the opportunity to train as independent prescribers (IP). All our employed pharmacists are now qualified IPs and are delivering the acute conditions service. As part of this service, patients can attend the pharmacy to be seen by a prescriber.

During the appointment, our pharmacists take a history, examine the patient, provide advice, safety net and, where needed, issue an NHS prescription.

Our pharmacists can see patients with a range of conditions including urinary tract infections, otitis media, otitis externa, respiratory tract infections, shingles, skin conditions and many more. The service provides timely and convenient access to high quality advice and treatment for our patients, but also reduces the demand for appointments at local GP surgeries. In addition to the above, as part of the commissioned independent prescriber service, our pharmacists have the opportunity to deliver a contraceptive review and supply service. Some of our pharmacists have already completed the training and are actively delivering the service whilst the rest are undergoing training. Again, this is improving access for patients as it can be offered outside of the normal working week on the weekend.

As time goes on and we get to grips with the new contract and the move towards 56 day prescribing creating more free time for our teams, the delivery of clinical services will become our number one priority as a company. This in turn should help our local population gain access to health care, putting community pharmacy as a central and integrated part of the primary care team.



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Prescribing information. Please refer to the appropriate Summary of Product Characteristics (SmPC) before prescribing. **Fixkoh Airmaster 50 microgram/100 microgram/ dose inhalation powder, pre-dispensed.** Single inhalation provides a delivered dose of 47 micrograms of salmeterol (as salmeterol xinafoate) and 92 micrograms of fluticasone propionate. Corresponds to a pre-metered dose of 50 micrograms of salmeterol and 100 micrograms fluticasone propionate. **Fixkoh Airmaster 50 microgram/250 microgram/ dose inhalation powder, pre-dispensed.** Single inhalation provides a delivered dose of 45 micrograms of salmeterol (as salmeterol xinafoate) and 229 micrograms of fluticasone propionate. Corresponds to a pre-metered dose of 50 micrograms of salmeterol and 250 micrograms fluticasone propionate. **Fixkoh Airmaster 50 microgram/500 microgram/ dose inhalation powder, pre-dispensed.** Single inhalation provides a delivered dose of 43 micrograms of salmeterol (as salmeterol xinafoate) and 432 micrograms of fluticasone propionate. Corresponds to a pre-metered dose of 50 micrograms of salmeterol and 500 micrograms fluticasone propionate. **Indication:** Fixkoh Airmaster is indicated in adults and adolescents 12 years of age and older. **Asthma:** in the regular treatment of asthma where use of a combination product (long-acting β₂ agonist and inhaled corticosteroid) is appropriate. In patients not adequately controlled with inhaled corticosteroids and "as needed" inhaled short-acting β₂ agonist, or patients already adequately controlled on both inhaled corticosteroid and long-acting β₂ agonist. Note: Fixkoh Airmaster 50 microgram/100 micrograms is not appropriate in adults and children with severe asthma. **Chronic Obstructive Pulmonary Disease (COPD)** For the symptomatic treatment of patients with COPD, with a FEV1 < 60% predicted normal (pre-bronchodilator) and a history of repeated exacerbations, who have significant symptoms despite regular bronchodilator therapy. **Dosage and administration:** Fixkoh Airmaster must be used daily for optimal benefit, even when asymptomatic. Patients should be regularly reassessed by a doctor, so that the strength of Fixkoh Airmaster they are receiving remains optimal and is only changed on medical advice. **The dose should be titrated to the lowest dose at which effective control of symptoms is maintained. Where the control of symptoms is maintained with the lowest strength of the combination given twice daily then the next step could include a test of inhaled corticosteroid alone.** Patients requiring a long-acting β₂ agonist could be titrated to Fixkoh Airmaster given once daily if, in the opinion of the prescriber, it would be adequate to maintain disease control. In the event of once daily dosing when the patient has a history of nocturnal symptoms the dose should be given at night, a history of mainly daytime symptoms the dose should be given in the morning. Patients should be given the strength of Fixkoh Airmaster containing the appropriate fluticasone propionate dosage for the severity of their disease. If an individual patient should require dosages outside the recommended regimen, appropriate doses of β₂ agonist and/or corticosteroid should be prescribed. **Recommended Doses:** **Asthma** Adults and adolescents 12 years and older: - One inhalation of 50 micrograms salmeterol and 100 micrograms fluticasone propionate twice daily, or - One inhalation of 50 micrograms salmeterol and 250 micrograms fluticasone propionate twice daily, or - One inhalation of 50 micrograms salmeterol and 500 micrograms fluticasone propionate twice daily. A short-term trial of Fixkoh Airmaster may be considered as initial maintenance therapy with moderate persistent asthma (defined as patients with daily symptoms, daily rescue use and moderate to severe airflow limitation) for whom rapid control of asthma is essential. In these cases, the recommended initial dose is one inhalation of 50 micrograms salmeterol and 100 micrograms fluticasone propionate twice daily. Once control of asthma is attained treatment should be reviewed and consideration given to use of an inhaled corticosteroid alone. Regular review of patients as treatment is stepped down is important. Fixkoh Airmaster is not intended for the initial management of mild asthma. Fixkoh Airmaster 50 microgram/100 micrograms is not appropriate in adults and children with severe asthma. Paediatric population Fixkoh Airmaster is not recommended for use in children aged under 12 years of age. **COPD Adults:** - One inhalation of 50 micrograms salmeterol and 500 micrograms fluticasone propionate twice daily. **Special patient groups** There is no need to adjust the dose in elderly patients or in those with renal impairment. **Method of administration** Inhalation use. Patients must also be advised to rinse their mouth afterwards with water and spit it out and/or brush their teeth after inhaling. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings and Precautions:** Deterioration of disease. Fixkoh Airmaster should not be used to treat acute asthma symptoms for which a fast and short-acting bronchodilator is required. Patients should be advised to have their inhaler to be used for relief in an acute asthma attack available at all times. Patients should not be initiated on Fixkoh Airmaster during an exacerbation, or if they have significantly worsening or acutely deteriorating asthma. Serious asthma-related adverse events and exacerbations may occur during treatment. Patients should continue treatment but seek medical advice if asthma symptoms remain uncontrolled or worsen. Increased requirements for use of reliever medication, or decreased response to reliever medication indicate deterioration of control and patients should be reviewed by a physician. Sudden and progressive deterioration in control of asthma is potentially life-threatening and the patient should undergo urgent medical assessment. Once asthma symptoms are controlled, consideration may be given to gradually reducing the dose of Fixkoh Airmaster. Regular review of patients as treatment is stepped down is important. For patients with COPD experiencing exacerbations, treatment with systemic corticosteroids is indicated, therefore patients should be instructed to seek medical attention if symptoms deteriorate. **Cessation of therapy** Treatment should not be stopped abruptly in patients with asthma due to risk of exacerbation. Therapy should be down-titrated under supervision. For patients with COPD cessation of therapy may also be associated with symptomatic decompensation and should be supervised by a physician. **Caution with special diseases** Fixkoh Airmaster should be administered with caution in patients with active or quiescent pulmonary tuberculosis and fungal, viral or other infections of the airway. **Cardiovascular effects** Rarely, Fixkoh Airmaster may cause cardiac arrhythmias e.g. supraventricular tachycardia, extrasystoles and atrial fibrillation, and a mild transient reduction in serum potassium at high therapeutic doses. Fixkoh Airmaster should be used with caution in patients with severe cardiovascular disorders or heart rhythm abnormalities and in patients with diabetes mellitus, thyrotoxicosis, uncorrected hypokalaemia or patients predisposed to low levels of serum potassium. **Hyperglycaemia** Rare reports of increases in blood glucose levels. This should be considered when prescribing to patients with a history of diabetes mellitus. **Paradoxical bronchospasm** Paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing. Paradoxical bronchospasm responds to a rapid-acting bronchodilator and should be treated straightaway. Fixkoh Airmaster should be discontinued immediately. **β₂ adrenoceptor agonists** Side effects of β₂ agonist treatment, such as tremor, palpitations and headache, have been reported, but tend to be transient and reduce with regular therapy. **Excipients** Contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Systemic corticosteroid effects** Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, cataract and glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). **It is important, therefore, that the patient is reviewed regularly and the dose of inhaled corticosteroid is reduced to the lowest dose at which effective control of**

asthma is maintained. Adrenal function Prolonged treatment of patients with high doses of inhaled corticosteroids may result in adrenal suppression and acute adrenal crisis. Very rare cases of adrenal suppression and acute adrenal crisis have also been described with doses of fluticasone propionate between 500 and less than 1,000 micrograms. Situations, which could potentially trigger acute adrenal crisis include trauma, surgery, infection or any rapid reduction in dosage. Presenting symptoms are typically vague and may include anorexia, abdominal pain, weight loss, tiredness, headache, nausea, vomiting, hypotension, decreased level of consciousness, hypoglycaemia, and seizures. Additional systemic corticosteroid cover should be considered during periods of stress or elective surgery. The benefits of inhaled fluticasone propionate therapy should minimise the need for oral steroids, but patients transferring from oral steroids may remain at risk of impaired adrenal reserve for a considerable time. These patients should be treated with special care and adrenocortical function regularly monitored. Patients who have required high dose emergency corticosteroid therapy may also be at risk. This possibility of residual impairment should always be borne in mind in emergency and elective situations likely to produce stress, and appropriate corticosteroid treatment should be considered. The extent of the adrenal impairment may require specialist advice before elective procedures. **Pneumonia in patients with COPD** An increase in the incidence of pneumonia, including pneumonia requiring hospitalisation. Physicians should remain vigilant for the possible development of pneumonia in patients with COPD as the clinical features overlap with the symptoms of COPD exacerbations. Risk factors for pneumonia in patients with COPD include current smoking, older age, low BMI and severe COPD. **Visual disturbance** If a patient presents with symptoms such as blurred vision or other visual disturbances, refer to an ophthalmologist for evaluation. **Paediatric population** Fixkoh Airmaster is not recommended for use in children under 12 years of age. Adolescents < 16 years taking high doses of fluticasone propionate (typically ≥ 1,000 micrograms/day) may be at particular risk. Systemic effects may occur, particularly at high doses prescribed for long periods. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, acute adrenal crisis and growth retardation in adolescents and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression. Consideration should be given to referring the adolescent to a paediatric respiratory specialist. It is recommended that the height of adolescents receiving prolonged treatment with inhaled corticosteroid is regularly monitored. **The dose of inhaled corticosteroid should be reduced to the lowest dose at which effective control of asthma is maintained. Pregnancy and lactation:** Pregnancy Data on pregnant women indicate no malformative or foetal/neonatal toxicity related to salmeterol and fluticasone propionate. Animal studies have shown reproductive toxicity after administration of β₂ adrenoceptor agonists and glucocorticosteroids. Administration of Fixkoh Airmaster to pregnant women should only be considered if the expected benefit to the mother is greater than any possible risk to the foetus. The lowest effective dose of fluticasone propionate needed to maintain adequate asthma control should be used in the treatment of pregnant women. **Breastfeeding** It is unknown whether salmeterol and fluticasone propionate/metabolites are excreted in human milk. Studies have shown that salmeterol and fluticasone propionate, and their metabolites, are excreted into the milk of lactating rats. A risk to breastfed newborns/infants cannot be excluded. A decision must be made whether to discontinue breastfeeding or to discontinue Fixkoh Airmaster therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman. **Undesirable effects:** For full list of side effects, consult SmPC. Very common and common events include: headache, nasopharyngitis, candidiasis of mouth and throat, pneumonia, bronchitis, hypokalaemia, headache, throat irritation, hoarseness/dysphonia, sinusitis, contusions, cramps, traumatic fractures, arthralgia, myalgia. Serious adverse events: bronchospasm, anaphylaxis, anaphylactic shock, Cushing's syndrome, growth retardation in children and adolescents, decreased bone mineral density, hyperglycaemia, anxiety, behavioural changes including hyperactivity (mainly in children), depression, aggression (mainly in children), tremor, cataract, glaucoma, blurred vision, palpitations, tachycardia, cardiac arrhythmias, atrial fibrillation, angina. **Overdose:** There are no data available from clinical trials on overdose with Fixkoh Airmaster. Overdose with both active substances are: Salmeterol: Dizziness, increases in systolic blood pressure, tremor, headache and tachycardia. If Fixkoh Airmaster therapy has to be withdrawn due to overdose of the β₂ agonist component of the medicinal product, provision of appropriate replacement therapy should be considered. Additionally, hypokalaemia can occur and therefore serum potassium levels should be monitored. Potassium replacement should be considered. **Fluticasone propionate** Acute: Acute inhalation of fluticasone propionate doses in excess of those recommended may lead to temporary suppression of adrenal function. This does not need emergency action as adrenal function is recovered in a few days. **Chronic overdose of inhaled fluticasone propionate:** Adrenal reserve should be monitored and treatment with a systemic corticosteroid may be necessary. When stabilised, treatment should be continued with an inhaled corticosteroid. **Legal Category:** POM **Pack size:** 1 - 60 dose Fixkoh Airmaster or 2 x 60 dose Fixkoh Airmaster or 3 x 60 dose Fixkoh Airmaster or 10 x 60 dose Fixkoh Airmaster. Prices: 50/100mcg £14.47; 50/250mcg £19.29; 50/500mcg £16.12. **MA Number:** PLO0240/0547, PLO0240/0548, PLO0240/0549. **MA Holder:** Thornton & Ross Ltd. (trading as 'STADA') Lintwhale, Huddersfield, HD7 5QH, UK. **Date of preparation:** December 2021 **Unique ID No.** FIX-004a.

