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In this issue

Editorial

In July 2023 the NHS celebrated its 75th anniversary – a remarkable milestone for an organisation that was born out of the ashes of the Second World War and has become enshrined in public consciousness as an institution that in many respects defines us as a nation.

Celebrations were held, though perhaps more muted than expected – a reflection of the ongoing crisis in the four healthcare systems of the UK, still recovering from the pandemic backlog, an ongoing staffing shortage, unprecedented strike action and cost constraints (to which we can add a major structural reform in England).

The public still greatly supports the idea of the NHS – a healthcare service free at the point of use for all – but patient satisfaction levels reflect the many challenges the system faces.

The question is: What to do about it? All of the proposed solutions (an increase in funding, further reform, the involvement of the private sector, more staff, etc.) have been tried before, and we are where we are. Will more of the same make a difference?

At PM Healthcare, one thing that we do believe is that meaningful change comes first and foremost from healthcare professionals (HCPs) creating practical and innovative solutions that can be shared as examples of best practice. And there are many examples of this happening in real time, for example in the NHS in England as HCPs work across primary care networks to discover shared solutions to common problems.

Our objective is to help you make these connections and bring you examples of change and improvement where we see them, whether in the PM Healthcare Journal or through our programme of events and conferences.

In this, our summer 2023 Journal, some of our regular contributors provide a personal perspective of the NHS as it reaches its 75th birthday – its past, present and future.

Lead Pharmacy Technician Sarah Chapman, supported by colleagues across Frimley ICS, describe how pharmacy technicians are making a meaningful difference to service provision.

Sandra Martin, Gemma Quinn and Suzanne Hill at Bradford University provide an academic perspective on the all-important area of pharmacy continual professional development and postgraduate education.

In our clinical focus, we have three informative articles covering areas as diverse as involving community pharmacy in communication about post-surgery opioid use; the development of the role of a specialist mental health pharmacist within a community mental health team in Northern Ireland; and evaluating the quality of valproate prescribing in a community mental health team in England.

And we also feature an informative White Paper summarising a panel discussion on the future of community pharmacy in England, with a focus on pharmacy prescribers.

As ever, please contact me to discuss any areas that you think we ought to be talking about and also to share suggestions for articles.

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PM Healthcare
PROGRESS THROUGH PARTNERSHIP

The NHS at 75

In this article, we asked some of our editorial board members to write a personal perspective of the NHS as it reaches its 75th birthday.

The 75th birthday of the NHS is a significant milestone since it was established in 1948. I am proud to have been one of the millions of babies delivered in an NHS hospital, some decades after its establishment, and have worked all my adult life at no other organisation but the NHS.

What a journey it has been for the NHS, which is now one of the largest and most respected healthcare systems worldwide. Its unique ethos of providing healthcare service at no cost at the point of use is undoubtedly enviable.

As it continues to develop and modernise, the emerging challenges cannot go unnoticed. Some of these challenges are due to higher levels of chronic, long term ill health in the population, expensive new treatments, new technologies, digital transformation and workforce shortages. Despite these emerging challenges, the NHS showed its resilience at best during the recent pandemic and trumped many other leading healthcare systems in the world on the COVID-19 vaccine roll out and uptake.

The changing role of the workforce is another adaptation the NHS is making to address some of its challenges. I am especially proud of how the pharmacy workforce and roles have changed significantly, with pharmacist prescribers, consultant pharmacists and community pharmacists undertaking roles that historically were only done by medics. Likewise, it is very common practice nowadays for technical pharmacy staff to undertake tasks such as prescription checking and medication reconciliation that previously were pharmacist-only tasks.

Happy 75th Birthday NHS and best wishes for a bright future.

Mildred Johnson, *Clinical Director of Pharmacy & Medicines Optimisation, Maidstone & Tunbridge Wells NHS Trust.*

Personally, I feel like the NHS is very much like fashion: if you wait around long enough then what was in place years ago comes back around again, except in the NHS it is usually named something different!

I am very proud to work for and in the NHS. I have done so for the past twenty years and have seen many changes, especially in pharmacy. When I started out, pharmacists went out to wards infrequently and were usually handed a set of keys to the drugs cupboard, and pharmacy technicians rarely left the dispensary.

Now, both professions are patient facing, clinical and much valued members of the multi-disciplinary team. Pharmacy support staff have also extended their roles. All of these advances, in every sector have been to the benefit of patient care and are something to be proud of.

I feel that the future is very bright for pharmacy as we expand our prescribing, genomic and collaborative approaches into practice.

Anthony Young MSc, MBA, MRPharmS, *Deputy Chief Pharmacist – North and North Cumbria Pharmacy Department, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust.*

Throughout its 75-year history, the NHS has played a vital role in providing high-quality medical care to all UK residents, regardless of their socio-economic status, with a strong focus on preventative care to reduce the overall burden on the health and social care systems.

The NHS faces significant challenges as it looks towards the future. An ageing population, combined with an increase in chronic diseases, the legacy of COVID, the rising cost of medical technologies, will continue to put immense pressure on the system.

The NHS has adapted as best it can to that demand, and the COVID response is a perfect example of how responsive it can be in the short term.

To meet the challenges of the next 75 years will require innovative solutions and ongoing investment to ensure that the system can continue to provide high-quality patient-centred care to all those who need it.

Adrian Mackenzie,
MAT Standards Clinical Lead, Pharmacy, Healthcare Improvement Scotland.

Marking the 75th anniversary of the NHS and as we look forward to future times, forefront in my mind is the responsiveness of our pharmacy and health services to patient needs, promoting equitable access to health and social care.

Lessons learned from the past three years have shown us that in times of crisis we can be amorphous, be less bureaucratic, less constrained and more agile and fluid in our operational planning and management. We now recognise the development of our highly skilled and progressive pharmacy workforce as part of wider healthcare professional teams.

Projecting forward, the NHS should seek to co-design systems and processes with patients, that are structured and robust, responsive and collaborative. Thinking, working and being as one, gives the NHS strength and focus.

Creating a culture of resilience and positivity amongst our pharmacy teams and wider NHS communities will equip us to anticipate, mitigate and navigate future challenges. Our goal should be to be the best version of what we can be. This goal is both aspirational and achievable.

Professor Liz Breen PhD, FHEA, *Director of the Digital Health Enterprise Zone (DHEZ), Professor of Health Service Operations, University of Bradford School of Pharmacy and Medical Sciences.*

Involving community pharmacy in communication about post-surgery opioid use: an observational study

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Abstract

Title

Involving community pharmacy in communication about post-surgery opioid use: an observational study

Author list

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Background

Opioids are often prescribed for moderate to severe pain management in the hospital setting and upon discharge. Acute exposure to opioids after surgery is associated with a risk of prolonged use.

Aim

To use the discharge medicines service enabling community pharmacies to query repeat supplies of an opioid following surgery.

Method

Patients undergoing orthopaedic surgery were to have a discharge medicines review note communicated in the discharge medicines service for community pharmacies as well as in the discharge summary for GP practices. This note advised against ongoing prescribing of the opioid supplied at discharge. Any further supplies from primary care were followed up within four weeks of discharge and, if necessary, then again at three months.

Results

Over approximately four months, only 11 of 63 patients followed up received a discharge medicines service, and 16 (25%) of all 63 patients received at least one further GP supply of a weak opioid within four weeks of discharge. At the three months follow up period, none of these 16 patients were still receiving an opioid.

Conclusion

Though there was no obvious demonstrable benefit from utilising the discharge medicines service, community pharmacists are in a key position to provide high-quality face-to-face care promoting the safe and effective use of opioids. New strategies should be developed with the involvement of all stakeholders to make this practice sustainable, and expanding the scope of patients included in the service may increase the benefit.

Keywords

Opioids · Orthopaedic surgery · Pharmacist · Transitions of care

Introduction

The overprescribing of opioid analgesics for chronic noncancer pain, particularly the prescribing practice of post-discharge analgesia, is a public health concern.[1,2] The number of patients discharged from hospital with opioids for ongoing management of acute pain is rising.[3] Although evidence suggests that opioid analgesics can provide some improvements in pain and function in the short term, compelling evidence of long-term benefits is lacking. This long-term use of opioid analgesics, including

daily doses exceeding guideline recommended thresholds, is associated with an increased risk of harms including overdose, dependence, and death. A 2019 review by Public Health England shows that in 2017 to 2018, 540,000 adults in England were prescribed opioid analgesics for 3 years or more.[4]

Acute exposure to opioids after surgery is associated with a risk of prolonged use and is a risk factor for developing long-term opioid dependence.[5,6] One review identified studies providing an estimate of persistent opioid use following patient discharge from hospital settings in Australia, and found persistent opioid use among surgical patients generally ranged from 3.9 to 10.5% at between 2 and 4 months after discharge.[7] As regards arthroplasty procedures, studies from outside the UK suggest 8% of previously opioid naïve patients undergoing total knee arthroplasty (TKA) and 4% of those undergoing total hip arthroplasty (THA) became new persistent opioid users.[8] Other data from America report that between 10% (THA) and 13% (TKA) of naive and between 47% (THA) and 62% (TKA) of chronic users continued opioid use at 1 year postoperatively.[9]

It is recognised that there is wide variation in how opioids are prescribed post-surgery, nationally and internationally. One survey of the American Association of Hip and Knee Surgeons for patients undergoing primary THA and TKA revealed substantial variation in opioid- and nonopioid-prescribing patterns during the early postoperative period.[10] A more recent small-scale study from Canada reported that patient-specific factors appeared not to be taken into consideration when opioids were prescribed for postoperative pain among patients who underwent THA or TKA.[11] Hence, it is essential that, once the patient has been discharged, opioids used for acute pain post-surgery are reviewed and discontinued to reduce the rate of persistent opioid use.

St Michael's Hospital (SMH) is part of the Royal Cornwall Hospitals NHS Trust (a 760-bed teaching hospital). SMH provides a range of specialist services including surgery for breast and orthopaedic patients (approximately 30 beds). Patients admitted for an elective hip/knee procedure have a prescribing bundle on the hospital's Electronic Prescribing and Medicines Administration (ePMA) system (Careflow Medicines Management) for their duration of stay. This bundle includes the non-steroidal anti-inflammatory drug (NSAID) ibuprofen and a weak opioid, though patient factors may mean that ibuprofen is not prescribed. At discharge, patients normally receive one week's supply of the weak opioid and, if appropriate, ibuprofen. This weak opioid prescribed at discharge is either codeine 60mg

four times a day or dihydrocodeine 30mg four times, both for 7 days, equating to a total of 168 oral morphine equivalents (OMEs) or 84 OMEs respectively. This duration of opioid supply provided assumes that any acute pain resolves after seven days.

It is well recognised that discharge from hospital is associated with an increased risk of avoidable medication related harm and guidance recommends medication related communication systems should be in place when patients move from one care setting to another.[12] In relation to surgery and opioids, guidance from the Faculty of Pain Medicine has a number of recommendations that are already in place in SMH.[13] These include that local protocols for the prescription of discharge medications after surgery should be developed to minimise the chances of subsequent inappropriate opioid use, and that the hospital discharge letter must explicitly state the recommended opioid dose, amount supplied and planned duration of use. Further recommendations are that guidance should be given about necessary medicine review following discharge from hospital, and that usually five days and no more than seven days of opioids should be prescribed. This guidance also notes that if a patient not usually on long term opioids is still taking opioids 90 days after surgery and is still in pain, this should trigger further assessment in primary or secondary care which may include referral to a pain service for investigation of chronic post-surgical pain or sometimes to a substance misuse service.

