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A Pharmacy Perspective

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Editorial

Things are getting exciting in the world of integrated care systems (ICSs) as we are beginning to see strategic plans published, providing a definite direction for organisations that have been busily engaged in planning since their inception last year. For the rest of 2023 we can expect to see exactly how these fledgling organisations will reconfigure services, watching with particular interest the Place (or middle level) of ICSs, where primary care networks and players such as community pharmacies are increasingly taking the lead in delivery.

In this issue, we begin what will be a series of articles on tackling healthcare inequalities (an NHS Long Term Plan priority attracting both funding and scrutiny), beginning with Jay Patel (Clinical Leadership Fellow, Health Education England) who provides a pharmacy perspective on the impact of language barriers to patient care and how these can be actively overcome.

Finlay Royle (Assistant Director of Medicines and Long-Term Conditions, South East London ICB) provides valuable insight into how integrated care boards view the role of community pharmacy, now and as the ICS experiment takes shape. Community pharmacies are often described as essential to the evolution of the NHS, increasingly providing services traditionally seen in other parts of the primary care system. Finlay gives us a hands-on perspective of what this might look like.

Clair Huckerby (Consultant Pharmacist, Primary Care Medicines Optimisation at Our Health Partnership), talks to us about her most rewarding career moment as a pharmacist, also sharing valuable insights into the profession and its future.

And we also have a timely insight into the important subject of resilience, provided by Imogen Gray (Professional Trainer for Pharmacy Management), of particular interest in these challenging times.

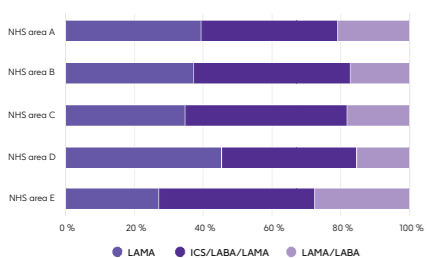
I hope that you will find the Journal both interesting and of use – our objective is to provide you with insights that translate into real-world examples of best practice and shared experiences. And, as ever, do please contact me with any ideas you have for articles and experiences of a changing healthcare system that is, to say the least, never dull.

John Chater
 Editor – PM Healthcare Journal
 E: editor@pmpublications.co.uk



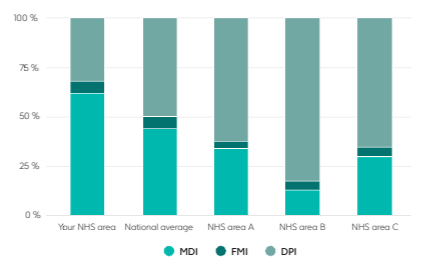
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The Impact of Language Barriers on Patient Care: A Pharmacy Perspective

By Jay Patel

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Abstract

Introduction

The number of non-proficient English speakers in England and Wales has increased over the years.

All patient-facing pharmacy professionals will interact with patients who experience language barriers during their career. Healthcare professionals should strive to provide high standard equitable care to all patients, regardless of their background. This however, is not always possible when language barriers are introduced.

Aim

To understand the experience of pharmacy professionals across sectors, when they encounter language barriers with patients.

Key Objectives

1. Investigate how pharmacy professionals feel when they encounter language barriers with patients
2. Understand the effect of language barriers on patient care from a pharmacy professional's perspective
3. Determine the benefits and challenges of using existing language barrier services

Method

A survey was distributed to patient-facing pharmacy professionals across England. Participants were asked a series of questions to help understand their experience when encountering language barriers with patients.

A total of 468 eligible responses were recorded and two subsequent focus groups were run.

Key Findings

Pharmacy professionals across sectors experience strong emotions, including frustration, helplessness and anxiety when communicating with patients who experience language barriers.

Pharmacy professionals report being under-skilled and feel they are not sufficiently trained or supported to care for patients who experience language barriers. Because of this, they feel they are not able to deliver high-quality equitable care.

There appears to be lots of variation in the quality and accessibility of language barrier services across workplaces, particularly for those working in the community sector. Overall, pharmacy professionals are not satisfied with the standard of these services.

Pharmacy professionals do not feel supported by their workplaces to utilise language barrier services.

Conclusion

Education and training around language barrier management is both needed and wanted.

Without adequate resourcing into translation and interpretation services, the health inequalities that exist within our healthcare system will continue to grow.

Introduction

The Office for National Statistics (ONS) estimates around 239,000 more people came into the UK than left between June 2020 and June 2021. This was primarily driven by non-EU immigration.¹

Provisional estimates show this figure more than doubled between June 2021 and June 2022. This is partially due to recovery in the travel industry following the coronavirus pandemic, and ongoing support for those requiring protection

such as Ukrainian nationals.² Immigration increases ethnic diversity within the UK and also contributes to the number of residents who do not speak English as a first language.

“Ethnicity is a complex, multidimensional term where a group can be identified by their shared common features such as their origin, skin colour and language spoken. Ethnicity however is subjective and is based on how individuals define themselves.”³

The 2011 census revealed that almost a million people in England and Wales could not speak English well or at all (non-proficient English speakers). Preliminary findings show this figure now exceeds one million.⁴ Only 65% of non-proficient English speakers reported being in good health compared to 88% of proficient English speakers. Lower English proficiency may contribute to reduced quality in care.⁵

People within ethnic minority groups are more likely to report being in poor health and report poorer experiences using healthcare services when compared to those identifying as ‘White British’.^{3,6} Health inequalities such as this are complex and arise due to a multitude of factors. An improvement in the management of language barriers could help to minimise existing health inequalities.

All patient-facing pharmacy professionals (pharmacists and pharmacy technicians) across England will interact with patients from ethnic minority backgrounds during their career. The frequency of these interactions increases for those working in culturally rich areas. The degree of English proficiency in patients from ethnic minority backgrounds can vary significantly. This means language barriers may be experienced more often with this cohort.

Healthcare professionals should strive to provide high standard equitable care to all patients,

regardless of their background. This, however, is not always possible when language barriers are introduced.

The information that pharmacy professionals gather through their interactions with patients is primarily related to medicines. Communication challenges arising from language barriers can contribute to poor medicines adherence and increased patient safety risk.^{7,8}

NHS England states, “Patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of healthcare as others.”⁹ Pharmacy professionals are therefore expected to utilise any language barrier services (LBS) that they have available to them when appropriate. However, access to these services varies considerably.

Indirectly communicating with patients using their relatives or friends (associates) to interpret is not recommended.⁹ In practice, however, this guidance is not always followed. This can put the patient at risk, particularly if information is misinterpreted. Privacy is also a concern when communicating through patient associates, as it can be difficult to determine whether the patient consents to sharing personal information with them. This could lead to patients withholding important information.

Primary care guidance states that where language is a problem in discussing health matters, a professional interpreter should always be offered.¹⁰ This guidance can be applicable to all settings. Accessibility to LBS should therefore be available to all patient-facing pharmacy professionals.

This report seeks to understand the experience that pharmacy professionals have when trying to overcome language barriers with patients, this is to establish if adequate support is in place.

Aim

To understand the experience of pharmacy professionals across sectors when they encounter language barriers with patients.

Objectives

1. To investigate how pharmacy professionals feel when they encounter language barriers with patients
2. To understand the effect of language barriers on patient care from a pharmacy professional’s perspective
3. To determine the benefits and challenges of using existing language barrier services
4. To make recommendations based on the findings to reduce health inequalities

Method

A survey was distributed to patient-facing pharmacy professionals across England using Microsoft Forms. Participants were asked a series of questions to help understand their experiences when they encounter language barriers with patients.

The survey also captured the quality of care they felt they were able to provide to this cohort and their confidence in any LBS available to them. Respondents were subsequently given the opportunity to participate in a focus group to help expand on the findings.

A total of 468 eligible responses were recorded with 369 from pharmacists and 99 from pharmacy technicians. Survey respondents were based across multiple sectors. Two focus groups were run following the survey.

Focus Group 1

1. Pharmacist (Primary Care) North East & Yorkshire
2. Pharmacist (Secondary Care) North West
3. Pharmacist (Primary Care) North West

Focus Group 2

1. Pharmacist (Mental Health) North West
2. Pharmacist (Secondary Care) North West
3. Pharmacist (Community & Primary Care) North East & Yorkshire
4. Pharmacist (Community & Secondary Care) North East & Yorkshire
5. Pharmacist (Secondary Care) North West
6. Pharmacy Technician (Community & Secondary Care) North West
7. Pharmacist (Health and Justice & Primary Care) Midlands
8. Pharmacist (Community & Primary Care) South West
9. Pharmacist (Secondary Care) North East & Yorkshire
10. Pharmacist (Secondary Care) North West

Are you a Pharmacist or a Pharmacy Technician?

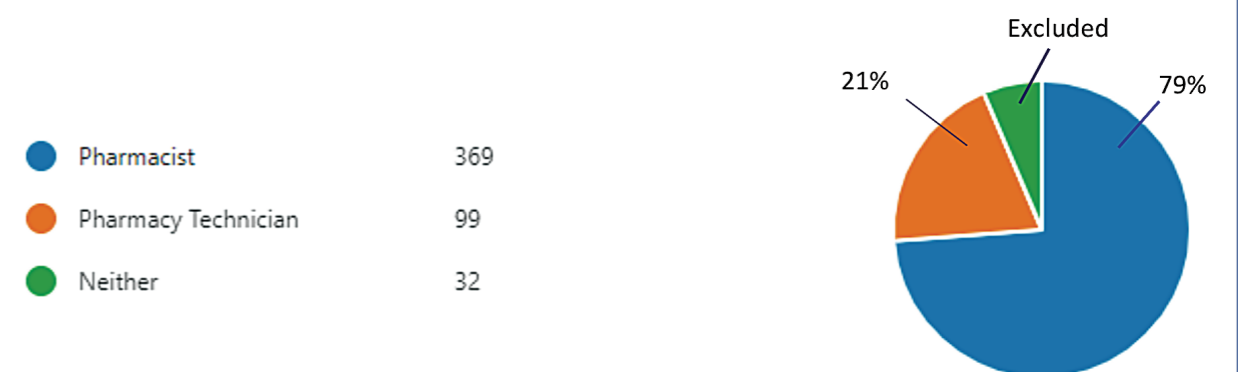


Figure 1 – Proportion of pharmacist and pharmacy technician respondents



Which patient facing sector do you work in?