Adverse events should be reported. Reporting forms and information can be found at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to 01484 848164

References: * Thornton & Ross Ltd. Fixkoh Airmaster™ 51% cost saving based on approved NHS price: Fixkoh Airmaster™ 50/500 mcg: £16.12 vs Seretide® 500 Accuhaler® Drug Tariff Price £32.74 (available at: bnf.nice.org.uk/medicinal-forms/fluticasone-with-salmeterol.html) accessed October 2022. 2. Fixkoh Airmaster™ 51% cost saving based on approved NHS prices: Fixkoh Airmaster™ 50/100 mcg: £14.47 Fixkoh Airmaster™ 50/250 mcg: £19.29 Fixkoh Airmaster™ 50/500 mcg: £16.12 versus NHS indicative price of same strength salmeterol / fluticasone DPI. (available at: bnf.nice.org.uk/medicinal-forms/fluticasone-with-salmeterol.html) accessed October 2022. 3. Fixkoh 50mcg/250mcg SmPC: www.medicines.org.uk/emc/product/12080 accessed October 2022. 4. Fixkoh 50mcg/500mcg SmPC: www.medicines.org.uk/emc/product/12082 accessed October 2022. 5. Swedish Medical Products Agency. 2019. Public Assessment Report: Scientific discussion. Sipwa Airmaster. 6. Pharmacy Management Journal. Available <https://www.pmhjournal.co.uk/journals/pm-healthcare-journal/16-17>. Access date: October 2022. Seretide® and Accuhaler® are registered trademarks of the GlaxoSmithKline group of companies. Job Code: UK-FIX-105(1). DoP: October 2022.



Addressing the Challenges of Managing Change

Author

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Introduction

Ivan Hollingsworth offers his perspective and insights from thought leaders outside of healthcare as to why change can be so challenging, the reasons for this and some practical strategies to improve how we can embrace and adapt to change. This article can support both those dealing with the reorganisation of the NHS in England, and colleagues dealing with change more broadly within healthcare.

Change is a constant, nothing ever really stays the same. Whether it's the weather (if you live in the UK, you'll certainly know that) or the day-to-day events of our lives. So why is it we seem to be so resistant to the concept of change?

Resistance to change is linked to our evolution and our brain function. It is the limbic system of the brain that controls our emotional responses, which is far more powerful than the neocortex (the decision-making centre). When major change occurs in our lives, we often attempt to deal with rationale and logical elements without recognising the 'softer' aspects of our feelings. It is this error that often leads to a failure in wider system and organisational change.

"Our brains are hardwired to see change as inherently unsafe"¹

Considering this, the responsibility to enable adaption to change predominantly rests on the shoulders of leaders, but there are also actions that team leaders, managers and individuals can do to positively manage their responses. Dr Brené Brown (social psychologist, research professor, lecturer, author and world-renown expert in empathy, courage, vulnerability and shame) states: 'We like to think we are rational beings who occasionally have an emotion', but rather, 'We are emotional, feeling beings, who, on rare occasions, think.'^{2,3}

At the present time, we must be cognisant of the impact and effect of the years in which we lived with the Covid pandemic, during which we experienced the most significant changes to our lives in living memory. It should therefore be unsurprising that we are now longing for some familiarity. It is the need to feel safe and an aversion to risk, uncertainty and the unknown, that can cause us to become overly resistant to change and make life even more difficult when the world changes unpredictably around us.

Working in the NHS, you may acknowledge that no two days are ever the same and perhaps would even go as far as to say that 'Life would be a bit boring' if they were. However, those working in the NHS will also attest that dealing with a major change is something altogether different to everyday change.

That the NHS in England is undergoing major reorganisation is not something new (if you've worked in or around the NHS for at least ten years this won't be your first rodeo!). To begin to meet the challenge of the current NHS reform programme we can look outside our healthcare 'bubble' and learn from the wider corporate world, noting that implementing change is not uniquely an NHS issue, but is in fact a challenging area for so many industries and sectors.

"McKinsey reported in 2015 that: '70% of major change programmes don't achieve the objectives they set out to and of these failures 70% were the result of human and cultural issues.'"⁴

If employees do not understand how to manage change, or are not personally motivated to change, then a major problem can result. The cited McKinsey report referenced the challenges that exist when management is not aligned to effective change management, or it lacks a clear vision and effective strategy to implement change. The confusion and even chaos that can result from mixed messages will only increase the likelihood that the intended goals of change will never be achieved or will be suboptimal.⁴

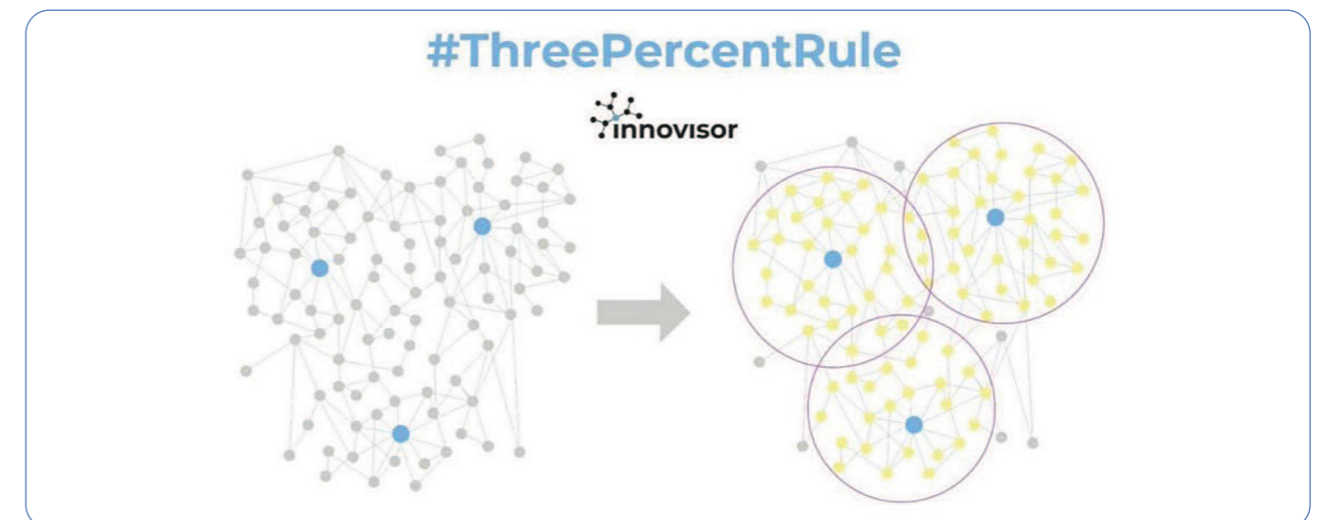
In studies, leaders acknowledge that if the goal is to achieve successful organisational change, then communicating empathetically is crucial. However, in one survey of over 200 leading company executives where 69% of respondents said that they were planning to launch or are currently conducting organisational change, 50% reported that they had not fully considered their team's sentiments about the change. More worryingly, around half said they were approaching the change programme by 'going on gut'.⁵

When adopting an empathetic approach it becomes crucial to plan how change will effectively be implemented and also to bring those affected with you. To do this, it is helpful to create profiles of your people, in order to help understand their beliefs, feelings, questions, and concerns. Through empathetic listening and gathered insights from such conversations, those who are excited, frustrated or frightened by the proposed change quickly become apparent. This approach enables you to adapt your communication style to meet the needs of those affected.

Identifying those who are 'excited' is a crucial element in this process. Employees who are excited are more likely to persuade those who are not and can be your most effective allies. If we consider the 'Three Percent Rule' outlined by the change management consultancy Innovisor,⁶ we see that 3% of people will potentially influence 85% of your organisation.

To implement this understanding, we need to move away from an out-of-date, hierarchical model of leadership and embrace a network approach. Your 'excited' colleagues are your super-connectors and through peer-to-peer support they will be far more powerful than any leader at engaging, connecting, and reducing the ambiguity of the wider organisation. Such individuals may also be more trusted by their organisational peers than those in senior leadership or management roles.

The graphic below illustrates the power and influence your super-connectors can have across a team or organisation.



To summarise the key points for leaders and managers to consider:

- Take time to listen, understand and support with empathy
- Create a safe, trusting space for your team and foster a culture of psychological safety
- Be wary of artificial harmony. You should embrace the concept of healthy conflict as it demonstrates that the team is working through important issues
- Collaborate and connect with other leaders and managers
- Recognise that your people will need a variety of ways to process this change: for example, 1:1s, peer support and team meetings
- Don't just focus on short-term positives or the superficial benefits of change. A long-term vision for the future builds individual and collective resilience
- Find your three percenters
- Be a positive role model
- Communicate, communicate, communicate!

Finally, it is important to consider what can be done personally. Feeling empowered to impact positively your response to change is as important as what those around you do to support you.

