PM Healthcare

JOURNAL

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In this issue

The whistle has blown and the game is on...

There are often moments in life that can shape a watershed in your views and priorities for the future.

Covid may well be one such moment for pharmacy in all parts of these islands.

The massive pressure that the pandemic placed on the NHS plus the significant backlog of patients now waiting for treatment in the system is simply carrying on - a moment that has real potential for professional development by pharmacy.

What can pharmacy do to win?

Let's spell out clearly what this new rainbow for pharmacy could look like.

Primary care-based pharmacists in GP practices can relieve the GP burden by reviewing the medicines of patients who do not need the attention of the clinician and operate clinics within the practice. Making much better use of resources into the bargain.

It will not be long until we see the arrival of "excellence hubs" in primary care where skills in such areas as hypertension/diabetes and other long-term conditions are congregated together to manage the patient who previously might have been referred to secondary-care with hubs retained within the community. Pharmacy has a major role to play here.

Hospital pharmacists have the ability to train and educate their primary care colleagues in the clinical skills which are necessary for managing conditions in the GP practice and the greater primary care organisation.

In hospitals as new treatment modalities arrive like Genomics, the role of the clinical pharmacist will be required to reach new heights as clinicians and other healthcare professionals look for guidance to utilise this advance for the maximum benefit of the patient.

By managing or optimising patients' medication effectively in the hospital, the pharmacy team can return patients to their homes more quickly and open up the prospect of the psychological uplift that will accompany that happening for the patient.

Community pharmacy did the nation proud during Covid by staying open when other healthcare professionals did not.

That now creates the opening for greater involvement in population health by that pharmacy group - again taking pressure off GP practices and making good use of NHS resources.

"The best way to predict the future is to create it." Abraham Lincoln

All these scenarios have one common theme to help demonstrate the answer to a key question which is (or should be) at the centre of all pharmacist thinking.

If I could show you a way of maintaining or improving patient care in a more cost-effective manner - would you be interested?

Pharmacists have the ability/training and experience to do that with great success through medicines optimisation.

As a profession there is too much humility - look how nurses have been able to grab centre stage over the past decades.

Do politicians ever mention pharmacists in the same breath as clinicians?.... they do with nurses.

Memory lane justification

I started life as a school teacher and can see many similarities in the humility that profession displays.

"I am only doing my job" was a quote I heard many times.

Is it only doing your job to rescue pupils from a trail leading to lifelong social problems and turning them into a decent human being? (A powerful human and social contribution).

My dear old mother who was a teacher used to say to me *"If you don't tell people what you have done how will they know?"*

"A person can change his future by merely changing his attitude." Earl Nightingale

How can we grow pharmacy in this "moment"?

A number of thoughts:

- How many pharmacists and pharmacy technicians understand how the NHS works and the opportunities for the profession? **Local workshops to demonstrate practical outcomes.**
- Can we get the profession talking together across the interface to help understand the pharmacy contribution on both sides of the primary/secondary care divide? **Create a "buddy" system between hospital pharmacist and primary care pharmacist.**
- Are the professional bodies of pharmacy promoting the role of pharmacy in the context of NHS needs? **RPS to deliver cost/benefit analysis of pharmacy.**
- Could bodies like UKCPA/GHP/PCPA set up working groups to design **the business case for pharmacy?**
- Is it possible to deliver regularly **communication skills training** to improve and sharpen engagement with other stakeholders in the NHS.

"The future starts today, not tomorrow." Pope John Paul II

Conclusion

In the 38 years that PM Healthcare has been privileged to work with pharmacy, there cannot have been a stronger set of circumstances for the profession to grow and deliver a major input to patient care and maximise NHS resources.

The NHS needs the skills of degree-educated professionals coupled with the experience of dealing with challenging circumstances.

PM Healthcare is committed to assisting the professional development of the profession so if there is anything we can do to help - please let us know.

Ted Butler, Chairman, www.pmhealthcare.co.uk/

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PM Healthcare
PROGRESS THROUGH PARTNERSHIP

The role of the PCN pharmacist in an emerging ICS structure

By Danny Bartlett

Lead Pharmacist, Horsham Central PCN
Senior Lecturer, Medicines Use, University of Brighton

Clinical pharmacy and the role of pharmacists within primary care are constantly evolving. In both larger NHS structures and smaller primary care systems, it can be hard to know what the pharmacy and pharmacist roles entail and what outcomes are actually being found from these clinical roles, specifically within general practice and how this links to larger integrated care system (ICS) priorities.

With a new structure emerging for the NHS and primary care, recommendations of NHS England and the passage of the Health and Care Act (2022), 42 ICSs were established across England on a statutory basis on 1 July 2022. This new structure followed several years of locally-led development and has an overall goal to improve the lives of people who live and work in the respective ICS areas.

ICSs are made up of integrated care boards (ICBs) and integrated care partnerships (ICPs). ICPs focus more on bringing together a wide alliance of local partners to improve health, care and wellbeing, whilst ICBs, following the dissolution of clinical commissioning groups (CCGs), focus on delivery and meeting the health needs of the population in regard to managing the NHS budget and arranging the provision of health services.

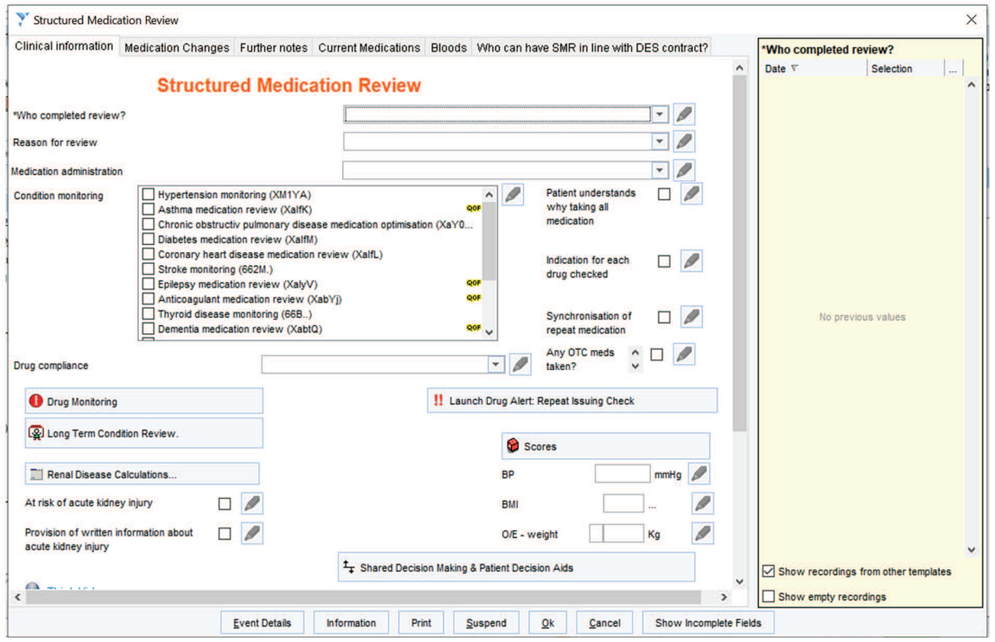
Each ICB has compulsory members, as listed below:

- Chair
- Chief Executive
- Partner Member(s) NHS trusts and foundation trusts
- Partner Member(s) primary medical services
- Partner Member(s) local authorities
- Non-executive Members
- Director of Finance
- Medical Director
- Director of Nursing

Whilst comprehensive, this list does not mandate a lead or executive role in regard to medicines or pharmacy. In CCGs of previous structures, medicine management teams formed a great communication interface to primary care colleagues and had real networking capabilities in involving the wider pharmacy workforce alongside general practice colleagues. With many of the ICBs adopting the integration of a pharmacy and medicines optimisation workforce, such as Sussex ICB, it is reassuring that although not a compulsory component, many ICBs are opting to involve the pharmacy workforce in their delivery of meeting health needs.

"With increasing numbers of pharmacists making the move to primary care and this new structure developing, it is essential to ensure a consistent feedback loop between colleagues on the frontline and key stakeholders trying to implement medicines optimisation and improving health outcomes."

The NHS Long Term Plan initially aimed for 7,000 primary care pharmacists by 2024 (Alshehri et al., 2021)[1] and although that figure may not be met, there is a substantial move to increase numbers in the sector as well as developing the role to encompass diverse general practice needs. As a lead pharmacist in Horsham Central Primary Care Network (PCN), my role is constantly evolving to not only develop my own and my team of



The structured medication review template, as developed

pharmacists and pharmacy technicians' clinical competence, but to embrace the increasing need of proactive medicine and medicines optimisation in the population.

With increased multi-morbidities and complex polypharmacy, many patients necessitate a specialised approach to their medication rather than a reactive and acute need of one long-term condition. Many patients have ten or more regular medications with notable interactions with each other and requiring different monitoring, so it is important to treat patients according to their individualised needs rather than taking a generalised approach.

This patient-centred care model has long been on the radar of healthcare professionals but has really come to the forefront in recent years. It has had varying success and some measures show it incredibly beneficial to improving compliance and concordance with treatment (Robinson et al., 2008)[4] though some inherent leadership models that exist can obstruct true transformation of the patient-centred model (Fix et al., 2018).[2] Pharmacists can have a key role to play in developing this patient-centred approach to improve health outcomes.

"Structured medication reviews (SMRs) have been a key part of the NHS Long Term Plan and help integrate primary care pharmacists into the workforce providing a platform to identify patients with complex medication needs (Lenander et al., 2014)."[3]

My role in this evolving profession (and mapping its development in the new ICS structure) is as a lead pharmacist for a PCN covering roughly 59,000 patients. I manage a team of pharmacists and pharmacy technicians and am always striving to improve health outcomes of our population. I have found that pharmacist-led interventions in patients with complex medication needs can have a great impact on improving prescribing safety and overall patient care. One key example of this is in our care

home population. Across our PCN, we cover in excess of 400 care home patients, some with complex polypharmacy.

We have attempted to conduct structured medication reviews alongside GPs, to try and rationalise and assess whether each patient was on medication necessary for their conditions or if there were medicines that we could de-prescribe. Using evidence-based recommendations and working closely with GPs we were able to de-prescribe 269 medications, including sedatives, antihypertensives and diuretics, making key impacts on reducing the likelihood of unnecessary hospital admissions.

SMRs have provided an excellent vehicle for putting in place a specific role for clinical pharmacists. Using our pharmacological expertise it has been one of my key successes in taking a DES contract-based ICS priority and applying it to a population. One of the principal ways I developed and secured this was through streamlining the process of carrying out an SMR. I developed specific clinical templates within the practice IT systems, and this allowed clinical pharmacists, nurses, GPs and other prescribers to access and input key clinical data into one template rather than many. This template has led to a fourfold increase in the number of SMRs conducted and is a key indicator of the clinical benefits of a more in-depth look at clinically complex patients.

These outcomes have greatly helped the team integrate with other healthcare professionals – a key step to improving outcomes and interprofessional working in a system under pressure. With GP numbers under scrutiny, other healthcare professionals are developing and taking up a large number of clinical projects in primary care. The additional roles reimbursement scheme (ARRS) enables PCNs to recruit paramedics, social prescribers, physician associates, clinical pharmacists, pharmacy technicians, physiotherapists and more, allowing them to integrate across multiple practices and be part of wider multi-practice projects to improve health outcomes.

My team's direct involvement with these other professionals has been key to improving the overall patient experience. I recently organised a multi-professional training session linking social prescribers with my team. Social prescribers have been incredible in helping patients with non-pharmacological needs (alongside clinicians), such as cost of living concerns, mental health and wellbeing, debt relief and stress (South et al., 2008).[5] This, alongside a tailored patient-centred approach and other clinicians, has been invaluable to our population within our PCN.

The roles funded under ARRS have been developing since PCNs formed but championing this and relaying the successes and roles within PCNs and communicating this to the ICBs is vital to link the higher NHS structure to real practice. It is excellent to have innovative projects, but if such best practice is not shared then it cannot benefit other PCNs.

A way in which my ICB is trying to achieve this sharing of best practice in relation to the pharmacy workforce is by utilising ICB-wide network meetings. These comprise all PCNs within the ICB attending a virtual meeting, key clinical guest speakers and sharing good practice, as well as ICB- specific projects communicated to the PCNs to improve medicines optimisation outcomes.

