PM Healthcare
PROGRESS THROUGH PARTNERSHIP

# JOURNAL

Incorporating *The Journal of Pharmacy Management* and *The Journal of Medicines Optimisation*

Winter 2024 | Issue 07

## Key contents:



# Editorial

In our first Journal of 2024, Amit Patel, CEO at Community Pharmacy South West London, and Raj Matharu, CEO, Community Pharmacy, South East London talk to PM Healthcare Chair Ted Butler about innovation and change in community pharmacy services in the capital.

Vicky Webb, Independent Prescribing Clinical Lead, University Hospitals Plymouth NHS Trust, explains how The Devon Teach and Treat Pilot supports community pharmacists from across the county to achieve their independent prescribing qualification.

Tara Humphrey, CEO of primary healthcare consultancy THC, assesses the impact of community pharmacy closures on the Community Pharmacist Consultation Service, and the opportunities this presents for remaining pharmacies.

Hemant Patel, Director of Medicines and Clinical Policy, Black Country ICB, describes how the ICS established an Integrated Medicines Optimisation Group, replacing four legacy area prescribing committees, driving forward system-level working and leadership across the region.

Ivan Hollingsworth, Director of Centric Consultants, shares his unique insight and experience of the much discussed subject of resilience. What is resilience, and how can we positively develop the skills needed to deal with life's professional and personal challenges?

I hope that you will find this edition of the Journal both interesting and of use – our objective is to bring you insights that translate into best practice and shared experiences.

As ever, do contact me with any ideas you have for articles and experiences you would like to share.

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# Resolutions and Reforms

## John Chater, editor at PM Healthcare, looks ahead to 2024 and what we might expect from the NHS in England

The beginning of the year is a good time for taking stock. We all do it of course, urged on by the excesses of the Christmas and New Year celebrations, a review of the year past, and an optimistic view of what we might achieve in the next 12 months. Alas, for many of us, when we review successive January diary entries, stacked up over the years, we usually find ourselves reading the same ambitions and commitments made in winter and abandoned by spring. Life has a habit of getting in the way.

The NHS also seems periodically to undergo an exercise of self-analysis and reflection, leading to ambitious self-improvement objectives. We call these 'reforms', but as we know from history, they are often as enduring and successful as the personal objectives we set in the cold winter months.

18 months ago, the NHS in England reformed again, bringing into being the era of the integrated care system (ICS). We've had time now to see how the 42 ICSs that cover the country have risen to the challenges that always come with system reform, and also to evaluate their impact on healthcare delivery.

They are now fully constituted and have worked hard to design five year delivery plans that will be annually reviewed to gauge progress. 18 months, of course, gives us little room to assess how successful the latest version of the English NHS is likely to be – one of the hazards of widescale system reform is that it can take years to properly embed itself in processes and teams – but so far, it does seem as if the overarching objectives are finding their way into day-to-day delivery.

We see a lot of activity in medicines optimisation and at the ambitious 'place' level of ICSs (where much of the magic is meant to happen), and the response of those coordinating efforts, at the system level, is encouraging (to my knowledge, no one has called for a return to the commissioner/provider model that ICSs replaced).

The elephant in the room, though, is the immense challenge caused by the covid legacy – eye-watering waiting lists, a mental health 'crisis', healthcare funding constraints, and substantial cost of living increases (exacerbating social and therefore healthcare inequalities). In a perfectly functioning system it would have been demanding enough, but the pre-covid NHS was anything but perfect.

**"Underpinning NHS reforms is the ambitious NHS Long Term Plan (2019), published the year before the pandemic. So, the plan itself, and the system designed to implement it, was in recovery mode from the start. Reform whilst in recovery – not exactly easy."**

If we look at current 18-week waiting lists (table 1) we see a record high approaching 8 million, and an increasing number of appointments still waiting within the 18-week period. Without a downward trend in at least one of these numbers the prospect of recovery is distant, and the pressure placed upon other services will remain significant.

We also see that 8 percent of people are waiting longer than 46 weeks, and that again the curve is upwards (figure 2).

Funding remains stable for the last three years shown in table 3, following a steady increase over the past decade (and uplift for covid). Healthcare spending is generally protected from inflation (to the envy of other departments of government) but it is more than simply a case of more funding for the system as a whole.

Calls are for spending to be better targeted and for productivity to be prioritised (an NHS Long Term Plan objective), but, as we have seen over many years, this is easier said than done. It is also by no means certain that productivity drives will improve