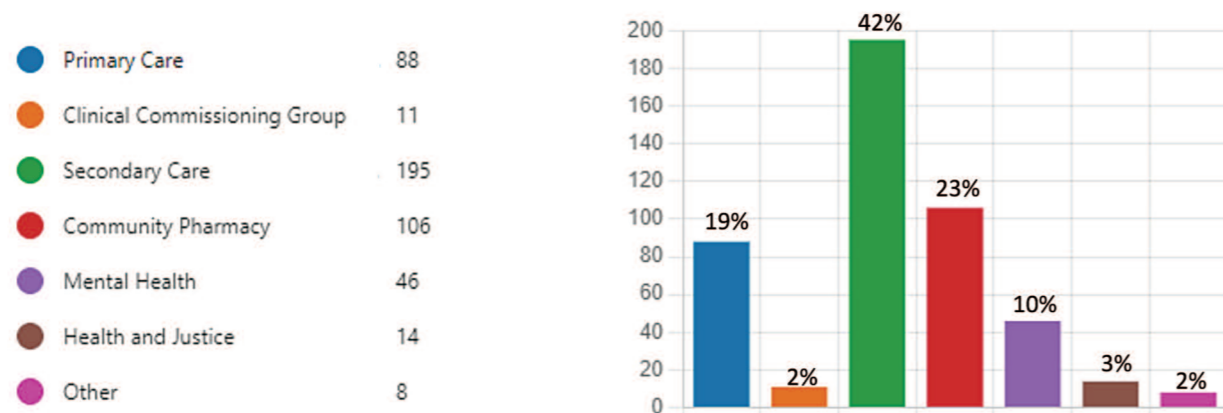


Figure 2 – Proportion of respondents per sector

Which region best describes where you work?

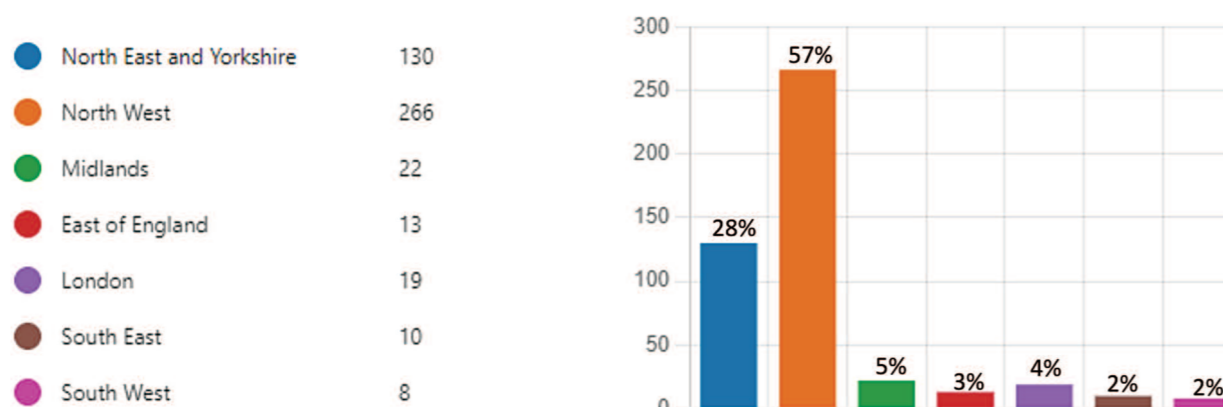


Figure 3 – Proportion of respondents per region

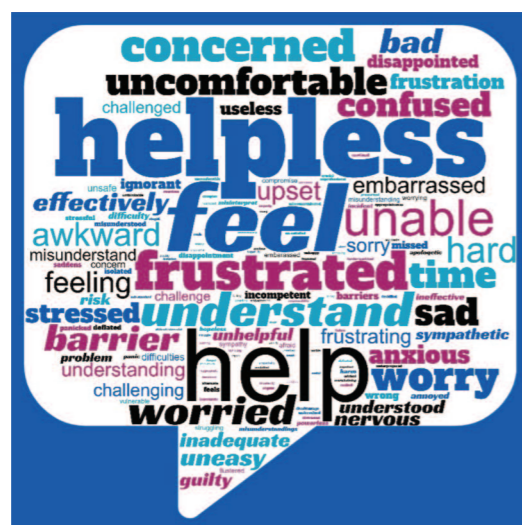


Figure 4 – Word cloud highlighting respondents' feelings when engaging with patients who experience language barriers.

Discussion

The impact of language barriers on pharmacy professionals and patient care

The word cloud seen in figure 4 highlights the overwhelming feelings of frustration, anxiety and helplessness that pharmacy professionals feel when communicating with patients who experience language barriers. Responses were the same regardless of region and profession. Some responses are listed below.

"I feel awkward, not sure what to do, embarrassed. I feel like walking off."

"I feel frustrated for the patient and myself. I feel they are not listened to by other professionals due to the language barrier."

"I feel frustrated, hopeless, defeated."

"It makes the job that needs carrying out more difficult. Sometimes it makes you feel like you are incompetent."

"I feel embarrassed that I can't understand them. It is annoying that I have to take longer to be able to talk to them, which will make my day more stressful."

"I feel concerned and under-skilled."

"I worry that they might be trying to tell me something important about their care that I need to be aware of. I feel frustrated as I know that accessing interpreter services is not straightforward."

"I feel like I cannot offer them the same quality of care and it saddens me."

Hundreds of similar responses were reported demonstrating that many pharmacy professionals are not adequately trained or supported to care for patients when there is a language barrier.

Respondents highlighted their concern for patient safety, and it is evident their own well-being is at risk based on the strong emotions they are experiencing. These feelings of incompetence and absence of skill may contribute to poor satisfaction and low retention rates.

Respondents identified that they are unable to offer the same level of service to patients who experience language barriers. Almost all believe that the quality and quantity of information shared with these patients can be reduced. (figure 5 and 6).

There were a few alternative views where pharmacy professionals believed the onus should be on the patient to overcome the language barrier.

"It makes me feel annoyed. Why do they assume that I can speak their language? I feel that they should at least bring someone to help them translate. I feel that they are causing unnecessary stress to the staff."

Frustration is evident in the statement above. All healthcare professionals however should be aware that it is their responsibility to accommodate any additional communication needs the patient may have.^{9,10} It should also be reiterated that use of patient associates to translate or interpret is not recommended.⁹

One bilingual interviewee from a focus group spoke of the challenges that patients face when they encounter language barriers in healthcare.

"During COVID, when there were limited interpreters, the patients on the wards looked scared. They were just suddenly having things done to them. When I was able to interpret for those who didn't speak English, they were really grateful. We need to appreciate the value of communication because sometimes, language barriers are really isolating."

Hospital admissions are often major life events that are never forgotten by the patient. Healthcare professionals should be mindful of the additional isolating effects language barriers can have and aim to reduce them by utilising LBS available to them.

Accessibility of language barrier services

Accessibility of LBS appears to be a major issue. As a result, multiple participants report using Google Translate to help them overcome language barriers. This is particularly prevalent in the community sector.

Do you think the quality of information shared with patients is reduced when there is a language barrier?



Figure 5 – The impact of language barriers on the quality of information shared with patients

Do you think the quantity (amount) of information shared with patients is reduced when there is a language barrier?

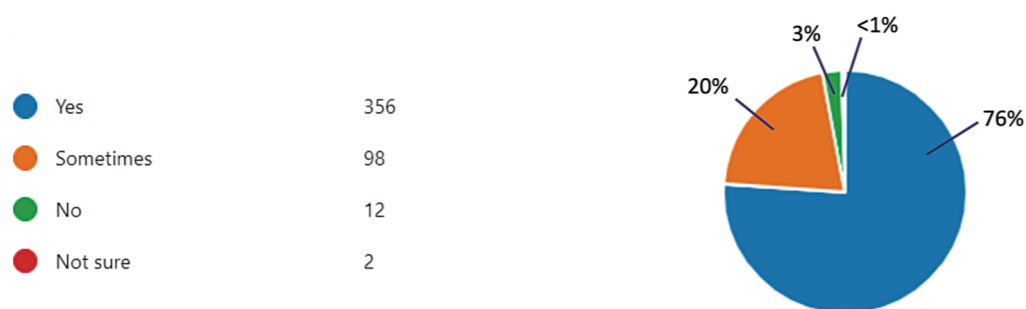


Figure 6 - The impact of language barriers on the quantity of information shared with patients

Does your workplace (to your knowledge) have any services to help overcome language barriers?



Figure 7 – Number of respondents with access to language barrier services

“I’ve had an experience previously where I needed to speak to a patient about an adverse effect of their medication. We ended up using Google Translate and it was an absolute nightmare. It was awful because it didn’t translate what we were trying to say at all.”

Evidence suggests that Google Translate is inaccurate and should not be used for medical discussions with patients.¹¹ Improvements to the accessibility of LBS across sectors should be made to reduce reliance on services which have not been validated.

The findings show greater access to LBS is required, however, 16% of respondents (76) were unaware if they had LBS available to support them (figure 7). There was no disparity between pharmacists and pharmacy technicians for this. Healthcare professionals should be shown how and when to access any LBS available to them by their employer. This is to ensure services are sufficiently utilised.

Only 14% of community pharmacy respondents reported having access to LBS. This figure is much lower than all other sectors indicating community pharmacy professionals have limited support (figure 8). This lack of support contributes to reliance on non-validated services such as Google Translate.

One GP Practice pharmacist said:

“We can ring (interpreters) at any point. I’ve never had a problem getting one. Previously, I worked in community pharmacy, and it was a lot trickier as we didn’t have the option of an interpreter, so I relied on Google Translate, which is much worse. In GP practice, it’s much better... I feel like they (community) need a lot more help.”

Below are some statements from community-based pharmacy professionals about the challenges they have faced.

“There is no access to any language barrier services in community pharmacy. If one was available, it would need to be accessible instantly.”

“I try to find solutions for the patient to assist them. I owe a duty of care and I feel I’m unable

to meet this due to language barriers, which is frustrating.”

“It’s very challenging to communicate your message.”

“It’s quite hard because you want to be able to help, but there are resources we can use like Google Translate.”

“It leaves me very confused and also sad that I can’t help the patient. I usually have to turn them away when I can’t get the information required to supply them with medicines or advice.”

Patients should never be turned away due to language barriers, regardless of sector. Community pharmacy professionals therefore need access to LBS or information which allows them to signpost patients appropriately.

Use of Google Translate was commonly reported. Pharmacy professionals need educating on the inaccuracies and risks associated with its use.

To ensure a more consistent level of care across England, access of LBS must be more equitable.

A secondary care pharmacist based in based in the most Northerly region in England said:

“Up here, there’s very little infrastructure or material to help you. Physical interpreters are very difficult to access and aren’t available on demand, because you need one so infrequently. So when you do come across a language barrier, everyone is just like, ‘oh dear...’ The best we get here is telephone interpretation, and it’s under-utilised, or not actually available.”

68% (318) of participants reported having access to LBS. Of these, 245 stated they had a telephone interpretation service (figure 9). Access to this type of service however was not without its challenges.

For some, the option to use telephone interpretation is only possible when working in practice. Remote roles have been steadily increasing across healthcare and particularly in primary care. Sufficient infrastructure should therefore be in place to ensure that patient care is not adversely affected by this change.