The Discharge Medicines Service (DMS), introduced in February 2021, pays community pharmacy (CP) teams in England that have received information from hospital trusts to check if any medicines awaiting collection by a patient recently discharged are still appropriate, and set up a consultation if the patient needs any help with understanding their new medicines regimen.[14] The DMS is an essential service offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework. Such a service has been reported to decrease hospital readmission rate and length of hospital stay.[15,16]

Aim

Our aim was to use the DMS as a means of allowing CPs to query with the patient's general practice (GP) team if repeat supplies of an opioid were prescribed after the surgical procedure and to ascertain the short-term rate of repeat opioid prescribing after discharge from SMH.

Ethics approval

"As this project falls under the definition of a service evaluation, according to UK NHS Research Ethics Committees, formal ethical approval was not required. This project was registered on the hospital's clinical audit database."

Method

Hospital discharge process

Patients discharged from SMH during the study period were to have a discharge medicines review (DMR) note incorporated into their ePMA record, such that this note appeared in the DMS for CPs as well as in the discharge summary for GP practices. This DMR note is also visible to the patient as they are provided with a copy of the discharge summary. Patients are consented for the DMS during the hospital admission medicines reconciliation process which enables the documentation of any other relevant medication (e.g., opioids, NSAIDs) taken by the patient prior to their procedure. Patients are prompted to choose their preferred pharmacy as the recipient of this electronic DMS communication, with this information then entered onto PharmOutcomes. This web-based system is used by community pharmacies to collect data from services provided, allowing for the data to be used for subsequent service evaluations.[17] Those patients having hip/knee surgery were the target group for our CP referral process though it was recognised that a small proportion of patients may have undergone other procedures such as shoulder or breast operations.

Patients taking repeat prescription of either oral or transdermal opioids (weak or strong) prior to surgery taking place were excluded from this study as these patients would be discharged on their original opioid regimen from admission and would not be provided with the discharge supply of a weak opioid. Not knowing the complete history of these patients, it was not considered appropriate to be making significant changes to their ongoing analgesia during the short admission for their elective surgical procedure.

The DMR note incorporated in the discharge summary and as part of the DMS stated "This patient has been discharged with opioid medication following their stay in hospital and the supplied course should provide sufficient analgesia for the procedure that has taken place. It is reasonable to dispense one further supply of (additional) opioid medication for postoperative pain. A further request may indicate a postoperative complication, or inappropriate continuation of opioid, and should therefore not be dispensed without medical review."

Data collection

The existence of this DMR note was used to identify patients discharged from SMH such that relevant data could be extracted from the ePMA system. Data included patient characteristics (age, gender, surgical procedure), relevant pre-admission and discharge medication, GP surgery and CP receiving the DMS. Data on the DMS referrals and whether they were completed or not was collected using PharmOutcomes.

Endpoints

Follow up of the patient's opioid requirements post-discharge was made by contacting the CP to which the DMS had been referred or contact with the patient's GP team within approximately four weeks after discharge. Those patients that had received a further supply of an opioid were then followed up again at about three months after discharge.

Results

The details for 65 patients discharged between the end of June 2022 to the start of October 2022 were collected. Fifty-six patients underwent total knee or total hip replacement or a revision of such surgery. Nine had other procedures (seven on the shoulder and two breast surgery). Thirty-six patients admitted into SMH for elective surgery on repeat opioids during this period were excluded. The mean age of the 65 patients was 62 years (range 20-85) and 36 (55%) were male. Only 36 (55%) had undergone medicines reconciliation by the hospital pharmacy team at admission, with 12 of these on a NSAID prior to admission.

"Seventeen (47%) of the 36 patients with medicines reconciliation received a DMS referral and 11 (65%) of these 17 had the DMS completed by the CP. Table 1 records the number of referrals to different types of pharmacies and the action taken within that four-week period since discharge. All 65 patients had the DMR note communicated to the GP in the discharge letter. Two patients registered in Devon were not followed up. "

Pharmacy organisation type	Number of DMS referrals	DMS completed within 4 weeks
Multiple or supermarket	14	9
Small chain / independent	2	1
Distance selling	1	1

Table 1. Community pharmacy DMS referrals n = 17

At the initial follow up period 16/63 (25%) patients, including two who had undergone procedures other than hip or knee surgery, received at least one further GP supply of a weak opioid within four weeks of discharge (see Table 2). These sixteen patients included five (45%) of the 11 patients who had received the completed DMS, and 11 (26%) of the 42 patients without a completed DMS referral. At the three months follow up period, none of these 16 patients who had received a supply within four weeks after discharge were still receiving an opioid.

Discussion

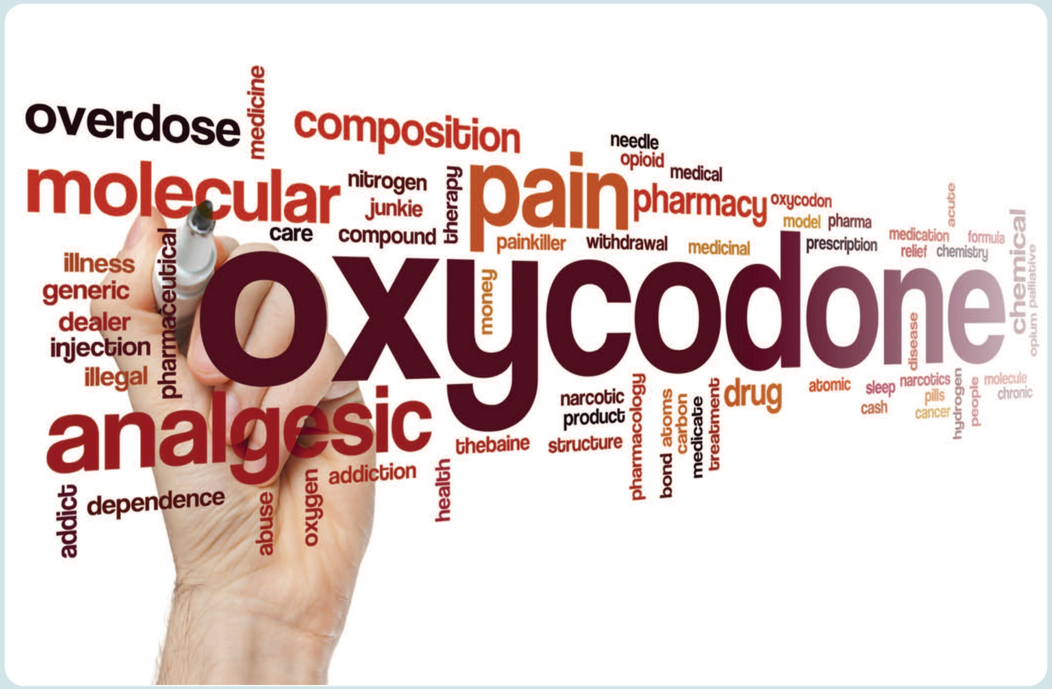
This small study was originally aimed at utilising the DMS as a means of communicating to CP about reviewing patients' opioid requirements after discharge following orthopaedic surgery, and prompting the need for CP involvement if ongoing opioid prescriptions were received in the pharmacy. However, we found poor fidelity of service implementation with only 17 of 65 admitted patients referred from the hospital for a DMS, and only 11 of these receiving a completed DMS. We also found for the 63 patients followed up a rate of re-prescribing of weak opioid of 16/63 (25%) patients within four weeks of discharge though none of these 16 were still on an opioid at three months. It is unclear if the CP had any input into the ceasing of an opioid supply by the 3-month period for the five patients who received the DMS and had an opioid supply within 4 weeks.

Only 36 (55%) of the 65 admitted patients had undergone medicines reconciliation at admission and therefore had an opportunity to be consented for the DMS. This is much lower than the proportion for the whole of the 760-bed hospital at just over 90% of patients who had been in hospital for three days or longer. This low rate of 55% of patients at SMH having medicines reconciliation can be explained by the high turnover of patients with some patients being admitted for less than 24 hours. Due to pharmacy team workload demands, it was not always possible to speak to patients on the day of surgery. However, the fact that 17 of these 36 were referred for a DMS was higher than the proportion of referred patients for the whole of the 760-bed hospital at the time of the study i.e., typically 28% of 1500 patients receiving medicines reconciliation each month.

We cannot compare directly our figure of 25% patients receiving a further initial weak opioid supply within four weeks after discharge with other studies for the main reason of the nature and quantity of opioid supplied during the inpatient stay and at discharge. At discharge, our patients received 84 or 168 OMEs of a weak opioid. One American study described opioid-naïve patients receiving a mean of 476 OMEs for the THA cohort and a mean of 528 OMEs for the TKA cohort for a supply period that was 14 days pre-surgery to 3 days post-discharge.[18] None of our patients were receiving opioids prior to surgery and our post-discharge supply was for 7 days. Another American study reported patients given a single prescription for oxycodone 5 mg totalling 84 tablets (equivalent to 636 OMEs) at discharge.[19] A Canadian study noted that at discharge following THA and TKA, patients received a median of 400 OMEs.[11] Lan and colleagues recommend prescribing less than 600 OMEs during the perioperative period (between 1 month prior to and 2 weeks after total joint arthroplasty) to reduce the risk of new persistent usage in opioid-naïve patients.[20] This recommended quantity far exceeds that received by our patients and perhaps illustrates a key difference in approach to use of post-surgery opioids in America.

	Mean age (range) years	Male
Patients discharged n = 63	63 (20 - 85)	35 (56%)
Patients referred for DMS n = 17	60 (20 – 82)	6 (35%)
Patients who received initial supply from GP within 4 weeks of discharge n = 16	62 (39 – 80)	8 (50%)

Table 2. Patient characteristics



As regards communication at discharge, an Australian study reported that when opioid-naive patients are discharged from hospital on opioids, communication from hospitals to GPs is poor.[21] Others have tried to improve on this situation and the impact of post-discharge pharmacist review on opioid use following TKA has been investigated in a short-term pre- and post-intervention study in Switzerland.[22] It was found that pharmacist-delivered post-discharge analgesia review reduced the percentage of patients taking opioids 3-weeks post-discharge following TKA, though this study did not utilise community pharmacy for the review process. The authors claim that this intervention has the potential to provide a smoother transition of care for patients supplied with opioids at the time of hospital discharge.[22]

More generally, others have looked at challenges faced by CPs when trying to play the role of opioid therapy optimiser.[23] Alenezi and colleagues noted that for CPs in the United Kingdom undertaking a medicines use review, prescribed opioids for chronic pain were not their priority, which may be attributable, in part, to a reported deficiency of patient information.[24] With our DMS referral there is clear information on proposed action for the CP to take at any review. Unfortunately, we are unable to evaluate whether the DMS, as initially planned, had any impact on the extent of patients receiving further opioid supplies after discharge due to the low number of patients who were referred for (17) and who actually received a completed DMS (11). Informal feedback from the pharmacies that were unable to complete the referral pointed to insufficient staff and capacity to enact the DMS.