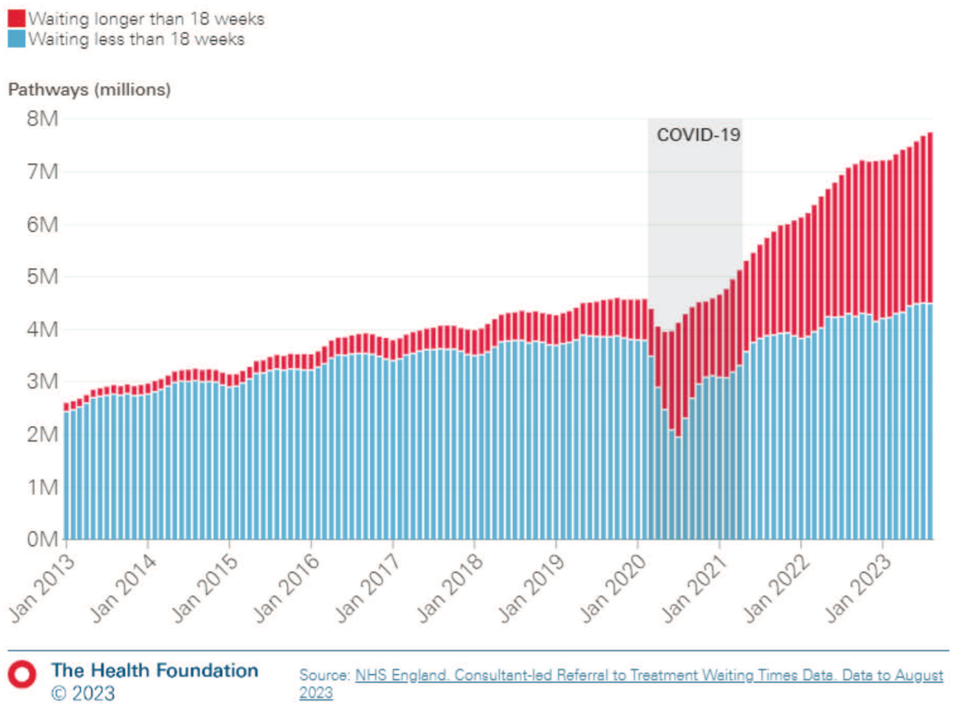


Figure 1

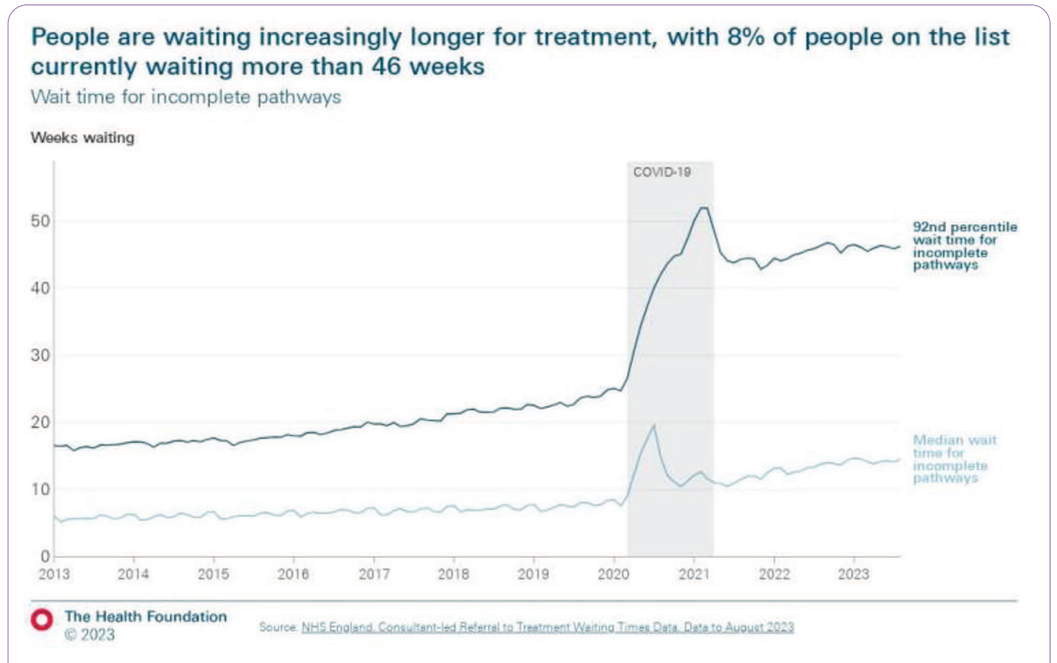


Figure 2

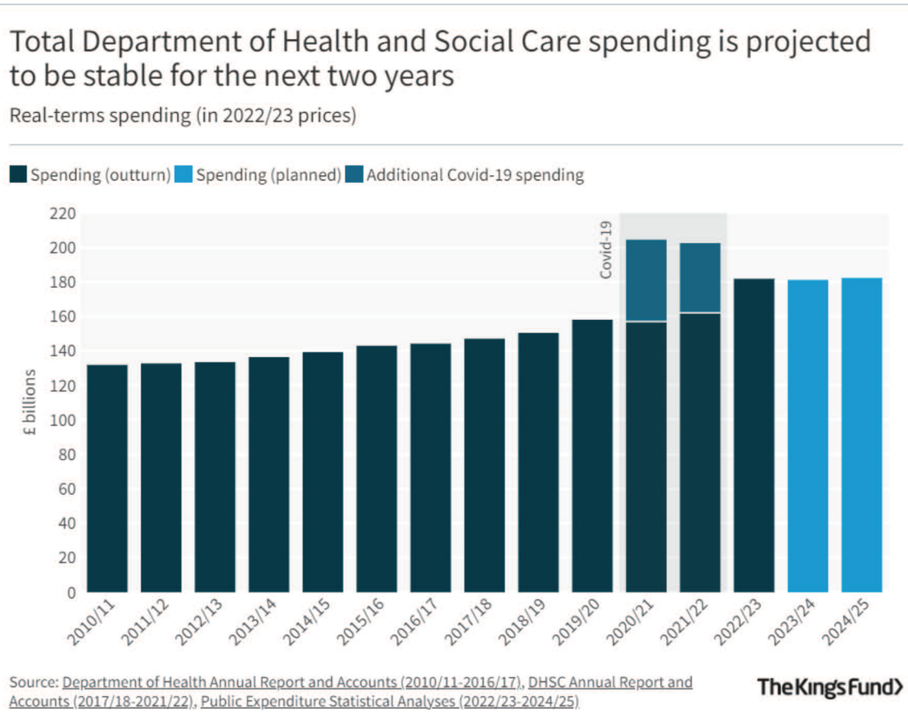


Figure 3

care outcomes. Indeed, the opposite might be true.

Community pharmacy is one sector that is seen as a potential solution to the current logjam in the system, of equal popularity with politicians and policy makers.

NHS England has published its strategy for expanding the role of community pharmacy: Delivery plan for recovering access to primary care (9 May 2023), in which it plans to invest up to £645 million over two years to expand community pharmacy services. A relocation of some prescribing responsibilities will also happen, with pharmacists directly prescribing specified prescription only medicines.

Prescribers in community pharmacy certainly want to move towards prescribing and diagnosis (as well as dispensing and retail), and it is tempting to imagine how much of the patient pathway could migrate to community pharmacies, staffed with prescribers and equipped with treatment rooms.

Against this ambition is the fact that many community pharmacies are closing due to lack of staff and funding. There were 11,500 active community pharmacies in England in 2021/22, which was the lowest number since 2015/16. In 2021/22, 308 new pharmacies opened and 418 closed. Although 297 community pharmacies opened in 2022/23, 388 closed, resulting in a net loss of 91 community pharmacies across England. It is a trend that needs to be reversed if ambitions are to be met.

Practical obstacles also include the need for improved data access, allowing prescribing pharmacists to see/write to patient records, and investment in premises refurbishment.

> **"If the above were not enough to content with, we cannot (as much as we might like to) avoid the fact that this is an election year. The NHS is party political, and we can expect to see the ante ramped up as our politicians vie for our votes."**

Labour's Shadow Health Secretary, Wes Streeting, has already stated that a Labour government would focus not on overall spending as much as on efficiency and saving money (a déjà vu moment for most of us), and the prospect of another raft of reforms cannot be ruled out (if the election polls are to be believed).

Perhaps then, as we look to the coming year, we should be a little more measured in our ambitions for the NHS. Some stability and progress are to be hoped for, with the reforms already underway working towards promised improvements in care, structure and waiting times. A measured ambition then, nothing too drastic or radical (exactly the approach I am going to take to renewed gym membership).





# Community pharmacy now and in the future – the London perspective

## An interview with Amit Patel, Chief Executive Officer at Community Pharmacy South West London

Amit Patel talks to PM Healthcare Chair Ted Butler about community pharmacy in South West London.

Connect with Amit Here

**Hello Amit and thank you for joining with me today. Could you start by give us a quick introduction to your local pharmaceutical committee (LPC) in South West London?**

Certainly Ted. I used to manage two LPCS, Merton Sutton and Wandsworth and Croydon LPC. Both merged with Kingston Richmond LPC in October 2023 to form Community Pharmacy Southwest London, where I am the Chief Executive.

> **"Southwest London is quite diverse, and we have a population of about 1.5 million people with just under 180 GP practices and around 295 pharmacies. We have areas like Wimbledon, which sits within Wandsworth and Richmond, areas that are quite affluent and with healthcare needs very different to areas like Croydon."**

A few years ago in Richmond when I met with some GPs when I used to run training hubs, I think the biggest problem that they were facing, for example, was bulimia. Whereas in Croydon we have a large BAME community and the council there will be the first that will change the definition of BAME, within the next five years, to be black and majority ethnic rather than minority.

With this change comes a lot of different healthcare needs. So if we look at areas like, for example, the menopause, this can begin a lot earlier in women of colour, so we need to start making interventions earlier, maybe at the age of 40 rather than the age of 50.

Also with the BAME communities and transient populations within London, a lot of people aren't registered with GPs or may be travelling in whilst registered with GPS outside. And that means that community pharmacy becomes a lot more vital because it becomes their point of contact when they are staying over in London during the week to work or catching a train in or out. It's not so easy for them in terms of access. So South West London is a really interesting patch to work in, bringing a lot of challenges and a lot of opportunities.

**In the context of that environment, which areas are your pharmacies focusing on?**

In terms of the actual pharmacy contract, there are three tiers of services: the essential, the advanced and then the services we do locally.

With essential services, it's the core services that you would expect to see in the pharmacy. So the dispensing, repeats dispensing and the talking to people coming into the pharmacy and supporting them to look after themselves and self-care signposting, promoting public health campaigns, taking in waste medication and the core dispensing function and everything that sits alongside that.

There's a lot that happens at this tier, from stoma


plans customisation in some pharmacies, to flu vaccinations. And looking at the number of services we now have in community pharmacy over the last five years from the public health services like stopping smoking, sexual health, needle exchange and supporting substance misuse with methadone or buprenorphine or whatever it may be. And also the mental health services that sits alongside this, as well as the big things we hear about in the contract.

So the community pharmacy consultation service is expanding to include people coming in from general practice, and soon those coming in from urgent care as well. And hopefully we'll be able to do this opportunistically. That's what we're really pushing for – that when somebody comes in, we can give them a proper consultation.

As well as that we have a range of private services, everything from travel clinics to services for the menopause. And different pharmacies will have different services mattering on their patient group directions (PGDs), so they have the medicines they can give alongside in a private clinic.

And we're doing some innovative things in Southwest London specifically. We have the Tympa ear health pathway service which is a community pharmacy service referred from general practice. In the last year we have had nearly 8,000 referrals from general practice across 20 pharmacies, which is fantastic. We've completed probably about 6,000 of them now, so 6,000 people not having to go into hospital. More importantly, they have their ears looked at and wax removal which had a pathway of 26 weeks before, now cut down to about three weeks.

**"Another service that we held locally that we're looking to recommission is the Winter Fit Service. I'll talk about the value of these types of services later, but it's making every contact and intervention count. So it sits alongside the prescribing, or it is opportunistic."**

We were given some funding by the integrated care board (ICB) to talk to 10 percent of the population who are over the age of 65 in South West London. And the aim was almost to provide a form of social prescribing, for example, to check in with them, to make sure they have access to warm spaces, that they've been fed, that they've been looked after, and if they need any information.