As individuals, we can become better equipped to deal with change if we have a greater sense of our purpose in life. Those who have meaningful goals and self-efficacy (a person's belief in their ability to

reach specific goals) have a greater ability to cope with adversity and a reason to persist. In the absence of these we are more fragile and will be detrimentally affected by change.

When experiencing a major change, such as the reorganisation of the NHS, we can feel overwhelmed by our emotions and fears for what the future holds. Rebalancing this takes composure, self-awareness, and a positive attitude.

Conclusion

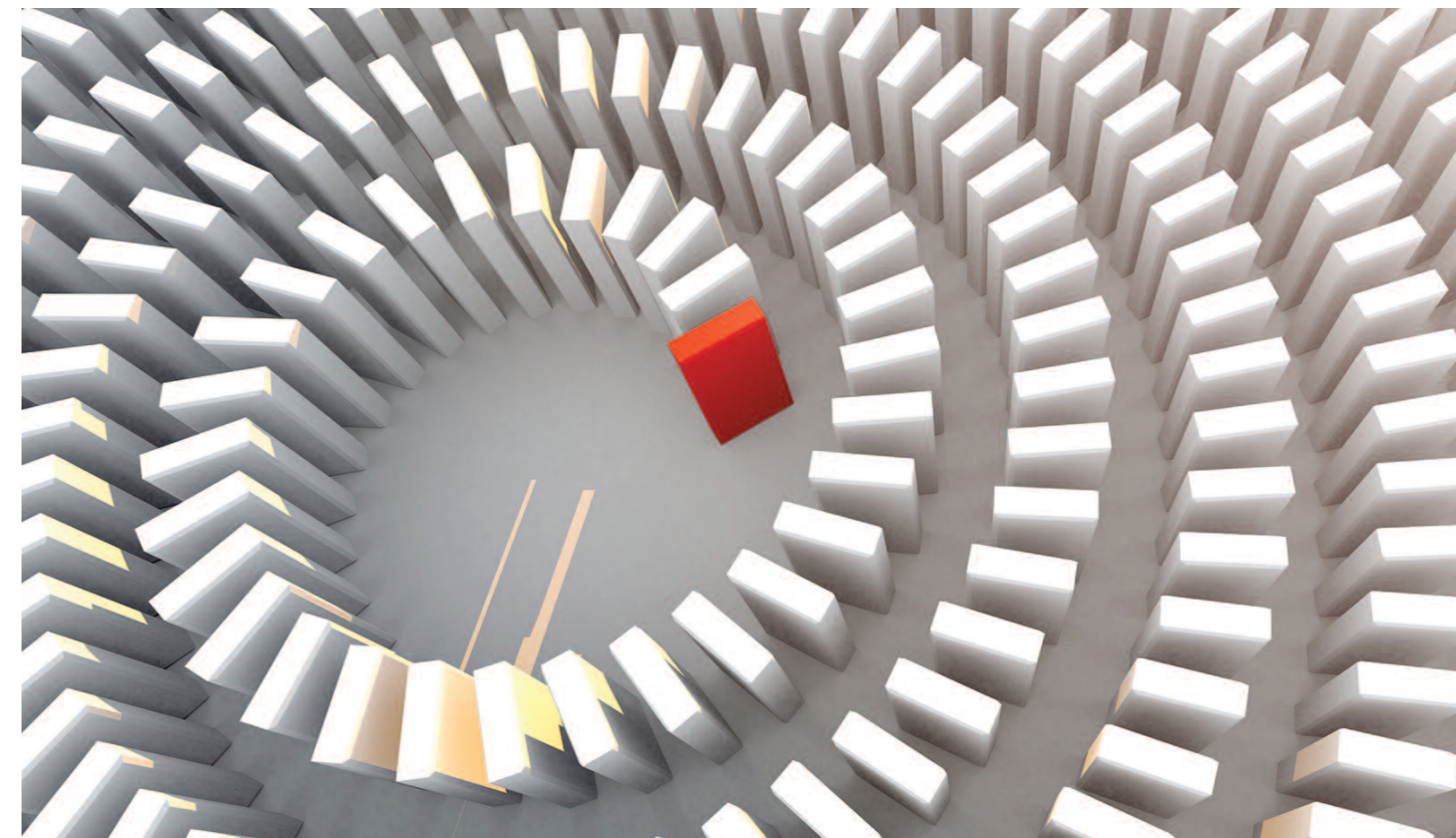
When change is inevitable and major reorganisation imminent, we need to adopt an approach that is more focussed on our feelings and emotions. In acknowledging this personally, we can show ourselves and those around us empathy, which will immediately start to diffuse some of the concerns and anxieties we are experiencing.

“Through a leadership style that takes the time to engage empathically with all of your people, with the intention of listening, learning and responding, you will have the best chance of not only surviving the change, but emerging stronger as a result.”

Exercise: Write down your personal vision statement. Essentially, who you are and why you do what you do.

Exercise: Working with your colleagues or manager, complete the three columns below specifically relating to the reorganisation you are undergoing. Identify what is positive, negative and interesting about the change. Use these in your team meetings and 1:1 session as the basis of your personal action plan.

POSITIVE	INTERESTING	NEGATIVE



About the Author

Ivan has over 16 years of experience in the pharmaceutical industry and is an award-winning leader in the charity sector. He now works as a Director of Centric Consultancy Limited. Working with NHS organisations across the UK, Ivan is an expert in leadership development, creating high performing teams and building workplaces that enable employees to thrive.

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Suggested Reading List

1. *Dare to Lead* – Brene Brown
2. *Emotional Agility* – Susan David
3. *The Infinite Game* – Simon Sinek
4. *Good to Great* – Jim Collins
5. *Think Again* – Adam Grant
6. *Impact Players* – Liz Wiseman



Assessing the impact of a specialist mental health pharmacist in a primary care mental health service

Authors

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Abstract

Introduction

There is an increasing demand for mental health support in primary care for a variety of reasons. An increasing effort has been made by the pharmacy profession to improve the support it provides to people with mental illness and to address some of the health inequalities faced by people with a mental illness. The NHS Long Term Plan has committed to the development of 280 community-based mental health pharmacy roles across England that will be supported by a bespoke training pathway developed by Health Education England (HEE).

Aim

To understand the contributions to care that can be made by a specialist mental health pharmacist in a primary care setting.

Objectives

- To understand the type of pharmaceutical interventions and their outcomes that can be made by a specialist mental health pharmacist in a primary care setting
- To understand the service user experience of a medication review led by a specialist mental health pharmacist

Methodology

A data collection tool was developed to capture the contributions to care made by the specialist pharmacist, the data collection tool also offered the opportunity to document 'free text' relevant to the consultation. In order to capture the service user experience, an anonymised electronic patient questionnaire was developed and sent to the patient following the consultation. Quantitative data was analysed descriptively, and free text analysed through thematic analysis.

Conclusion

This evaluation indicates that a specialist mental health pharmacist can add significant value to patient care in a primary care setting. Their contributions are generally well accepted by GPs and patients alike.

Keywords:

Pharmacist, Pharmacy, Mental Health, Psychiatry, Health Inequalities, Service evaluation.

Introduction

Mental health services in England have been the subject of significant changes in healthcare policy over the past 30 years where care has changed from principally hospitalising people with mental health problems into psychiatric institutions to treating patients in community-based settings. Between 1987/8 and 2016/17 the number of inpatient mental health beds in England decreased from 67,112 to 18,730 (Kings Fund, 2017). This shift in healthcare policy along with greater awareness and help-seeking has led to a significant increase in demand for mental health support in primary care (McManus et al 2016). In a survey of 1,000 GPs published in 2018, respondents indicated that approximately 40 per cent of GP appointments involve mental health matters (Mind, 2018). Similarly, referrals from primary care to community mental health teams have increased by 19 per cent between 2010/11 and 2014/15 in England, and prescriptions for antidepressants doubled between 2005 and 2015 (British Medical Association 2017).

People with a diagnosis of mental illness particularly severe mental illness (SMI) experience significant health inequalities that contribute to a life expectancy that is up to 20 years shorter than the general population (NHS England, 2016a). In addition to the shorter life expectancy, in comparison to the general population, people aged under-75 in contact with mental health services in England have death rates that are 5 times higher for liver disease, 4.7 times higher for respiratory disease, 3.3 times higher for cardiovascular disease and 2 times higher for cancer (Public Health England, 2017). The mechanisms through which these health inequalities, increased burden of physical ill-health and reduced life expectancy arise are complex and involve interrelated factors that include (1) wider social factors such as unemployment and poverty, (2) increased behaviours that pose a risk to health such as smoking and poor diet, (3) lack of assistance to access care and support, (4) effects of medication which include weight gain, (5) stigma, discrimination, isolation and exclusion preventing people from seeking help and (6) diagnostic overshadowing which is the misattribution of physical health symptoms to part of an existing mental health diagnosis (NHS England, 2016b).

An increasing effort has been made by the pharmacy profession to improve the support it provides to people with mental illness to address the increased demand and health inequalities described above. In 2018 the Royal Pharmaceutical Society held a roundtable discussion event to identify ways in which the pharmacy workforce can support people with mental health problems (RPS, 2018) that led to the publication of a profession-wide guidance titled "Improving care of people with mental health conditions: how pharmacists can help" (RPS, 2020). Supporting this strategy, the Centre for Pharmacy Postgraduate Education (CPPE) launched a national learning campaign on mental health conditions to develop competence and the confidence of pharmacy staff in supporting people with mental illness. In line with these sentiments the NHS Long Term Plan identified a need to develop 280 community-based mental health pharmacy roles across England (HEE, 2022). This initiative has been supported by Health Education England (HEE) who have developed a bespoke specialist mental health training pathway to prepare these pharmacists in the community (HEE, 2022).

In July 2020 as part of an NHS England pilot, the author's organisation launched an enhanced primary care mental health service (EPMHS). The service aimed to provide mental health support to people with moderate mental ill health by offering prompt advice and support to bridge any gaps between the primary and secondary care interface. The EPMHS included a range of clinicians such as specialist mental health nurses, psychiatrists, occupational therapists, psychologists, primary care workers and a pharmacist. A key offering included in the EPMHS through the specialist pharmacist was the provision of support for any medication related issues directly to service users and primary care clinicians. It was envisaged that the specialist Pharmacist within the EPMHS would:

- Provide personalised care through a medication review for patients suffering from moderate mental health disorders. The medication review would involve a holistic approach to mental healthcare including a discussion on medicines in the context of their mental health, potential adverse effects of such medication, physical health, lifestyle, and beliefs around medicines.





- Provide support to the network of primary care network (PCN) pharmacists and GP practice pharmacists to ensure they are skilled to support the pharmaceutical needs of patients with mental illness.
- Develop, promote, and implement tools for pharmacists across the integrated care system (ICS) so they can undertake brief interventions that improve the physical health of patients with mental health, for example, smoking cessation, weight management, and accessing cancer screening programmes.

This evaluation aims to understand the contributions to care made by the specialist mental health pharmacist as part of the enhanced primary care mental health service.

Aim

To understand the contributions to care that can be made by a specialist mental health pharmacist in a primary care setting.