Does your workplace (to your knowledge) have any services to help overcome language barriers (by sector)

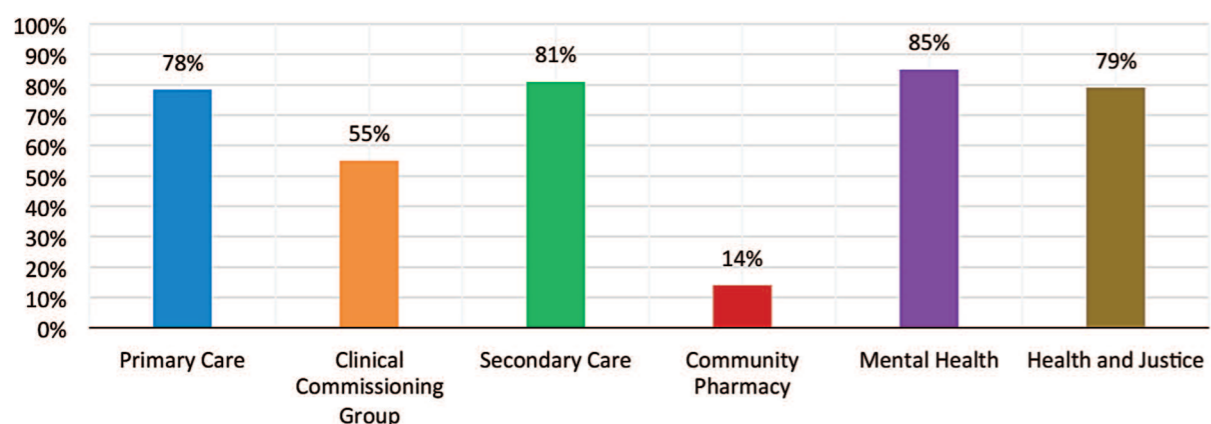


Figure 8 – Proportion of respondents (per sector) with access to language barrier services

What service(s) does your workplace use to help overcome language barriers?

Telephone interpretation	245
Video interpretation	19
Face to face interpreters	170
Other	55



Figure 9 - Type of language barrier services available (for respondents with access)

Have you ever used these service(s) to communicate with a patient?

Yes	174
No	144

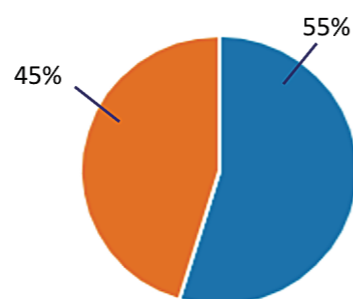


Figure 10 – Previous use of language barrier services (for respondents with access)

Despite LBS being available for some, only 55% of those who were aware they had them had actually used them (figure 10). Low usage could be partially attributed to those working in less culturally diverse areas.

"We don't have many patients who would need that service, so that's probably why I'm not aware of how to use it, but I'm sure they're there."

A majority of those who have used LBS in the past believe that they helped facilitate conversation. This suggests they are beneficial (figure 11). Unfortunately, more than half of the respondents with them have avoided using them. (figure 12). To expand on this, focus group participants were asked why they thought this was.

One mental health pharmacist said:

"What I find frustrating is accessing services in a timely manner. When I need to perform a medicines reconciliation, get consent, or ask questions about a medical history, I can't get the information there and then. It's really frustrating that there is nobody readily available to support me."

Another secondary care pharmacist said:

"It's just the timeliness, getting somebody there at the right time. It's not right, but we try and work around it. So if you're completing a medicines reconciliation, you would probably just avoid using the patient as a source (of information), which is wrong."

Patients are often a valuable source of information. Aversion due to accessibility issues contributes to inequities in patient care.

"Sometimes the process is very complicated and long, so the time needed can put you off."

Most interviewees agreed that increased speed in the delivery of LBS would improve uptake.

Workplace associated barriers

Workplaces should ensure their pharmacy professionals are supported with the additional time it takes to accommodate patients who experience language barriers.

Government guidance suggests an interpreted consultation should take approximately twice as long.¹⁰ Responses unfortunately suggest that workplaces do not support this.

There appears to be a lack of clarity on when LBS should be used in NHS Trust settings. Multiple interviewees believe that interpreters are reserved for medical consultations and should seldom be accessed by pharmacy. When questioned on this, one participant said they were told not to use LBS by a senior, due to the high cost of the service.

Delayed action or inaction from pharmacy can have a significant impact on patient well-being. LBS should therefore be accessible to all pharmacy professionals. Clarity on the correct way to use LBS across workplaces would ensure greater consistency of care.

Many interviewees stated they had never been shown how to access LBS in their workplace.

"In our trust, we encounter language barriers a lot. We have a good telephone service, but it's poorly utilised. There are two barriers: one is a poor understanding of how to use the service, the other is that you have to go on hold for a while. In addition, the phones aren't always portable so getting a patient to one can be an issue."

A demonstration of appropriate LBS use during induction would be a rapid way to improve both awareness and uptake of services for little to no cost. Portability of hardware must be improved to accommodate patients unable to mobilise.

Survey respondents and interviewees mentioned utilising multilingual colleagues to interpret as common practice. Multilingual interviewees however reported this to be an additional responsibility which unfairly increases their workload. They also worry about misinterpreting information which could cause harm to the patient.

Language barrier service quality

Less than half of the respondents who had used them were content with the standard of LBS (figure 12).

"I once had a poor experience with a local interpretation service where it was later



Did these service(s) improve the communication between you and the patient?

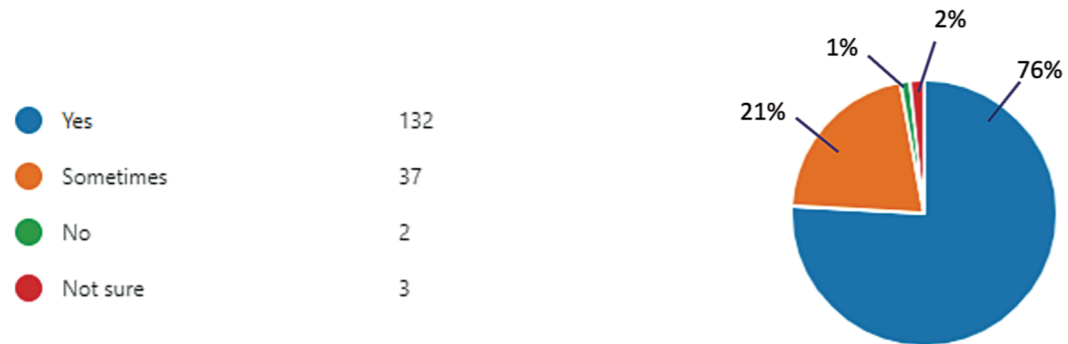


Figure 11 – Language barrier service improvements to communication

Did these service(s) help you communicate to a standard you were happy with?

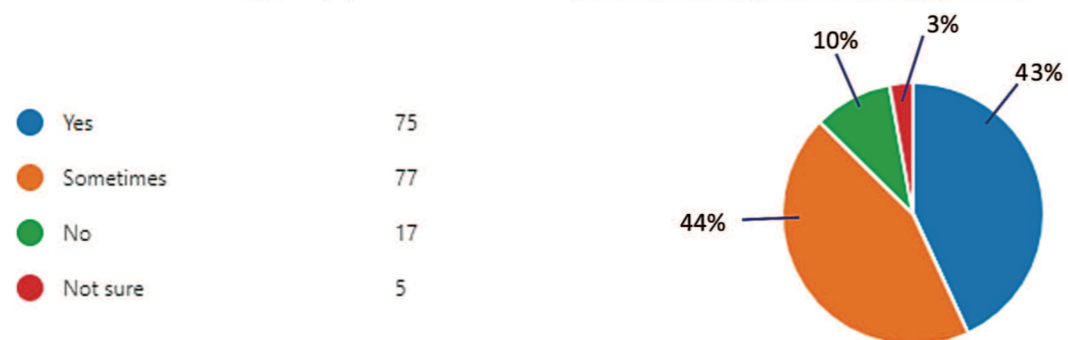


Figure 12 – The effect of language barrier services on facilitating an acceptable communication standard

Have you ever avoided using these language barrier service(s)?

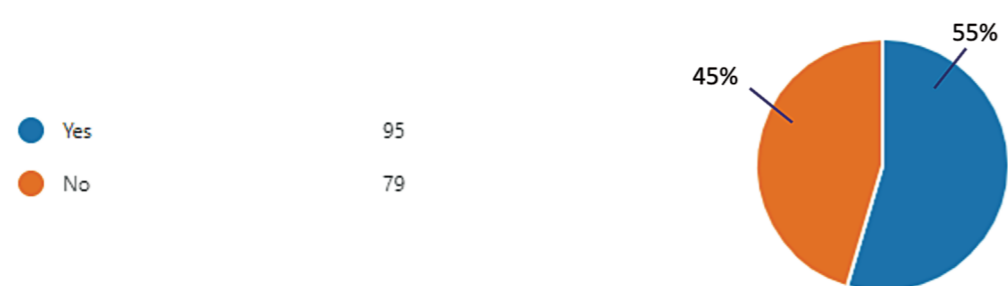


Figure 13 – Previous aversion of language barrier services (for respondents with access)

discovered that the information relayed to the patient was the complete opposite of what I wanted them to hear."

"I do not feel confident in the services when I use them. The quantity of information passed over is noticeably less. Often, I am sitting with these patients during interpretation. If I show them specific boxes of medication, they seem confused, as if they don't understand what is being said or what is happening."

Quality assurance and regulation of LBS across sectors does not currently exist. This must be reviewed given they are a necessity for many patients to be able to communicate effectively.

Interviewees were quick to point out the advantages a physical interpreter has over telephone interpretation despite the majority of available services being telephone-based (figure 9). Body language was referenced to be a very important form of non-verbal communication which is missed in telephone interpretation. Unfortunately, only 36% of respondents reported having access to physical interpreters.

Excluding those unsure, 73% of respondents believe that overall, the quality of care provided to patients who experience language barriers is worse than those who do not. Only a quarter believe their care is equitable (figure 14).

Inadequate LBS quality, coupled with accessibility issues, prevents the goal of equitable care from being achieved.

Education and Training

77% of respondents stated they would like further education and training on how to address and overcome language barriers (figure 15). Statements from the focus groups corroborated these findings.

"There's an internal training need to make sure that people aren't frightened to access the LBS that are available because currently, they are."

"I've noticed when I'm locuming and a patient who doesn't speak English comes in, the response from the staff is not good. They're often frustrated by their arrival. So, the clinicians and the staff definitely need a bit of training in cultural and language bias."

Training should allow pharmacy professionals to approach all patients, confidently and competently. Pharmacy professionals should be supported to access LBS or know where to signpost patients to when necessary. Prequalification training should include cultural competence, ensuring pharmacy professionals are aware of the potential biases which may influence care provision.

Limitations

A majority of survey respondents and interviewees were from the North of England. Findings, therefore, are less conclusive for the Midlands, East and South of England.

Survey responses for mental health, health and justice and clinical commissioning group (CCG) sectors were much lower than other sectors. Having said this, community pharmacy, primary care and secondary care are more popular sectors, so response rates per sector are fairly typical.

The sample size of one of the focus groups was small however a rich discussion was still held.