Many of these meetings have produced beneficial outcomes, linking good practice to the real-time needs of other healthcare professionals – for example, an expert pharmacist speaking on dependence-forming medications such as opiates and techniques to review patients on high doses of these medications and dose reduction or de-prescribing, as necessary. This was both informative and current, based on the needs of an ICB-wide population overprescribed high risk medications (and provided targeted learning).

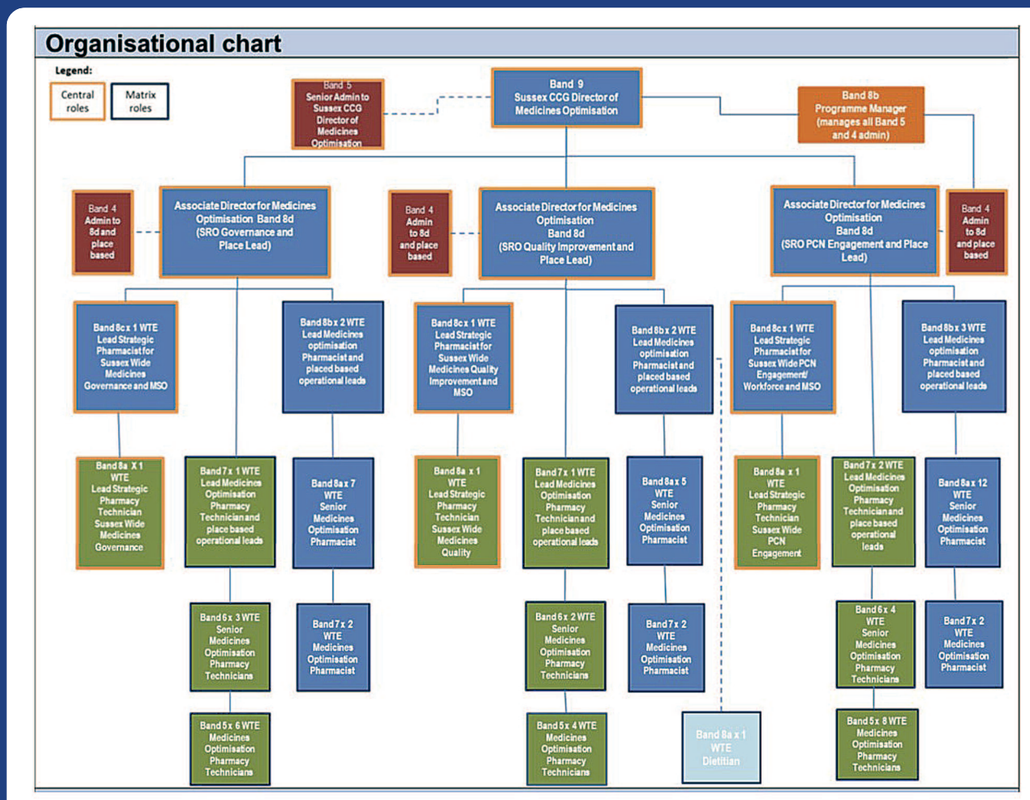
> **"One drawback of these meetings is that they can feel very generalised and, due to the large volume and quantity of attendees, can feel very impersonal. It is therefore difficult to gauge if the ICB is fully in touch with key issues on the ground."**

Within my ICB we have an allocated medicines optimisation pharmacist and pharmacy technician who cover several PCNS in our locality. This helps me link with the wider directives of the ICB and also feels more tailored to what our on the ground needs are. The pharmacist and technician help steer us towards any financially beneficial medicines optimisation projects, such as the medicines optimisation incentive scheme (MOIS), as well as helping us with queries relating to locally commissioned services (LCSs) that my local practices have signed up to. I have found this to be very effective at creating direct links for specific queries for both me and my team, as well as helping with wider sharing of best practice and communicating positive projects that my team are developing.

Patient education can be a key rate-limiting factor in the effectiveness of this evolving pharmacy workforce. Many patients are unaware of the new roles within primary care and may rigidly desire only to be seen by a GP, which can prevent the key multidisciplinary workforce from innovating and developing a more robust healthcare structure. GPs may have less involvement with a number of healthcare processes than previously, and many patients have not been provided with the necessary information to enable them to be aware of these system changes.

A key area of activity is chronic disease management where conditions such as asthma, COPD, diabetes and hypertension are simply dealt with by nurses and clinical pharmacists. In an increasingly strained system, these professionals have been invaluable at taking the lead in not only monitoring but taking over the management of these conditions from GPs, thereby improving access for patients whilst streamlining overall treatment.

Considering the example of hypertension as the most recent condition to be removed from the GP remit in my PCN, it has been incredible to discover how many patients are unaware that clinical pharmacists are able to train to prescribe and titrate medications. We have a 'Raised BP' group which is



Sussex Medicines Optimisation Structure within Sussex ICB

risk stratified and allows any patient with a high BP to be booked in with a clinical pharmacist. Pharmacist independent prescribers are able to titrate and initiate treatment to manage patients' BP, and for non-prescribers they are able to liaise with a GP and, once authority is given, take complete control in changing the regime and taking over management of that patient. This has provided an incredible relief to the workload of GPs, allowing them to focus on more acute issues, for example the invasive Group A streptococcal outbreak.

Patient awareness of such protocols and processes is low, which can lead to reluctance to accept treatment changes from anyone other than a GP. Although this is being managed brilliantly in our PCN through increased communications, a wider piece of work is outstanding to educate the public on the role of clinical pharmacists and other ARRS roles within primary care, as well as examples of good practice being shared within professional forums (and conveyed at an ICS level and beyond to the public).

Within primary care, pharmacy is developing at a rapid pace and part of my role within this structure is to develop a team that is flexible, adaptable and safe; therefore, the education of new clinical responsibilities, such as hypertension management and prescribing decisions, is key. Using evidence-based practice and also my role as a senior lecturer at the University of Brighton, it is clear that involving enhanced clinical placements of pharmacy students into primary care as part of their development journey can play a key role in not only developing the clinical pharmacists of the future but also in cementing new knowledge and skills within practicing pharmacists.

It is an exciting time to be in the primary care branch of our profession – and maintaining links within new ICS structures, sharing good practice, innovation and continuing to support our educational 'backbone' are all pivotal to its success.