Objectives

- To understand the type of pharmaceutical interventions and their outcomes that can be made by a specialist mental health pharmacist in a primary care setting

- To understand the service user experience of a medication review led by a specialist mental health pharmacist.

Methodology

An experienced mental health clinical pharmacist was recruited and integrated into the EPMHS multidisciplinary team (MDT) in May 2020 who quickly became a pivotal member of the EPMHS. The pharmacist was a key member of the EPMHS team that undertook promotional activities to introduce the new EPMHS to GP practices, Primary Care Network (PCN) leads, Local Pharmaceutical Committee (LPC) and Clinical Commissioning Group (CCG) leads.

In order to evaluate the pharmacist's role within the EPMHS and their contributions to care, the authors developed a data collection tool based on the work undertaken by Rogers et al (2016). Descriptive notes of activities undertaken relevant to individual patient consultations were documented. Descriptive notes included: circumstances prompting the referral; outcomes of the consultation such as referrals made to other teams and services; advice, suggestions and recommendations given to patients and healthcare professionals; identification of inappropriate referrals. The tool allowed the pharmacist to capture data on their routine clinical activity and

interventions. In order to capture the service user experience of the specialist pharmacist-led medicines consultation, an anonymised electronic patient questionnaire was developed.

Quantitative data was analysed descriptively to categorise various activities recorded by the pharmacist and responses obtained from the service user questionnaire. Thematic analysis of collated free text notes was undertaken.

Results

A total of 203 referrals were made to the EPMHS pharmacist between 17th July 2020 and 24th November 2021. In total 166 patients were referred as some patients were referred on more than one occasion during the data collection period. Patient demographics included 148 female (73%), 54 male (26.5%) and 1 other (0.5%). The mean age of patients was 38 years (range between 18 to 76 years, median 36 years). Patients were referred for multiple

reasons including medication review (135), counselling (115), medicines information (96), management of side effects (48), drug interactions (10) and other reasons such as monitoring of physical health parameters.

The average time spent on preparing for the consultations, undertaking the consultation itself, and completing post consultation activities are shown in Table 1.

In total 554 contributions to care were made by the pharmacist across the 166 patients reviewed. Figure 1 displays the contributions to care by different categories. A significant number of contributions focussed on general medication counselling and lifestyle advice. Approximately 23% of the contributions to care involved a recommendation to adjust the dose of a medication or a change in medication.

The descriptive notes documented relevant to

Time spent (Mins)	Mean	Min	Max	Range	SD
Preparing	18	0	75	75	16.14
Consulting	50	0	148	148	27.54
Post consultation	66	5	180	175	29.18

Table 1: Pharmacist time spent on patient consultations

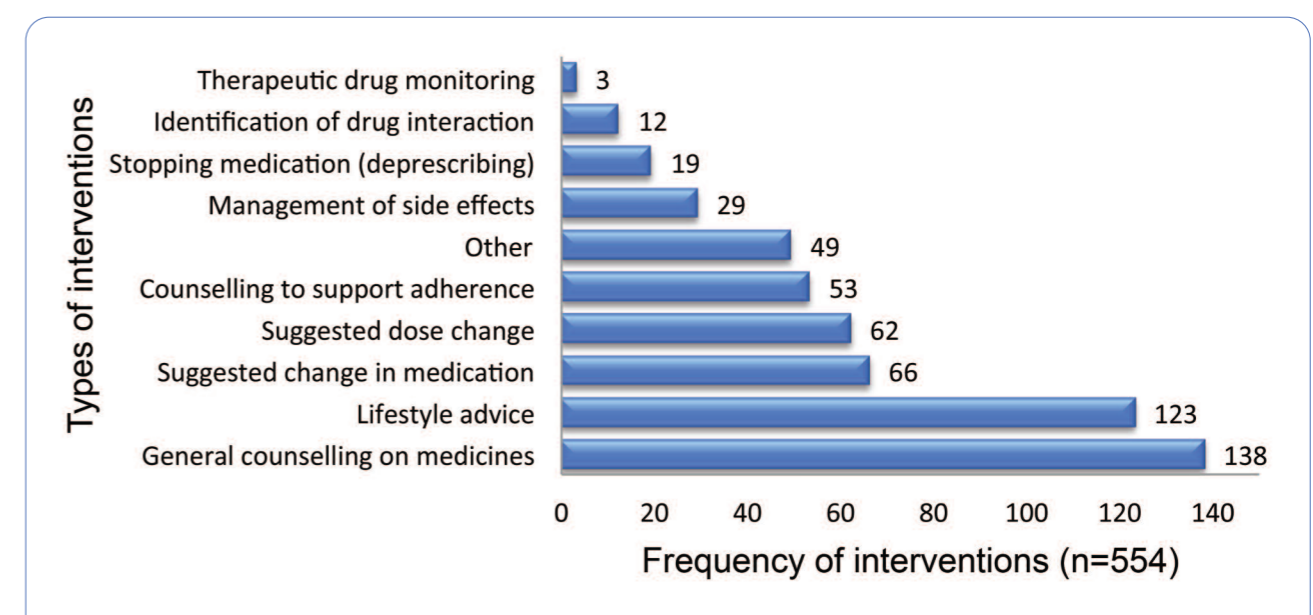


Figure 1: Types and frequency of interventions made



individual patient consultations were thematically analysed. The key themes identified from the collated notes included physical and mental health interdependencies, medicines optimisation support, individualised care, and integrated services provision. These themes are discussed in detail below:

Physical and mental health Interdependencies

The dependency between mental and physical health was noted during several consultations. Often, patients' presenting complaints related to their mental health was associated with on-going physical ill health or problems. For example, depression due to a physical health problem such as hormonal imbalance (menopausal) symptoms, Type 1 diabetes, chronic pain, debilitating gastrointestinal conditions, urinary incontinence, obesity and vitamin deficiencies and emerging disabling conditions such as loss of sight. Conversely, mental ill-health was also identified as a precursor to physical health problems, for example, fatigue and exhaustion from inadequate sleep durations/routine due to anxiety. These findings during the specialist pharmacist consultation often led to recommendations to the patient's GP to conduct specific tests or reviews such as conducting thyroid function tests, follicle-stimulating hormone test, HbA1C or review of pain management.

Medicines optimisation support

Thematic analysis of notes suggested that the medication related recommendations focussed on initiating (start or consider starting) new medicines, deprescribing (stop or consider stopping) medicines, increasing or decreasing dosages, switching to a different medication that is more suitable for the patient. These recommendations in general aimed to improve adherence, manage side-effects, align medicines use better with the patient's routine, improve treatment outcomes where the current drug choice no longer had beneficial outcomes. Examples of recommendations which were followed by the patients' GP included in one patient the initiation of pregabalin to manage anxiety, in one patient discontinuation of mirtazapine due to increases in weight and emergence of diabetes, in one patient a

switch from duloxetine to vortioxetine, in one patient advising against an antidepressant who scored as having mild depression on the PHQ-9 scale who was also recently diagnosed with seizures, suggesting cognitive behavioural therapy as an alternative.

"The recommendations were made directly to the GP or if appropriate any other health professionals involved in the patient's care with the patient being informed and a follow up consultation booked if required. Patients were also counselled on the medicines use, how to manage side-effects including use of non-pharmacological interventions and general healthy lifestyle guidance."

Individualised care

The generous time allocated for the whole consultation (see table 1) facilitated the opportunity to spend time with the patient and tailor the care provided, follow-up on agreed actions and review of outcomes. Significant time was dedicated in reassuring patients around their treatment, lifestyle advice particularly around good sleep hygiene, healthy eating, and exercise. Discussions also included review of daily routine to support home and family commitments. In one patient, support and signposting around problem gambling was provided.

Integrated service provision

During the consultation patients were often referred or signposted to other healthcare professionals including professionals within the EPMHS particularly for physical health reviews independent of an ongoing mental health related condition. For example, in one patient a referral to the GP to undertake an asthma review was made.

Figure 2 displays the results of the service user experience survey of the specialist pharmacist led medication review clinic. In total 137 surveys were handed out of which 50 were returned, resulting in a 36.5% response rate.

Discussion

The evaluation demonstrated the positive value of incorporating a specialist mental health pharmacist into a new service designed to support patients in primary care. The findings in this evaluation somewhat support the ambitions of the NHS Long Term Plan to develop 280 new community based mental health pharmacy roles across England. Figure 1 displays the types of contributions to care made by the pharmacist across the 166 service users they consulted with. Of the 554 interventions undertaken by the pharmacist 128 (23%) included either a dose change or change in treatment. The qualitative data captured in the study provide some examples on the clinical interventions made by the pharmacist. A key factor in the success of this project was the skills, competencies, and knowledge of the postholder, who was an

experienced specialist mental health pharmacist. The authors do believe the outcomes obtained in this project will be difficult to replicate through the network of PCN pharmacists as they lack the specialist knowledge in mental health. Therefore, a key aim of the specialist pharmacist role within the EPMHS was to build collaborations with the PCN pharmacists so they can be supported with any psychotropic drug-related issues that arise when undertaking structured medication reviews. The results of the service user experience survey displayed overwhelmingly positive feedback on the specialist pharmacist consultations, one patient who has been under the care of mental health services for over 20 years replied with such positive and detailed feedback that they were invited to share their experience with the trust board.

The aims and objectives of this study in part reflect that of the work conducted by Raynsford and colleagues in 2018 in which they investigated the contribution that a specialist mental health clinical pharmacy team could make to the care of patients on the SMI register in primary care. Their study