We had a social prescribing website built up alongside to help the intervention. We were asked to make 10,000 interventions, but because the funding came late we only had six weeks to deliver the service across around 80 pharmacies. And we delivered 10,000 interventions in four weeks and three days, which was phenomenal, and the outcomes were even better.

So if we look at it from a patient perspective, we had people coming into the pharmacies having conversations in tears. We had one lady who came into a pharmacy in Sutton who didn't know where to apply for her pension credits and we could point her in the right direction. We found that she was a carer for her husband who had been bedbound for the last two years and was in the final stages of cancer. She was around 80 years old and very secluded, and she felt heard. That was a big thing.

She got the advice that she needed, and she got support and actually the pharmacy followed up with her after, which wasn't part of the service and wasn't paid for but it wouldn't have happened if we couldn't have the support to have that initial conversation with the support of the right advice and info. But we had a lot of people that actually felt heard.

And on the other side, I had staff members (because it wasn't just the pharmacists doing this, it was the whole team that was able to deliver this intervention) calling me saying thank you for winning this service because I feel like getting up in the morning and I want to go in, whereas before things had been really hard. So even from a staff perspective, it really motivated people and brought a lot of joy. It was fantastic.

## Where do you see the opportunities and the challenges at the moment in community pharmacy?

Let me think about this because it is bringing a lot of what we've been talking about for a long time to reality. So we created the 'London Community Pharmacy: Our offer to London (Pharmacy Strategy 2020)', an offer to really integrate pharmacy into the system and deliver not just a service but to allow our profession the space and ability to be more caring.

And that was based around breaking down everything we do into six tenets, including urgent care, planned care and managing long term conditions, making of every contact count, like the Winter Fit service that we had, and then having actual clinical interventions, point of care testing and services to enhance the relationship between the pharmacy team and the patient. And also to have those areas really supported by proper infrastructure support and workforce development. And I think we're having those conversations now.

**"The big thing for us has been the devolution of the pharmacy contract, which has allowed me to have those conversations because I can now challenge my ICB. So if we look at an ICS constitution – and the South West London ICS Constitution is a great example – we see that the ICSs were created to manage healthcare across a specific geography and their constitution states their membership."**

Now Appendix A of the ICS Constitution for South West London stated their membership as every GP practice. That was it. That's their membership, and the previous organisations, clinical commissioning groups (CCGs) had been the same. You know, GPs vote at their AGM, GPS make the decisions, GPS are the clinical leads. I have a general practice background, so you know that I once benefited from it on that side.

Now I work in community pharmacy and as this has been devolved, I can challenge the constitution. I can get into a room where I couldn't before, and I can really have these conversations. I can challenge the ICB when they talk about primary care, because when people talk about primary care it's just general practice, when it isn't really. So that's been really great for us.

The other thing that's really helped is the government easing VAT on the use of the pharmacy team and not just the pharmacists, because that means that we can start to use things like pharmacy federations and provider companies to deliver services where actually we're not VAT registered and we don't have to drain an extra 20% from the NHS to have a service that's not just delivered by pharmacists, because we have a huge pharmacist workforce shortage.

We also have the Additional Roles Reimbursement Scheme (ARRS), which is taking pharmacists from community pharmacy and from hospitals into general practice (primary care networks) where we have 20,000 pharmacists looking to move into general practice, but actually Health Education England are only training another 6,000. So it doesn't really balance. We need to use teams better because putting this all on pharmacists alone is going to make services fail.

**That leads me to the next question. What support and skills do you think community pharmacists need to deliver this agenda?**

There is a huge lack of leadership in community pharmacy. Let's look at the makeup of an LPC. It's a contractor organisation, so we respond to owners. We don't respond to the pharmacy teams like the Royal Pharmaceutical Society does.

We have a group of people who are looking at an exit strategy towards the end of their careers and we have new people coming into pharmacy who have not had the opportunity to develop because pharmacy, whilst it's being utilised a lot more, which is fantastic, leaves very little time for self-development.

When we start thinking about how the NHS manages leadership, we have the Primary Care Improvement Program, we have the Primary Care Leaders Program, but only open to general practice first of all. So people in community pharmacy can't develop alongside, so development isn't integrated even though care needs to be integrated and that needs us to work together a lot better.

Also, when people aren't developing together and learning together, those relationships then don't get formed, and you start working in silos. The other thing that I'm really seeing is that we are now looking at wellbeing a lot more in pharmacy. But whilst we look at wellbeing in pharmacy, it needs to be taught from an undergraduate level, because leadership and self-leadership, managing your emotions, need to be taught earlier.

We have graduates who are coming out and working as locums, and straightaway they're coming into pharmacies, having to manage a team with no management experience and no leadership experience and managing all of these services. So it's a lot of responsibility that they are taking on and we don't have a programme to support them. And then in 10 years' time, when they don't want to develop to become leaders because they don't have that strong foundation, we wonder why.

**Looking ahead, where would you like to see community pharmacy moving to in the future?**

As I mentioned before, I think we need to recognise the effect of ARRS roles and the workforce shortage. There needs to be a recognition of the pharmacy team enhancing counter staff, making sure that we are using the people within our grasp a lot better, and where that could take us.

**"And where I'd like to see pharmacy in the future is achieving the targets of bringing care closer to home and enhancing access for our populations, using greater access to the patient record more and integrated pathways where care actually does follow the user."**

I don't want to see someone walk into a pharmacy in the future and us not to have access to their records. And actually I'd like to see children able to get their jabs in a pharmacy and for us to have access to their records so there are no contraindications, not just us having to do it through a private service.

**My last question is, I'm going to give you a magic wand and one wish for community pharmacy in the future to encompass where you would like to see pharmacy going. What would you wish for?**

OK, so I could give you the long political answer, which is bringing everything I said all together. Or I could answer the question in its true sense and really ask for one thing, which would be to stop the pilots! Community pharmacy has proven itself time and time again, but we keep waving the pilot stick, and it's harmful in many ways, and not just to the sector where we train, where we get ready, where we deliver a service, where we know it does really well, where we prove the outcomes.

We do the pilot, and afterwards get told that actually we didn't think about the fact that there's no money to run the service after! I'd love to see us get rid of that mentality. And it's really harmful to our patients and our services, because it confuses them as to what we can do in community pharmacy.

When you asked before, what can you get from your local community pharmacy, what do we deliver in South West London, that's part of the problem, because we deliver so much. But it comes and goes in waves as people decide to commission us or not.

And the other thing just to add before we close is – another wish if I may – feedback I've had from my chairs is that we need to bring more non-pharmacists into the fray. So I'm not just probably the first non-pharmacist to do any of my roles, I'm definitely the first non-clinician to do them. I know you only asked for one wish, but I think we need diversity of thought within the sector as well.

**A great place to end I think. Thank you so much for that fascinating insight into community pharmacy in South West London Amit.**

# Community pharmacy now and in the future – the London perspective

**An interview with Raj Matharu, CEO, Community Pharmacy South East London, and Chair, Community Pharmacy London**

Raj Matharu talks to PM Healthcare Chair Ted Butler about community pharmacy in South East London.

**Hello Raj and many thanks for giving me your time today. To set the scene, could you tell us a little about your Local Pharmaceutical Committee (LPC) and the area you serve?**

Thanks Ted. So I ran two LPCs in South East London and in October 2023 they were merged into one. We cover six boroughs in total. Inner city boroughs like Lambeth and Southwark, going all the way out to Bromley, which is the largest borough in London and is semi-rural. They all have different levels of need.

The inner city ones are obviously more deprived and therefore require a different level of attention. We have roughly 330 community pharmacies spread across South East London – the demographics of the pharmacies are fairly equally spread out. Being located in some deprived areas is, of course, very helpful for us in tackling health inequalities. We have approximately 220 GP surgeries, all of us serving a population I think of about two and a half million. So it can be a dense inner-city environment, coming all the way down to a very suburban population as well. We have a very diverse population, being a London LPC.