Interestingly, a systematic review notes that up to 92% of patients reported unused opioids after surgery.[25] Though we observed that 25% patients required further supplies within 4 weeks of surgery, we did not evaluate to what extent the discharge supply of 7 days of a weak opioid was taken by the other 75% of patients. This approach of having default opioid prescription quantities as occurs at SMH has been reported in another systematic review to appear effective in improving the appropriate prescribing of opioids upon hospital discharge.[26]

Future work requires consenting of patients to become more routine at the pre-admission clinic stage rather than when admitted into hospital, and closer working with community pharmacies and the Local Pharmaceutical Committees so that the DMS is completed.[27]

Strengths and limitations

To the best of our knowledge, this is the first observational study conducted to assess the role of a formal CP service in supporting post-surgery patients discharged on opioids. The strengths of this study are that we followed up patients both at four weeks and again at three months if they were at risk of receiving prolonged opioid treatment. The limited uptake of the DMS is also of interest in relation to how hospitals and CP engage in a more impactful way with this service. Future work to improve referral activity and uptake should involve the new role of the Integrated Care System Community Pharmacy Clinical Lead, and to increase engagement in the future, CP could be consulted to understand how the DMS service can be utilised to have the greatest impact on patient care.

We recognise the limitations of this single-centered study. First, it is limited by its retrospective and observational design, and small number of patients enrolled. Not all admissions and therefore discharges had hospital pharmacy team input e.g., during weekends, day cases and out of hours. A further limitation was that co-morbidities/existing medical conditions of the patients were not accounted for, and these could potentially have influenced the extent to which further opioid supplies were made. We did not look at any patient outcomes, and any observation on weak opioid use is based on what was prescribed rather than consumption. Also, we had no baseline data prior to the introduction of this DMS and this DMR communication so we do not know if that DMR messaging as part of the discharge communication had any effect.

Conclusion

Despite being unable to demonstrate any benefit from the DMS, we believe that CPs are in a key position to provide high-quality face-to-face care promoting the safe and effective use of opioids and hence new strategies should be developed with the involvement of all stakeholders to make this practice sustainable. There is a role for the Integrated Care System Community Pharmacy Clinical Lead in helping to strengthen relationships between CP and hospitals when discharging patients, highlighting that effective cross boundary communication will only lead to a benefit to patient care.

Declaration of interests

The authors declare that no funds, grants, or other support were received during the preparation of this manuscript.

Author Contributions

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Michael Wilcock. The first draft of the manuscript was written by Michael Wilcock and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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Development of the Role of a Specialist Mental Health Pharmacist within a Community Mental Health Team in Northern Ireland

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Abstract

There has been an increase in referrals to community mental health teams over the past number of years. An independent pharmacist prescriber could assist workload by providing medicines optimisation clinics. The aim of pharmacist-led clinics is to improve patient outcomes and adherence through the provision of medicine reviews and education.

A pharmacist worked as part of one team two days a week. Staff referred patients whom they felt may benefit from a medication review, to optimise medications, medication adjustments, assistance with adherence or deciding on treatment options.

The pharmacist assisted optimising the medication of more than 75 patients referred by team members within six months. One hundred percent of both patients and staff felt that the service benefitted patients.

A pharmacist can benefit this service by increasing the capacity of reviews, optimising medication, monitoring, and making physical health interventions. They are well placed to improve standards of care and patient safety regarding medicines optimisation.

Keywords

medicines optimisation, patient centred, mental health, pharmacist, adherence, nonmedical prescriber, community mental health.

Introduction

Patients with severe mental illness (SMI) have a life expectancy on average 15 to 20 years less than the general population.[1] Increased levels of ischaemic heart disease and cancer contribute significantly to the excess mortality in patients with schizophrenia.[2] In addition, there is believed to be both an under-detection and under-treatment of physical health disorders in people with mental illness.[3] Patients with psychotic illness frequently do not fully engage with services.[4] Lacking motivation and impaired cognitive function may be contributory factors.

Appropriate treatment with antipsychotic medication greatly helps psychotic illnesses but weight gain, most prominent in the first two months of treatment, can be associated with the development of diabetes and dyslipidaemia. In addition, antipsychotic medication is associated with adverse cardiac effects including QT prolongation and endocrine changes due to hyperprolactinaemia.[5] There are increasing numbers of patients on complex medication regimens requiring regular physical health monitoring, follow-up reviews and rationalisation of medicines.

In addition to this, patients diagnosed with an anxiety disorder and/or depression are at more risk of suicidal ideation and thoughts of life not worth living when compared with the general population. These disorders are also associated with physical conditions including headaches, sweating and irritable bowel syndrome.[6-8]

One of the recommendations contained within the Mental Health Strategy for Northern Ireland states the need to:

> **"Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into Mental Health Service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines, to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.[9]"**

The Royal College of Psychiatrists Accreditation for Community Mental Health Services has set a standard that a pharmacist should be a member of the multidisciplinary team and that patients should have access to a specialist pharmacist to discuss and make recommendations about their medicines.[10]

The National Institute for Health and Care Excellence (NICE) has also developed quality standards associated with medication use to drive improvements and produce better patient outcomes. These include 'Medicines Optimisation', 'Service user experience in Adult Mental Health Services', and 'Managing the use of medicines in community settings for people receiving social care'.[11-13]

The Carter Report (2016) described how by focusing on the pharmacy workforce the NHS could endeavour to create maximum value and patient outcomes from the £7 billion annual medicines spend. The report's scope extended, from September 2016, to include community and mental health trusts. It illustrated that every £1 spent on clinical pharmacy services can potentially lead to a saving of £5 within the healthcare system.[14]

There is a need to optimise the skills mix within community mental health teams (CMHT). By ensuring pharmacists with specialist training in pharmacological interventions review medications and provide expert guidance and education to staff, and that patients and carers are embedded within the team, time can be freed for other team members. This is reinforced nationally by NICE's recommendation that medicines reconciliation and reviews should be conducted by staff trained and competent to undertake these roles. The guidance recognises pharmacists as an example of such suitable staff.[11]

The Health Education England (HEE) report recently proposed that NHS England require 260 additional pharmacists for the adult severe mental illnesses (SMI) community care programme, and 20 additional pharmacists for the community perinatal mental health programme by year five (2023/24).[15] This programme is currently underway as recruitment of pharmacists into community teams continues to increase, recruiting approximately 70 pharmacists a year.[16]

Recent papers conclude: 'Pharmacist interventions improve patient safety significantly. Patient-centred approach and including patients in discussions improves patient satisfaction'[17] and, 'The pharmacist independent prescriber is a valued asset, with high levels of interaction between all staff, carers and an integral aspect of services provided'.[18]

The Northern Health and Social Care Trust is one of five hospital trusts within Northern Ireland. It provides care to some 460,000 people spread across a large geographical area. CMHTs within the Trust have seen an increase in referrals of approximately 75% in the past 3 years.

Funding was obtained from mental health community services to pilot the addition of a specialist pharmacist with independent prescribing qualifications to one of the CMHTs for a period of six months.

Aim

To establish the benefit of a pharmacist independent prescriber to a CMHT in Northern Ireland with regards to:

- The establishment of a pharmacist led medicines optimisation clinic
- The provision of medicines related education to patients and staff
- Introduction of interventions to improve patients' physical health

Method

A specialist mental health pharmacist with a postgraduate diploma in psychiatric pharmacy, an MSc in clinical pharmacy and independent prescribing qualifications was designated to work as part of the Antrim area CMHT multidisciplinary team on two consecutive days for a six-month pilot period.

The pilot study was introduced to the team during a weekly team meeting, so all the team were made aware of the project and the presence of a pharmacist to assist them and their patients.

The pharmacist established a weekly clinic on a Tuesday, and patients or their case were then referred to this clinic when a medic or their key worker considered it needing the input of a medicines expert. Roles included the introduction or switching of medication, medication reviews and education, and lifestyle advice. Patients were then reviewed and followed up as appropriate.

Data was then collected on the interventions made throughout the pilot. In addition, staff and patient feedback relating to the new service was obtained using surveys via Citizen Space.

Ethical approval and patients' consent were not required for this project.

Results

Within a 6-month period, 78 patients were referred to the pharmacy-led clinic from staff. Referrals were made via differing sources including email, ward rounds, face to face or by telephone.

The majority of those referred (n=59; 76%) had a diagnosis of anxiety and/or depression. The remaining patients had a diagnosis of schizophrenia or bipolar disorder.

Ineffective current medication or adherence were the main referral reasons from key workers – follow-up review requests after medication switches from the team's speciality doctor, full medication review requests from consultants and requests for supportive medicines or attention deficit hyperactivity disorder (ADHD) repeat prescriptions from patients via administrative staff.

Between mid-November and end of March 2022, 90 clinic appointments occurred at the Tuesday pharmacist clinic (two sessions a day) and 39 patients availed of this service for review and follow-up. As some of the patients were seen a few times, this gave the opportunity for the pharmacist to assist patients with education on their medication and help with their adherence if necessary.

Advice and recommendations made during this time included:

- Switching psychotropic medications when patients have not received an adequate response or were not tolerating them
- Addition of medications to augment those already prescribed, for example, with treatment resistant depression
- Adjusting doses so each patient obtains optimal response to their medication, taking into consideration side effects they experienced
- Supportive medication additions including medication to aid with sleeping or anxiety symptoms
- Physical medication added including metformin for applicable patients or statins after a QRISK3 assessment
- Vitamin and mineral supplements, for example folic acid and iron
- Nutritional supplements in patients who were not eating properly and losing weight
- Analgesia in, for example, patients with fibromyalgia
- Blood monitoring not related to psychotropics
- ADHD repeat prescriptions
- Advice to patients including written and oral (motivational interviewing)
- Medication adherence advice

Currently, in Northern Ireland, advice notes are sent from CMHTs to GPs who prescribe medication for patients with a mental illness through a HS21 prescription. Only one of the notes described below was refused by a GP as it was an unlicensed use of an analgesic.