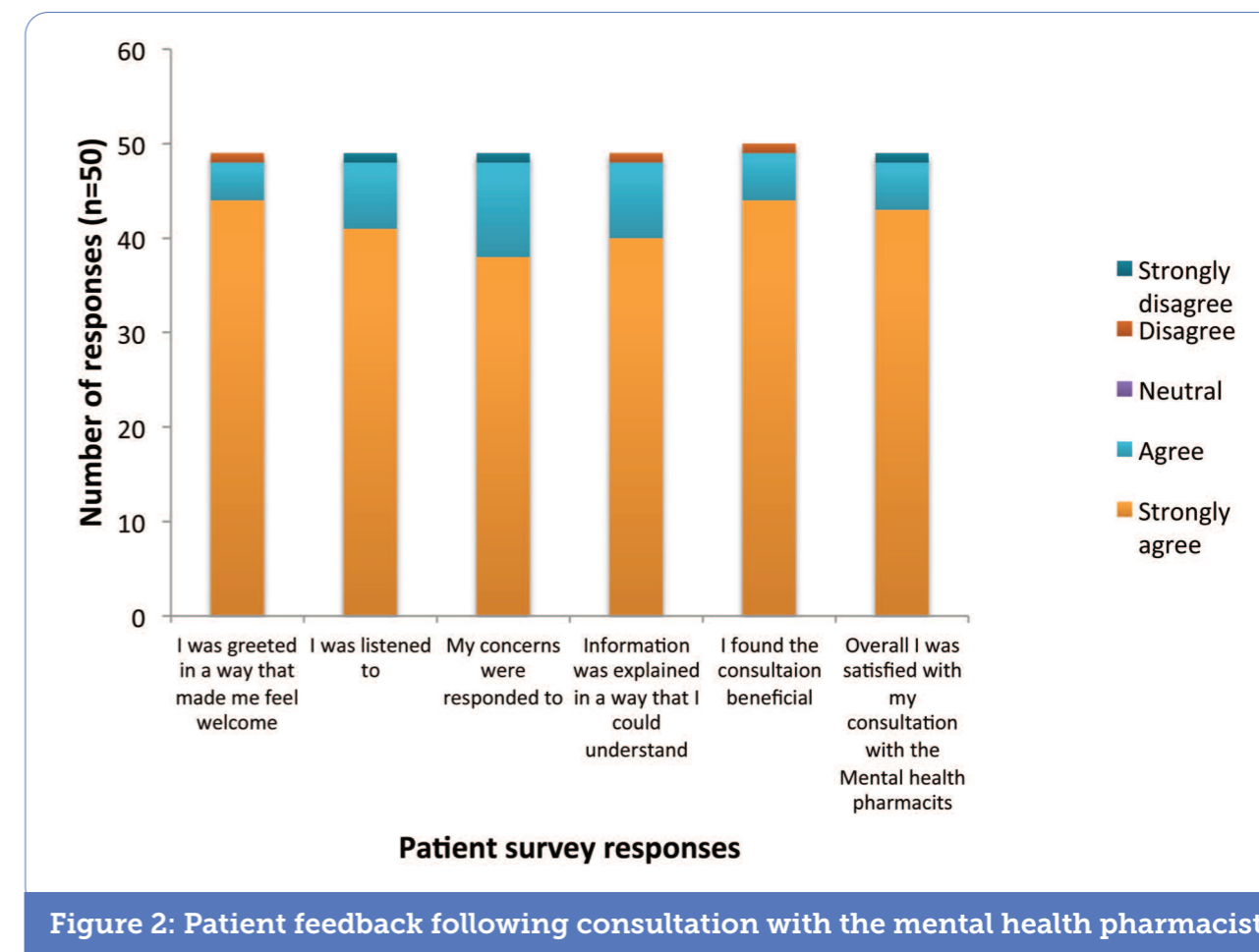


Figure 2: Patient feedback following consultation with the mental health pharmacist



identified that a variety of medicines management issues existed in the SMI population in primary care such as incomplete medicines reconciliation, inadequate physical health monitoring, poor adherence, poor communication, and drug errors (Raynsford et al, 2018). The study concluded that a specialist mental health clinical pharmacy team can improve medicines optimisation in patients with severe mental illness in primary care and help build bridges between primary and secondary care (Raynsford et al, 2018). Key differences existed between the EPMHS pharmacist service and that described in the publication by Raynsford et al, 2018 such as the latter service model was centred on a desktop review of clinical data, focussed solely on the SMI population, and was a standalone service. In contrast, the EPMHS pharmacist was part of a wider multidisciplinary team whose focus was on patients with mild to moderate mental illness, the pharmacist undertook in-person consultations with patients and worked in collaboration with the PCN pharmacists where appropriate. Despite these different service models, both studies clearly demonstrated the positive value of specialist mental health pharmacy input into primary care.

“The timing of the launch of the EPMHS coincided with the downward trajectory of the first COVID-19 pandemic peak and loosening of lockdown restrictions in England. The COVID-19 pandemic with all its associated restrictions has resulted in many people’s mental health being significantly adversely affected particularly those with pre-existing mental health conditions (WHO, 2022). Therefore, the EPMHS, including the specialist pharmacist offering has been an extremely valuable and well received service.”

Despite the significant efforts by successive governments to ensure parity of esteem between mental and physical health services, there are still significant gaps in resources to achieve this aim. This gap in resources extends to mental health research (including mental health pharmacy practice research) which has lagged behind many other areas in terms of priority, funding, and therefore discoveries (DH, 2017). Therefore, this evaluation adds evidence to the literature for supporting the development of specialist mental health pharmacist roles in the primary care setting.

Conclusion

This evaluation indicates that a specialist mental health pharmacist can add significant value to patient care in a primary care setting. Their contributions are generally well accepted by GPs and patients alike. A key limitation of the service model developed is the challenge in expanding it to other PCNs as there are a limited number of specialist pharmacists in mental health.

Limitations

One of the limitations of this evaluation is that contributions to care were self-reported by the specialist pharmacist which can lead to the introduction of bias. Another limitation is that not all recommendations were followed up to ascertain if they were acted upon and therefore may have been declined.

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The potential impact of specialist mental health pharmacy input into community settings and integrated care systems and the challenges in achieving them: findings from a mixed method survey and case study examples

Authors

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Abstract

Introduction

Pharmacists and pharmacy technicians have an increasingly important role in mental health community teams and within integrated care systems (ICS) as highlighted in the *NHS Long Term Plan*. The aim was to collate examples of good practice to establish which patient-facing activities deliver the best patient outcomes and explore how these can be replicated to maximise the impact on patient care.

Methods

In September 2021, an online survey (using SurveyMonkey) was designed and shared with mental health NHS trust pharmacy departments. It was disseminated via the international College of Mental Health Pharmacy (CMHP) online members forum. Examples of good practice were also collated via the CHMP forum following a literature search of the evidence. The impact of implementing agreed key performance indicators on the amount of pharmacy time spent on direct patient-facing activities was collated from a London mental health trusts stakeholder group.

Results

Four good practice case examples that have embedded pharmacy staff into patient-facing roles highlight demonstrable improvements in patient outcomes, helping to release multidisciplinary staff time and how best to use NHS staff resources to maximise patient care.

Forty pharmacy professionals across a range of pay bands from 19 NHS trusts across England responded to the national survey. Of these, 88% were pharmacists and 90% were employed in a specialist community mental health pharmacy team role. The range of activities reported within the national survey varied widely across the 19 NHS trusts with the amount of time staff spend on patient-facing activities ranging from 0-70% between responders. Implementing key performance indicators for six months has been successful in increasing pharmacy patient-facing time by up to 60%.

Discussion

The good practice case studies highlight the significant potential to improve outcomes for patient and staff by pharmacists and pharmacy technicians being more patient-facing and taking on extended roles, including reducing patient wait times, reducing the number of occupied bed days, increasing minimum standards of physical health monitoring and helping manage medical vacancy gaps. However, findings from the national survey show that there is widespread variation in practice amongst the 19 NHS trusts across England that responded, which presents challenges that need to be addressed before such benefits can be achieved.

Conclusion

There are challenges that need addressing to bridge the gap borne out from these findings. These include the widespread variation in pharmacy time spent on being patient-facing. Consideration should be given for nationally agreed key performance indicators to help benchmark and monitor this. Another challenge is the lack of pharmacists using their prescribing qualifications. Better use of technology may enable staff to be released from administrative tasks to focus on clinical care.

Keywords:

survey, mental health, pharmacy, case study, community, integrated care.

Introduction

Pharmacists and pharmacy technicians are increasingly being recognised for their specialist expertise, especially in the context of psychiatry. Roles have rapidly evolved in recent years. A narrative review by Rubio-Valera, et al, (2014),¹ found that having a pharmacist in these teams can result in significant improvements in the overall healthcare in patients with a mental illness.

As part of the *NHS Long Term Plan*, local areas were asked to realign community mental health services with primary care networks (PCNs) to create 'new and integrated models of primary and community mental health care' by 2023/24.² Subsequently, NHS England published a Community Mental Health Framework, which set out a vision of what these models of care might look like.³ In 2019, twelve sites across England became early implementers of this framework.

Pharmacy staff have a vital role to play within integrated care systems to help deliver the *NHS Long Term Plan*.² The Plan provides the direction of travel for pharmacy staff working in these teams, describing 'clinical pharmacists and pharmacy technicians' taking on 'extended roles' to 'increase the amount of time they can spend with patients'. This requires staff to be patient-facing.

This report shares findings from a recent scoping exercise to highlight the types of activities most commonly being undertaken by pharmacy staff nationally within these new models of care. It shares examples of good practice case studies of pharmacy staff in direct patient-facing roles that have delivered demonstrable improvements in

patient outcomes. It discusses the potential impact if the models described in these good practice studies were replicated.

Finally, it highlights some challenges the profession needs to address to embed these and bridge the gap borne out from the findings of the national scoping exercise and good practice cases and provides some solutions to consider. This includes communicating findings from one region that developed agreed key performance indicators (KPIs) with the aim to reduce variation in practice and increase patient-facing activities following the scoping exercise.

The report highlights the need to prioritise further research to better understand the challenges pharmacy staff face in taking on more extended roles, including pharmacists using their prescribing qualifications, so these can be addressed as the profession prepares for newly qualified pharmacists who will qualify as non-medical prescribers from the point of registration from 2025/26.

Aims and Objectives

The aim was to collate good practice cases to establish what direct patient-facing pharmacy activities deliver the best patient outcomes and explore how these models of care can be replicated to make best use of pharmacy skills and resources to maximise the impact on patient care. The objective was to survey pharmacy staff nationally working and embedded within integrated care systems to investigate the types of activities being undertaken and identify the type of pharmacy staff working in these teams (for example their banding) and compare this with the good practice cases to recommend future approaches.



Methods

National survey of pharmacy staff

In September 2021, a mixed method survey was designed by a small working group of pharmacists and distributed to members of the College of Mental Health Pharmacy (CMHP) via their discussion group. Staff were given the option to complete the survey anonymously if they preferred. The survey was open for two weeks. Pharmacy staff providing specialist mental health input into community mental health settings (community mental health teams/CMHTs [or equivalent], PCNs or specialist teams such as perinatal, learning disabilities or other) were asked to complete the survey via SurveyMonkey to help understand more about the staffing (e.g. banding, job roles, skill set) and type of activities being provided.

Key performance indicators (KPIs)

A stakeholder group comprising of pharmacists from London mental health trusts developed agreed KPIs with the aim to increase pharmacy input into direct patient-facing activities and help reduce the variation highlighted from the national scoping exercise. Once agreed, the KPIs were shared with pharmacy staff working within these teams across all the London mental health trusts. Staff were asked to record their activity daily between April – September 2022 inclusive on an excel spreadsheet. Each month, staff would submit their KPI activity to a nominated individual to collate. The impact of shared KPIs on pharmacy input into direct patient-facing care was evaluated six months post-implementation

by comparing with baseline data, obtained from the national survey results.

Collation of good practice case examples

A literature search of databases including EMBASE, PsycInfo, OVID Medline was initially done to identify the evidence-base of pharmacy impact on patient outcomes in mental health from staff working across integrated care systems. Due to the lack of published evidence, all the cases were subsequently collated via the CHMP forum following a request to share service models of pharmacy staff working in direct patient-facing roles which have demonstrated improvements in patient outcomes.

Results

In total, there were 40 responders to the national mixed method pharmacy staff survey from 19 NHS trusts across England. 15% of responses (n=6) were answered anonymously. 88% (n=35) disclosed their place of work.