Conclusion

Pharmacy professionals across sectors experience strong emotions, including frustration, helplessness and anxiety when communicating with patients who experience language barriers. This puts their mental health and well-being at risk and also increases the risk to patient safety.

Pharmacy professionals report feeling under-skilled and feel they are not sufficiently trained or supported to care for patients who experience language barriers. Because of this, they feel they are not able to deliver high-quality equitable care. This contributes to the health inequalities that exist within our healthcare system.

The extensive time needed to access LBS can have major impacts on service delivery. This is contributing to their aversion and subsequent disparities in care. Those in the community sector have significantly less access to LBS when compared to other sectors.

Clarity on the correct use of LBS is needed to ensure resources are used appropriately. Workplaces do not currently support pharmacy professionals with the adequate time needed to

How do you think the care provided to a patient who experiences language barriers compares to the care provided to a patient who speaks English well?

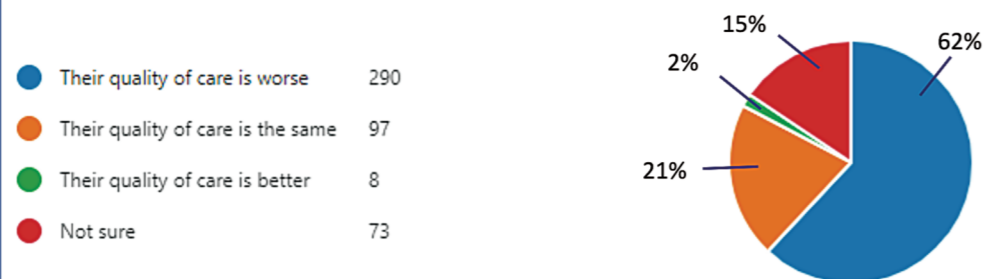


Figure 14 – The effect of language barriers on patient care

Do you think additional training and support on how to address and overcome language barriers would be beneficial to you?



Figure 15 – Number of respondents wanting additional training and support on managing language barriers

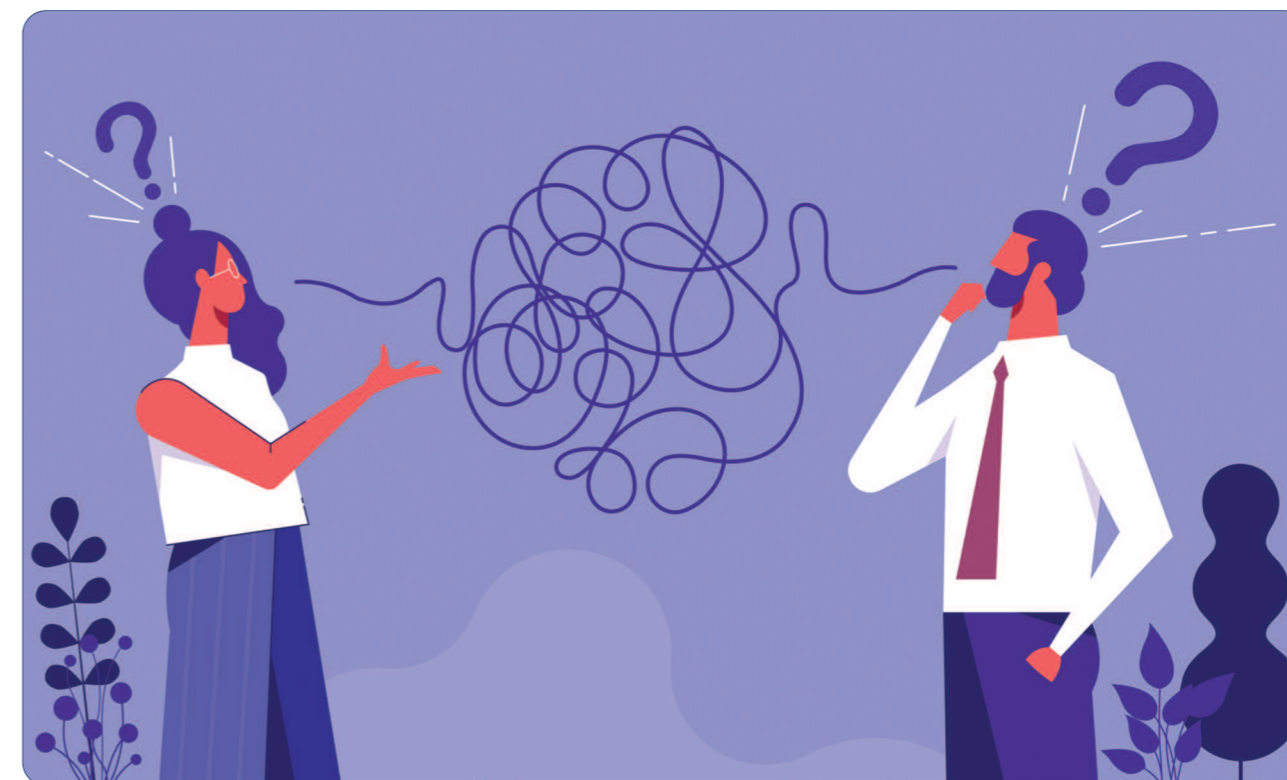
care for patients who experience language barriers.

Most pharmacy professionals stated that LBS help facilitate communication, however, there appears to be lots of variation in quality and overall, the standard of LBS is not satisfactory.

Education and training around language barrier management is both needed and wanted. Healthcare professionals should be aware that they are responsible for fair care provision, regardless of background and be aware of the impact cultural bias can have on patient care.

While this report highlights the contribution of language barriers to health inequalities, further work should be undertaken to identify examples of high-quality care using LBS, to inform and direct employers and organisations.

Health inequalities stifle the NHS and left unchecked, they will continue to grow. By addressing the issues highlighted in this report, pharmacy professionals will be able to deliver a more inclusive service that meets the needs of the public. From 2026, newly qualified pharmacists will qualify with prescribing abilities, therefore, it is likely they will adopt a more consultative role. For this reason, the barriers identified in this report must be addressed.



Recommendations

For Regulatory Bodies

- Consider how the findings of this report apply to current EDI strategies
- Consider the inclusion of competent language barrier management for pharmacy professionals, when reviewing the initial education and training (IET) standards and the professional standards

For NHS England and other NHS bodies

- Recognise translation and interpretation services are poorly resourced. Investment is needed to ensure access to high-quality LBS exists across England
- Work with educational providers to support pharmacy professionals engage with patients who experience language barriers
- Improve access to LBS and sharing of resources, particularly for those in the community sector
- Investigate how language barriers impact care from the patient's perspective

For Educational Providers

- Ensure pharmacy professionals are culturally competent and aware that care should be

equitable for all patients, regardless of background

For Employers

- Ensure that pharmacy professionals' mental health and well-being is protected by supporting use of high-quality LBS
- Support pharmacy professionals with the additional time that is needed to care for patients who experience language barriers
- Ensure that new and existing staff are signposted to the LBS available to them and are shown how and when to access them
- Recognise the additional workload and pressure that multilingual staff face when asked to interpret or translate. Employers must protect these staff if they are expected to provide this service
- Ensure healthcare professionals are aware of the risks to patient safety when using translation and interpretation methods such as Google Translate and patient's friends and family members
- Ensure LBS are accessible to staff working remotely



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David Gibson, Associate Dean, Early Career Pharmacists Team, North School of Pharmacy and Medicine Optimisation, Health Education England.

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Implementation of diabetes service redevelopment at North Stockton PCN

By Nadia Malik,

PCN Clinical Pharmacist, North Stockton PCN

Diabetes is a complex disease, progressive in nature and unfortunately growing in prevalence.¹ The landscape of diabetes management is evolving and to change the trajectory of associated complications a multifactorial approach is required to maintain health outcomes.^{1,16,17} Diabetes UK has identified 4.9 million people in the UK currently living with diabetes, and this figure is expected to rise to 5.5 million by 2030.¹

"Covid-19 has impacted all aspects of our lives, but none more so than healthcare. Acting as a catalyst it has expedited changes in the way healthcare services are delivered, alongside the challenges of managing new and ongoing clinical care."²

Lockdown restrictions throughout the pandemic have contributed to the disruption of diabetes management including limiting new diagnosis, cancellation of routine reviews, digitisation of structured education and lack of treatment intensification, with areas of deprivation being disproportionately affected.^{2,3,4}

NICE describes health inequalities as unfair differences in health status between groups of people or communities that exacerbate health disparities.⁷ In the North-East of England spending per person fell by 30% compared to 15% in the South-West, the disparity in public services negatively impacting the more deprived areas and with Covid-19 further exacerbating the situation.⁸ The National Diabetes Audit (NDA) starkly exposed that there were greater decreases in the nine-care

process delivery for people with Type 2 Diabetes (T2D) living in the most deprived quintile.⁵

All people with diabetes aged 12 years and over should receive all of the 9 NICE recommended care processes and attend a structured education programme shortly after diagnosis.²⁴

Deprivation underpins almost all health inequalities and, crucially, health inequalities are avoidable. The most deprived areas typically have fewer GPs per head and lower rates of admission to elective healthcare despite having a higher disease burden and are precisely the areas with the greatest need.^{9,10} It is no coincidence that major risk factors for T2D in the UK such as obesity, reduced physical activity, smoking and poor diet are disproportionately higher in areas of socio-economic deprivation.^{1,10}

The effect of the Covid-19 pandemic has resulted in a significant interruption of routine appointments compared with pre-pandemic levels. Additionally, many thousands of diagnoses of T2D will have been delayed or missed.¹⁴ An article in the *BMJ*¹¹ identified that between March and December 2020, the rate of prescribing new diabetes medications fell by 19%, raising concern as clinical inertia from failure to intensify therapy is a contributing factor to serious and costly longterm complications.⁴

(The definition of clinical inertia has been expanded to include: a failure to establish appropriate targets; to escalate or de-escalate treatments in order to achieve treatment goals; and to prevent over-treatment in recognition that for some people with diabetes, particularly frail older adults, overtreatment can cause significant harm through hypoglycaemia or weight gain.)²¹

This, in combination with ADA/EASD guidance necessitating patient-centred glycaemic management, formed our protocol for medicine



How PARM Diabetes works

Step 1 – GP practice extracts Diabetes patient dataset from clinical system using a predefined search as provided in the associated PARM Diabetes user guide.

Step 2 – Copy and paste the practice's diabetes patient data into the PARM Diabetes tool. The tool then converts the raw data into a user-friendly dashboard, with additional tabs displaying patient cohorts in different formats.

Step 3 – The practice's own PARM Diabetes tool can be saved in a shared space for the multidisciplinary team to begin identifying patients whose treatment may be optimised/is to be reviewed and working together on smaller, more manageable patient cohorts.