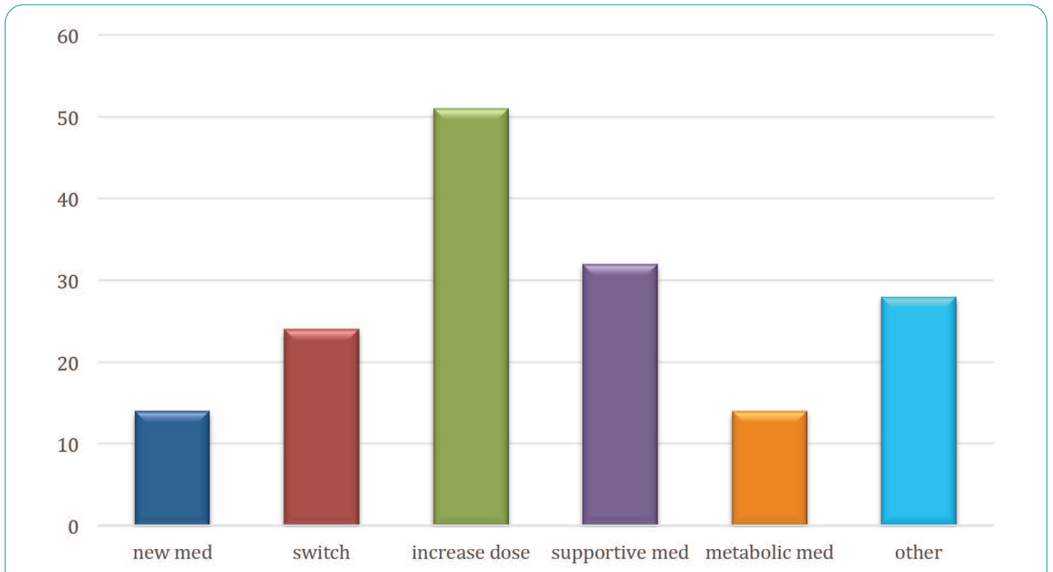

Figure 1: Number of advice notes sent to GP practices

The following is a breakdown of the types of advice notes sent to GPs within the Antrim area:

1. 14 requesting new psychotropic medication
2. 24 requesting switches of psychotropic medication
3. 51 requesting a psychotropic medication dose increase
4. 32 requesting new supportive medication, for example, medication to aid with sleep
5. 14 requesting new metabolic medication including metformin or a statin
6. 28 notes sent for other recommendations including stopping or reducing medication or the addition of supplements or analgesia

Other patient focused clinical input during the pilot:

- To commence the role and introduce the pharmacist to the team, initially the laboratory results of 100 patients with a SMI prescribed an antipsychotic were reviewed and any that needed to be repeated due to expiration or further investigation were identified
- The pharmacist also reviewed weekly blood analysis results from the team's wellness clinic (six patients per week) and addressed abnormal values through supplementation, getting the analysis repeated, calculating QRISK3 risk, etc
- Referrals to endocrinology, neurology, cardiology and dermatology for direct and indirect medication-related questions
- The availability of the pharmacist on Tuesday and Wednesday on site at the clinic helped facilitate the rapid resolution of urgent medication-related Same Day Assessment queries.

Staff training and development of clinical guidance:

- Prolactin was identified as being missed in applicable wellness clinic patients, thus a 'prolactin reference sheet' was rapidly created with a trust guideline as regards analysis and management of hyperprolactinaemia currently being developed by this pharmacist
- Staff education session on clozapine monitoring and side effect management
- Separate patient and staff education sessions in supported living units on healthy eating/lifestyles, antipsychotic side effects and illicit drug use
- Multidisciplinary team discussion around the high-risk side effect of constipation potentially leading to fatal gastrointestinal obstruction and difficulties for staff identifying and managing this. Therefore, guidelines for the assessment and treatment of clozapine induced constipation were developed for the team with a plan for wider dissemination of this document

Feedback results

Staff and services users were invited to complete satisfaction questionnaires via Citizen Space.

Option	Total	Percent
My medicine was changed	15	93.75%
A problem with my medicine was sorted out	14	87.50%
It provided me with useful information about my medicines	14	87.50%
I feel more confident in managing my medication	15	93.75%
My symptoms improved	12	75.00%
I now know how to identify and report medication side effects	6	37.50%
None of the above	0	0.00%
Not Answered	0	0.00%

Figure 2: Potential benefits of the service applied to patients after receiving a pharmacist consultation

One hundred percent of patients asked for feedback (n=16) stated that the pharmacist gave them the opportunity to be involved in making decisions about their medication and that the service should be permanent. Fifteen (94%) patients commented that they were more confident managing their medication after speaking to the pharmacist whilst twelve (75%) stated that their symptoms had improved after intervention. No patient felt that there were any disadvantages to the service. One hundred percent of staff from all disciplines (n=11) also deemed the service to be of benefit to patients. Ten (91%) remarked that the pharmacist freed up other staff time and improved medicines optimisation. The other staff member answered, 'not sure'.

Discussion

The current clinic time prioritised urgent requests for patients who were relapsing or patients newly presenting unwell to the team requiring urgent medication reviews and commencement of medication.

This role has the potential of increasing the capacity of the clinic for patients needing assessment by a prescriber. For example, 90 appointments were freed up for medical staff during the six months through the clinic assessments that took place. This is based on only 1 day a week, so by extrapolation this could increase the medication-related appointments within the team by 900 a year if the role was full time equivalent. Although difficult to quantify, the availability of the pharmacist can also assist with prescribers' time as they can resolve telephone issues from patients that necessitate medication adjustments too.

"The weekly multidisciplinary team meeting is a beneficial source for identifying patients who may benefit from input, so attending this is valuable."

All patients and staff members interviewed thought that the pharmacist benefitted the team and ultimately patient care. Patients were given the opportunity to make decisions about their medicines and the service should be permanent. Most surveyed also stated that their symptoms had improved after consultation with the pharmacist.

The pharmacist held an educational session on managing clozapine side effects and eight members of staff remarked on the benefit of this in their qualitative feedback. The intention would be to expand these educational sessions to cover other medications and diagnosis.

Considering qualitative information from the staff surveys, ten members of staff remarked on how the pharmacist can assist in getting medication-related issues resolved more quickly and can 'afford medical staff more opportunity for diagnostic appointments.'

Other comments made included that the pharmacist should be available more days a week, the service is 'fantastic,' the service should 'be

available at more sites' and 'having now had this service, I don't want to lose it.'

Plans are in place in the coming months for multidisciplinary medication adherence course led by the pharmacist and speciality doctor with patients in Ferrard House, based on a recovery college model.

Further educational talks are being organised for CMHT staff, supportive living staff and patients on, for example, antidepressants and ADHD medication.

Another gauge of the success of the work was, as of mid-March, the pharmacist's clinic time had to increase from two sessions a week to three sessions a week due to the number of referrals and reviews in his workload.

A business case will be prepared to increase this post to full time, based on the successful initial phase to introduce a pharmaceutical resource across the nine CMHTs within our trust to ensure equity of service and to support patients prescribed clozapine, depot medication, high dose antipsychotic therapy (HDAT), lithium or complex medication regimes, to provide a day-to-day pharmacist presence by providing input to the team by way of answering queries about medications such as interactions or choices in treatment, rationalisation of treatment regimes, addressing adherence issues, obtaining and reviewing medication summaries from GPs, liaising with community pharmacies, providing education and ongoing specific medicines support to patients, carers and staff.

There is finite resource of pharmacist availability within mental health in the UK. An option to get the maximum out of the above role could be, if necessary, to split the role up where junior pharmacists monitor patients' physical health characteristics, organise training and prepare medication reviews, and a more senior pharmacist could oversee the clinical consultations. If necessary, pharmacists could cover more than one CMHT. Input could also be tailored to the needs, priorities and wishes of each individual CMHT. Another role to consider would be the support of a clinical technician to each team, who could assist with, for example, counselling patients, improving adherence or helping with laboratory result analysis.

> **"Another option could be the setting up of pharmacist-led anxiety and depression clinics over several CMHTs within a sector of the trust."**

Teams have seen a significant increase in referrals of patients with ADHD in the past number of years. A pharmacy team could help run a relevant clinic for these patients and perform the necessary physical monitoring too as well as assist with prescribing repeat prescriptions. This too adds to the capacity of a CMHT.

Limitations

One limitation was that the project was limited to two days per week and many referrals and queries came through on the other days of the week. However, this could be interpreted positively, that the role was successful and fundamental, and the role has the potential to be essential throughout the week. The coronavirus pandemic also had an impact on the development of group-based work to help improve medication adherence, but the team hopes to commence this in the coming months.

Conclusion

The results and feedback from this pilot project indicate that a non-medical prescribing (NMP) pharmacist can be a helpful addition to a CMHT. They can help increase the capacity of clinics and number of patients seen each week and help with the physical monitoring and education of staff and patients and improve medication adherence. Patient feedback was extremely positive – it clearly demonstrates the advantages of having a collaborative approach for decision-making regarding medication choices. This role has the potential to free up time for all staff and the feedback from patients and staff illustrates that both groups consider this a beneficial service which could be adopted in other CMHTs.

Declaration of Interest

All authors have nothing to declare.

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Evaluating the Quality of Valproate Prescribing in a Community Mental Health Team in England

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Abstract

Valproate is a medication widely used in psychiatry to treat bipolar affective disorder as well as various other indications and target symptoms off-label. Valproate can cause an array of side effects, many of which are shared with medicines co-prescribed frequently, such as antipsychotics. While recently valproate has attracted considerable attention due to its teratogenic effects, there has been little focus on how clinicians document intended patient outcomes associated with valproate prescribing in a mental health setting.

We collected data based on a community mental health team valproate caseload in the South of England with the help of the national Prescribing Observatory for Mental Health's (POMH) audit tool between October and December 2022. We noted that in more than half of cases no clear rationale for treatment with valproate was documented in the electronic patient record. 96% of the patients seen in clinic were co-prescribed at least one antipsychotic and the majority of these reported side-effects possibly attributable to the antipsychotic, valproate, both or neither, either completely or in part. Decisions, therefore, to either continue or stop prescribing valproate in order to alleviate these side-effects, without clear documentation regarding rationale – and response to – treatment, were complex and potentially risky. Thus improving the quality of documentation particularly relating to indication and/or target symptoms is paramount to delivering better clinical outcomes for patients.

A pharmacist can benefit this service by increasing the capacity of reviews, optimising medication, monitoring, and making physical health interventions. They are well placed to improve standards of care and patient safety regarding medicines optimisation.

Summary / Relevance Statement

Valproate can cause an array of adverse effects, many of which are shared with several other commonly co-prescribed psychotropic drugs, such as antipsychotics. Identifying the causative drug is often fraught with challenges as adjusting or stopping the incorrect drug may not only yield little to no alleviation but also lead to a deterioration in mental health. Clear documentation is therefore essential to support the ongoing assessment of risks and benefits of prescribing.

Introduction

Valproate – the pharmacologically active moiety of valproic acid and sodium valproate – is a medication with multimodal action which primarily includes increasing GABA levels in the central nervous system. Its acidic form is a branched, short-chain fatty acid, derived from the naturally occurring plant metabolite, valeric (pentanoic) acid.[1] Some preparations contain only the acid form or the sodium salt, whilst others are formulated as semisodium valproate (also known as divalproex sodium), which is a coordination complex comprised of sodium valproate and valproic acid in a 1:1 molar relationship. These are summarised in Table 1.

Whilst only licensed for the acute treatment and prevention of mania and/or epilepsy in the UK, valproate-containing medicinal products have been shown to have an effect in a variety of conditions and clinical presentations, ranging from migraine prophylaxis[2] and aggression[3-4] to panic disorder[5] and PTSD symptoms.[6] In psychiatry, however, it is most commonly known as a treatment for bipolar disorder.

There is an increasing list of severe risks associated with valproate (e.g. teratogenicity and impaired fertility),[7] and NICE only recommend its use in bipolar disorder if lithium is either ineffective, poorly tolerated or otherwise not suitable.[8] In addition, valproate can cause an array of adverse effects – including metabolic, extrapyramidal and CNS-depressant – many of which are shared across several other classes of commonly co-prescribed psychotropic drugs, such as antipsychotics. As a result, identifying the causative drug of a specific undesired effect, particularly those with a delayed onset, is often fraught with challenges as adjusting or stopping the incorrect drug may not only yield little to no alleviation but also lead to a deterioration in mental health.

Clear documentation of the rationale for prescribing valproate (e.g., clinical diagnosis and/or specific target symptoms) is therefore imperative in ensuring that treatment may be reviewed appropriately by all healthcare professionals - present and future - involved in the care of patients.