Staffing

Of the total number of responses (n=40):

- Feedback ranged from band 5 to 8a pharmacy staff
- 90% (n=36) responded to say they were employed in a specialist mental health pharmacy team role based in a community setting

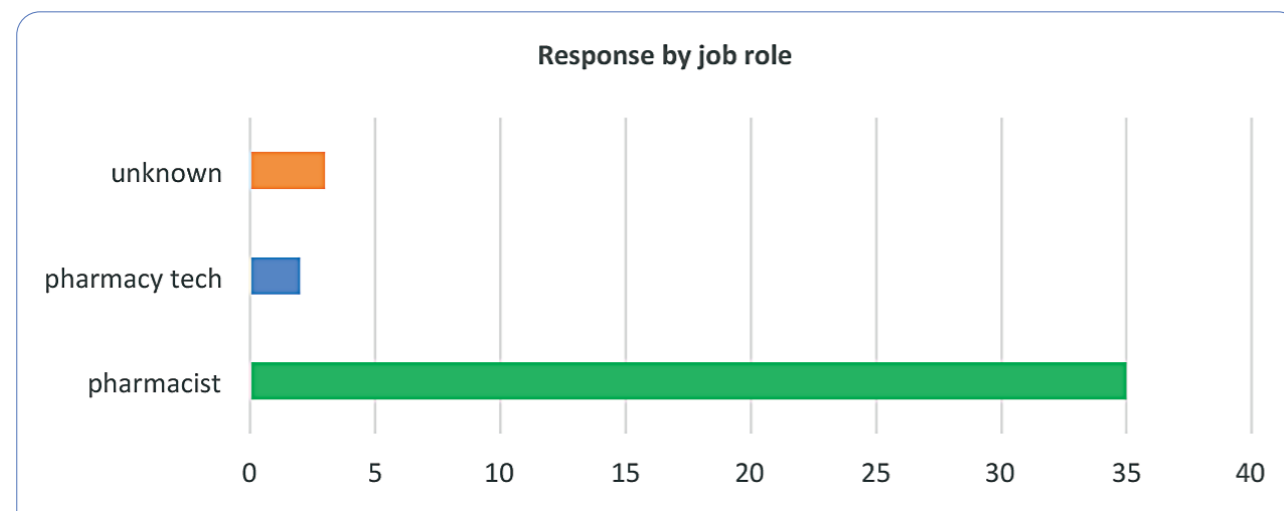


Figure 1: Response of survey by job role

- the majority (65%, n=26) were employed as 8a pharmacists; 15% (n=6) were band 7 pharmacists; 5% (n=2) were band 6 pharmacists/technicians; 3% (n=1) were band 5 technicians and 12% (n=5) responded as other
- 45% (n=18) were full-time; 53% (n=21) part-time. In 1 case, this was not disclosed
- 88% (n=35) were in a permanent post; 10% (n=4) in a temporary position and 1 person reported being in a 1 year fixed-term post

Figure 1 provides response by job role, with 88% of responses being from pharmacists.

Independent prescribing status

Figure 2 shows that 55% of staff (n=22) working within these teams were independent prescribers, however less than two thirds (64%, n=14) were using their prescribing qualifications. Exploring the reasons why the pharmacists were not using their prescribing qualifications was outside the scope of this study.

Type of activities

Figure 3 shows the types of activities responders were involved in within their roles. The greatest activity comprised of medicine audits (22%). Patient-facing activities included running clinics which comprised 20% total activities. However, within these clinics prescribing only comprised

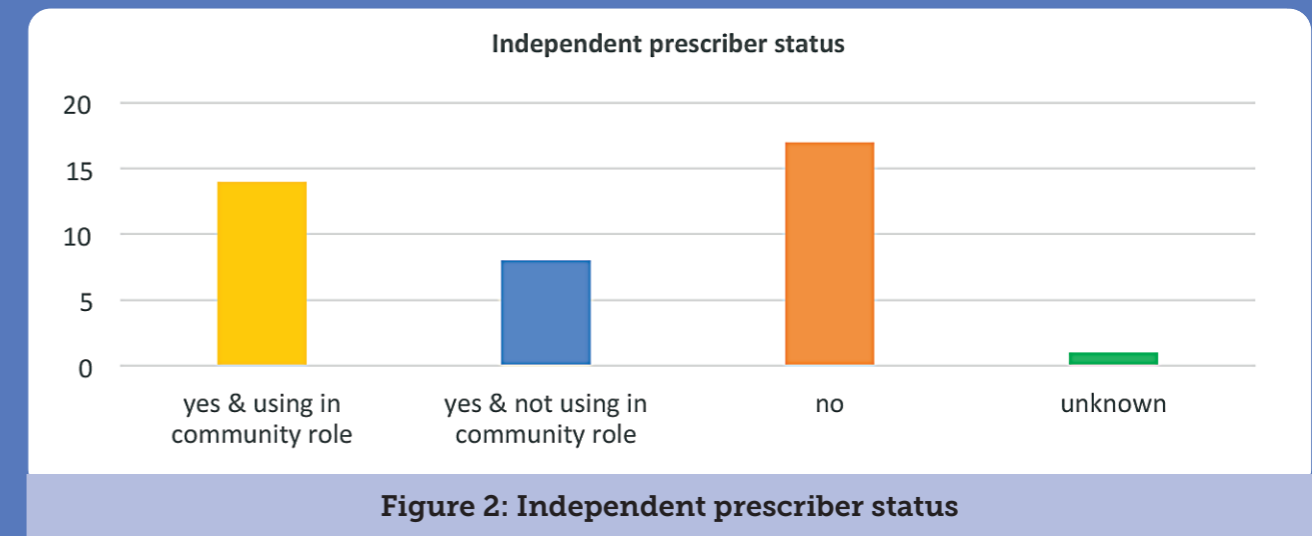


Figure 2: Independent prescriber status

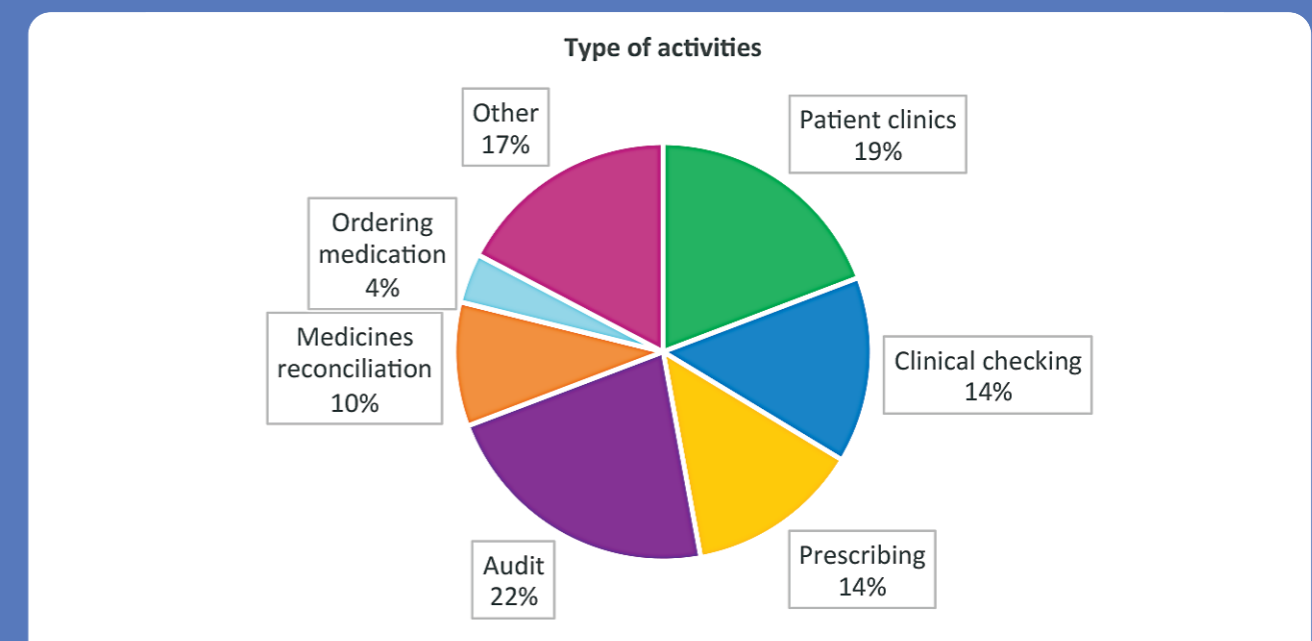


Figure 3: Types of activities reported by responders

11% of activities. Clinical checking charts and other unspecified activities (such as training) each comprised 16% of total activities. Ordering medication was the least reported activity and only reported by 10 responders comprising of 8% of total activities.

Responders were asked to describe their typical day in terms of percentage spent on patient-facing activities and non-patient-facing activities (clinical, operational, management and other). Given the pandemic, virtual patient consultations were considered as patient-facing.

Patient-facing activities

88% of total responders (n=35) fed back. Figure 4 shows the composition of time spent on patient-facing clinical activities on a typical day. This ranged from 0-70% between responders. Responders' time spent on non-patient-facing clinical activities ranged from 0-100% and operational activities ranged from 0-80%. Although less common, management was an activity for over half (51%, n=18) of responders. 49% (n=17) reported other activities, e.g. training and administrative tasks.

Key performance indicators

Pharmacy staff from five London mental health trusts submitted data, however one was excluded as there was no pre-implementation data to compare against. Data submitted by the four mental health trusts (from 14 staff) showed that three trusts had an increase in pharmacy input into patient-facing activities post-

implementation; one trust showed no change in pharmacy input into patient-facing activities. Pre and post-implementation findings respectively were: trust 1 an increase from 0% to 20%; trust 2 an increase from 20% to 50%; trust 3 an increase from 10% to 70%; and, trust 4 remained at 50%.

Good practice case study examples of pharmacy staff working in direct patient-facing roles (shared with consent from the organisations)

Case study 1: Central and North West London NHS Foundation Trust

'A band 8 independent prescribing pharmacist worked within a consultant psychiatrist team covering one adult community mental health hub (17 GP practices) and a population of approximately 105,000 to help manage the increase in referrals and wait list for assessment and treatment as a result of the Covid pandemic. Referrals received from general practitioners, home treatment team and occasionally liaison psychiatry were triaged and allocated to members of the consultant psychiatrist team as appropriate.

The prescribing pharmacist took on the responsibility of reviewing patients with complex medication needs which released capacity within the team, allowing the psychiatrists to focus on non-medication related reviews. Within three

months, this model reduced the wait time for assessment and treatment from 12-16 weeks to 4-6 weeks from the point of referral.

The pharmacist supported the team one day a week; each session comprised of reviewing 3-4 patients. These included conducting a mental state examination, risk assessment, doing a thorough medication review and prescribing as appropriate followed by any necessary paperwork; writing outcome letters to general practitioners/referrers; follow-up and reviewing physical health tests such as bloods and electrocardiograms (ECGs).

"Since starting in July 2021, the pharmacist released 21 hours of psychiatrist time over a three-month period through reviewing 40 patients. Interventions included initiating, switching or stopping medication; medicines optimisation; physical health monitoring; side effect management and referral to services such as social prescribing and psychology."

Patients, staff and general practitioners are very satisfied with the service and the CMHT staff have reported feeling better supported as they have greater access to a specialist pharmacist for advice on medicines. When asked to compare the 'quality of service' and the 'response time' to that previously provided by a psychiatrist, 63% of staff described the quality of service as better when provided by the pharmacist and 88% fed back that their patient was reviewed sooner.