We have committee members – 15 in the unified LPC – and what we have actually done, working with the commissioners, is set up a provider company called SEL Pharmacy Alliance which will be used as a conduit to drive primary care community pharmacy services. So I see the role of the LPC becoming very strategic, providing oversight and scrutiny almost of the services that are coming down to us. And then we will hand all of that over to the SEL Pharmacy Alliance to operationalise and provide support and drive services forward.

**What kind of services do your pharmacists currently provide, above those things that we might regard as core services? I mean services that 10 years ago we might not have seen or heard about.**

So, all community pharmacies provide Essential Services, and then we have the Advance Services which we are focusing on with our integrated care board (ICB). Then, we have the locally Enhanced Services and something of interest here that we are collaborating on Making Every Contact Count (MECC) services.

We did one during the pandemic, called the COVID Champion Service, to tackle vaccine hesitancy. And the legacy of that, which won a PresQipp award, was to develop the service into what we call a Community Pharmacy Health and Wellness Service, that is focused around the 'Vital 5' (the five leading causes of poor health in our communities). So these would be blood pressure, mental health, obesity, alcohol status and smoking status.

It's going very well at the moment, and we are piloting it in the hope of spreading it across all of South East London. Again, it fits into the preventative agenda – we want to stop people getting ill over their life's course and we've started the pilot in the most deprived wards or deprived localities to help reduce some of the health inequalities that we do see in South East London.

There is a big difference in the COVID vaccination uptake in affluent areas like Bromley as compared to inner city areas is like Lambeth and Southwark. So that disparity exists across the system, which we want to tackle as well.

## What do you think has been the most significant development in the integration of community pharmacy into the local strategy? Have you found that the creation of integrated care boards (ICBs), for example, has change the game.

I can only speak from a South East London perspective, and I think the game has changed for us purely because of the pandemic, which showed community pharmacy was able to look after patients. I think we were the only ones that had our doors open with no triage needed. You just walked in and got served. So that was a game changer for us. With regards to South East London, I've been asked to chair a committee called the Community Pharmacy Integration Group, and this brings all the integrated care system (ICS) place-level leads or the borough leads as we call them, together.

**"And we have identified four pillars. One is leadership, one is prevention, one is acute and urgent care, and one is long term conditions. And within each of these we will put the advanced services that are being commissioned by NHS England. We will look at Enhanced Services that are being commissioned by NHS England-London Region and also some of the services that the ICB will commission."**

Now I have got funding for leadership for Community Pharmacy Neighbourhood Leads. We haven't called them primary care network (PCN) leads because I think the PCN remit is far too narrow and is very geared towards general practice. We've gone for Community Pharmacy Neighbourhood Leads to ensure that we're able to support and deliver those advanced services such as the blood pressure screen service, the community pharmacy consultation service and sexual health service. We can therefore align ourselves with the strategy that the ICS has, and cardiovascular disease is right up there for them, and it aligns with the NHS Blood Pressure Screening service as well.

As the LPC chief and also chairing the SEL ICB Community Pharmacy Integration Group will allow the LPC to drive and provide an oversight and an insight, ensures that we are going in the right direction. I think it is innovative and the ICB Chief Pharmacist, Vanessa Burgess, should be commended for this approach, and also the ICS Chief Operating Officer, Andrew Bland.

Andrew and the chair of the ICS, Richard Douglas, both have visited the pharmacy, and we had a really good, long chat about what was needed by the ICS and ICB to invest in community pharmacy. And they also visited other pharmacies so they could see what the network is capable of.




It is also about making every asset count. You have different assets, and you need to ensure that you utilise that estate and the pharmacy teams within it.

## What do you view currently as the opportunities and the challenges for community pharmacy?

I think the opportunities are fantastic. Working with my ICB is an immense opportunity and it is about co-designing services so that at the very beginning each partner in the relationship knows what is possible and what is not possible. My ambition is to design a service that is not bureaucratic and burdensome on the community pharmacy teams to deliver, because I know they're busy and I know that makes it very difficult to deliver overly cumbersome services.

I also want to be able to market these services directly to patients so that they're aware that they are available. Far too often we're not allowed to say we can provide services. So in that respect I'm quite lucky compared to other ICSs and ICBs in that I've had a very good working relationship with my commissioners.

This is what I've been working on with Vanessa for a long period of time – to look at the organisational development of community pharmacy as a whole sector. I really want to look at leadership as well, because I need more community pharmacy leaders to be present at all of the meetings that I attend.

I've put a proposal to the new LPC that we should have one contractor attend all the Local Care Partnership meetings that are at the place-level. SEL Pharmacy Alliance should be present as well, and I as an LPC representative should also be present. So, you've got three different community pharmacy leaders there representing and providing a different perspective to the local sort of commissioners.

Leadership and representation are very key to me and if I can, if I'm able to develop these at all ICS levels – at neighbourhood, place and system – then hopefully there will be generations of community pharmacists who are able to learn and cut their teeth at a local level and then go on to represent the profession at a regional or national level.

What I'd like to instil in the leadership group is that it's small incremental changes that we need to make. We can't make a 50 percent change, so let's go for one percent here, one percent there, and gradually we'll build up for the benefit of the communities we serve.

And the other aspect of leadership I want to develop is a broader distribution leadership model, whereas the LPC is a contractual organisation, so

we represent contractors, I want to bring in community pharmacists who are not contractors, who are locums or managers. I feel it is almost a professional obligation to ensure that I bring them into the fold, so they feel that they are contributing to the profession as a whole. That's why I focus on leadership – it's got to be about everybody.

I was challenged by a young pharmacist who said to me, 'What has your generation done to our profession?' And I thought 'Oh, that's a challenge!' It was a question about funding really, and I thought, OK, I'm going to make sure that I leave the profession in a better state than I found it. That is a powerful source of motivation for me.

**Are there any areas where you think the NHS might be missing a trick? I'm thinking of areas where some pressure could be taken off the system and improve patient care.**

I think there are. I think the NHS doesn't realise the asset that they have in community pharmacy and in the network that we have. The key point is about convenient access to a healthcare team, and we do see people walking freely into our pharmacies, not only our regular patients, but individuals who just come into the pharmacy. I think what we need to do is develop those MECC services that I mentioned, because those are vital in community pharmacy.

We've had 75 years of the NHS, and it has been great, it's absolutely been great. We can be proud of that. But the next 75 years will depend on us actually ensuring that people live longer, healthier lives and are not sick most of the time. The preventative agenda is absolutely crucial, and funded MECC services need to be a part of our Essential Services.

I think it also needs to be about follow up. It's no good me talking to you and saying you need to look after yourself and do a bit more exercise, and the next time I see you I don't pick up that conversation. I'd like to know whether you've taken up anything. So those kinds of things, I think, are vital.

If we're resourced properly, if you look at the supply chain, I mean we have absolutely made that efficient. You know you can walk into any pharmacy and be able to access medicines. Let's just park the fact that we've got supply issues – that's not pharmacy's fault – at any given time, if you look at the 11,000 pharmacies across England, they all have about £50,000 to £75,000 worth of stock for medicines. It doesn't cost the NHS a penny until we dispense something.

So the level of support that we offer to the NHS, it's incredible. Now they need to be able to ensure that alongside that they provide a preventative medicine service. I think that fully funded MECC services are the way to go.

**Final question Raj, if you had a magic wand and could wave it and have one pharmacy-related wish, what would it be?**

I would like to be able to take repeat prescribing away from general practice so that we don't waste time chasing prescriptions, GPs don't waste time writing prescriptions, and patients don't get ping-ponged between community pharmacy and general practice. The level of clinical knowledge in community pharmacies is very high and it's going to improve even more when, in 2026, we will have graduate prescribers coming out of universities.

So this almost archaic system of patients and pharmacies writing pieces of paper, patients saying 'Please sir, can I have my meds?', must go. We have got to understand that patients have busy lives, and they would like to be able to just walk into a pharmacy and say, 'I need my medicines please'.

I had a conversation with a GP colleague, and he said that if we could do that it would reduce his administration by 25 percent at a stroke. It would also reduce our telephone calls and emails significantly, and lead to a much more pleasant relationship with patients, doctors and GPs.

**Raj, that's a great place to end. Thank you very much for your time and sharing with us the excellent work that is going on in South East London.**





# Trainee independent prescriber supervision for community pharmacists in Devon – A novel approach

## Project Aim - The Devon Teach and Treat Pilot aims to support community pharmacists from across the county to achieve their independent prescribing qualification by providing access to suitable supervisors and clinical environment.