This audit set out to evaluate the quality of valproate prescribing in a community mental health team in the South of England, with a special focus on the availability of documentation regarding indications or target symptoms to support the ongoing use of valproate.

Method

The community mental health caseload was reviewed by several members of the team (including administrators and clinicians) to identify all patients being prescribed valproate between October and December 2022. A database was created encompassing these patients, who were then contacted by post, inviting them to attend a face-to-face annual valproate review clinic with the team's mental health pharmacist. Each review was conducted using the 2022 POMH audit 'Improving the quality of valproate prescribing in adult mental health services' data collection tool. For those patients who did not attend a review, only data available from their electronic patient record (EPR) was used, whereas for those attending, information obtained during this clinic was used to supplement the electronic documentation – this included the assessment of potential side-effects using the

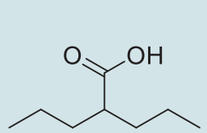
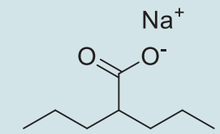
Structural Formula				
Form		Valproic acid	Semisodium valproate	Sodium valproate
Molar mass (g/mol)		144.21	N/A	166.19
Licensed clinical indications and corresponding Brand names	Bipolar Affective Disorder	-	Depakote Syonell Belvo	Episenta
	Epilepsy	Convulex	-	Epilim Episenta

Table 1. Comparison of valproate preparations

Valproate Side Effect Rating Scale (VSERS). All data captured were collated, pseudonymised using identification numbers, and analysed in Microsoft Excel against the audit standards set out by POMH-UK. Because patients were seen as part of routine annual monitoring and their data analysed for the purposes of a local clinical audit - rather than for research - explicit participant consent was not required. Similarly, ethics approval was not needed to conduct this clinical audit.

Results

The audit identified a total number of N=35 patients that were on the team caseload currently being prescribed valproate. 23% of these were female, only one of whom was of childbearing age. The age of patients ranged from 21 to 65 years, with an average of 49. 25 of the 35 patients attended their face-to-face review, each lasting between 20 and 45 minutes.

All patients had at least one psychiatric diagnosis documented, which primarily included schizophrenia (n=15), schizoaffective disorder (n=12) and bipolar affective disorder (n=6). Of these, the mean total daily valproate dose was lowest in the former group (907mg) and highest in the latter two (1321mg and 1333mg, respectively). Specific uses and indications identified in this cohort for valproate were classified using the POMH audit categories (see Table 2); in more than half of total cases (n=20) no clear rationale for treatment with valproate was documented in the EPR. With regards to the chemical form of valproate, both semisodium (n=19) and sodium salts (n=16) were being prescribed. Cross-referencing diagnoses against the corresponding prescribed valproate preparation showed that in 80% of cases, valproate was prescribed outside its marketing authorisation (off-label). It was estimated that through medicines optimisation and switching, off-label prescribing could only be reduced to 78% due to the fact that, in most cases, valproate was being used in the absence of a licensed UK indication irrespective of the specific preparation (i.e. not used for either bipolar illness or epilepsy). VSERS was used among the patients who attended the clinic to assess the breadth and severity of common associated adverse effects. The results of this showed that the most common side-effects were tremors (resting, postural or intention) (80%), weight gain (72%),

Indication / Target Symptoms	Average daily valproate dose (mg)	Number of patients (%)
Continuation of longstanding valproate prescription: the reason for prescribing is not documented/not known	1157.5	20 (57%)
Prevention of clozapine-related seizures	500.0	1 (3%)
Prevention of clozapine-related seizures & To treat epilepsy	800.0	1 (3%)
To prevent manic / hypomanic relapse of bipolar disorder	1500.0	1 (3%)
To treat an acute episode of mania/hypomania	1375.0	2 (6%)
To prevent manic / hypomanic relapse of bipolar disorder & To prevent depressive relapse of bipolar disorder	1000.0	1 (3%)
To treat emotional instability	1350.0	2 (6%)
To treat epilepsy	600.0	2 (6%)
To treat mood / affective symptoms in schizophrenia / schizoaffective disorder	1310.0	5 (14%)
	TOTAL	35 (100%)

Table 2. Indication / Target Symptoms for Valproate As Documented in EPR

drowsiness (64%) and lack of energy (44%). As 24 of the 25 patients who attended the clinic were also prescribed at least one concomitant long-term antipsychotic, it was not possible to conclude whether these side-effects were caused by the antipsychotic, valproate, both or neither, either completely or in part.

Conclusion

This audit looked at valproate prescribing in a community mental health team in the South of England, focusing on the availability and quality of documentation pertaining to indications or target symptoms to support the ongoing use of valproate.

Most patients in the cohort analysed were found to be prescribed valproate without a clear rationale documented in their electronic patient records. However, it is postulated that valproate was frequently being used for its mood-stabilising effect, as demonstrated by higher mean prescribed doses for diagnoses with an affective component. Whilst a dose-response relationship for valproate in acute mania is supported by the literature,[9] up-to-date serum levels (in the past year) were only available for two patients. The lack of access to historic documentation pertaining to the rationale of treatment on commencing valproate, as well as the paucity of subsequent reviews with details of a clear indication for valproate use, have meant that assessing tolerability and response – and in turn, making decisions to either continue or stop prescribing - is increasingly difficult by clinical teams that inherit patients later during treatment. This finding also posits that in a number of cases continued prescribing may be groundless, unjustifiable and inappropriate - not to mention the potential medicolegal consequences of off-label prescribing, which is thought to be a relatively common practice in psychiatry – one study reporting this to be as high as 28.5% for mood-stabilising drugs in a tertiary care unit.[10] Valproate shares a range of adverse effects with psychotropic drugs commonly co-prescribed, such as antipsychotics. In other words, identifying the causative drug is rarely possible. Improving the quality of prescribing of valproate through clear electronic documentation particularly relating to indication and/or target symptoms is thus paramount to delivering better clinical outcomes for patients. The authors propose that such improvements could be introduced through provision of regular education and training opportunities for clinical teams specific to conducting medication reviews and high-quality documentation encompassing side-effect and target symptoms monitoring.

Declaration of Interest

The authors declare no conflict of interest.

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Author Contributions

Conceptualization, BA and SS.; methodology, BA; software, BA; validation, BA; formal analysis, BA; investigation, BA; resources, BA; data curation, BA; writing—original draft preparation, BA and SS; writing—review and editing, BA and SS; visualization, BA; project administration, BA. All authors have read and agreed to the published version of the manuscript.

Data Availability

The data that support the findings of this study are available from the corresponding author, BA, upon reasonable request.

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The Impact of Pharmacy Technicians in Primary Care

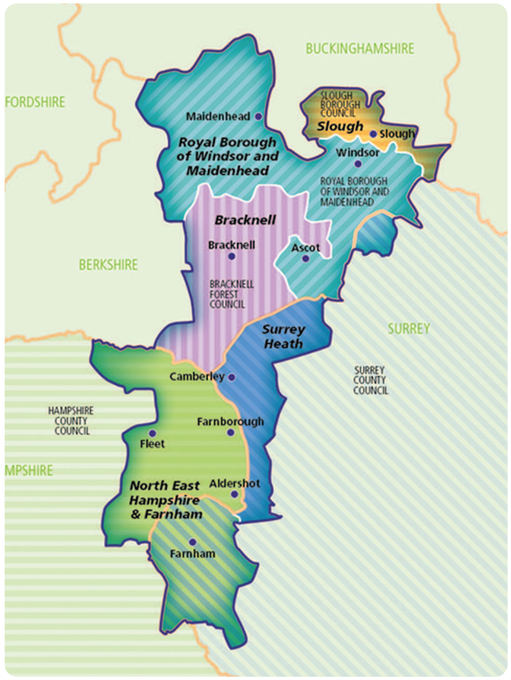
How pharmacy technicians are making a difference

By Sarah Chapman

MAPharmT, Lead Pharmacy Technician, Ascot Primary Care Network, Berkshire Primary Care.

(With thanks to pharmacy technicians across Frimley ICS for their contributions to the content of this article.)

Frimley Integrated Care System



As a registered pharmacy technician (an often 'overlooked' profession), I wanted to write about the impact that we are having in primary care and the difference to patient care that pharmacy technicians contribute to.

Currently, I am employed as a primary care network (PCN) pharmacy technician in Berkshire, but my career started in a small high street pharmacy in Hampshire. After college, I was conflicted about whether to apply for university or to enter the workplace. I chose to apply for a job in my local pharmacy as I was drawn to the fact that I would be earning a wage and also be enrolled on a course in pharmaceutical studies – the best of both worlds in my eyes.

To work in a high street pharmacy all staff must complete NVQ and BTEC level 1 in pharmaceutical science and service skills. Then, to progress into the dispensary, they must complete the level 2 qualification. I was also fortunate enough to complete the level 3 pharmacy technician course – two year distance learning – that I completed whilst working and with the full endorsement of the company I worked for.

> **"As a profession, pharmacy technicians are registered with the General Pharmaceutical Council (GPhC) and must complete set pieces of study for annual continued professional development."**

During my time in community pharmacy, working alongside a responsible pharmacist, I was involved in dispensing medication, answering patients' queries, sourcing hard to come by pharmaceutical stock and undertaking the general management and maintenance of the dispensary.

In 2019, a five-year framework was developed by NHS England to implement the NHS Long Term Plan. Under the Network Contract Directed Enhanced Service (DES), funding was made

Pharmacy technicians in action – The GP perspective

Overall, I would say that having the pharmacy team in practice has been helpful. The medicine reconciliation of discharge summaries has cut down my workload and we have also been able to direct meds queries to them as well as BP follow ups and medication reviews.

GP, *Ascot, Berkshire.*

Thank you for all your help, I would definitely say there is a beneficial impact from the care home reviews, these are complex patients with polypharmacy where pharmacy team support has been valuable.

GP Partner, *Ascot, Berkshire.*

available to PCNs through an Additional Roles Reimbursement Scheme (ARRS) to recruit up to an additional 20,000 full time equivalent posts across five specific roles.

The aim was to grow additional capacity through new roles, and by doing so help to solve the workforce shortage in general practice. One of the identified roles was pharmacy technicians and in summer 2020 I decided that this was a route I would like to explore.

At the start of 2021 I was accepted into a PCN to begin my journey as a pharmacy technician working alongside general practice. I was the first pharmacy technician employed by the PCN, which already employed two pharmacists. Initially, I was faced with questions from GPs and receptionists such as: 'What is a pharmacy technician?', 'What can a pharmacy technician do?', and 'Are you a pharmacist?', which emphasised the need for the profession to be more widely known and understood.

It occurred to me that we had some work to do to distinguish between the roles. In community pharmacy and hospital settings, where there have been pharmacy technicians and pharmacists for many years, the two roles are very distinct and well developed. It is very clear as to what defines a pharmacist (with a degree in pharmacy) and a pharmacy technician (with a BTEC/NVQ 3 in pharmaceutical science and services) and what their competencies and roles are.

One of the main differences I found after joining the PCN was that I no longer worked under the supervision of a pharmacist. This was because although a pharmacy technician is a registered healthcare professional in their own right, in high street pharmacies there is a legislative requirement that a pharmacist will take overall responsibility for all of the work undertaken in the pharmacy.