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The Challenges for Pharmacy in 2023 An interview with Kandarp Thakkar

Kandarp Thakkar, Chief Pharmacist and Clinical Director of Medicines Optimisation, University Hospitals Plymouth NHS Trust, talks to PM Healthcare Chair Ted Butler about the challenges facing hospital pharmacy and the wider sector in what is predicted to be a particularly difficult year for the NHS.

Before we look at the challenges for pharmacy in the year ahead, could you share with us your career to date, leading to your current role as Chief Pharmacist and Clinical Director of Medicines Optimisation at Plymouth?

Absolutely. And thank you very much for the full job title, which is a bit of a mouthful!

It's perhaps worth starting by saying that at heart I consider myself first and foremost a clinical pharmacist. I trained in a hospital setting and then really spent the first ten or so years within various hospitals, mainly in London, doing clinical pharmacy predominantly within acute medicine, with some antimicrobials on the side for good measure.

Then, literally by accident, I was involved in a very large-scale project management role across a big patch of Northwest London, which my then boss asked me to do. And one of the reflections, aside from really enjoying quality improvement, was that I loved the leadership and the change management side of things. And at that point, I thought I've really enjoyed my clinical pharmacy journey, but it is time to do something slightly different and I applied for my first Deputy Chief role.

Even then, I was a bit precious about clinical services, so that particular role was a deputy within clinical services. I was very lucky to be successful, did that for a couple of years, absolutely loved it and was inspired by what I saw other chief pharmacists doing. This was when I went on to get my first Chief Pharmacist role.

The trust I was in had a really good work ethic culture, but the pharmacy department itself was rather stuck in the '80s and there was a huge piece of transformation work that I undertook over 18 to 24 months. This included everything from workforce recruitment, opening hours, strategy, automation, etcetera. This went really well and then one fine day I was called in by our Medical Director and Chief Operating Officer – I thought, here goes, I'm in trouble! – but actually it was a really pleasant conversation where I was humbled by their compliments on my leadership style and what I had done over the last 18 months.

They invited me to apply for a role in addition to the Chief Pharmacist role, and before I knew it, I found myself as divisional clinical director for surgery. This was a little bit scary, and it took my coach telling me that it's not so much about knowing things to do with surgery, but more about leadership. I did that for a further 18 months, during which time I set up the quality and governance structures within the surgical division that took us through a CQC inspection, and then did similar work for the women's and children's division.

At the time, and I guess this is my advice to people doing multiple roles, being Chief Pharmacist and divisional clinical directors across two areas left me feeling burnt out and I really just wanted to do something different. At this time I had the opportunity to go on a sabbatical to Dubai and be part of the team that set up the first NHS-style hospital (albeit private) there, where I became Chief Pharmacist. We built the hospital from what was literally a construction site to a fully functional hospital, which was absolutely brilliant.

But when my sabbatical came to an end, I realised that I missed the NHS because it's a different environment in the private sector in the Middle East, and I came back to my previous Trust leading on a merger between two hospitals as a director of integration.

Not only was this a different role and again got me close to my passion, which is change and transformation, but I also joined a board as a non-voting director. The experience was great, gaining that experience first-hand of executives, non-executives and governors, because it was a foundation trust. Then Covid struck, and I can promise you that doing a merger over Covid isn't something that you want to be doing every day. I really enjoyed it, but one of my biggest reflections amongst many other things during Covid was that I really missed pharmacy, so here I am back again.

Thanks Kardarp, that's a great introduction. Could you tell us how things are changing and developing in the NHS at the moment, as a result of the restructuring that we saw last year in England? Specifically, how are things developing locally at the moment and what are you seeing that's changing in the West Country in medicines and pharmacy as a result of the creation of the ICS?

Yes, certainly, but before I talk about my own ICS or region it's probably worth acknowledging that although the legalities and the statutory requirements of ICSs are now embedded, it's important to recognise that the country is absolutely at different stages of ICS development. I was in a meeting recently, speaking to people from a big city area in the Midlands, and also from some parts of London, who are far ahead compared to where we are in the West Country. This doesn't mean that anyone is right or wrong, rather it's currently a sort of organic situation. But it's recognising that those developments are absolutely at different paces. So down here in the West Country, particularly where I am which is within Devon ICS, we are very much in the forming phase at the moment.

One of the main issues that we are working on from a pharmacy perspective is workforce. We are still to recruit an ICS chief pharmacist and ICS workforce lead, but we do have a community pharmacy clinical lead. But without the single lead of a chief pharmacist we are very much going down the route of a distributed leadership model and everyone is pulling their weight to make things happen.

The clinical commissioning group (CCG) team, who are now effectively the integrated care board (ICB) team, are working hard to define their new role within the ICS structure and how that fits into the bigger picture ICB board. There is also something about who is doing what and who is who, because it is literally all change!

"So we are very much in that forming phase where people are being recruited and people are trying to figure out each other's roles. In addition, it is probably important to say that you could have all of the right people in-post, but unless you've got the right governance and committee structure it is hard to see how things will work."

We have a regional medicines optimisation committee, so we've absolutely got an RMOC, but we still have individual trusts running their own drugs and therapeutics committees. We've got the former CCG, still having an area prescribing committee, and certainly the new ICS structure is not aligned in terms of medicines governance. So that is something I suspect will happen over the next six to 12 months. And then last but not least we're at risk in pharmacy in that sometimes we operate in a siloed way.

The other thing that is happening in the region is understanding how pharmacy and medicines fits into the wider scheme of things. Within our ICS there are several important clinical forums, and at the moment pharmacy is not particularly well-represented on those because it is all very early days. So it is understanding how pharmacy and medicines position themselves within the wider forums and then actually aligning with what the biggest priorities are. So, all in all we are in a forming phase, early days, but I think we've certainly got a direction of travel.

From what you've just described, if we looked at the year 2023, what are the challenges that you see lying ahead for hospital pharmacy?

I would say – and I'm going to say it three times and make no apology for it! My biggest challenge in hospital pharmacy, and I suspect this is also across the board, is workforce, workforce and workforce. It is a huge challenge all the way starting from recruitment. There are simply not the numbers needed and we are expanding in all sectors, which is great for the profession, that there is a demand for us in all sectors, particularly the newer sectors such as primary care networks (PCNs), but there are simply not enough people to go around.

"To accommodate this we are having to do innovative things, for example we are doing quite a lot of recruitment internationally and from the EU just to fill the short-term gaps, and also doubling or even tripling our training numbers. So recruitment is a challenge."