Since this model is almost £18K less expensive than a psychiatrist (costings based on a band 8a pharmacist vs a middle-grade psychiatrist, both at mid-spine point), a business case has been approved to replicate this model across the trust with the primary objective to help manage the increased referrals and reduce patient wait times

and also to support medical staffing vacancies and release psychiatrists' time.

Case study 2: Central and North West London NHS Foundation Trust

From July 2020, one band 7 pharmacist (1.0 WTE) and two band 5 pharmacy technicians (0.5 WTE each) were recruited to cover 8 CMHTs/PCNs. In November 2020, an additional band 7 pharmacist

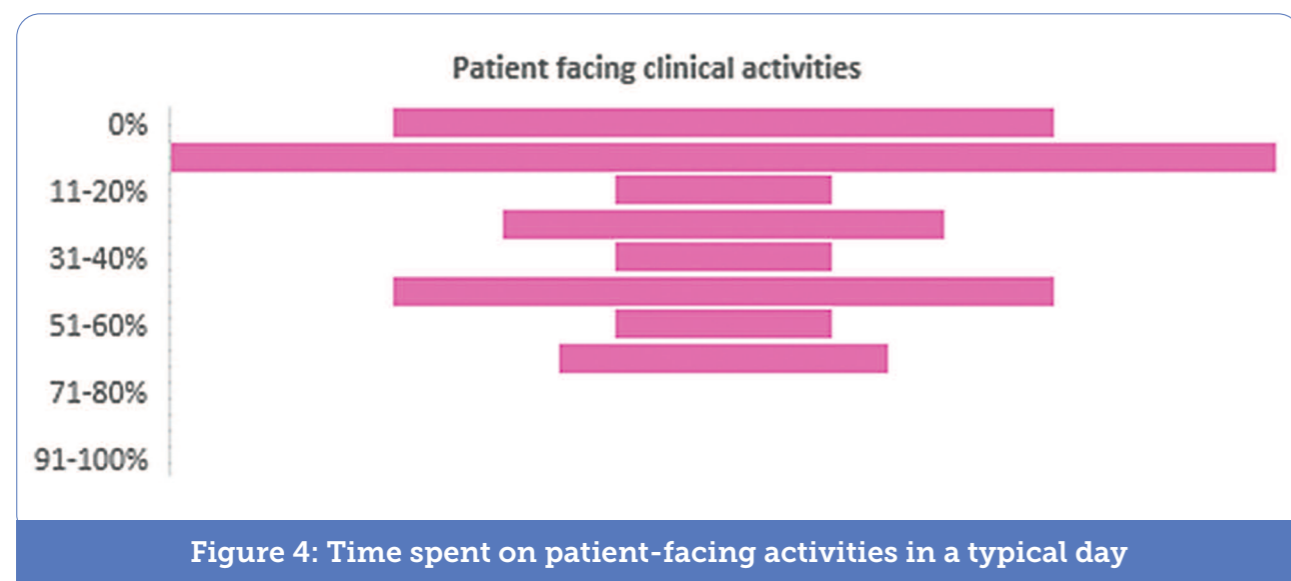
(1.0 WTE) was recruited to the project. Tasks involved medication reviews; patient one to one medication sessions; side effect assessments using the Glasgow Antipsychotic Side effect Scale (GASS); carer groups; caseload reviews; receiving and dealing with general practitioner referrals and ensuring appropriate monitoring of high-risk medicines (e.g. clozapine, valproate, lithium, long-acting antipsychotic injectables). Previously pharmacy provided minimal support to CMHTs.

Activity data from July 2020 until February 2021 included 651 high risk medicines interventions, 176 patient one to one sessions, 120 medication reviews (many of which were complex), 121 GASS tool assessments, 65 patients' general practitioners informed to update their summary care record with clozapine and 20 general practitioner referrals.

Community staff were asked how much of their time was saved as a result of pharmacy presence in community teams. Of the 7 doctors who responded, the majority (n=3, 43%) reported 3-4 hours/week. The remaining reported: up to 1.5 hours/week (n=1, 14%); 1-2 hours/week (n=1, 14%); 2-3 hours/week (n=1, 14%) and 2-4 hours/week (n=1, 14%). 12 care-coordinators responded, with the majority (n=6, 50%) reporting 1-2 hours/week. The remaining reported: 0.5-1 hour/week (n=3, 33%) and 2-3 hours/week (n=2, 17%).

Case study 3: Derbyshire Healthcare NHS Foundation Trust

In 2019/20, Derbyshire Healthcare NHS Foundation Trust invested £310,000 in additional pharmacy staff to expand their clinical pharmacy service to community mental health teams and establish the most effective way of supporting these teams to prevent admissions and reduce





occupied bed day usage (OBDs). Six main workstreams were targeted including improving evidence-based prescribing, access to medication, medication adherence, access to advice and medication safety. Data showed a reduction of 957 OBDs per year due to proactive pharmacy involvement and the potential for a further reduction totalling 1200 OBDs annually when operating at full capacity. Numerous other beneficial outcomes were detected including, community staff feeling better supported to complete their role and a significant increase in antipsychotic side effect monitoring.

Case study 4: Lancashire and South Cumbria Foundation Trust

In 2017, Lancashire and South Cumbria Foundation Trust recruited a band 5 pharmacy technician (0.2 WTE) to support one community mental health team. The one-year pilot involved the pharmacy technician running a physical health clinic for patients on psychotropic medication to ensure monitoring was completed

as per national guidelines. This included carrying out physical health checks such as BMI/weight/waist circumference, blood pressure and pulse, and highlighting any bloods tests due such as prolactin, blood glucose and lipids. Data after 12-months showed the number of patients who received the necessary minimum standards of physical health monitoring as per national guidelines increased across all parameters from 0% to 73% for weight; 55% to 100% for blood pressure and 13% to 70% for ECG. Blood tests also improved for glycated haemoglobin - HBA1C (from 45% to 92%), glucose (from 38% to 75%), lipids (from 37% to 91%) and prolactin (up to 87%). In addition, the technician would promote medication adherence, check smoking status and alcohol intake and monitor side effects using the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS).

Discussion

The *NHS Long Term Plan* describes 'clinical pharmacists and pharmacy technicians' taking on 'extended roles' to 'increase the amount of time they can spend with patients'. This requires pharmacy staff to be patient-facing.

The good practice case examples from organisations that have embraced changes mentioned in the *NHS Long Term Plan* highlight the positive impact pharmacy staff have had on improving patient outcomes, reducing multidisciplinary workload pressures and on helping the health economy. However, there is huge potential to do more. For example, if 50 mental health sites replicated and embedded all of the good practice models outlined in the case studies, this could result in a significant reduction in patient wait times (based on case 1 reporting a reduction from 12-16 weeks to 4-6 weeks); help medical vacancy gaps and cost £900K less than employing middle-grade psychiatrists (based on case 1); a reduction in occupied bed days by almost 50,000 (based on case 3) and better minimum standards of physical health monitoring (based on case 4).

Sadly, findings from the national survey show that there is widespread variation in practice amongst the 19 NHS trusts across England that responded, with many organisations still focusing on 'traditional' pharmacy roles rather than patient-facing activities. The composition of direct patient-facing activities reported as being carried out on a typical day, ranged from 0-70%. Over half of responders (51%, n=18) reported spending only up to 20% of their day on patient-facing clinical activities; of which a third (n=6) reported spending none. Only 14% (n=6) report being patient-facing for greater than 50% on their day.

Whilst it was promising to see from the survey that patient clinics comprise of 20% of total pharmacy activities in these teams, it was somewhat surprising that within these clinics only 11% of tasks comprised of prescribing despite more than half of staff (55%, n=22) reporting being independent prescribers. It is unclear why this is the case and whether this was out of choice or due to lack of confidence, supervision or other potential barriers.^{4,5,6} However, it highlights an important area to focus on to bridge the gap borne out from

the findings of the national scoping exercise and good practice cases.

Across London, some mental health trusts have started tackling variations in practice by implementing standard KPIs. Data 6 months post-implementing shows how this approach successfully increased pharmacy involvement into direct patient-facing activities in three out of four organisations (the remaining had no change) by up to 60%.

Conclusion

The case study examples provide evidence of exemplary models of care across integrated care systems where pharmacy staff have made measurable improvements to patients and staff, including reduction in patient wait times, an increase in patients receiving the minimum standards of physical health monitoring and releasing multidisciplinary staff time. If these models were replicated and embedded across other organisations, there is potential for the pharmacy workforce to significantly benefit both patients and staff. However, the scoping exercise has highlighted some challenges and addressing these must be a priority to close the gap.

"One of these challenges is the wide variation in pharmacy time spent on patient-facing activities. This could be tackled by developing nationally agreed key performance indicators with a focus on activities related to direct patient care. This approach has been successfully tested locally within the London region and provided positive results, increasing time spent by up to 60%."

Another challenge is the lack of pharmacists using their prescribing qualifications even when staff are in patient-facing roles. Exploring the reasons for

this was outside the scope of this study, but one approach could be to use pharmacy technicians to release pharmacists. Additionally, organisations should explore how better to use technology as an enabler to release staff time to focus on clinical care and 'reduce administrative burden' 2 on tasks such as medicines audits which was an activity reported by 22% of staff working in these teams.

There is also an opportunity to develop networks to share good practice and learn from those who have embedded these new models across integrated care systems. Teams should also help build the evidence base on the impact of patient outcomes as a result of pharmacy staff working in these teams through publication.

Authors' contributions

Yogita Dawda conceived and implemented the survey, analysed the associated data, performed literature search and appraisal of evidence-base, conceived the paper, contributed to and collated the good practice case study examples, critical revision and final review of the manuscript.

Rosalind Gittins supported initial draft, critical revision and final review of the manuscript. Both authors read and approved the final manuscript.

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Ethics

Ethical approval is not required because this work is being conducted as a service development project

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Declaration of interests

Yogita Dawda and Rosalind Gittins are credentialed College of Mental Health Pharmacy (CMHP) Council members: Yogita Dawda is co-educational lead and Rosalind Gittins is President.

Reshaping Prescribing Governance in a Changing NHS Environment

Author

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Introduction

As the NHS undertakes a transition into new integrated care board (ICB) structures that bring existing organisations within local health systems closer together but also forge close links with local authorities and social care, many localities will be looking at the structures and mechanisms they have in place to manage prescribing and medicines use.

Having gone through a number of significant changes with our structures and processes over the past few years and, whilst recognising Frimley ICB is one of the smaller systems in the country, it is not without its own complexities. I hope sharing our experience will provide useful insights of our journey that could be helpful to colleagues looking at solutions for their own geography.

Historical context

Many of these changes began in 2015 when Frimley Park Hospital NHS Foundation Trust (FPH) acquired its northern neighbour Heatherwood & Wexham Park Hospitals NHS Foundation Trust (H&WPH). Though these organisations were not physically distant, in terms of regional geography, they had been part of separate clinical networks and commissioning geographies. As such this was seen as an opportune time to review how we wished to govern prescribing and medicines within the new organisation, Frimley Health NHS Foundation Trust (FHFT).