Features of PARM Diabetes include:

- PARM Diabetes Dashboard
- HbA1c Profiles
- Blood Pressure Profiles
- National Diabetes Audit Calculator
- New Features in PARM v2021

	Ph on Sulphonylureas	Ph on Metformin	Ph on Oral Monotherapy (incl. Metformin)	Ph on Metformin + 1 Oral Therapy	Ph on Dual Oral Therapy (Metformin (incl. Metformin))	Ph on Metformin + 2 Oral Therapies	Ph on 3+ Oral Therapies (incl. Metformin)	Ph on GLP-1	Ph on Insulin	Total
HbA1c >= 7.5	0	8	1	8	1	2	0	1	0	21
HbA1c 6.5 - 7.4	0	14	3	18	3	8	0	5	0	51
HbA1c 5.5 - 6.4	0	9	3	10	1	5	1	4	0	32
HbA1c 4.5 - 5.4	0	17	3	9	0	1	0	2	0	31
HbA1c < 4.4	1	0	3	4	0	1	0	0	2	11
No HbA1c recorded	0	0	0	0	0	1	0	0	0	3
Total	1	50	12	48	5	18	1	12	2	149

■ Immediate safety issue. ■ Need review by practice team. Non-urgent action.
■ Likely to need more specialist input. ■ In target.
■ Prompt action required by practice team. ■ Need HbA1c test.
■ Need review by practice team.

optimisation, ensuring diabetes care was delivered in a structured way to enhance engagement.¹⁶ The influence of clinical characteristics ensured that medication regimens were simplified and de-intensified where appropriate to support adherence, targets for weight and glycaemic management plans were individualised and SMART.^{5,16}

It is currently estimated that around 10% of the NHS yearly budget is spent on the treatment of diabetes, equating to £9 billion annually.¹² Those living in the most deprived areas such as the North-East of England have seen their routine care most affected with the prevalence of T2D higher than the national average. This could represent a target for early intervention.⁴

A survey carried out by Diabetes UK as part of the Diabetes is Serious campaign highlighted that 1 in 3 patients with diabetes had not had contact with their diabetes healthcare team throughout the pandemic. 63% of survey participants that reported having difficulties managing their diabetes during the pandemic referred to a lack of access to services and support by their diabetes healthcare team as the reason, rising to 71% in the most deprived quintile.¹ This will potentially have a longterm impact on them and the NHS in the future, as access to healthcare is vital in supporting patients to manage their condition and reduce the risk of serious diabetic complications.

Specifically, Tees Valley Clinical Commissioning Group (CCG) demonstrated, using the validated IQVIA CORE diabetes model,²³ that over 3-years,

a delay of one year in treatment intensification in 17,252 people with type 2 diabetes was estimated to result in a budget impact of £2,311,709 in direct costs.¹⁸

Restoring services and tackling the backlog at North Stockton PCN

North Stockton PCN, based in the North East of England, is comprised of three surgeries: Queens Park Medical Centre (QPMC), Tennant Street Medical Practice (TSMP), and Alma Medical Centre (AMC), and has a population of 45,017 (January 2022). The initial pilot was carried out at the largest of the practices, QPMC, which has a type 2 diabetes population of 1,164 (identified using searches on SystmOne) and the service will later be extrapolated to the remaining PCN.

Method

Initially patients were identified by the recall system built within SystmOne, however it quickly became apparent that this was reactive, essentially firefighting. Guidance from the Primary Care Diabetes Society (PCDS),¹⁴ and the National Diabetes Audit (NDA) in combination with a risk stratification tool were used to shift the onus from ad-hoc treatment to a more pro-active approach.

ProActive Register Management (PARM) is a population health management tool that enabled identification and management of specific patient

cohorts as part of a risk stratification strategy. It was developed by Lilly Diabetes and NHS Devon CCG with input from Kernow CCG.

The PARM tool was employed to prioritise patients according to HbA1c and medication regimen. It is widely documented that reductions in HbA1c reduce complications associated with diabetes.^{17,19,20} Following a consultation with the healthcare assistant for baseline measurements and bloods patients received a consultation with the PCN pharmacist.

“The PCDS article highlighted the importance of planning to avoid pitfalls, specifically stating the need to ensure that patients see the right member of staff at the right time to receive the right care.”¹⁴

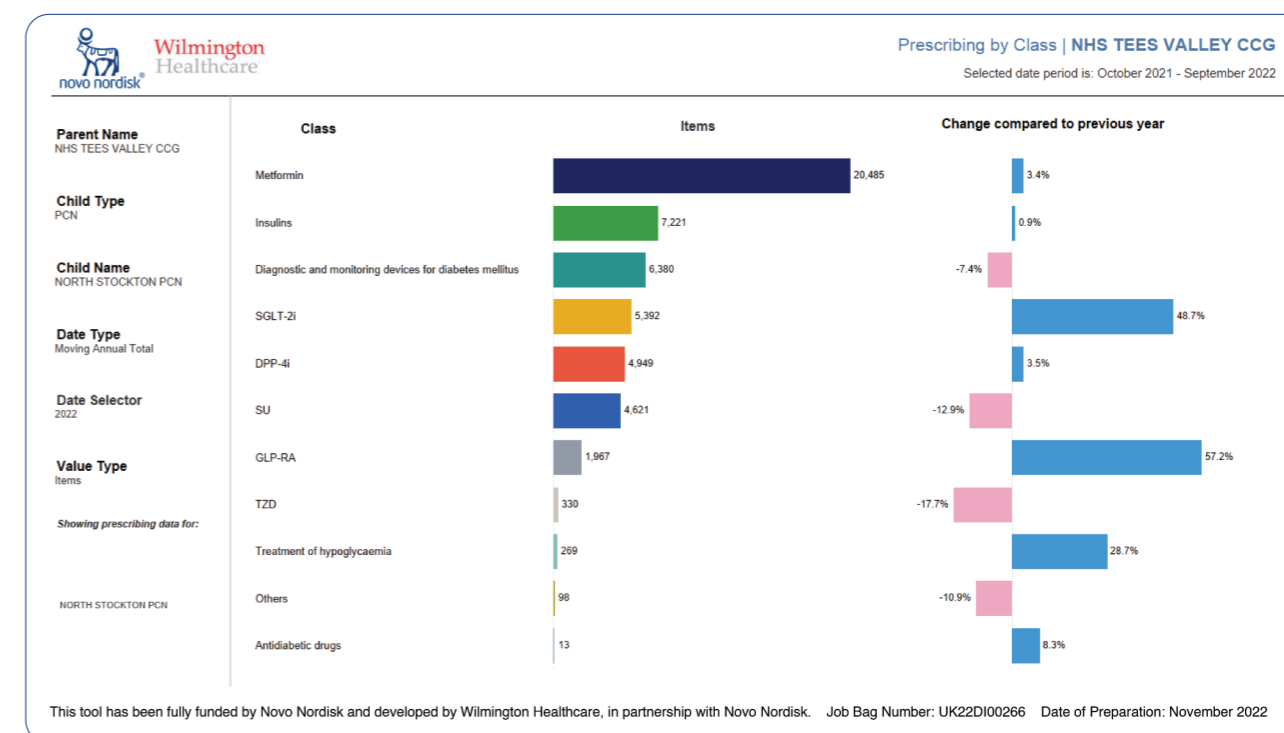
To avoid further exacerbating clinical inertia, the upskilling of healthcare professionals within the PCN was vital, ensuring they were ideally placed to strengthen more cohesive working between diabetes services in primary care and specialist services in secondary care and district nursing

teams, helping to clear the backlog from Covid-19.¹⁴ Alongside diabetes education and access to technology, care closer to home has been imperative in supporting patients with self-management of their condition thus reducing health inequalities and improving health outcomes. The involvement of pharmacy technicians, social prescribers and health and wellbeing coaches allowed for a multi-disciplinary and holistic approach, taking into account the support patients required for socio-economic influences, emotional wellbeing and mental health.

Medicine optimisation

As per protocol, all patients registered as having Type 2 Diabetes at QPMC were invited to attend their annual review when due. Limited by capacity, (June 2021- May 2021), 174 patients were allocated to a PCN pharmacist, who attended a primary consultation and agreed to further management in the form of medicine optimisation. Of these, 13 (7.5%) had a reduction in medication and 60 (34.5%) were initiated on new treatments, including injectable and oral GLP-1 RA, which would otherwise have needed a hospital referral for initiation.

12 patients were identified as receiving insulin treatment and 9 treated with sulphonylureas that had an HbA1c level <48mmol/mol, indicating an immediate safety issue. Seven people were able to



reduce their insulin dose (basal or premixed insulin, ranging from 68-328 Units/day), with a total mean unit dose reduction of 70 Units/day per person. Nine people overall no longer required blood glucose monitoring strips, resulting in further cost savings.

Risk stratification allowed identification of people with diabetes and CVD risk, and treatment optimisation towards SGLT-2 inhibitors and GLP-1 RA, in line with the ADA/EASD consensus report and NICE guidance (NG28).^{2,3} SGLT-2 inhibitor and GLP-1 RA prescribing increased by 48.7% and 57.2% respectively during October 21 - September 22 compared with the previous year at QPMC. In addition, there were decreases in sulphonylureas (-12.9%) and thiazolidinediones (-17.7%) prescribing and small increases in DPP-4 inhibitors (3.5%) and insulin (0.9%) prescribing.

“Due to limited resources, from June 2021-May 2022, only 64 (34.6%) people with diabetes had ≥ 2 HbA1c tests, however appropriate treatment initiation in primary care and medicines optimisation resulted in improvements in glycaemic control resulting in a mean reduction in HbA1c of 13 mmol/mol.”

A patient survey was circulated to 50 patients who attended for a review with the pharmacist in August 2022: 35 responses were received, with 71% of patients rating their overall consultation with the pharmacist as ‘outstanding’.

Working with the district nurse team

The Covid-19 pandemic placed healthcare professionals under immense strain. District nurse (DN) teams are responsible for managing some of the most vulnerable patients, including those that require support with insulin administration. An average cost for a DN is £75, each visit lasting up to

25 mins, with some patients requiring multiple daily visits, a service that continued despite the restrictions imposed by the pandemic.²²

Under the umbrella of the Network Contract Directed Enhanced Service (DES) contract framework, we can work alongside the DN team and review T2D patients that are likely to be most in need and may otherwise slip through the net.

Ten patients that required DN support for insulin administration were identified following an MDT with the DN team and PCN pharmacist, followed by a review of their diabetes medication and management. Hypoglycaemia risks in frail patients, number of visits and complexity of regimen were used to identify patients.

The reviews showed that out of the ten patients, eight had received no interaction with any other healthcare provider other than the DN team during the whole pandemic. Six patients had not tried oral therapies such as DPP-4 inhibitors or SGLT2i. (They had been initiated onto insulin due to hyperglycaemia, however due to the pandemic had subsequently been reviewed.) Of those six patients, four patients had medication deprescribed, changing twice daily insulin to once daily long acting analogue insulin and/or oral and injectable GLP1-RA. Not only has this improved patient care by improving clinical outcomes, but it has also reduced the number of visits required by the DN team, thus reducing costs. At present, we are looking to implement continuous glucose monitoring for LD and Care home patients that qualify to further optimise patients care.