My first tasks when I joined primary care were reading and actioning the prescribing newsletter written by our Integrated Care Board (ICB) – Frimley is the ICB within which my PCN sits. The medicines

Pharmacy technicians in action – Smoking cessation

'I run a phone-based, quit smoking service in conjunction with Smoke Free Hampshire, where patients are usually signposted to me by the other clinicians at the surgery.

I call patients weekly to give support and advice (I am registered with the National Centre for Smoking Cessation & Training). In appointments we discuss smoking habit, the reasons they want to quit and then decide the best therapy/prescribing option to pursue (organised through their GP).

I had experience of running clinics when I was based in community pharmacy, and it has been great to continue doing this in primary care.

We have had many success stories along the way (and obviously quitting smoking is one of the most effective things anyone can do to improve their health).'

Sally, *a pharmacy technician working in North East Hampshire & Farnham.*

Pharmacy technicians in action – Surrey Heath Primary Care Network

I am a pharmacy technician for Surrey Heath Primary Care Network (since August 2022).

In the relatively short span of working in a surgery I have been able to make a difference and help manage the workload around medications and reviews.

Some of the areas that I have contributed to are outlined below:

- Taken the majority of the workload from our pharmacist regarding processing discharge summaries and doing medication reconciliation for smoother medication requests post discharge
- Undertaken training for inhaler technique and have advised patients on the correct way to use inhalers (I also hope to begin face to face clinics to change patients from MDI to DPI and help our asthma nurse if patients need inhaler technique review)
- Answered medication queries from patients and receptionists
- Helped to reduce the workload on doctors and dispensary by communicating with our local five care homes and reconciling their medicines mid cycle to make sure they have adequate stock, so the cycle runs smoothly and mid cycle requests are reduced
- Set up a process for new residents' medications to be reconciled immediately to avoid delays in issuing medications
- Provided SMR pre-work for pharmacist to sign off, suggesting any polypharmacy, optimising medications and doses according to newer guidelines
- Involvement in incentive schemes for surgeries undertaking changes to patients' statins to high intensity doses, as recommended to reduce the risk of CVD events and have set up a statin clinic to start/initiate statins in people who have Qrisk>20%
- Involved in Impact and Investment Fund (IIF) targets to do SMRs, issue emergency steroid cards, and also do high risk drug monitoring making sure patient's bloods are monitored

Arshavi, *pharmacy technician in Surrey Heath PCN.*

optimisation team at Frimley ICB send out a monthly newsletter to all primary care clinicians. The newsletter includes information regarding patient safety, medicine shortages, prescribing guidelines, NHS cost savings and any relevant information to safe and responsible prescribing.

The first project I undertook at the PCN derived from the prescribing newsletter – the implementation of the emergency steroid card. The ICB explained that the Society for Endocrinology had released new guidance stating that anyone prescribed potent or long-term steroids must carry an emergency steroid card highlighting that they were on steroid treatment, so that if they required emergency medical care their steroid treatment regime could be safely continued to prevent adrenal insufficiency.

My task was to identify all patients who met the criteria at each of the four surgeries within the PCN, contact the patient/representative to explain the importance of carrying an emergency steroid card and to supply the card. I also contacted our local community pharmacies to explain the guidance and where new cards could be obtained from, so they could be distributed to patients when dispensing prescriptions. Being a pharmacy technician with previous experience of working in a community pharmacy placed me in a prime position to carry out this task effectively (e.g. my familiarity with the website used to order the cards – it being the same as where pharmacies order prescription tokens).

The next stage in the process was for me to notify all prescribers at the surgeries that when prescribing potent or long-term steroids they should explain and supply an emergency steroid card as well. This was a considerable project that took a number of weeks to complete and had there not been a pharmacy technician in the surgeries to action the guidance it would have

Pharmacy technicians in action – A pharmacist's perspective

Having a pharmacy technician working with me has definitely made my working life easier.

They have helped me by sharing responsibility for prescribing indicators and also greatly assisted with medical records. Lots of queries are now directed to the technician before they might reach me, including the management of the care home inbox.

As a colleague who understands the work pressures we face, and is someone I can bounce ideas off, the technician has become an integral part of the surgery team, making my working life more bearable and allowing me to more effectively manage my workload as responsibilities are shared between us.

Pharmacist, *Bracknell PCN.*.

required actioning by GPs, or might possibly have been overlooked, putting patient safety at risk.

Another important task that pharmacy technicians are responsible for is medication brand switches. An example of this was when the ICB advised us that prescribing particular brands of macrogol compound oral powder provided significantly better value by approximately £50 per patient per year, based on the dose of one sachet per day.

I undertook the switching of macrogol prescription to the locally preferred brands and cascaded the message to all prescribers as well as actioning drug safety updates such as skin emollients and fire risk (highlighting to patients that emollients can soak into fabric and the build-up of dried emollient on fabrics can increase the risk of fires and cause severe and fatal burns).

In the early days of my work in primary care much of my workload was taken up with medication reconciliation (comparing a patient's medication orders to all of the medications that they have been taking to avoid medication errors) and this remains so today. Medicines reconciliation is

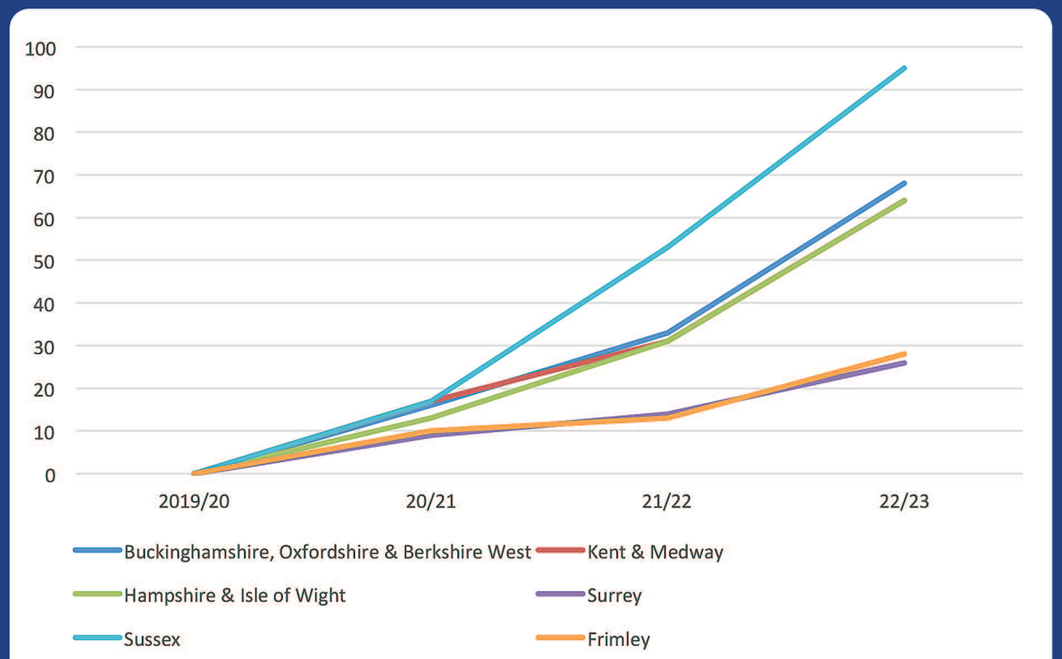


Figure 1: Pharmacy Technicians employed in Primary Care Networks in South East England

undertaken by pharmacy technicians across the whole of Frimley ICB, each of us doing between 100-200 per week.

When a patient is seen in a private clinic, hospital or pharmacy, the clinician will send a copy of the appointment notes to the patient's GP surgery. The letters are scanned into the pharmacy technician inbox, and our task is to translate any notes and medication changes onto the patient's medical record.

This has to be done in a timely fashion because if a patient is seen, for example, by a consultant in neurology and they have had their Parkinson's medication regime altered to better control symptoms, if this information has not been amended on a patient's repeat list, then when they next order their medication the pharmacy will receive a prescription with incorrect directions. This could potentially lead to the patient's symptoms being exacerbated, requiring a further appointment with the neurologist.

This can of course be avoided with good transfer of care, and prompt medicines reconciliation. Previously, these clinical documents were all sent to GPs to be actioned (usually after a full day of seeing patients). Now, pharmacy technicians do the majority of this work, allowing GPs to prioritise more complex patient care.

As part of the NHS contract, pharmacy technicians employed in primary care are enrolled onto the Centre for Pharmacy Postgraduate Education (CPPE) primary care pathway, which is where I was able to develop my clinical skills. During this 15-month course, I learnt how to conduct a medication review with patients using shared decision-making, clinical assessment skills such as taking a pulse and checking respiration rate and how to integrate myself as part of the general practice team.

"Now, after two years of working in primary care I hold my own clinics. I conduct asthma reviews on well controlled patients, freeing up appointments with the asthma nurse to allow them to focus on poorly controlled patients who need their asthma medication optimised."

Pharmacy technicians in action – Herschel Medical Centre

The Key roles for pharmacy technicians at Herschel Medical Centre include:

- New patient health checks
- Mental health patient reviews
- Dementia reviews,
- Action of at least 30 docman letters per day (which include the addition of new medication/implement changes)
- Childhood immunisation targets
- QOF targets
- Prescription queries (at least 10 daily), also queries where a patient has contacted the prescription team about their medication, including out of stock with pharmacy so needing an alternative)
- Medicines optimisation targets (appropriate prescribing of drugs), steroid cards, and also do high risk drug monitoring making sure patient's bloods are monitored

Herschel Medical Centre, *45 Osborne Street, Slough, Berkshire, SL1 1TT.*

I review stable hypertensive patients, giving lifestyle advice and supporting them to continue a healthy path. This frees up appointments with other clinicians for more complex patients such as people with diabetes. I also continue with my patient safety work, drug safety updates, medicines reconciliation, queries from patients and reception and I am a point of contact for the nurses in my local care homes and our local community pharmacy teams.

Pharmacy technicians also play a key role in providing structured medication reviews to all care home patients. A structured medication review can take considerable time to complete as the clinical pharmacist must review each medication, check recent blood tests and any other clinical data available to ensure the patient is on the correct medication for their condition, changing and deprescribing medication where appropriate.

The pharmacy technician will, with help from the patient, gather available information, their Medicine Administration Record (MAR) charts and information from care home nurses (e.g. up-to-date blood pressure reading, weight, mobility, medication adherence/compliance issues. etc.). All information available is recorded on a medication review form provided by the medicines optimisation care homes team and given to the clinical pharmacist in preparation for the structured medication review.

"The future is looking bright for pharmacy technicians in primary care. We will be holding more face-to-face clinics with patients, with opportunities for us to undertake phlebotomy training to enhance further our clinics and patient centred care."

In Frimley we are also looking into cross sector pharmacy technician training (hospital, primary care, community pharmacy) so that we can develop our very own multi-skilled pharmacy technicians.