**Vicky Webb**, *Independent Prescribing Clinical Lead, Strategic Lead for Devon Teach and Treat, Pharmacy Department, University Hospitals Plymouth NHS Trust.*

## Profile

Vicky's healthcare career began in 2004, working as an auxiliary nurse at University Hospitals Plymouth NHS Trust, then completing her BSc in Adult Nursing in 2013. As a registered nurse she has worked in respiratory medicine, general surgery and ICU, completing a PG Cert Professional Development in Critical Care.

She started as a Trainee Advanced Clinical Practitioner in Cardiothoracic Surgery in 2017, completing her MSc in Advanced Professional Practice in 2020.

In May 2023 she started in a new role as Independent Prescribing Clinical Lead. Her primary remit is as the strategic lead for Devon's Teach and Treat Pilot, a project to support community pharmacists with their prescribing qualification by providing access to appropriate supervisors and clinical environment.

## Social media

My LinkedIn- (34) Vicky Webb | LinkedIn

My X/Twitter-(2) Vicky Webb BA BSc RN MSc (@v_p_webb) / X (twitter.com)

Devon T&T X/Twitter- (2) Devon Teach & Treat Pilot (@UHP_Teach_Treat) / X (twitter.com)

## Outcomes

### Primary

- Increase the number of independent prescribers in community pharmacy. Aiming for 20 in the first year of the pilot and 40 in the second year.
- Establish a sustainable model of supervision.

### Secondary

- Set up a community of practice for community pharmacist independent prescribers.
- Facilitate relationships between the primary care networks and community pharmacy.
- Raise awareness of the role of the Designated Prescribing Practitioner (DPP).
- Increase DPP capacity, particularly in the context of the Initial education and training of pharmacists (IETP) reforms coming into force from 2026.

"This pilot is an important strategic initiative. The doors at the front of our hospitals are heaving and there is a real opportunity for community pharmacy to help reduce this demand. However, in the short term, as hospitals have the bigger education and training infrastructure, we need to support our community pharmacy colleagues in developing the skills they need to ultimately help us."

Kandarp Thakkar
Chief Pharmacist
University Hospitals Plymouth NHS Trust

## Background

There is a national drive to expand community pharmacist service provision to include a wider range of clinical services and independent prescribing (General Pharmaceutical Council 2022). Additionally, from September 2026, all newly qualified pharmacists will be independent prescribers (IP) at the point of registration (General Pharmaceutical Council 2021). This will give patients an additional point of access to experienced and skilled clinicians who will be able to consult, assess, diagnose, and prescribe within a specific remit. In turn, this should assist with some of the workload experienced by general practice and urgent care.

For community pharmacists who want to do their independent prescribing course, one of the biggest obstacles they face is identifying a Designated Prescribing Practitioner (DPP) and clinical environment to facilitate the course requirement of 90 hours of supervised practice learning (Ofori-Atta 2022). The DPP must work with the trainee prescriber for approximately half of these hours and will be responsible for signing off against the GPhC and RPS competencies. Some courses also require a practice supervisor in addition to a DPP. As prescribing does not yet exist within community pharmacies in England, supervision and practice learning must be sourced from another healthcare sector.

### GP response to supervision enquiry:

'Unfortunately we, like most practices, are struggling to meet demand and at the same time teaching trainee GPs and medical students. We also have inadequate rooms at present.

So unfortunately, at present it's not possible for us to help.'

Traditionally a GP from the local surgery is the first source of supervision to be considered and more recently, suitably experienced independent prescribers can act as a DPP. Anecdotally, trainee prescribers could self-fund supervision and travel across the country for relevant clinical exposure. However, even with extending the criteria of who can function as a DPP, there are significant barriers that prevent enthused GP surgeries and primary care networks (PCNs) from being able to support their local community pharmacists with their prescribing qualification:

- Time
- Money
- Existing training commitments
- Limited supervision capacity

In the southwest, as part of a fellowship project, some provisional and unpublished data has been gleaned to assess the current DPP capacity for pharmacist trainee prescribers. Of the 585 non-medical prescribers (NMPs) who responded to a survey, 65% were nurses and 59% worked in secondary care. 63% had sufficient experience to act as a DPP and only a quarter of those had been a DPP (Wareing 2022).

It is acknowledged that the total sample size is unknown and there were some contradictory responses, however, there are some general conclusions that can be drawn: there is a significant need to expand supervision capacity for pharmacists and we must actively engage IPs and promote multi-professional supervision.

To that end, NHS Health Education England offered funding to the integrated care boards (ICB) in the South West to pilot 'Teach and Treat' clinics as a way of creating supervision capacity for community pharmacists (NHS Health Education