To allow the DN team and other healthcare professionals to be able to have the confidence and support to continue providing this level of care, a Diabetes Interest Group (DIG) has been set up. The Tees Valley DIG provides upskilling through learning, education and a much-needed support network for healthcare professionals, who often work alone.

Summary

With diabetes costing the NHS an estimated £10 billion a year, approximately a tenth of the health budget, we must harness the expertise of the hundreds of pharmacists that are now employed



by PCNs to deliver the care that the NHS requires to help clear the existing backlog of patients.

The anticipated deterioration of blood glucose levels and cardiovascular risk factors due to delayed diagnoses and reduced monitoring of patients with established diabetes need to be addressed, and PCN teams are ideally placed to help support.^{4,14} Although PCNs are at differing stages of development, PCN teams can still offer a multidisciplinary approach to this multifactorial condition, focusing on the most underserved populations.¹⁴

Behaviours that promoted weight gain during lockdown such as poor diet, reduced physical activity, increased alcohol consumption, poorer mental health, and reduced sleep quality when compared with before lockdown can be addressed by utilising non-clinical team members such as social prescribers and health and wellbeing coaches. It is not a one size fits all approach, but a blueprint could be established with the flexibility to tailor bespoke aspects according to the individual requirements of the PCN demographic.

The case study at QPMC was the basis for the business case when applying for integrated care board (ICB) funding to allow further expansion of the pilot across the PCN. The case study highlighted that there is still considerable clinical inertia in the management of diabetes in primary care, which underlines the importance of implementing more cohesive working for better patient outcomes. The evidence supports the implementation of a pharmacist-led multidisciplinary team (MDT) model, allowing patients with complex polypharmacy to undergo a

comprehensive review of their medication regimen, considering all aspects of their health and wellbeing and not just clinical characteristics.

More comprehensive data is required to understand fully the impact and benefits of a pharmacist led PCN approach towards managing long term conditions such as diabetes. The subsequent work will help identify key learning areas, develop best practice and support service redevelopment to reduce referrals and workload in secondary care, whilst providing care closer to home for patients and thus reducing clinical inertia and health inequalities.

In a wider context, clinical inertia from delays in therapeutic intensification are known to have economic implications.²⁴ By initiating new treatments in patients who would otherwise disengage, cost savings could be expected and would form the basis of further work at North Stockton PCN.

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How does the ICB view the role of community pharmacy now and in the future?

PM Healthcare interviews Finlay Royle, MPharm, MSc, MRPharmS, Assistant Director of Medicines and Long-Term Conditions (South East London ICB).

Finlay, could you give us a brief overview of your position and its responsibilities?

With a colleague, I lead the borough's medicines optimisation team in supporting general practice and broader primary care, to manage the prescribing budget, implement guidelines, support practice pharmacists and community pharmacists in doing their job. We also have responsibility for managing diabetes, cardiovascular and respiratory pathways and local services. It is a change from the traditional medicines management function of managing the budget, to being more about the implementation of strategy and helping to support the people who see patients take a more holistic approach to pharmaceutical care.

And then we also work upwards through South East London integrated care system (ICS) teams to help influence disease pathways and working with secondary care colleagues around implementation of new drugs.

Can you give us an outline of South East London's demographics and its resources, to help us understand community pharmacy in that context?

We have a population of around two million that is highly variable in terms of deprivation, ethnicity and age. We have pockets of high deprivation, multiple languages spoken, and variability in health outcomes.

Within the ICS there are three acute trusts, two mental health trusts, one stand-alone community health trust, over 200 GP practices and over 300 community pharmacies, which is a huge network of resource in our communities. At that scale, there is more scope to consider how that resource can be used more effectively to help

improve care for people and improve outcomes.

And we spend around £800 million in total on medicines across South East London – everything from general practice, prescribing and all way through to the specialist medicines that we are using in secondary care.

Where does community pharmacy sit in the agenda of the ICS?

The Covid pandemic was immensely challenging for healthcare systems, not only for the population's health at large, but also for our workforce. Many of our residents and colleagues are still suffering from the impact of that now, both in terms of mental health as well as physical health.

I think one of the things that came out of that was that we need to be much better at how we support colleagues in terms of mental health, capacity constraints, and all those things which affect colleagues everywhere. There is an important piece there, I think, reflecting back during that time when community pharmacy was open: they literally opened their doors. That is something we really have got to applaud and recognise and celebrate.

So, I think there is a real recognition, not just from pharmacists but from broader ICS colleagues, that pharmacies were offering things that maybe they were not traditionally offering, such as blood pressure checks, which have now translated into the national frameworks.

And when the vaccines came, of course, pharmacies were really critical in terms of actually delivering that programme, and I think across South East London they delivered about two thirds of all of our Covid vaccines. And so that has been a really important change.





Do you have any examples of things that community pharmacies are doing now which perhaps two or three years ago they wouldn't have been doing, which helps to take pressure off primary care resources?

Absolutely. With vaccines, we implemented a vaccine champions programme during Covid, which enabled pharmacies to have conversations with people about their vaccine concerns. We have since upgraded that into a health and well-being scheme, essentially a programme where pharmacies can offer interventions such as blood pressure checks, signposting to smoking cessation services, and weight management services.

“So really doing that kind of prevention piece, targeted around health inequality so that we are identifying people who might be at greatest risk. That is the scheme that we have put in place and we are exploring Pharmacy First Schemes from the health inequalities perspective.”

The other thing that we are doing is investing through a pilot programme in Lambeth a community pharmacy primary care network (PCN) leadership programme. We are developing new pharmacy leaders to help develop relationships at the PCN level.

And we are giving them protected time to go to meetings, to speak to pharmacy colleagues. Really the starting point is the national contract services, so thinking particularly of blood pressure services, particularly about the Community Pharmacist Consultation Service (CPCS) services, so they start to raise awareness in general practice of what is happening. I think that's part of the challenge.

How do you see community pharmacy developing in the next 12-24 months?

One area that I think will come quickly will be around vaccinations. With Covid and flu it is fairly straightforward, but I think there is real potential around childhood immunisation.

With the current general practice set-up there are some barriers that we've reached in terms of how many people are taking up those vaccines. And we have had outbreaks of diseases such as measles, and detection of polio in London. One of the challenges for us is around access, which is really important. I think community pharmacy can help support childhood immunisation programmes.

How do you think GPs are responding to the greater involvement of community pharmacy? Do you think there is an awareness of what is happening and that the benefits are seen and understood?

We've got some great GP leaders across South East London in our practices, PCNs and on the integrated care board (ICB). Together with our emerging pharmacy leaders, they have some really great insights into what community pharmacy can offer and the important role that it is going to play in the future. There is also the understanding that the GP practice is not the whole of primary care – that primary care is actually made up of all the four components of primary care including community pharmacy.

“So there is a lot of language and culture change happening, and we've got our local pharmaceutical committee (LPC) CEO Raj Mathar working closely alongside our ICB and trust chief pharmacists across South East London.”

And so those conversations are happening now at a much higher level which in turn is helping to develop relationships across traditional boundaries. I think that is how we will keep the momentum going – how we expand that reach and make sure that it isn't just the top leaders that understand what pharmacy has to offer, but also at the PCN level and practice level that people are being exposed to what pharmacies are doing and hearing that voice. I think that is a really important thing.

Do you see a role for the pharmaceutical industry in terms of facilitating an exchange of learning, best practice, creating meetings, etc? What would be the attitude of the ICB towards appropriate support from industry, specifically to help the

agenda for community pharmacy development within the ICS?

I think the pharmaceutical industry can certainly support around things like the leadership aspect. If you think of it from the broader national perspective, how do we support community pharmacy colleagues when they first come into this space? There is something around leadership, skills training and influencing perhaps. That is the sort of thing that perhaps industry could have a role in, where that provision isn't necessarily universally available, although I always feel that these things should be done by the NHS. But if there is a gap then perhaps there is a space for industry to work in a partnership model.

What should we be looking out for in South East London in the next few months that could impact on community pharmacy development?

There are several clear markers to look out for in South East London. Details of our community pharmacy leadership programme in PCNs, which will create a broader range of voices and develop emerging leaders. There will also be an improved uptake of the new pharmacy integrated services. We also have our new Community Pharmacy Clinical Lead role, which will help us take forward the community pharmacy agenda. And finally, the development of new local services delivered via Community Pharmacy.

Finlay, thank you for providing us with the ICS perspective on community pharmacy and a fascinating insight into your work in South East London.

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The Road Ahead for Pharmacy – Cancer and Community Pharmacy

Andrew Walker, Lead Pharmacist for Oncology - The Mid Yorkshire Hospitals NHS Trust and Chair of the British Oncology Pharmacy Association (BOPA) community pharmacy committee

In January 2019, the NHS long term plan outlined the key priority areas for the next decade of healthcare in England. This plan sets out ambitious commitments to improve cancer outcomes with a clear focus on prioritising survival rates and enhancing patients' quality of life.¹

Early diagnosis of cancer is one of the most significant prognostic factors in determining patient outcomes.² This is recognised within the NHS long term plan, which provides a clear target to identify 75% of all new cancer diagnoses at stage I or II by 2028.¹ The current rate of early cancer diagnosis in England has remained around 50% averaged across all cancer types for several years, proving some indication of the scale of the challenge required to meet this target, and improve patient outcomes.³

In June 2022 Amanda Pritchard, NHS England chief executive, announced a pilot project to investigate the potential of community pharmacies to identify opportunistic presentations of cancers, and to explore the viability of direct

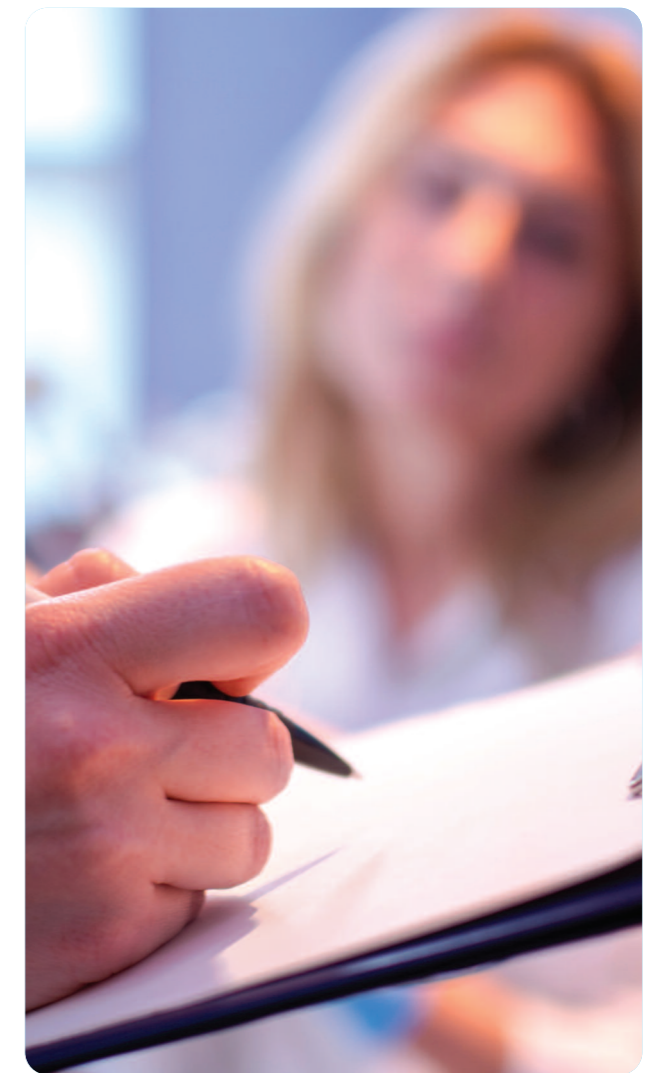
referrals from community pharmacies into diagnostic screening services.⁴ This announcement recognises the huge potential of community pharmacy to act as a resource in identification of patients with symptoms of possible cancers, and the positive impact that a new model of referral which does not rely on GPs may have.⁵

The success of this project will rely upon upskilling the whole community pharmacy team, from pharmacy assistants through to qualified pharmacists to recognise symptoms of potential malignancies, and to correctly identify and refer patients. To provide the required level of educational support the British Oncology Pharmacy Association (BOPA), with funding from Pfizer, has created a bite-sized e-learning programme called 'Lets Communicate Cancer'.⁶ This award winning and NHS England endorsed programme has been recognised within the pilot project and is now included within the Pharmacy Quality Scheme for 23/24.