Retention is also a major challenge, particularly post-Covid, and people are changing sectors. This is specifically relevant to hospital pharmacy as they are moving away to organisations such as PCNs, where they might have a more routine 9-5 working life, without being on call-out and so on.

But equally there are people leaving the profession because they are exhausted from the two years of Covid. There is also something to be said about the way Covid has showed us a new way of working that we have adopted, for example using Teams and other virtual platforms. However, it is difficult to strike a balance because as clinical pharmacists we absolutely should be patient-facing. Some of the newer generation of pharmacists are absolutely proactively applying for jobs saying, can they work for two days a week or can they work for less hours over three days. Lots of people want flexibility and portfolio careers are also becoming more common.

People are a lot more mindful about their work life balance and their own health and wellbeing. So for that reason retention is also very difficult. The other aspect from a workforce perspective is dealing with that serious burnout issue – how you keep people motivated in this very tough environment. I estimate that the biggest challenges for workforce are not going to go anywhere for another two or three years. That is how long it is going to take to really overcome the workforce challenge.

To talk about one more challenge in hospitals – generally speaking, unless you are in one of those lucky hospitals that is getting a lot of funding to be a new future hospital, the general hospital infrastructure, particularly in pharmacy, is quite poor. If you think about a lot of the innovation we want to do, for example, if you think about aseptics transformation, if you think about automation, all of these things need capital and capital is extremely limited. Unfortunately, many things such as pharmacy and medicines go to the back of the queue when you compare them to a new cath lab or a new scanner. So with that poor infrastructure and no available capital to fix it, it becomes really difficult to do innovation.

There are many other challenges, but these are two of the big ones.

Looking outside of the hospital, towards primary care and community pharmacy in the PCN, what do you see happening in that sector over the next 12 months?

I wouldn't want to paint a gloomy picture – for those of you know me I'm a glass half full person! – but perhaps we need to recognise that the backdrop in primary care is that there is still a further 12 months or so to go in getting to grips with the Covid recovery. There are still many patients with chronic conditions who have not followed up in primary care as perhaps they would have done pre-Covid, so there is a considerable backlog within GP surgeries.

There are also new conditions that have so far been under the tip of the iceberg so to speak, that are now showing up. We also have to remember that there is a really big backlog within the acute sector as well, meaning that those patients are also out in the community. Therefore, any sort of relapse or symptomatic episode they have, they will again go back to primary care. So primary care in that sense is absolutely swamped and I suspect it will still be on catch-up for another 12 or 18 months.

The other thing in terms of community pharmacy is the implication of new contractual frameworks. I've talked about workforce, and this is a particularly serious problem in community pharmacy – I'm sure people are aware of the media coverage around several pharmacies having to shut for a few hours a day because of staff holidays. That combination is really poor, because you have media messaging along the lines of "Don't go to your GP, don't go to your A&E, go to the community pharmacy instead", even though community pharmacy is itself having a lot of problems. So that combination is really brewing a perfect storm.

However, I will go glass half full! Your question was what we will happen over the next 12 months, perhaps to help mitigate some of these challenges. I think we have an opportunity here as a system, because we are currently guilty of working in silos and I think we need to absolutely change that to try and work more collaboratively.

"I will give you two tangible examples. We are going to get involved in something called a 'teach and treat pilot'. And within that pilot we will be using experienced hospital pharmacy pharmacist prescribers to help train community pharmacists to become prescribers themselves."

What's the point of that? Well, it's access for patients, but more importantly we help make community pharmacy a more clinical profession and therefore potentially attract more of the workforce. We are doing that actively and I would have never thought, a few years ago, that we would be having prescribers in hospital training community pharmacists. So that is an example of system working.

The other really good example is we've doubled our training places here in University Hospitals Plymouth. And we know that if we put adverts out to hospital trainees, we will fill all those vacancies, but that's not the route we've gone down. We have kept five to six places to carry on our pipeline in hospital, but we have actively chosen to make a large proportion of those new training places cross-sector. So we are working with our PCN partners, working with community pharmacy, with chains and independents to try and create those places to really give people a good flavour of different sectors and also what system working means.

"And we hope that some of those initiatives will mean that we can all help each other with our challenges. But make no mistake, it is going to be tough everywhere for the next 12 to 18 months."

One other thing I often see as one of the big drivers for people being in hospital pharmacy is an extremely clear career pathway. The career pathway within community pharmacy is not developed unless you go down a management route, and it is not particularly well developed within the PCN route either. What tends to happen in those sectors because the career pathway is not defined is that pharmacists will often swing back into hospital. So I think having defined career pathways in these other sectors in primary care, just like there is in hospital, would also help with the overall system challenges.

For our last question, if you had to make a list of key actions for 2023, what would be in your top three? What would you like to see, or you would like to manage and pay attention to in Plymouth over the next 12 months?

Absolutely workforce, doing everything that is necessary in terms of recruitment and trying to be innovative in that approach and getting to treat our staff right, that is a really important. That and the retention piece. Education and training of our workforce is a big enabler for retention and obviously the right thing to do by the workforce.

And the one thing I will add is that I've recently picked up another hat that I'm really proud of. I am now the chair of the Inclusive Pharmacy Practice Group across the southwest. And I think doing the right thing by inclusion and equality and diversity for our workforce, particularly in the southwest where we have a different dynamic in terms of pharmacy workforce as compared to, for example, London or Birmingham, I think it is really important for our workforce recruitment, so that is a huge priority for me. And as touched on with the cross-sector training, doing that in the ethos of a system rather than just thinking about hospital would be very high on the priority list.

And perhaps the second thing is, playing our part, if you like. I think system working only works if everyone plays their part. I think if it all becomes about the acute sector (and some of us chief pharmacists in the acute sector are very guilty of thinking that the world starts and stops with us), it simply won't work.

If you want that system approach, and equally if you're a community and mental health trust, you know it doesn't start and stop with just you. It genuinely needs everyone to work together and everyone playing their part and putting their hat in the ring. So for me, trying to carve out time in what is already a very busy diary, to play my part in the system, is very high in that priority list.

And thirdly, there are some burning issues that are very much hospital based, and the best example of that is our provision of aseptic services, which is absolutely crumbling. And I think again as a system we have some opportunities to do some joined-up work, but importantly align that with bigger system priorities.