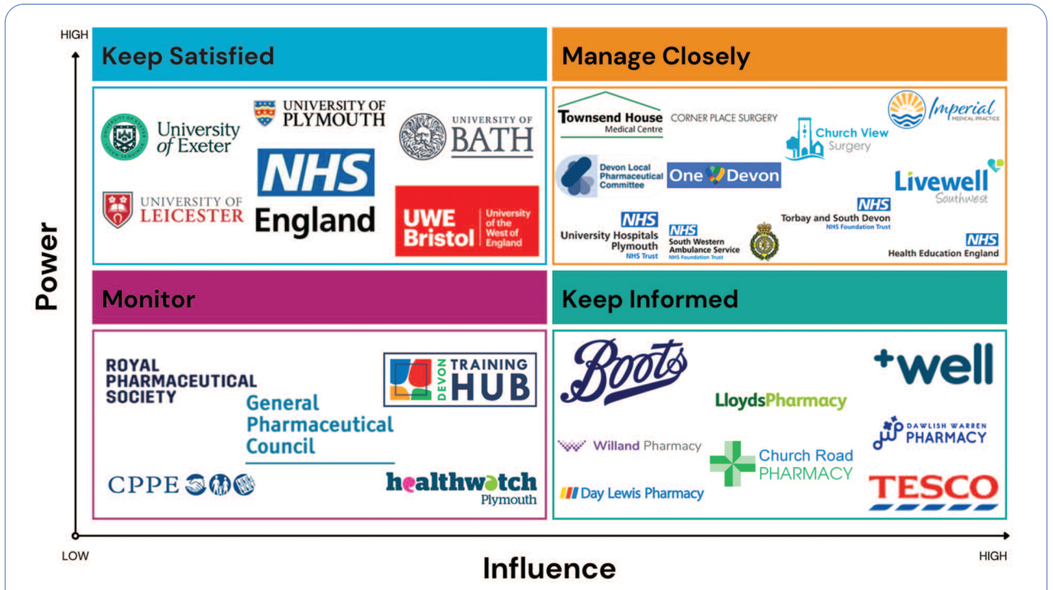


Figure 1. Stakeholder analysis

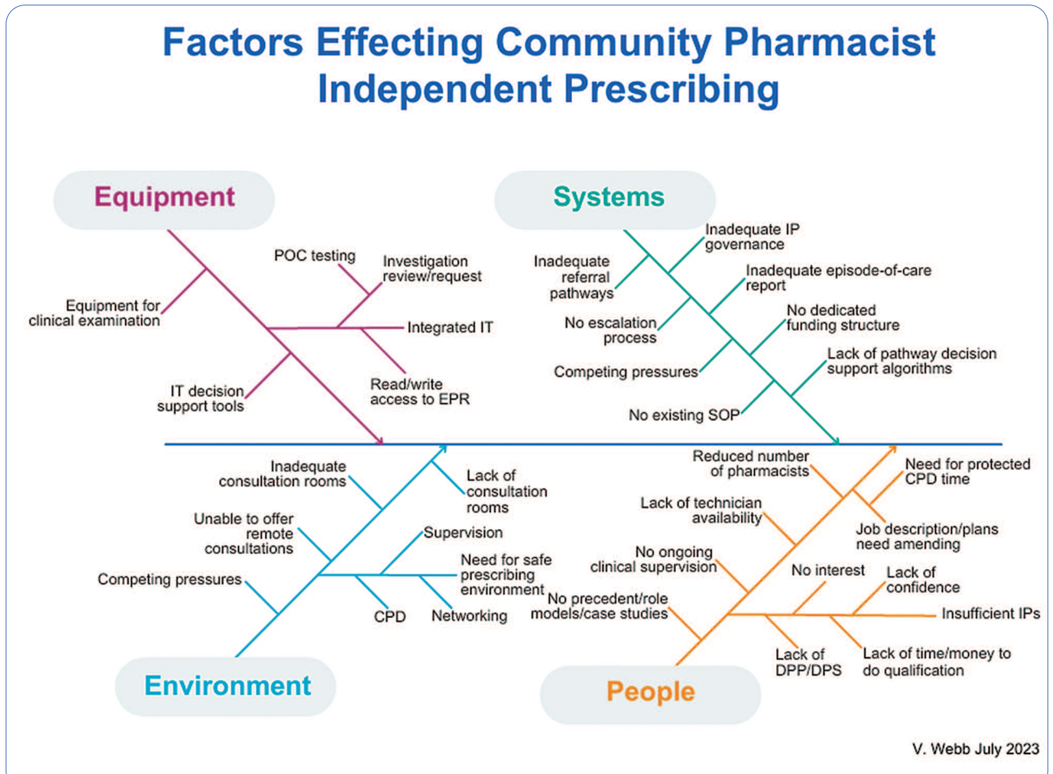


**Figure 2. Fishbone diagram of factors affecting community pharmacist independent prescribing**

England 2022). The overall concept is that these Teach and Treat clinics would be able to support several pharmacists training to be prescribers by providing a DPP and suitable clinical environment. The Teach and Treat pilots have been variously implemented in the six ICBs that bid to take part. This article documents the initial stages of Devon's Teach and Treat (T&T) pilot project.

## Starting out

In May 2023, in collaboration with the Devon ICB pharmacy prescribing and workforce leads, the pharmacy department at University Hospitals Plymouth (UHP) recruited a nurse advanced clinical practitioner (ACP) into the role of independent prescribing clinical lead (IPCL). The primary remit of the IPCL was to be the strategic lead for Devon's Teach and Treat pilot, to establish and operationalise a model that would facilitate the supervision of multiple trainee prescribers.

Although an experienced prescriber, the IPCL was new to pharmacy and primary care. The first few weeks of this role involved identifying [Fig.1] and then extensive networking with key stakeholders. The IPCL also spent time in community pharmacies, GP surgeries, specialist community teams, LPC and urgent treatment centres to comprehend the particular challenges faced by community pharmacists [Fig.2] and gauge where potential supervision could be accessed.

There were also a few key things that were already in place before the IPCL started in the post:

- The Devon Local Pharmaceutical Committee (LPC) (now Community Pharmacy Devon) had invited expressions of interest (EOI) from community pharmacists seeking DPP support and had received 32 responses.
- From the initial EOI, the steering group had selected ten pharmacists to apply for their prescribing qualification with the support of Devon T&T from September 2023.
- There was a vision that Devon's T&T would adopt a hub-and-spoke model with the IPCL as the hub and coordinating supervision at partner spoke sites.

So the pressure was on to identify DPPs for these trainee prescribers.

## Finding DPPs and practice supervisors

Despite relentless, multifaceted pressures, it remains that the best source of DPPs for community pharmacist trainee IPs is from the local PCN as these are the professional relationships that must continue beyond the 6-month course. A letter was sent to all Devon practices via the local training hub and the LPC, inviting them to take part in the pilot and host a community pharmacist for their 90 hours of supervised practice learning (funding was made available). This approach was limited in its effectiveness and generated zero initial engagement; we've subsequently found that the letter hadn't necessarily filtered down to the people that could action it. What did help was identifying the practice manager, clinical pharmacist, and IPs in the practices local to the trainee prescriber and emailing them directly with the generic letter as an attachment. A personalised email is harder to ignore, although not impossible, as the response rate was still disappointingly low.

> "A similar letter was sent to the ACPs at UHP, and the T&T steering group members used their network to seek engagement from other organisations in the primary and secondary care sectors. With the IPCL in a dedicated post, it was intended that she support 5 community pharmacists directly as their DPP and coordinate the supervision for the rest of the group. Thus, the Devon T&T pilot has evolved into a cross-sector, multi-professional hub-and-spoke model of supervision [Fig.3]."

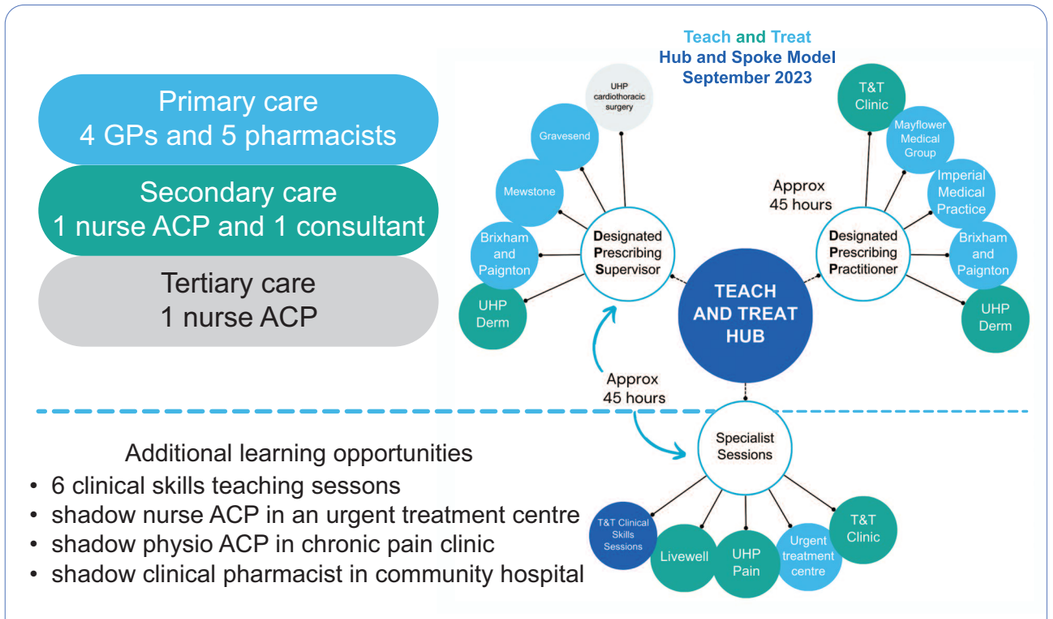


**Figure 3. Hub and Spoke model**

## T&T clinical environment

Setting up the infrastructure for a dedicated T&T hub clinic simply wasn't achievable for September 2023. A lot of consideration was given to the desired clinical scope of the trainee IPs, the established scope of the IPCL and how this could be extended, course requirements and the available patient groups. A workable solution was to align with an existing service, so the IPCL selectively sees patients with her trainee prescribers within the ambulatory emergency department at UHP. There is a good mix of minor illness presentations, referrals from primary care, and a lot of cardio and respiratory complaints. There are also established governance structures that ensure safety, and that the IPCL and T&T trainees function within their scope.

## Additional learning opportunities

### Intended Teach and Treat clinical skills teaching sessions:

1. History taking and consultation
2. Respiratory
3. Cardiovascular
4. Abdominal
5. Musculoskeletal
6. Ear, nose and throat

The Bristol, North Somerset and South Gloucestershire (BNSSG) ICB's Teach and Treat pilot is wholly hosted by their out-of-hours provider Medvivo. One of the key elements of their model that has been incorporated into the Devon model is an additional schedule of six clinical examination teaching sessions tailored to the shared learning needs of community pharmacist trainee prescribers. With suggestions from the trainees, these 4-hour sessions were to be held on a Saturday, at the Cumberland Urgent Treatment Centre in Plymouth. We invited trainee prescribers from other sectors to attend and we secured opportunities to shadow other professionals in specialist environments such as in a physio ACP's chronic pain clinic. The hope is that including other professions from different sectors, will broaden the learning experience and network of the community pharmacist IP.

## Funding

The Devon T&T was fortunate to secure an additional tranche of funding which we could use as an incentive to those organisations that could host a community pharmacist for all of their 90 hours and provide a DPP.

## Challenges

### Everything takes time

Raising the profile of the project, connecting with stakeholders, seeking engagement, targeted communications, networking, and planning was almost a full-time commitment for the first 3 months to ensure that the model was operational for September. Most emails sent will go unanswered, and you will get more negative responses than positive engagement.

### Competing priorities

The healthcare sector is under enormous pressure as demand outstrips capacity to deliver at every level. Although the future of community pharmacist IP can help share general practice workload, primary care providers are already committed to supervising their own trainee IPs and GPs. Larger organisations such as community hospitals and out-of-hours providers echoed the same challenges which prevented them from being able to support trainee IPs from community pharmacies.