Following the success of this programme, an expansion of 'Lets Communicate Cancer' has been commissioned to provide additional support. This enhanced content will help to further upskill the pharmacy workforce and provide a range of additional resources to meet the initial and ongoing training needs of pharmacy professionals. In addition to this update, Health Education England and BOPA have produced a range of downloadable factsheet resources to help counter-staff spot and respond to symptoms of some of the most common cancers, which are due to be published in the coming months.

"This project has the potential to change the shape of many patient journeys to diagnosis, and to help the NHS meet its commitment to improve cancer diagnosis rates. It is also an opportunity to demonstrate how community pharmacy could be utilised as a resource to identify and refer patients into diagnostic screening services for other conditions, in addition to suspected cancers."

Utilisation of community pharmacy in this manner would represent a watershed moment in pharmacy practice and illustrate the increasingly complex services provided within community pharmacies. It is exciting to see the potential of the community pharmacy workforce recognised by the most senior leaders within NHS England, and new models of care explored to better utilise this valuable resource.



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The most rewarding moment in my pharmacy career so far....

Clair Huckerby, Consultant Pharmacist, Primary Care Medicines Optimisation at Our Health Partnership talks to PM Healthcare about her most rewarding moment.

The most rewarding moment in my pharmacy career so far has to be in 2017, when I was credentialled as a Consultant Pharmacist.

Having worked in primary care since 1998, I have regularly faced challenges and barriers. Initially, it was due to the attitudes and behaviours of colleagues who weren't familiar with what a primary care pharmacist could do. Many of us working in primary care roles have felt we have had to continually justify the value of our role, either through demonstrating quality improvement or return on investment.

"In 2004 I became one of the first supplementary prescribing pharmacists in the country, and in 2007, following legislative change, I became one of the first independent prescribing pharmacists. Whilst I seized these opportunities, timing wasn't ideal as both coincided with maternity leave. My belief was to lead by example and take opportunities as they presented."

As the years progressed and I have developed in my role, I have led and developed teams of primary care pharmacists, technicians and more recently other professionals and additional reimbursable roles (ARRs), working in primary care networks and general practice. A key driver to the development of new roles is the reporting of success – communicating these outcomes to

stakeholders – which has started to see a change in attitudes as they begin to understand what a difference primary care pharmacists can make to a primary care team.

As NHS England established programs to introduce primary care pharmacists into mainstream general practice, one of the selling points was that pharmacists would save GPs time. This concept has been the focus to some and is open to misinterpretation. These new roles will undoubtedly save time, however they are training roles initially and it is becoming apparent that you get out what you put in. GPs need to put time and support into the development of these roles in order to see their positive impact. For me in a leadership role as a consultant pharmacist, working with our practices and GPs to ensure our pharmacists and technicians have adequate support and training in order to develop in their role, is a priority.

I am fortunate that in the position I am in, I am able to influence national and local policy. My passion is workforce development. I have also been fortunate to work with some inspirational leaders, peers and colleagues over the years. Back in 2016, with the support of my mentor, I decided to challenge the process for credentialling as a consultant pharmacist. At that time, it was a process which only hospital pharmacists followed – primary care pharmacy careers were fairly flat with little chance of progression beyond a prescribing qualification if you wanted to remain in a clinical role. I wanted to demonstrate that pharmacists could progress to working at advanced level without becoming advanced clinical practitioners.

I worked with Royal Pharmaceutical Society colleagues to develop my portfolio and apply to be credentialled as a consultant pharmacist. This involved working with my employer to amend my job description and with stakeholders at Health



Education England and NHS England to challenge the existing process for credentialling. Pushing boundaries once more, I received notification that I had satisfied necessary criteria to be called a consultant pharmacist, to say I was proud was an understatement.

"It didn't make a difference in terms of pay grade, however what it did was create a model which could be replicated across other workforces. There is plenty more to do, and I look forward to inspiring others to push boundaries and to develop the role of the pharmacist in the future."

Building resilience – how to cope with life's challenges

By Imogen Gray

Professional Trainer for Pharmacy Management

When it comes to resilience, it is important to be aware of the things that can help build your resilience, but also to accept that you can't do it all. A good way to break this down is to focus on three principles – minimise, maximise and prioritise.

1. Minimise

Become aware of the things that cause you everyday stress and wear down your resilience battery. Where possible, think of ways to minimise these stressors. Unfortunately, it won't be achievable to minimise them all, but you may be surprised how a few simple changes could make a big difference. Something as small as getting yours/your family's clothes ready the night before can have a huge impact on your stress levels the next morning.

2. Maximise

Gain an understanding of the things that help to charge up your resilience battery. Perhaps it is exercise, listening to music, having a bath, socialising with friends, going out for a walk, practicing mindfulness etc.

"Whilst there are some common things many people find helpful, this list should be personal to you. There is no right or wrong, however do be careful that 'coping habits' don't become unhealthy habits – for example drinking alcohol or smoking."

Also, be aware that sometimes the 'minimise'/'maximise' lists may crossover. For example, socialising with friends may feel great for your resilience at the time, but if that also means a

tiring evening of chatting followed by a late night then it may actually have a negative impact on your resilience the next day. Experiment with finding the right balance for you.

3. Prioritise

Accept that you can't do it all. You may have a whole list of things that you want to 'maximise', but when you're also trying to juggle work and family life it is not realistic to expect to do them all regularly. Instead, prioritise the top actions based on those which have the most positive impact on your resilience and also which you are most likely to stick to consistently.

Working with your team

To build resilience within your teams, it can help to encourage honest conversations within meetings and 1:1s.

Having an activity as a foundation for these conversations can be useful – one of my favourites is called 'the stress bucket'. Simply search this phrase online and you will find various different versions which you can work through as a team to open up the conversation around resilience. Have an empathetic listening ear for each other, and make time to properly check in.

Whilst it can be easier said than done, taking a proper break is also so important for your resilience and can actually make you more productive afterwards. Try to create a culture within your team where a proper break is not only encouraged but actually becomes the norm. And to really maximise this time, take active breaks where possible.

Overall, think of building resilience as the segments of an orange – the actions don't need to be huge, life changing things but the accumulation of lots of small actions can have a big impact.

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Changes in the prescribing landscape and how the pharmacy role continues to develop

An interview with Dr Janine Barnes MBE, Neurology Specialist Pharmacist, The Dudley Group NHS Foundation Trust.

Janine Barnes talks to PM Healthcare Chair Ted Butler about the evolving role of the pharmacist in the NHS, with a focus on the prescription and use of sodium valproate and Primidone.

Hello Janine. Would you be able to give us a quick overview of your career to date? How have you got to where you are today?

Certainly. So, I've had a very varied career – in hospital pharmacy, community pharmacy and then academia, working as an academic lecturer (having completed my PhD in neuropharmacology). I have worked as a Neurology Specialist Pharmacist since 2009 and this really innovative role was developed by Dudley CCG at that time and so they were very much ahead of the game really.

I was initially employed two days a week by the clinical commissioning group (CCG) as was, and then this role was taken over by the trust. So very soon the trust increased my role to four days a week because they could see the benefits from it. And now it's full time and we're looking at expanding the pharmacy team, which is great.

And over time, similar roles for neurology specialist pharmacists have been developed, but very much the roles tend to develop around what is needed locally. So my role initially was split between clinical, medicines management and education. For clinical, this involved running pharmacist-led independent prescribing clinics, predominantly I specialise in Parkinson's disease, and also long-term neurological conditions, including epilepsy.

Medicines management was about ensuring formulary applications were up to date, and also guidelines (for which I was responsible in the area of neurology). The educational side involved working with GP practices and other healthcare professionals within secondary care to make sure that we all have a consistent level of knowledge in neurology.

"Over time my role very much became clinical and I would say that now it is probably more than 90 percent clinical, and that is really what was needed because of long waiting lists locally, and particularly in neurology."

And then what was really nice, sort of culminating all of this, was the MBE that was awarded to me for services to pharmacy and all the work that I had done outside of my employed role. It felt good to be acknowledged for doing things differently and working nationally, particularly with The National Institute for Health and Care Excellence (NICE).



Thank you, that's great career history. How does your job in the current environment cross over between primary and secondary care? Are you a big link in terms of getting continuity of treatment?

I've certainly been working at it and I think I have been more or less from the start, coming from primary care then going to secondary care. So I was always sitting somewhere in between and obviously I had the contacts from both, that has helped. In truth though, with the new integrated care system (ICS) and integrated care board (ICB) we are still finding our feet.

I have formed good links with primary care network pharmacists (PCNs) and ICS pharmacists, as well as the community pharmacists. It is keeping those links, because many of the practice-based pharmacists that I used to work with are now primary care pharmacists. That is helpful and I'd like to think that if any of my colleagues were struggling to manage a neurology patient, they would know where to go and who to ask.

How do you think that secondary care can ensure continuity of prescribing through to GPs? Are there any things that could be offered to support or improve the situation, or is it going well at the moment?

Could I just give you a brief background on the Black Country Integrated Care Board that is responsible for buying and supplying NHS services to meet the local demands? It works across Dudley, Sandwell, Walsall and Wolverhampton, and this is where the process has changed – they formed a joint formulary group to review any applications, and they use a decision-support tool to formulate any decisions.

So the big change is that we have now got a joint formulary, and that has helped enormously because if a drug is not on the formulary then it can't be prescribed without a very good clinical reason. GPs can now easily see what can be prescribed and they have to be able to justify going off-formulary, by explaining a clinical reason to justify their decision so the process has helped to build more joined up working.