Continual professional development and postgraduate pharmacy education – an academic perspective

Sandra Martin, *Associate Professor in Pharmacy Practice & Programme Lead Foundation Pharmacy Practice (multi-sector) Programme, School of Pharmacy & Medical Sciences, University of Bradford.* **Gemma Quinn,** *Director of Postgraduate Pharmacy Education and Director of Studies, School of Pharmacy & Medical Sciences, University of Bradford.* **Suzanne Hill,** *Programme Lead for Advanced Pharmacy Practice Programme, School of Pharmacy & Medical Sciences, University of Bradford.*

The role of pharmacists in the NHS

Since the formation of the NHS in 1948, pharmacists have had an essential role in supporting the needs of the health services and their patients. Pharmacists are experts in medicines, with traditional roles of checking, dispensing, providing information about them and more recently, prescribing them. To meet the changing needs of the NHS for patients, pharmacists have continually adapted and developed their skills to provide safe, effective person-centred care.

For pharmacists in patient-facing roles, the 1980s saw the development of pharmaceutical care, which was first defined by Mikeal *et al.* in 1975 as: 'The care that a given patient requires and receives, which assures safe and rational drug use'.[1] This definition was refined in 1988 by Heppler and Strand, who defined pharmaceutical care as: 'The responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life'.[2] Activities to support pharmaceutical care for patients started to become embedded into pharmacist roles during the 1990s and have developed subsequently to support opportunities during NHS re-organisations over the last 30 years.

The NHS Long Term Plan (2019) provides the latest iteration for NHS reorganisation in England.[3] This document sets out proposals to improve patient care over the next 10 years. Groups of local NHS organisations have worked together with each other, local councils and other partners, to develop and implement their own strategies from 2019-2024. Initiatives to tackle health inequalities and promote cross-sector working are key aspirations for the plan with opportunities for pharmacists from all sectors of practice (community, primary care and secondary care) to work more closely together. Workforce development, chapter four in the Plan, is a central component of this, with new roles and inter-disciplinary credentialing programmes to enable more workforce flexibility across an individual's NHS career and between individual staff groups.

Pharmacy education in the UK

The General Pharmaceutical Council (GPhC) sets the standards for the initial education and training for pharmacists in Great Britain, with thirty-three higher education institutions currently accredited to deliver this.[4] In addition, the GPhC also regulates postgraduate independent prescribing courses for pharmacists. As part of their continuing professional registration, pharmacists are expected to undertake mandatory continuing professional development (CPD), which is submitted annually to the regulator.

In addition to undertaking CPD as part of maintaining professional registration, many pharmacists opt to undertake formal postgraduate study to equip them with the necessary education and training for professional development and to enable them to carry out their roles safely and effectively. Routes for formal postgraduate education include research or practice-based routes. Figure 1 shows the variety of formal postgraduate opportunities typically undertaken by pharmacists:

Programme	Total
Postgraduate clinical diplomas (PGDip) or Masters (MSc in Clinical Pharmacy)	Typically practice-based, can be studied full-time or part-time (typically 2-3 years)
Independent Prescribing (IPresc)	Practice-based, short course (typically 4-6 months)
Masters in Research (MRes)	Research focused (can be studied part-time or full-time (typically 1-2 years)
Doctor of Pharmacy (DPharm)	Research focused, can be studied part-time or full-time (typically 3-6 years)
Doctor of Philosophy (PhD)	Research focused, can be studied part-time or full-time (typically 3-6 years respectively)

Figure 1 The variety of formal postgraduate opportunities typically undertaken by pharmacists

Postgraduate programmes offer flexibility in that they can be studied either full-time or part-time, the latter combining studies with working in practice. Pharmacists who take the clinical or practice-based route for postgraduate education do so typically for career development, for example in secondary care to progress from Band 6 posts to Band 7 and upwards, in addition to developing their knowledge and skills. In addition, the Royal Pharmaceutical Society (RPS) curricula for Post-registration, Core-advanced and Consultant pharmacists further support development by providing guidance for core skills and attributes useful for career development from early stages to expert practice.

Funding for provision of postgraduate pharmacy education is provided by statutory education bodies such as Health Education England, the Scottish Government, Health Education and Improvement Wales and the Northern Ireland Centre for Pharmacy Learning & Development. Funding is provided for educational organisations, to commission and deliver programmes, and also for learners to fund studies through either payment of tuition fees or educational grants to support time away from the workplace.

Academic perspective for postgraduate pharmacy practice education provision

The University of Bradford was one of the first providers of a postgraduate pharmacy programme with the launch of their hospital postgraduate taught masters/diploma in clinical pharmacy in the late 1980s. Pharmacists studied the diploma part-time over two years, whilst working in clinical practice. There was the opportunity to extend the programme to a master's degree through a further year of part-time study which focused on successful completion of a practice-based research project.

Over the years, higher education institutes have adapted their postgraduate pharmacy provision based upon the needs of NHS service provision and student requirements. Pharmacy practice postgraduate programmes can be undertaken either fulltime or parttime, on-campus or online, or a combination of both (sometimes termed blended learning). Postgraduate clinical diplomas or master's degrees differ from other postgraduate training pathways in that students' exit awards are recognised and credit bearing at level 7 through academic quality assurance. For level 7 education, attributes such as critical thinking and critical evaluation are required, in addition to knowledge and skills to undertake a particular role.[5] The learning outcomes for postgraduate programmes can also map to the RPS curricula, helping to scaffold student learning to support completion of these professional curricula.

To reflect the aspirations of the NHS Long Term Plan, in January 2020 the University of Bradford reconfigured the postgraduate pharmacy practice programmes from separate sectors (community, primary care and secondary care) to multi-sector programmes. Periodic review of the programmes was undertaken by academic staff, students, expert patients and external stakeholders, including employers from different sectors of pharmacy practice and education leads at NHS organisations. Input from students, expert patients and external stakeholders ensures that the programmes are contemporary, fit-for-purpose and allow for an authentic learning experience. Increasingly the patient voice is being heard in healthcare education and co-creation of programmes, in addition to supporting delivery through teaching, learning and assessment permits this.[6]

For these new programmes, provision is tailored to student experiential backgrounds, with separate programmes aimed at early career and more experienced pharmacists through the MSc/PGDip Foundation Pharmacy (multi-sector) programme and MSc/PGDip Advanced Pharmacy Practice programme respectively.

Postgraduate pharmacy students are adult learners. They are familiar with the academic requirements for teaching, learning and assessment at level 7 (higher education master's level) through successful attainment of their undergraduate pharmacy degrees. Successful pedagogical approaches for adult learners offer: 'Student-focused approaches that adopt discussions and group work'[7] rather than didactic or rote learning strategies. Flexibility for student studies is provided through a blended learning approach, with on-campus study days and self-directed learning.

At the University of Bradford, on-campus teaching utilises a mixture of workshops led by expert tutors from practice, and the application of clinical knowledge through case-based scenarios. On-campus study days permit the development of a community of learning for students to network and share experiences with peers and tutors. This approach is supported by pre-work materials tailored to the topics, along with recorded teaching materials that students can access at times convenient for them. Self-directed study permits flexibility for studying to fit into the student's work/life balance and requirements for continuity of service provision for the employer. This blended learning approach, along with differing pedagogical strategies also supports the differing learning styles for students. In addition, at the University of Bradford, we incorporate the evidence-based 'Team-Based Learning' (TBL) approach to teaching, learning and assessment.[8]

This approach is successfully utilised in the undergraduate Master of Pharmacy programme at the University of Bradford and was extended to the postgraduate diplomas from September 2018 as it supports adult learning. See figure 2 for components of the TBL pedagogical approach:

The learner/student journey in undertaking postgraduate education

Undertaking postgraduate pharmacy education presents unique challenges for learners. For those working whilst studying part-time, there are time-based challenges of continued work pressures in the NHS and juggling family or personal commitments whilst trying to undertake studying and meeting deadlines for submitting assignments.

Some students embark on a postgraduate programme early in their career, so study skills are fresh in their minds. For those who have waited to start programmes who have gained more practical experience but academic skills are less familiar and/or technological developments may mean that new study skills are required to undertake the learning. Universities have experience with supporting learners from differing educational and social backgrounds and can provide advice about aspects of studying, such as academic skills, library skills and student wellbeing. Student pastoral support is provided by academic staff, many of whom have undertaken postgraduate programmes themselves so can offer first-hand experience of working whilst studying. Further support is provided by work-based tutors and peers on the programmes and specialist services including counselling and academic skills.

In addition to the academic qualification, undertaking formal postgraduate study provides the opportunity to develop other skills such as time management, to broaden professional vision, and personal empowerment. The use of different assessment techniques encourages development of so called 'softer' skills, for example assessed presentations develop communication skills and group project work encourages team-working. Application of experiential knowledge for clinical scenarios encourages the development of literature searching and critical evaluation skills. Many programmes offer the flexibility of choosing modules which learners can tailor to their personal developmental needs. Options often include traditional 'clinical' modules which encompass therapeutic topics, communication skills or prescribing courses, in addition to less clinically focused modules such as leadership, service improvement, research or education focused modules.

The student experience of being part of a community of learning permits networking with peers to share experiences. Sharing of experiences further allows students to process learning opportunities and reflect on application to their work practices. Self-reflection permits deeper learning opportunities and development as a reflective practitioner. Self-reflection can be through formal methods including peer assessment of assignments or informally through self-evaluation against learning outcomes and developing study action plans.

Approach	Application
Pre-work packs	Pre-work tailored to study day topics and completed by students prior to attendance. Ensures students have the underpinning knowledge required.
Readiness Assurance Process (RAP)	Short knowledge-based test with multiple choice questions based on the pre-work. Undertaken individually by student (iRAT - individual Readiness Assurance Test) and in pre-defined, purposefully-formed small teams (tRAT -team Readiness Assurance Test).
Application Exercise	Case-based clinical scenario, written by expert tutors, and peer-evaluated in teams.

Figure 2: Components of TBL utilised in postgraduate programmes at the University of Bradford.

The future for postgraduate pharmacy provision

With the new 2021 initial education and training standards for pharmacists 4, pharmacists will be independent prescribers on registration. Implications for postgraduate pharmacy provision will mean that learning outcomes for early career diplomas will need to be re-assessed. Knowledge and skills currently provided by postgraduate programmes, such as clinical decision making, physical assessment and prescribing will be incorporated in the undergraduate curriculum.

"This means that these pharmacists' learning requirements for a postgraduate programme will be different to existing early career pharmacists. Whilst there will be an overlap of several years to support the early career pharmacists who register between now and September 2026, higher education providers will need to work with all stakeholders to ensure that their provision meets both the needs of existing registered pharmacists (who may not be prescribers) and newly registered pharmacist prescribers."

An increased emphasis on advanced practice has already seen a growth in postgraduate pharmacy provision aimed at more experienced pharmacists over the last few years, and this trend looks likely to continue. In the future, pharmacists could access CPD modules which they use to 'build' their own bespoke diploma to support their professional development and requirements for person-centred care, workforce development and service provision in the future NHS.

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White Paper: The future of community pharmacy in England

Developing a roadmap of how to get there with a focus on pharmacy prescribers

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This White Paper summarises the finding of the PM Healthcare think tank, sponsored and organised by Viatris Medical, on the future of community pharmacy in England.

Panelled by expert representatives from community pharmacy and secondary care, the discussion focused on the opportunities and challenges facing community pharmacy now, the changing role of community pharmacy, workforce development and the future of the sector.

Community pharmacy today

Community pharmacy remained open to the general public during the pandemic, arguably the only walk-in service to do so. Its resilience during lockdown and the willingness of pharmacists to continue face-to-face provision is an indication of the sector's strength and its ability to adapt to change.