A really good example I'll give you of that is virtual wards. Virtual wards are a massive system priority. Aseptics and, for example, the provision of antibiotics for elastomerics will fit into virtual wards. So this is helping to solve some of the wicked issues in hospital pharmacy which have an impact on the big system priorities.

Kandarp, thank you so much for giving us your time today. We're really grateful. Thank you very much indeed.

Breathe New Life into Your Conversations

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Introduction

Hilary Shields describes the importance of communication in managing teams in a high-pressured environment.

Hilary was a Commissioned Officer in the Royal Air Force and this taught her leadership, moral courage and understanding in many different and significant ways. She has further developed her insight and experience from 16 years of working in the pharmaceutical industry and a variety of roles within the NHS.

Since 2002, she has worked with over 3,000 delegates to give them the skills they need to succeed. Hilary is a qualified practitioner in Transactional Analysis, Belbin Team Roles, Gallup Strengths and the Thomas-Kilmann Conflict Mode Instrument (TKI).

She also a Justice of the Peace, and in her volunteer role as a magistrate she facilitates groups of challenging individuals with very different views and opinions.

Team management

There are many challenges that you face working in a healthcare organisation. The problems and dilemmas you deal with often feel constant and, at times, it may prove difficult to manage the morale and motivation of the highly skilled individuals who work within your team and the wider NHS.

Pharmacy professionals are already skilled communicators, but sometimes you may feel that the point you wished to make has 'missed its mark'. You are a motivated set of individuals with aspirations to be highly successful and recognised for your achievements – how then can you enhance communications to achieve your objectives and realise ambitions?

A good starting point is to articulate our needs with a series of questions:

1. How can you build on your expertise to maximise the results of working in a team?
2. How can you generate energy, creativity, and collaboration in your team?
3. How can you explore new ways of working together when you're under pressure?
4. What about conflict in the team?

> **"So many questions! The answer to all of these is *communication.*"**

Although you may be concerned about conflict, remember that, paradoxically, conflict does have an upside. It demonstrates engagement and a desire for change (although it may not feel like that to you). Conflict has a positive effect on questioning, debate and challenging the status quo. Conflict is normal, but it is manageable.

When you are working with, coaching or mentoring your team, they will need to be challenged occasionally, otherwise you are accommodating their concerns at the expense of the organisation and stakeholders. In the NHS, that stakeholder group seems to get bigger all the time. How can you move things forward effectively in your team and ensure quality?

The 'sweet spot' is collaboration – achieved through a balance of support and challenge and an adult-to-adult conversation. Remember, the most important key to effective team management is communication. Here are some tips on how to deal with these issues.

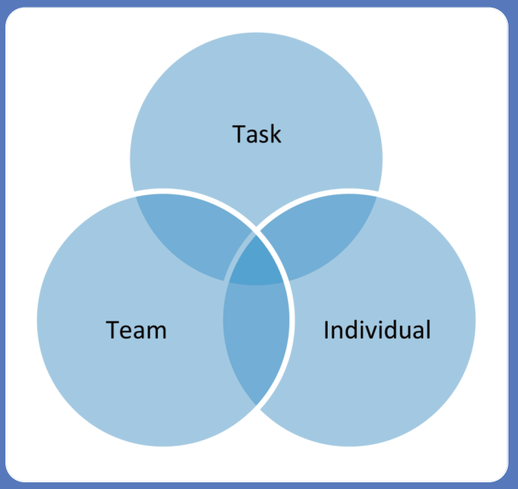
Creating a communication plan: briefing with clarity and direction

The best team leaders can fail because of poor or ineffective communication. You may have felt at times that you didn't have all of the information, or that information has been withheld. Perfect communication would be a great achievement and it would be helpful to have some models of communication to highlight good practice and where you can improve in other areas.

In John Adair's book, *The Path to Leadership*[1] his model of Action-Centred Leadership is represented by a 'three circles' Venn diagram that illustrates three core management responsibilities:

1. Achieving the task.
2. Managing the team or group.
3. Managing individuals.

These areas overlap and you ignore them at your peril! Becoming too task orientated could lead to demoralisation and rebellion (sometimes hidden) and, likewise, concentrating too much on the team can lead to poor objective fulfilment. Too much attention to an individual within the team can lead to bad team dynamics and failure to fulfil team goals. As a team leader, you must act with clarity and direction when you inform (or brief) your team and other colleagues.



SMEAC

Brief your team using SMEAC – a briefing tool used by the armed forces to give clear direction and check understanding. Good leaders always brief even the simplest of procedures like this:

S ituation or background (what is the current situation?)

M ission or objectives (what do we need to do?)

E xecution or implementation (how will we do it?)

A ny questions (what don't we know?)

C heck understanding (ask them questions by using the three Ps: Pose the question, Pause to give them time to think about the answer, Pounce and ask someone the question)

Top tips for better team management (the professional approach)

- Disengage from the situation/emotion and return to it later
- Stay open to your feelings to learn from them and take the appropriate action (recognise and reflect)
- Never indulge in hearsay – establish the facts of the matter

Top tips for better team management (what I *really* do)

- Stop and think (hide away somewhere if necessary). I take a break to disengage (play a game on my phone for 10 minutes and stop googling 'arbitration services') or have a coffee.
- Pick my battles! If I said this to my best friend, how would I say it and how might they feel?
- Ask what other gossip they've heard – there must be other stuff, right?

As with all new habits, practise makes perfect. All of your skills and experiences are transferable between situations. Start with something small and non-critical, like saying 'No' to someone who wants to move ahead of you in a queue. Practise your SMEAC briefing technique with friends or family so that it feels more natural to use in a team environment. Using these skills will

benefit your NHS colleagues and ultimately your patients too.

Remember, it's all about communication.

"Rarely are opportunities presented to you in a perfect way, in a nice little box with a yellow bow on top. 'Here, open it, it's perfect. You'll love it.' Opportunities—the good ones—are messy, confusing and hard to recognise. They're risky. They challenge you." — Susan Wojcicki, CEO, YouTube[2]

References

1. *The Path to Leadership,* John Adair 1) John Adair. Effective Strategic Leadership: An Essential Path to Success Guided by the World's Great Leaders. 2002.
2. 'Susan Wojcicki's JHU commencement speech makes a splash' Speech to the Johns Hopkins University class. Susan Wojcicki, 2014: https://hub.jhu.edu/2014/05/29/commencement-wisdom-wojcicki/

How can community pharmacy support PCNs in delivering population health? An interview with Mark Burdon

Mark Burdon, an experienced pharmacist in the NHS and private sector, talks to PM Heathcare Chair Ted Butler about how community pharmacy can support primary care networks (PCNs) in delivering population health.