As the acquiring trust, there might have been a temptation to impose existing FPH processes across the entire footprint but recognising that these historical arrangements were not ideal, I and others argued this was an opportunity to reconfigure arrangements to have more inclusive

and robust decision-making processes, tailored to the new population we served. Initially I gained support from the FHFT chief pharmacist and the DTC chair, in my capacity as DTC secretary, to lead exploratory discussions with clinical commissioning group (CCG) medicines optimisation leads across our enlarged footprint.

These progressed well with a shared vision for managing formulary decisions emerging which we disseminated to wider stakeholders including the medical director and the membership of the existing legacy DTC/APC committees within FPH and H&WPH. These legacy bodies were subsequently brought together into a new body, the Frimley Health Area Prescribing Committee (FHAPC). This new body was tasked with formulary decision-making for new items coming to market as well as a programme to review the existing clinical guidelines and the formulary, which due to bringing together a number of localities in its initial form, had to acknowledge historical variation and subsequently agree consensus positions that would apply across the enlarged geography that FHFT would now be serving.

One of the challenges at this time was that this body, whilst recognised as a decision-making body by the enlarged hospital trust, was only advisory to the CCGs that commissioned services from the organisation as they were not allowed to delegate decision-making responsibilities to another organisation. As such, its decisions had to be ratified by each of the five CCGs that were part of our geographic footprint. This extended the time period for decision implementation and still left the possibility for geographic variation if decisions were not uniformly adopted.



Subsequently in 2016, sustainability and transformation plans (STP) were rolled out across the NHS, requiring NHS providers and CCGs to come together into STP footprints to facilitate the delivery of multiyear plans to address the needs of their local populations. The STP had a number of priority workstreams that brought together professionals across different organisational and professional boundaries to look at creative solutions to longstanding issues with how care was delivered in our system.

This allowed a reframing of this work into a system-based approach, with organisations and individuals becoming less wedded to historical decisions and arrangements and more open to new solutions that worked for the wider system. In the following few years, the separate CCGs went through a number of mergers so that we went from five CCGs to three in 2018, and finally a single merged CCG in 2021. As a consequence, the FHAPC was reviewed, and agreement reached to replace this with a new Medicines Optimisation Board (MOB), which was empowered to be the decision-making body for medicines for our system.

This allowed for decisions that were made to be implemented in a timely manner. However, there was still a significant issue of capacity to progress all the relevant items of work through the MOB,

even though there were a number of subgroups and subcommittees that supported particular medicines optimisation workstreams. Consequently, we have recently reviewed arrangements again since the establishment of the ICB, and the MOB has now become our ICB Medicines Board. This body has a much more strategic role in our ICB to develop and implement key elements of the strategy for medicines optimisation, with most of the operational decision-making delegated down to a number of subcommittees. These subcommittees are tasked with working on particular specialised areas of work and making decisions in relation to these, then reporting to the Medicines Board for assurance purposes. The Medicines Board may undertake further review and adjustment by exception. The Medicines Board itself reports to the ICB Quality and Delivery Committee, which is accountable directly to the ICB Board.

Challenges and Learning

One of the early challenges was making the case for change. This was made easier in some instances, for example within the Pharmacy and Medicines Optimisations teams, as there were a number of long-established working relationships across the geography. Thus it was easier to gain acceptance for the concept of changing

governance arrangements to promote greater collaboration on decisions.

In contrast, there was some work needed initially to convince senior executives whose perception had been shaped by the context of the commissioner/provider relationship that had held sway within the NHS for many years and had not been without its tensions historically. This was overcome by having the right individuals again with established relationships with the executive teams act as champions, making the case for the change we were proposing.

Resourcing was a big challenge. Whilst such work can be attempted by asking individuals to incorporate this into their existing work plans and responsibilities, invariably in such cases progress is slow and this can prove frustrating. Thankfully we were able to secure additional resource to support this work through a fixed two-year appointment of a Formulary and Clinical Integration Pharmacist (FCIP), whose work was invaluable in bringing our various disparate guidelines and formulary decisions together into a single formulary.

“When this fixed term post ended it was notable that progress slowed significantly. It was recognised that having established a baseline from which we could build towards having consistent and unified decisions across our geography, whilst we did not need the same level of support as had been provided by the FCIP, nevertheless support was needed to prevent this work losing momentum.”

Therefore an administrator was appointed to provide ongoing support to the medicines optimisation work stream of our ICS.

Trust was a key element in enabling change that needed to be built and maintained. Bringing disparate organisations together it was crucial that everyone felt they had a voice that was being heard within the discussions and also that no organisation felt they were being dictated to by others or that their historical decisions and views were being discarded offhand. This meant that our initial joint formulary did have to state and highlight some geographic variation, but this was recognised as necessary in the initial period and would be addressed as we progressed with the work of revising and updating the formulary.

Looking back one of the other learnings was that sometimes naivety can be helpful. As an example, bringing the legacy committees together into a single new body was something that happened very swiftly and perhaps without the usual level of discussion and consultation with the membership of these groups. In contrast some of the other committees within our geography, where consolidation was recognised as being desirable, were seemingly approached in a much more deferential manner and a number of years later had still not managed to converge into a single body.

A healthy dose of pragmatism is the last vital ingredient I would wish to highlight. Such change cannot be delivered if the focus is on perfection. Whilst it is certainly not wise in any health-related field to have a cavalier approach, equally it is important to maintain a focus on the overall goal and not get bogged down in finessing the detail.

Had we not been prepared to make changes and take decisions until we were certain we had all the right stakeholders on board, or we had the terms of reference written exactly as everyone wanted, we would still be discussing ideas as opposed to having gone through the process of trying a variety of solutions until we arrived where we are, with what we feel works well within our system.

This pragmatism is also vital when working with neighbouring ICBs. Patients do not always stay solely in one healthcare system geography, with cross-border patient flows common, it is important to have pragmatic guidance available to prescribers on how these should be managed.



Conclusion

This is clearly a time of much change and some uncertainty within the NHS. This can be unsettling, but equally we have found it can be empowering. It is an opportunity to look at what has been in place historically and how this may be improved in the future, to engage with passionate colleagues that want to improve how healthcare is delivered, including how decisions on medications are made at a local level.

I and other colleagues that I have worked with have found this work challenging but also very rewarding. Setting up new governance bodies, especially to address areas where we had been aware of deficiencies historically (such as on the use of medical devices) and putting arrangements in place that we hope will see patients across our system geography consistently provided with timely access to high quality medicines has been a fantastic experience.

“We know more change is coming (e.g. the delegation of specialised commissioning functions by NHS England to ICBs) but we feel in the context of medicines optimisation we have the structures and processes in place to enable us to meet successfully the fresh challenges around the corner.”

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Celebrating 15 years of proudly servicing NHS Homecare patients



Based in the Heart of England in Birmingham, Quest has a strong heritage in Homecare, Research and Development and Pharmaceutical Manufacturing.

The two founding brothers, Majad and Yasar Hussain, are both pharmacists with strong formulation capability. They have built their business over the last 15 years through building relationships with NHS Homecare leads, NHS hospital pharmacists and R&D collaborations with industry and academic institutions to improve patient outcomes. The company's success can be directly attributed to its highly customer-orientated approach, delivering its services to the needs of each individual customer and patient.

Quest core expertise lies in the provision of low and mid-tech, national homecare services and formulation and manufacture of unlicensed compounded medicines. The dual capability enables them to offer high quality, timely supply to patients.

Yasar leads the R&D and manufacturing operations of the business. He explains how Quest's unique range of extended shelf-life batch products have been developed as a result of demand from a variety of sources, including NHS trusts typically contacting them for help to address patient medicines compliance issues:

“We recognise that with the ageing population and increasing complexities of medication management, clinicians may be seeking alternative forms of medicines. Our formulation team regularly respond to clinicians and hospital pharmacists to advise on medication management. Our ability to develop foams, sprays, liquids and fast melts has been an area of significant innovation for Quest.”



Quest operates from two sites, at Phoenix Park and Mount Street in Birmingham, both of which have received significant investment to build capability and increased capacity by over 40%.



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Quest Healthcare employs UK registered Pharmacists and Accredited Technicians, trained specifically in the provision of homecare services, with a key responsibility of checking dispensed items before they are delivered to homecare patients and following up any patient queries when necessary.

With our General Pharmaceutical Council (GPhC), Medicines and Healthcare products Regulatory Agency (MHRA) and wholesalers' dealers licence, Quest is committed to the highest standards in regulatory compliance and patient safety in supporting the NHS and private referring centres. Quality is central to the ethos of the company.

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Quest prides itself on its high level of agility and responsiveness to supporting NHS trusts and their patients. Through its in-house compounding facility, it can ensure continuity of supply to patients during times of market shortages, and support NHS providers by creating capacity for their own compounding units.

Key Facts

✓ MHRA Licenced
✓ Products manufactured to EU GMP regulation
✓ Unlicensed products R&D
✓ Creams, sprays, fast melts, liquids, topicals
✓ Mid-Low tech frameworks
✓ GPhC registered, ISO 9001:2015 certified
✓ Over 4,200 patients nationally
✓ NCHA member

Helping to deliver your needs

Quest is committed to working closely with the NHS, private hospitals and pharmaceutical companies to develop and deliver high quality and efficient homecare services.

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As members of the National Clinical Homecare Association (NCHA), we continue to welcome enquiries in the following areas:

Homecare

- Low and mid-tech homecare services nationally on NHS and HealthTrust Europe (HTE) frameworks
- Dosettes for homecare patients
- Supply of ancillaries

Key homecare therapy areas in which we specialise include the following (but we welcome requests outside these areas as well):

- Infection – HIV, cystic fibrosis
- Musculoskeletal – rheumatology
- Malignant disease
- Cardiology
- Nutrition & blood

We pride ourselves in demonstrating a highly responsive service to pharmacy and homecare leads. Our customers can expect a quick turnaround on queries and no long waiting times for a response. Our standard home delivery or collect service is supported by phone call and SMS text option.

R&D and unlicensed compounded supply of medicines

When NHS trusts contact us with issues on patient compliance, we work closely with them to identify solutions through different unlicensed product presentations, e.g. liquid, sachets, fast melts, etc. In cases where clinicians are seeking a single combination product, as an alternative, our formulation pharmacists are available discuss patient needs with prescribers and provide support as necessary.

KPI performance tracking and customer feedback

All key data sets are captured under our homecare agreements.

Testimonials

'We have now trialled a number of patients with Quest and we are happy with the service. We are happy to switch the rest of our patients'

Senior Clinical Pharmacist,
Chesterfield Royal Hospital
NHS Foundation Trust

'The clinical teams are thrilled with the service'
Advanced Pharmacist - Homecare Medicines,
University Hospitals of Derby & Burton
NHS Foundation Trust

'We have been very pleased with our relationship with Quest and everything has gone smoothly from our perspective'

Homecare Specialist, Sandoz UK Limited

'High quality and price conscious service; the transition has never been so smooth! Thank you!'
Head of Medicines Management
Birmingham's Children's Hospital

'The service has been fantastic. It has been a breath of fresh air You have been extremely responsive to all our queries and have gone above and beyond to ensure a smooth transition'

Chief Pharmacist Technician,
Outsourced Services, Heartlands Hospital



Contact Us

We would love to hear from you to see if we can help you on homecare or unlicensed R&D and manufacturing. Please get in touch on:

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