### Local variance

As an observation, workforce skill mix, supervision capacity and progressive approach can vary greatly between practices, PCNs and providers in other sectors. The Devon T&T model very much reflects what could be implemented with the resources available locally.

## Successes

### A dedicated strategic lead

The primary role of the IPCL was to be the strategic lead for Devon's T&T and work to facilitate community pharmacist independent prescribing. With the support of a steering group, the IPCL has the time and the latitude to exploit every opportunity that supports the goal.

### 11 trainee IPs

Despite the challenges, 11 community pharmacists started their prescribing course with the support of T&T in September 2023. The majority of DPPs and practice supervisors are from primary care, albeit most of these are supporting trainees from outside of their local network.

### A dynamic model

Future iterations of this model will look slightly different as it is reflective of trainee location and growing supervision capacity.

## Next steps

With no time left to plan, it seems over-simplified that the next steps were just 'do':

- Operationalise the model that had evolved.
- Introduce the first T&T trainees to each other.
- Facilitate supervision.
- Deliver the proposed teaching sessions.
- Continue networking.
- Share progress with stakeholders.
- Create a forum for Devon community pharmacist IPs.
- Seek feedback.
- Prepare for future cohorts.

The intent is that these next steps will be covered in a subsequent article, to build towards a report of the whole project.

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# Digital, Data and AI Solutions in Pharmacy

## PM Healthcare Special Issue – April 2024

### Call for articles

Building on the recommendations from the Wachter Report (2016), digital transformation and improving the digital literacy of the workforce is one of the key elements of the NHS Long Term Plan (2019), with areas of focus including the need to provide digital services and tools to give people more control over their own health.

Experience from how the NHS responded to the COVID-19 pandemic strengthened recommendations of the Topol (2019) review for the need of extensive education and training of the clinical workforce and in particular for pharmacy, relating to robotics, health-related apps ('digiceuticals'), remote consultations, pharmacogenetics and genomic data.

This special issue of PM Healthcare Journal aims to gain insight into the current use of and learnings from digital solutions in delivering pharmacy services and supporting patients. Supplementary to this, it aims to identify key technologies which offer benefit to our pharmacy teams, create a repository of sources and contribute to our objective of sharing best practice and identifying excellence.

Topics of interest include the following, but other related topics will be considered:

1. The role of the patient in the design/use of digital solutions to support their health
2. The use of technology to support patient remote monitoring and service provision
3. The use of technology in diagnosis, treatment and outcomes
4. Data security and governance
5. Robotics in all pharmacy settings
6. Digital solutions in pharmacy workforce development
7. Solutions to drive efficiency and effectiveness
8. The impact of AI on practice, drug development, manufacturing and clinical trials
9. Learning from other sectors and industries to enhance pharmacy operational practice

### Submission details

Submission will be made via the normal PM Healthcare process and will be subject to peer review. Guidance for authors and further details of this Special Issue can be requested from editor@pmpublications.co.uk

Timeline for submissions.

1. Expressions of interest 14/02/24
2. Receipt of first outline/draft 28/02/24
3. Review and creation of final draft 31/03/24
4. Publication date 15/04/24

You may direct any issues regarding article content to the Special Issue editors: Mr Atif Saddiq (a.saddiq9@bradford.ac.uk) and Professor Liz Breen (l.breen@bradford.ac.uk).

### Supporting references


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UNIVERSITY of BRADFORD

PM Healthcare PROGRESS THROUGH PARTNERSHIP

# The impact of community pharmacy closures on the Community Pharmacist Consultation Service (CPCS) — and the consequences and opportunities this presents for remaining pharmacies

Tara Humphrey delves into the subject of community pharmacy closures — the effects on patients, remaining pharmacies and the evolving CPCS service as a whole. Offering her perspective as a primary care network specialist, Tara emphasises the importance of primary care leaders gaining a better understanding of the remit and opportunities pharmacies have now that their role has irrevocably changed.


Tara Humphrey is CEO of leading primary healthcare consultancy THC, a provider of interim primary care network (PCN) management and training for PCN Managers, Administrators and Clinical Directors. Tara is also the founder and host of The Business of Healthcare Podcast, a show which takes a behind-the-scenes look at the business side of healthcare with guests including NHS and private healthcare leaders. Tara is a wife and mother to three daughters and holds an MBA in Healthcare Leadership and Management.

LinkedIn: https://www.linkedin.com/in/tarahumphreythc/


The NHS Community Pharmacist Consultation Service (CPCS) was launched by NHS England on 29 October 2019, to facilitate patients having a same-day appointment with their community pharmacist for minor illness or an urgent supply of a regular medicine.

The service was designed to help alleviate pressure on GP appointments and emergency departments, in addition to harnessing the skills and medicines knowledge of pharmacists. In theory, patients with more complex complaints will be better able to book GP appointments and every patient will be able to access convenient services and treatment close to their homes at a location of their choice, with many able to do so on the same day help is sought.

## The impact of the CPCS on community pharmacies

The introduction of the CPCS transformed not only the day-to-day services offered by community pharmacies but also the way they are perceived by service users. The traditional pharmacy roles of dispensing doctor-issued prescriptions and existing as a place where over-the-counter medicines are purchased have changed considerably. Along with the CPCS came a new role for community pharmacies — that of patient consultant and advisor. Ipsos reported in December 2022 that nearly all (91%) of those who had used a pharmacy in the last year for advice about medicines, a health problem or an injury, were overwhelmingly positive about the quality of the advice they received. And nearly everyone questioned (90%) said they would feel comfortable seeing a community pharmacist for a minor illness, having spoken to the GP receptionist, instead of

organising an appointment with their GP. According to Community Pharmacy England in an article updated November 2023, since the CPCS was launched, 10,500 patients per week on average are being referred to a pharmacist for a consultation following a call to NHS 111. Without the CPCS in place, these patients may have otherwise booked to see their GP, delaying or preventing people in greater need from securing an appointment.

> **"From a pharmacist's point of view, the CPCS provides the opportunity for community pharmacy to play a more vital role than ever within the care system — that of first-step professional advisor in cases of low acuity medical illness."**

In April 2023, in an interview with The Business of Healthcare podcast, Shilpa Shah, CEO of Community Pharmacy North East London said: "Six out of 10 patient referrals to community pharmacists are advisory. Only one in 10 results in the pharmacist referring the patient back to the GP because the issue is more complex." Shah goes on to say: "The service educates patients that (for minor illness) people can go straight to the pharmacy and don't need to go to the GP first. That frees up practice and A&E time even more. The overall effect on the NHS could be phenomenal if every area implemented GP CPCS in this way."

## The value of community pharmacies

Findings from Pharmacy Advice Audit 2022 reported that:

- Over half a million consultations take place every week in each community pharmacy hub (for clinical advice alone) and where no sale of a medicine is made.
- As many as a quarter of a million people visit England's community pharmacies each week because they are unable to access other areas of the NHS. The number of patients presenting in pharmacies with urgent medical needs runs into the millions.
- Almost half of the patients said that if they did not have easy access to a pharmacy, they would have visited their GP. As such, we can estimate that pharmacy advice saves 32.2 million GP appointments over the course of one year.

Community pharmacies are usually situated in highly practical locations for easy patient access, including town and village high streets, shopping centres, supermarkets, and within the heart of some of the UK's most deprived communities. Many provide out-of-hours services and operate extended opening hours during evenings and at weekends to maximise patient capacity and convenience. Some are open until midnight, or even later, and on public holidays.

## Pharmacy Closures

Despite the numbers of GP appointments being saved and patient feedback, which indicates high levels of trust in pharmacists' knowledge and advice, community pharmacies are closing down at an unprecedented rate.

The CCA's analysis of NHS data found that between 2015 and 2022, 808 community pharmacies closed permanently in England. During that period, only 138 new pharmacies opened – a net loss of 670 pharmacies, with over 40% of closures taking place in the 20% most deprived parts of England.

The closures can be attributed to a number of factors. First, the rising cost of running a community pharmacy has directly impacted pharmacy owners' finances and profitability. Second, like many other industries, pharmacies are faced with constraints within the labour market and the ongoing challenges of recruitment and retention. Third, there are contractual factors at play, as highlighted by Dr Leyla Hannbeck, Chief Executive of the Association of Independent Multiple Pharmacies, who said: "We've been left with a contract that doesn't take into account any rises in inflation or cost of living".