Mark, could you give us a bit of flavour of your background in pharmacy, about where you come from and what you do?

I qualified in 2000, and in 2004 I bought my first pharmacy, which we grew to a certain size because I knew that you had to have a critical mass to be able to diversify and achieve economies of scale. So we grew and grew and had little offshoots and little branches and lots of side interests and various things. We now have six pharmacies, spread quite widely across the North East of England, all the way from the top end of North Yorkshire, right up to Northumberland, very well spread out.

I travel around them myself, which is very interesting. I'm still a practising community pharmacist and am not too interested in the detail of the business function, so very early on I developed a head office which allowed us to build the professional side of the business.

Over the years we've done prison healthcare, when that was coming back into the NHS from the Prison Health Service, and we also look after hospices and work in palliative and end of life care. We have contracts with universities to teach undergraduates and postgraduates and are active in research. And we do GP practices work in spades! I do lots of GP work myself and have done so for many years. I've worked in general practice since I qualified, and I have a very good understanding of what happens there.

Last year, I was asked to lead the PCN in South Tyneside, which I did for a number of months, and it was fascinating to see how PCNs work. General practice is a big part of what I do, and I was for about 16 years the north east regional representative of the Pharmaceutical Services Negotiating Committee (PSNC) and a senior member of the PSNC for the majority of that time, which was fascinating.

> **"More recently I have become the Secretary General of the World Pharmacy Council, which is about lobbying for and promoting the role of the community pharmacist in the clinical sense rather than just as being suppliers of medicines as organisations, as the Organisation for Economic Co-operation and Development (OECD) has focused on over the years. And our mission is to influence all of the key stakeholders internationally about how we are perceived as healthcare providers."**

So that's a bit about me, very wide-ranging and it has been very interesting.

Thank you Mark, that is certainly a diverse and interesting résumé. How do you think that community pharmacy can support PCNs in delivering population health? Have you got any experiences you could share with us regarding some population health situations that you have been involved in?

Yes, a very exciting one that we have experience of in the north east is the urinary tract infection (UTI) service that was commissioned by our integrated care system (ICS) across the whole of our region, being the north east and north Cumbria. It's a very large area and we have quite a wide range of different needs – we identified fairly early on that there were problems with access to antibiotics for example.

From a population health point of view, that one ticked many boxes, being about access to services, choosing the right antibiotic and reducing conditions such as urosepsis, which will happen with UTIs in some cases. So that is a really good example.

From the community pharmacy side we have organised ourselves into a provider company called PSNE (Pharmacy Services North East) which has its own website on which you can find out more about our UTI service.

The UTI service is one of a suite of services that PSNE is involved in, working with the ICS. And we have brilliant links with our ICS, primarily because we have an excellent chief pharmacist there, Ewan Maule, who has worked in many different parts of pharmacy, largely around secondary care, but really understands community pharmacy and has worked with us to develop those services. It's excellent to have such an advocate on our side.

Each ICS will be working on prescribing pilots in community pharmacy, and I hope to be involved in that myself, which is really exciting. This will entail developing the framework and the infrastructure to support prescribing in community pharmacy. So for example, UTI is an excellent way of utilising prescribing pharmacists. Rather than relying on patient group directions we can use our prescribing qualification and we have expressed an interest to be one of the pilot sites in the north region.

Another thing that is really exciting is an invitation to be involved in end of life care. That is something that community pharmacy can have a major impact on. I have an interest in this – as an organisation we provide services to hospices around County Durham. We have a PhD student who is working on this, it's part-funded by the National Pharmacy Association's Health Education Foundation. They have committed funding towards looking at how community pharmacy can be involved better in end of life care, which is really exciting.

From your experience, what do you think are the important things that community pharmacy needs to do to co-act with PCNs? What are the messages that PCNs need to get from community pharmacy about how they can help to manage population health?

The key thing that we have to address is understanding the PCN and its constituent practices and understanding what community pharmacy can do (as well as some of the challenges that community faces at the minute).

"We are establishing relationships with those practices – meeting them and talking to them, getting to know the practice managers in particular and the GPs. Practice nurses are a massive resource for us, working with them, and also communications – how we get our message across to PCNs and the various people who work within them."

So in terms of PCNs, they have their Impact and Investment Fund, which is a big focus for them at the minute, and they have a real interest in maximising the national contract services,

particularly the newer ones. We have things like the new medicine service, which has been around for ages, and there are some great wins around, for example, switching to dry powder inhalers, which is a target for PCNs.

There is the CPCS (Community Pharmacist Consultation Service) that they are incentivised to use, which is great – not as much as I would like and not as universally as I would like, but we can continue to work on that.

There is the hypertension case finding service, with which we have had some real success, and practices and PCNs are very keen to work with us to identify patients at the practice and send them an SMS message to invite them to a community pharmacy for a blood pressure check.

The Pharmacy Quality Scheme contains a number of things that are useful for PCNs – the inhaler technique work, for example, and I've mentioned switching to dry powder, the greener devices as they are called.

Community pharmacists will get funded to do that will they?

They will. It's rather like the Quality and Outcomes Framework (QOF) – I remember when the contract first came out, people were saying, "Well, why can't we have a QOF?" and now we have something that resembles a QOF in a way, the Pharmacy Quality Scheme (PQS).

But I think the key thing is how the PQS and the PCN initiatives are integrated together. So you have practices and PCNs pushing patients towards community pharmacy, referring them in. That is a brilliant tool for the engagement of patients – that they have been referred by their practice has a lot of meaning for them.

All of these things really help.

Can I ask you a practical question? You obviously know how this works, but if we are thinking about people in community pharmacy, how do they find out where these things are available from within their PCN?

In the early part of the Pharmacy Quality Scheme, there was some funding for PCN community pharmacy leads, and it has worked well in some areas. They have been really helpful in opening doors, bringing the pharmacists together and organising meetings, whether face to face, Teams or even WhatsApp groups – bringing the community pharmacists in a PCN together to work in a coordinated way.