Is that unusual – having a formulary that crosses the whole of the network?

I think this is the way it is going now. Across the four sectors we should all be sharing the same formulary, which is also helpful for out-of-area patients. The other thing is, from a historic perspective, in secondary care if you start somebody on a particular treatment, then obviously the GP would follow it through anyway. So I think clinic letters are very important as well from secondary care in ensuring seamless care all the way through the patient journey. A lot of time has gone into the interface between primary and secondary care, getting them working together effectively.

Do you see this environment creating a really positive platform for the development of pharmacy?

Yes, I do. And certainly with the fact that all GP practices now have pharmacists embedded within them. I was in one of the first cohorts of practice based pharmacists over 20 years ago – again Dudley were very proactive with this, getting pharmacists first of all prescribing and then embedded in primary care, in GP practices. So for us it wasn't such a major change, whereas a lot of places are having to recruit now and bring them in, whereas we had them already in place.

It's funny how it takes years to be accepted as well. Initially it was hard work, with questions about why a pharmacist is needed in a practice and what they can add. Now, every practice is saying, 'Well, I've only got four hours of a pharmacist, I need at least eight'. They are fighting for pharmacist time!

Can we move on to the challenges about sodium valproate? What are the challenges you see and how has it been managed? Is it easy to use optimal formulations and is it easy to drive cost-effective prescribing in that arena?

It has always been a bit of a 'nightmare' area and in most health authorities sodium valproate isn't regularly prescribed for epilepsy in view of concern over its safety profile. And now we have the Commission on Human Medicines saying that anybody under 55 should not be prescribed

sodium valproate – male and female, because it also potentially affects fertility in males. So it's a broad ban unless two specialists have reviewed the patient and decided that it is the only effective or tolerated treatment.

So straight away as a clinician you are thinking that you need to find two specialists to review a decision to prescribe, which is quite limiting, and I've seen reports of people with epilepsy getting quite upset. And then you have the pregnancy prevention programme, so the patient is aware of the risks, which is very important. And again, community pharmacy has got involved to provide a second check.

From the Trust angle we have to be careful to ensure that the annual risk acknowledgement form is completed each year, and it is usually the consultants that complete these when they are doing the patient epilepsy reviews. So I would say that the processes are now in place, and I do feel that people are more aware of safety checks to be made as there has been so much publicity around the safety of prescribing sodium valproate e.g. from the Medicines and Healthcare products Regulatory Agency (MHRA) and General Pharmaceutical Council (GPhC).

So really it is about being aware of the cost-effectiveness of the drug, because I think a lot of prescribers are so concerned about the safety aspects that they do not look beyond this and so it is not considered as a possible option by many prescribers.

I think that the safety concerns will become more apparent now that the guidance involves males too. There is also a ban on the use of valproate for migraine or bipolar during pregnancy, unless there is no other effective treatment, but there are so many treatments available that prescribers may never get to consider sodium valproate.

So when you look at the situation how are you managing it from your perspective?

Well I suppose I would be doing similar really to community pharmacy or the hospital. I would be checking everything, and I think as well my role is almost reassuring people that if everything is in

place – clinicians, prescribers – then it is fine, and obviously there are patients over 55 who the medication may be appropriate for.

So it's just making sure within my practice that I follow all the risk assessments, making sure they are on the PPP, but really also trying to highlight that it is appropriate and very effective medication for some people.

Well, one of my questions is about communication challenges and how you might overcome them. Do you become involved in changing guidance and making sure everyone knows exactly what the situation is?

Not massively, because the procedures are laid down and I'm almost double-checking. And the health care professionals, clinicians and consultants, are all aware of the situation, which has been communicated nationally. We ensure that the annual risk acknowledgement is done and there are also alerts (for example on computer – pop ups reminding you to sign and check), so I think there is not a huge amount that is needed other than an overview – keeping an eye on it all and making sure everything is in place.

And I do think really that it is reassurance that is needed, that when these things are in place there will be people for whom it is also very appropriate.

Do you think that community pharmacies will be another important stakeholder in this process as far as patients are concerned?

Yes, absolutely. Community pharmacists will be major stakeholders. They are frontline and very accessible and -so I think that they have a very important role to play.



I get the impression that the plates are moving in the direction of community pharmacy at the moment for a lot of reasons. I heard recently that one of the ICBs is going to do a population health contract with community pharmacists.

I think that is where ICSs will really come in, to stop siloed working because they are geographically based partnerships bringing together providers and commissioners of NHS services. It is going to be much easier to make sure that community pharmacy is a stakeholder from the beginning.

I've done many presentations for patients and I tell them that the community pharmacist is so important and often patients are surprised to hear that pharmacists have a degree! There is a lack of insight into how educated pharmacists are and what they can do to help people with a wide range of medical conditions. Sadly I still hear from the general public that they think of community pharmacists as shop keepers-which is very upsetting considering their extensive education and training.

So from what you're seeing at the moment, as long as the right processes are in place you think sodium valproate can be managed effectively.

Yes.

Can I ask about medicines optimisation with Primidone? What have been the challenges and what are the things that you have seen with Primidone that you have become involved in?

I have become involved as a clinician prescribing primidone as I find it excellent for essential tremor, and we are getting a lot of essential tremor patients coming through.

You think of beta blockers as a first line for essential tremor, but there are so many groups of patients for whom a beta blocker would be contraindicated – obviously with asthmatics and uncontrolled hypertension or hypotension, and cardiac issues. In

these cases, Primidone is more suitable and the main side effect that I've seen, and rarely, is sedation and, as it is taken at night, this is not a problem at all. So I've found it to be very good.

Do you see more usage of Primidone now?

I do. I'm working in an area where I have quite a few patients on Primidone and doing very well on it, and often on a very low dose. A 25mg Primidone tablet would be very useful for starting essential tremor patients on Primidone as we are currently having to halve a 50mg tablet.

Do you see the neurology specialist pharmacist remit developing more with Primidone and sodium valproate – can you see clinicians looking to you more to give specialist clinical advice in both of these areas?

Yes, in very many areas really as the pharmacist is seen as the expert in medication. So it would be my remit to be making sure that everybody is aware of available drugs and their side effects. We work as a very close team and have multidisciplinary team meetings to discuss patients. Regular discussions with the consultant neurologists also take place and we learn best practice by discussing patient outcomes at our meetings.

Are you going to increase the size of your pharmacy team?

We are certainly looking at it, though of course there are cost pressures to consider. We have needed to do so for a while, and the consultant neurologists are keen to increase the pharmacy workforce as they can see how pharmacy input supports their patients and their roles too.

It's almost like selling what we do on a daily basis and that is hard as we are so busy firefighting and trying to manage our large caseloads. No trust is in very good shape financially at the moment, but certainly business cases have gone in and we and the consultants are absolutely on board. We need more pharmacy input to help support the infrastructure of the trust when so many vacancies are appearing amongst healthcare professionals.

I get the strong impression that there is definitely a movement towards the role of pharmacists and what pharmacists can do. One of the things that I want PM Healthcare to do is to make sure that we give pharmacists the tools, education and support to get the business case across very clearly to all the stakeholders about what pharmacy can do.

Can I ask about opportunities for pharmacy and pharmacists?

Yes, there is definitely something to say about the opportunities for pharmacists in the months ahead.

There is a New Medicines Service, including epilepsy and Parkinson's, where, for the first time, community pharmacists advise patients with these conditions and then follow them up for at least two consecutive reviews. So that is very important and exciting for the pharmacy profession.

"There are 3,000 new independent prescribing places being funded, and by summer 2026 all newly qualified pharmacists will be prescribers, which again will be very important for the area of neurology."

Then there is the Discharge Medicines Service, which is especially important for neurology drugs because of their complexity. Patients leaving hospital are referred to community pharmacy on discharge and they get information about changes made in hospital. It really demonstrates how pharmacy can help secondary care, taking the pressures off the NHS, and it improves outcomes, prevents harm and reduces hospital admissions. So again another very important role for pharmacy.

I mentioned about how the ICS can stop silo working, which will make it easier to get more

pharmacists into different areas. Then there are the NHS proposals for the 10-Year Cancer Plan, where people will get assessed and referred for a hospital check up from the local pharmacy – this is in England – without the need to see a GP. So they will be referred straight to a specialist. Well, this could also work for any long-term condition, like epilepsy or Parkinson's.

And finally, a little plug really, for the Parkinson's Disease Specialist Pharmacy Network (PDSPN), which I founded and chaired in 2018– The network is now chaired by Stephanie Bancroft (Community Pharmacist and Co-Chair of the Pharmacists Consortium London North West) and I am now Deputy Chair. We have over 350 members and the Network is designed to upskill pharmacists and their teams in the management of Parkinson's, but it could work so well for all of the neurological conditions. And we are trying to increase the number of pharmacists feeling competent to care for people with longterm condition like Parkinson's.

"We have had huge interest from the pharmacy profession, and we are targeting our education at PCN pharmacists at the moment. This is all Parkinson's related, and we have learning modules to help pharmacists integrate into primary care."

But it struck me that this could so easily be done with epilepsy too, and we have worked with Parkinson's UK and an epilepsy network could align themselves with the Epilepsy Society. Although I don't currently have capacity to start this network as there are already not enough hours in my day, I would encourage pharmacy colleagues who have an interest in epilepsy to pick it up and run with it, because it is a great way of creating shared learning with like-minded colleagues, obviously with excellent organisations like Pharmacy Management working with them and giving their backing.



It seems as if there is a great opportunity to move into epilepsy if there is a need.

There is a huge need, as there are so few epilepsy nurses and consultants specialising in epilepsy so locally we are training pharmacists to manage epilepsy patients. We have shown how successful a team of pharmacists can be in managing Parkinson's, and so the process could be replicated for epilepsy. With the knowledge obtained from setting up the PDSPN we could definitely help iron out teething issues and share best practice with anybody who would be interested in starting a pharmacy epilepsy network.

It's a wonderful idea and certainly something PM would like to support. We will add contact details for the PDSPN at the end of the interview and would like to be involved in supporting anybody interested in doing the same for epilepsy.

I started the PDSPN by contacting some pharmacists that I knew in the area of Parkinson's in order to create a steering committee. Considering it was all voluntary and done in their

own time, I was staggered by the enthusiasm and support that I received from pharmacy colleagues. We soon had a steering committee in place, and we hold regular meetings and our third national conference next year as well as hosting learning modules with Parkinson's UK. I am very proud that the pharmacy profession always seem to put the people they serve at the forefront of their endeavours and are very free with their time when they feel that it is for the good of the general population. This makes me extremely proud to be a pharmacist.

Well, we would be delighted to help and if any of our audience would like to become involved, they can contact us directly. Many thanks Janine, for an extremely interesting conversation.

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Parkinson's Disease Specialist Pharmacy Network (PDSPN):
<https://www.parkinsons.org.uk/professionals/parkinsons-disease-specialist-pharmacy-network>
Anybody wanting to join the PDSPN can email:
pdpharmacynetwork@gmail.com