Now, with a genuinely unprecedented crisis in the NHS – a combination of the covid backlog and staff shortages – attention turns again to community pharmacy to see if it may provide some solutions to these seemingly intractable problems.

These challenges occur at a time when significant structural changes have taken place in the NHS in England, with the introduction of integrated care systems (ICSs) replacing clinical commissioning groups, the establishment of primary care networks (PCNS), and the responsibility for commissioning a range of services moving from NHS England to ICSs.

With the advent of ICSs, there has been a rebasing of the relationship between community pharmacy and the local prescribing committee (LPC), which has provided an opportunity to have a different kind of conversation with contractors via the LPC. The dynamics and the conversations with LPCs, and now directly with contractors, seem more optimistic than in the past. There is still a lot of nurturing of new relationships to be achieved, and we are still very much at the early stage of the 'ICS experiment'.

An important consideration will be what happens both at the national and individual ICS level as more commissioning is devolved to localities. This is especially important to patients, for whom NHS boundaries are not relevant but who may experience different service levels in different ICSs.

What is felt is an acknowledgement around the power and importance of community pharmacy in the wider sector of primary care and community services, and the acknowledgement that community pharmacy can play a key role in preventative healthcare, patient care in relation to minor ailments and illnesses, signposting and the provision of information.

These changes present an opportunity to have a different narrative around community pharmacy, especially the local commissioning of services (at the neighbourhood level of the ICS) and the potential for systems to increase investment in community pharmacy.

In the community sector there has been a consistent and proactive stance on vaccination – flu and covid in particular. This success provides community pharmacy with the opportunity to have more meaningful conversations around how services are structured across the wider system. Having the majority of vaccinations provided in community pharmacy has also changed the way the public views the sector and has perhaps created an awareness in the public mind that other services, currently provided by GPs for example, could also be provided there.

At both the national and local levels, conversations have changed about opportunities going forward. For example, in cardiovascular disease there is an ambition to see hypertension services more widely available in community pharmacy and delivered there at scale, which would support the objective set out in the NHS Long Term Plan to improve prevention through lifestyle changes and early interventions.

This and other service initiatives have already seen PCNs expressing an interest in working more closely with their local community pharmacies, with contracts being aligned for that purpose. If contracts support the interests of both parties, then relationship are improved and some of the issues around sector segmentation may be overcome.

Developing the community pharmacy workforce

Store closures due to staff shortages are increasingly a problem in community pharmacy, caused by a lack of pharmacists and also by a significant number of pharmacists leaving community pharmacy and moving into primary care. At the PCN level there is extra funding available for additional staff, e.g. for frailty projects, health and wellbeing advisers, dieticians and physios – under the additional roles reimbursement scheme (ARRS) scheme – which is influencing decisions to move.

This 'brain drain' is partly due to funding issues, but possibly because the community pharmacy profession does not have a single representative voice, for example equivalent to the BMA or the GMC, who have fully trained and experienced negotiators who can influence media, government and therefore policy. Pharmacy has associations of independent multiples such as the Company Chemists' Association (CCA) and the Pharmaceutical Services Negotiating Committee (PSNC), but representation is splintered and there is no single voice to represent the sector. There is also an overall lack of a coherent strategy for community pharmacy, including within government and NHS England.

"There is no uniformity in our voice. Our colleagues in nursing and medical colleagues have an exceptional understanding of the language and rhetoric to use when negotiating with government. We do not use any of that when we're having the same conversation. It's about having the calibre and weight to hold the government to account."

Yousaf Ahmad, *Integrated Care System Chief Pharmacist and Director of Medicines Optimisation, NHS Frimley Integrated Care Board*

What is needed now is not to move away from the supply of medicines function, which is a vital area for pharmacy to retain, but to have services built onto that function, for example consultations and prevention activity (blood pressure monitoring, prescribing initiations, etc). These areas, if properly funded and implemented, will be of particular

importance to growing the community pharmacy sector and reducing the pressure on GPs and other healthcare providers.

This is all a part of ensuring the community pharmacy sector recruits and retains the necessary

prescribers and other staff. The profession needs to be attractive to people, and one way of facilitating this is to make it varied and interesting. Standing behind a counter and dispensing medicines is not necessarily something that highly trained pharmacists aspire to do.

"There is lobbying to change the categorisation of community pharmacy as healthcare rather than retail."

Mark Burdon, *Owner Burdon Pharmacy Group*

There is a variety of ways that this can be achieved – for example, retraining the existing workforce and utilising technology to enable pharmacists to move away from a purely dispensing role and creating joint posts (e.g. in academia, general practice, prisons, hospices, etc). The move required is one from a quantitative based system, where volume counts, to a qualitative one in which a wider variety of services, including prescribing, are delivered.

"We need to reconfigure the community pharmacy workforce in the way we have done for general practice, to make it more fit for the future. People want attractive jobs and if they don't find them behind the counter at their community pharmacy they will go elsewhere."

Helen Williams, *Consultant Pharmacist for CVD, SE London CCG and UCLPartners*

For pharmacists who have been working in the community space for a number of years the demands of a changing profession are perhaps more apparent. Greater visibility, providing advice and a range of services relatively new to the sector all demand an open-minded and flexible approach to a patent population that may increasingly see them as first-line healthcare providers.

The change required is challenging in the current climate and ICSs will require sufficient time to identify opportunities and to provide the resource to create different service pathways and to provide the necessary funding for the initiatives considered. (For example, NHS England is progressing ideas such as community pharmacy independent prescribing.)

Careful planning will be required to mitigate unintended consequences. There are great opportunities, but it requires a sufficiently wider workforce to capitalise on them.

"Change at this level will require legislators to amend the law to allow technicians to do the bulk of work that community pharmacists are currently doing, to free them up to be able to prescribe."

Chris Grahame, *Senior Clinical Pharmacist, Blue PCN Northampton*

The role of the specialist community pharmacist

There is within community pharmacy the potential to create new specialisms and for pharmacists to become advanced practitioners in different areas, for example menopause, asthma and COPD, contraception and UTIs. Specialisation should be an option, building upon existing initiatives, with the intention of creating training opportunities and resources for supporting developments in these areas. However, 'super specialists' were not seen as the way to go in the community pharmacy space, as the generalist is still the community pharmacy's 'unique selling point'.

"There is an argument for considering 'generalism' as a specialism, and that what is needed is pharmacists who can manage multiple long-term conditions in community settings, both in GP practices and the wider healthcare community rather than in very narrow specialist roles.

This is one of the strengths of community pharmacists – offering a broad range of generalist input, rather than a narrow range of very specialist input."

Helen Williams, *Consultant Pharmacist for CVD, SE London CCG and UCLPartners*

In the example of chronic pain and pain management in community pharmacy, by analysis of the patient population, pharmacists were able to identify patients who could be seen and treated in the community space rather than being referred to a hospital specialist. This provided a successful example of segmenting patient populations to determine which care setting was most appropriate.

An identified role for the consultant pharmacist is one where they move from an ultra-specialism to providing training and education for community colleagues (in a PCN or community pharmacy) to deliver a particular intervention in primary care. In this way, the relationship between specialist pharmacy professionals and generalists can support the prescribing and clinical services that community pharmacy wants to deliver, whilst developing expertise in-house to support colleagues delivering enhanced services in community settings.

The effectiveness of specialists working with generalists in both primary care and community settings was demonstrated in the development of a virtual clinic model to support patients with atrial fibrillation (AF), where it was known that many patients with AF were under-prescribed anticoagulants. The decision was made to bring the pharmacist out the hospital to review patients in the GP practice and identify those who could be supported and manged in general practice, freeing up resource and appointments in secondary care. The intention was to bring community pharmacy into this pathway, particularly around safe hypertension management receiving more adherence support for patients who are not following their prescriptions.

The new care models supported by the ICS structure is expected to allow for greater flexibly and there is an expectation that hospital pharmacists will have the opportunity to focus not just on ward patients but on patients in primary care – the 'cross contamination' of different skills that are available when hospital and community pharmacists meet.

What might community pharmacy look like in five years' time?

ICSs, introduced in July 2022, are the most important change to the structure of the NHS in England in a decade. They aim to provide new opportunities for service development, and also to bridge the silos that exist between sectors.

Immediate challenges to pharmacy include a lack of clinical supervision to train new prescribers to prescribe and give them the support needed to build confidence and competence, and also an ongoing 'drain' of pharmacists into primary care that is creating a shortage of pharmacists in the community pharmacy space.

It is hoped that ICSs, including new organisation structures such as PCNs, will help community pharmacies evolve and overcome some of these immediate obstacles to service improvement, through the pooling of resources and the development of the profession. For example, in the case of one UTI service across a geographically large ICS, services are now commissioned at the PCN level, which has led to co-located PCNs

merging UTI services to deliver efficiencies and consistent care, and the greater involvement of community pharmacy services.

If community pharmacy is to develop to provide a consulting and prescribing service, then the pharmacist cannot remain in the dispensary but must be available for the additional services that they are anticipated to provide. This thinking is already informing discussions with LPCs and contractors, especially in light of the fact that in 2026 all graduating pharmacists will be qualified prescribers.

"An essential component of restructuring the community pharmacy sector is to ensure training and support for pharmacists, both in the community and also when they are undergraduates. This is fundamental to providing them with the confidence and the ability to be a part of the community pharmacy team."

Chris Grahame, *Senior Clinical Pharmacist, Blue PCN Northampton*

The achievable ambitions are considerable. For example, making every patient contact in the community pharmacy an opportunity to fully assess needs (e.g. taking blood pressure, cholesterol and other point of care testing currently conducted by the GP surgery) and then ensuring that the community pharmacy can access and update the medical record, which emphasises the need for integrated IT systems operating between sectors.

In another example, a pharmacy has been redesigned to include consulting rooms, with the dispensary moved upstairs. The aim was to redesign the concept of what a community pharmacy is, where the first thing the public sees is not the traditional dispensary but rather the prescribers and community pharmacist who will provide services additional to dispensing. The intention is also to provide audiology, physiotherapy and podiatry services, working to create a comprehensive community healthcare hub.

What is envisaged is therefore a significant redesign of not just the profession, but also the community pharmacy itself as a means to realising these ambitions.

"I want community pharmacy to go on the same journey that GPs went on in the days of primary care trusts, which allowed GPs to fully come into the wider NHS family and to be seen as a core part of the service."

Yousaf Ahmad, *Integrated Care System Chief Pharmacist and Director of Medicines Optimisation, NHS Frimley Integrated Care Board*

Summary

Community pharmacy is changing and is increasingly being called upon to expand its range and capacity to support patient services in other parts of the NHS. There is a willingness in the sector to engage with the new opportunities that are emerging in a recently reformed healthcare service.

Post-covid challenges, staffing and capacity shortages have made the wider engagement of community pharmacy expedient, and the NHS has signalled its intention that the sector be engaged in areas such as independent prescribing, testing and consultation. There are, however, significant questions to address, such as IT, access to patient records, infrastructure, capacity and reform.

The expectation is that community pharmacy will be called upon to do more in primary care to support other service providers. This is the direction of travel signalled by NHS England, which has already committed to providing the required investment and direction that is necessary to achieve its ambitions for the sector.

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