For example, I had a practice manager send me a message on WhatsApp saying they had been referring patients for the Community Pharmacist Consultation Service (CPCS) who had been rejected. Was there anything I could do to help? I made contact with the PCN community pharmacy lead and asked if they could put a message out to the effect that this was happening, that patients were being rejected, which they did. It was fantastic because the pharmacist knew that he had to be delivering the service and now had an opportunity to feed back where a problem occurred. It was a non-blame way of saying we have got to sort this out and providing a solution, which was excellent.

Obviously, the Pharmaceutical Services Negotiating Committee (PSNC) website is a brilliant resource for all manner of things. And there are lots of things in the Pharmacy Quality Scheme - I read through it last night, to refresh my knowledge, and it is massive and we've got to do it by the end of the financial year! It's a lot of training we've got to do, a lot of training around weight management and identifying patients who could be referred into the various NHS schemes, and antibiotics are really topical, with strep A at the moment. So there are lots of things that we have to do.

> **"I'll come on to some of the opportunities in a while, but just to address some of the challenges in community pharmacy at the moment."**

I think workload is a challenge – I've just mentioned that there is a great deal to do. And then you get all of the things that come left-of-field like strep A, which has been a major headache for us all. Just access to antibiotics has been a huge problem, with stock shortages and supply chains in all kinds of turmoil. It is nobody's fault – it is just a complex system that has been stretched over the last few months.

I read an article in The Times about shortages of over-the-counter medicines, which was a bit of a political stab at the government, saying it should have done more. But we also saw this in 2001 when there was a flu outbreak. This is not a new phenomenon, but it's certainly worse than it has ever been in my time, and I think our biggest challenge is around labour and how we mobilise the workforce itself.

There is also competition with PCNs – community pharmacists and PCN pharmacists competing for posts. This doesn't have to be the case and it is perfectly reasonable for people to straddle both. And I think it is incredibly helpful to have people who are active in community pharmacy and in PCNs, as I have been. That works well.

We have examples locally of where we have tried to work more closely with hospital trusts – working

with PCNs – and that works well in some areas, though it is a bit of a challenge in the short term. I think we will get there eventually, especially using pharmacy technicians better.

The costs of labour have gone up and there are increases in prevailing costs, inflation, and a squeeze on numbers that has pushed salaries up as well. With training and development we need to be releasing people, getting them out there, getting them on prescribing courses and finding placements. The biggest win of course is that we will get a workforce that is able to do what we want it to do, as envisaged by the Royal Pharmaceutical Society and the Kings Fund, which I think is really good.

Do you see a role for the pharmaceutical industry in working collaboratively with PCNs and community pharmacies to ensure that population health is maximised through medicines?

Yes. And we are doing it already but we can certainly develop it even more, and I speak to industry quite regularly myself on a one-to-one basis.

There are many opportunities, especially as industry is now acknowledging that pharmacists have a degree of professional autonomy, especially because we can prescribe and supply. And we have this broader strength as well, that people are starting to develop specialties, which is great.

They are developing individual interests and that can lead to anything from diabetes to cardiovascular disease to respiratory. All of the major ones, but also some funny little side-lines – for example, I've been working on public health outbreaks recently, because with a shortage of GPs, if there is a public health outbreak I get involved in the care homes through The UK Health Security Agency (UKHSA), formerly Public Health England. So that's interesting, but there are lots of other things.

I think one of the biggest things will always be vaccinations, and we are quite well established in that area now. We have done travel vaccines but could do more with childhood immunisation and vaccination. I mentioned outbreaks, obviously the Covid vaccinations were a huge success and will continue to be. I have done some work recently with Pfizer, through the World Pharmacy Council, and we have produced a report that is looking at

how the role of the community pharmacist can be expanded in vaccinations.

I was going to ask you: do you see industry as being a good partner in terms of facilitating meetings and things like that?

Yes. I've used industry, and when I was running the PCNs I brought a number of industry partners in to talk about the key areas within the Impact and Investment fund. So we had people talking about the inhaler switches, we had somebody talking about DOACs and the atrial fibrillation side of things. I think this is something that helps bridge the gap between community pharmacy and PCN pharmacy, and it is definitely helpful.

Is there anything that you think we've missed in terms of the overall development of community pharmacy, its relationship with PCNs and its developing role? Also, do you think that some community pharmacies need help in terms of understanding the new structure of the NHS and how it could benefit them?

I talked about the challenges, and I think the reason for highlighting them is the fact that people have got their heads down and are buried in the here and now. They haven't had the opportunity to really digest what is going on.

"So, the LPCs are working on building those links to their ICS and integrated care board structures. But I think community pharmacists need to know more. The same can also be said for GPs, who may know very little about what PCNs do. So there is a lot of learning to do across all of primary care."

One of the biggest things that we can do around population health as pharmacists is to work on medicines use. We had medicines use reviews which were decommissioned, and we have structured medicine medication reviews now, which I'm rather lukewarm about because I think they have been something of a means to an end in training pharmacists through the CPPE pathway, but they are not particularly popular with GPs.

But medicines adherence and drug dependence are two big issues that community pharmacy, PCN pharmacists and GPs need to work better on. We see it all the time with opiates, and I'm working with some practices here because we have identified the high use of opioids. Codeine is a particular problem, and we see that as community pharmacists.

But I think my biggest thing about how community pharmacy can bring something to PCNs is around the use of technology in specific drug areas, for example in diabetes and weight management, the use of GLP-1s, oral GLP-1s and injectables. There are newer insulins, SGLT2s (which are not new at all but there are some who don't know how they work) and inhalers. Moving from one tech to another is something we support with lipids, and there is quite a lot going on with lipids around the newer inclisiran and bempedoic acid and those things.

But one final thought, when you look at the genesis of community pharmacy services, they tend to start small, and they tend to start on the private side. So look at vaccinations. We started with flu many years ago and it started as a private service funded by Novartis originally. And they provided the training, the resources, the governance, etc. When we got that off the ground we moved on to other vaccines, we moved on to things like weight management services. We can do anything through private services, and then once the case has been proven there it is very easy to push that into the NHS and start to take work there.

That is a really interesting thought to end on Mark. Many thanks to you for sharing these insights with us, it has been extremely interesting, and I know will be very useful to others.

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