There are also serious issues relating to the stock supply chain. In February 2023, Medthority reported on a catalogue of factors causing empty


pharmacy shelves and drug shortages, including delays in authorisation by the Medicines and Healthcare products Regulatory Agency and the rise in demand for certain medications, with hormone replacement therapy (HRT) being a prime example. Over the last seven years, the demand for HRT has increased by 38%.

## The impact on a community when a pharmacy closes

In January 2023 Lloyds Pharmacy announced that it was withdrawing pharmacy services from every one of the 237 branches of Sainsbury's where it operated, citing "changing market conditions" as the reason. Commenting on the announcement in The Guardian newspaper, Nigel Swift, Managing Director of Rowlands Pharmacy blamed insufficient government funding, stating: "Since the start of the pharmacy contract there has been a massive cut in real-term funding, resulting in hundreds of [pharmacy] closures."

Sainsbury's wasn't the only supermarket to lose its pharmacy services. In April 2023, three months after the Lloyds Pharmacy story broke, Tesco announced it was closing eight of its in-store pharmacies, while pharmacy retail giant Boots is set to close 300 of its 2,200 UK stores before the end of 2024.

The fallout following pharmacy closures can be felt both by the patients and the pharmacies that remain open. While prescriptions can now be ordered online and delivered to patients' homes, that requires a certain amount of knowhow and trust in technology, which the elderly and more vulnerable members of society may be less likely to have.

Age UK released findings in September 2023 revealing that 34% of people aged 75 and over in the UK do not use the internet. In such cases, a physical pharmacy within easy access presents a solution to sourcing advice and treatments while circumventing the need for internet usage. But if that physical pharmacy closes, the source of advice and treatment disappears along with it.

## Growing reliance on community pharmacies

"I feel sorry for the patients more than anything", says Danny Bartlett, Lead Pharmacist at Horsham Central Primary Care Network and Royal Pharmaceutical Society English Pharmacy Board

member. “Closures will often happen without a great deal of warning. If you imagine how many patients use that pharmacy to get their medication and suddenly that pharmacy’s not there anymore, it can be quite discombobulating.”

Peterborough based GP Partner, ICP lead, and GP Federation Chairman Dr Neil Modha agrees that the impact on patients within the community is stark: “It’s awful when the organisation you turn to for much-needed medicine suddenly disappears. A lot of patients will turn to online pharmacies but it’s not the same. If you need antibiotics, how quickly can the online provider provide you with what you need?”

Dr Modha goes on to comment about how people’s reliance on community pharmacies increased during the pandemic, making their closure feel like even more of a loss. “During the pandemic, when most GP practices had to close their doors, a lot of community pharmacy colleagues had their doors open so patients could still pick up medicines. As soon as organisations that people turn to close, it has a massive effect on them. When you lose the quantity of providers, it can also often decrease competition, choice and levels of service.”

## Pharmacy users’ experiences

A report published January 2024 by Healthwatch Richmond Upon Thames in response to the closure of two community pharmacies in Hampton, found that 64% of the 600 survey respondents were using the remaining (Boots) pharmacy after the closures compared with 26% who had been using it before.

98% of those using the remaining pharmacy stated that waiting times were worse or significantly worse since the closures, and 79% reported their waiting time had increased, with around a third (35%) saying they waited 30-60 minutes for their prescription to be ready upon arriving.

Quotes from patients included:

> *“I have gone without medication as I can’t stand very long. There are queues — I have waited over half an hour.”*

> *“Queueing is very difficult for both of us as we are both pensioners with very bad osteoarthritis.”*

> *“You have to wait at least half an hour before being seen at the pharmacy. I have terminal cancer and my partner has to go to queue for me and I’m alone the whole time he is waiting and queuing…”*

## The hardest hit

Closures often affect those within the most vulnerable sectors of the community most, such as the elderly or those on low income, who rely heavily on the proximity of their local pharmacy for fulfilment of their prescriptions or general management of their day to day, over-the-counter needs. This could, in turn, lead to potential delays, or interruptions in their treatment plans, and have an adverse knock-on effect on the rest of the health care system with patients either presenting to A&E or having to contact their GP practice.

For pharmacies that remain open, the burden placed on them can feel overwhelming. Almost three quarters (74%) of those who responded to the Chemist + Druggist Salary Survey 2022, reported “high” or “very high” stress levels. In a Sky News report published August 2023, Dr Leyla Hannbeck commented: "Pharmacies are drowning because the workload from those other pharmacies (that have closed) is landing on them."

Having to deal with patients who are frustrated by inconvenience, longer waiting times and stock issues adds stress to a workforce, who may already be feeling the pressure of serving a higher volume of patients, and the potential personal and professional dangers that poses, such as an increased risk to patient safety. In turn, the existing challenges caused by recruitment and retention issues are heightened, as staff dissatisfaction grows.

## Opportunities for remaining pharmacies

While the picture painted may seem gloomy, the closures of community pharmacies could actually present several opportunities for those which remain.



## Hiring Staff

The closure of some community pharmacies means that there will be experienced individuals in the region looking for jobs. Seeking them out and offering them positions should help soak up the extra demand caused by the closures while helping remaining pharmacies fill their recruitment shortfall.

## New funding routes

NHS England is soon to be extending the CPCS to become the NHS Pharmacy First Service. Announced in May 2023 for a 31 January 2024 launch, NHS Pharmacy First commits to making greater use of community pharmacists’ skills and patient engagement by expanding the role of pharmacies to support the management of seven common conditions following specific clinical pathways.

This new iteration of the initiative builds on the previous CPCS service by enabling community pharmacies to offer self-care, safe-netting advice and, where appropriate, supply certain over the counter and prescription only medicines.

For the pharmacies that remain open, this move presents an opportunity to shift from a reliance on dispensing profit to a business funded by offering advanced and enhanced services.

## From large multiples to smaller independents

The swathes of multiple ownership pharmacies that have closed over the last 12 months present an opportunity for smaller, independently owned community pharmacies to fill the holes they leave. By their nature, smaller enterprises have the advantage of being agile, fleet of foot and able to make decisions and therefore changes quicker, including moving more into NHS and private services.

Opportunities to upskill in the near future will be rife for remaining pharmacies, leading to new and enhanced income streams. For example, from 2026, everyone who qualifies as a pharmacist will be trained as an independent prescriber. Pharmacies may also take the decision to open their doors for areas where people pay privately,


such as travel vaccines and the seasonal flu jab. With fewer pharmacies in the area for patients to go to, the pharmacies which offer such services could find themselves with little competition and reaping the financial rewards.

## Real-life experience of a new community pharmacy — “It wasn’t all glossy”

As well as being a partner GP, Dr Modha also owns a community pharmacy, which is located in his GP centre. He explains how his pharmacy responded to the challenges of nearby pharmacy closures and recruitment issues:

> **”When we started (with the pharmacy) it wasn’t all glossy and lovely. We had security controlling the queue and at times we felt we weren’t doing a good job and were letting people down.”**

The problem wasn't management capacity — it was the workforce we were dependent on. You can't revolutionise a service overnight. People have notice periods. It took six months to bring in the workforce, technology and innovation to get the pharmacy to where it should be.

> **"We can look back now we're in a more positive position and feel very happy about the journey we were on, but at the time it brought tears to the eye and security to the door."**

When asked how he is taking his pharmacy forward, Dr Modha says that training has been key:

"As a GP centre, we're a training practice. We now train people across the GP practice and the pharmacy so people rotate around both. This helps to build up communication and improve working relationships. We have four pharmacy technicians, and four in development, who are supported through funding from the NHS whilst we support them with access to training and supervision. At the end of the training, when they become qualified pharmacy technicians, they will be useful for both the general practice and the pharmacy, which is helping to develop the future workforce as well as what's happening now."

## The importance of good relationships with local NHS partners

Even with the recent flurry of pharmacy closures, the CPCS service can still be hugely effective, but only in cases where there is good communication between practices and pharmacies.

Dr Modha explains the real impact the CPCS is having:

"Last month we referred around 400 cases. We generally find that fewer than 10% of cases are returned to us, with over 90% being managed through the pharmacy. These cases are ones that would not have been prioritised by our general practice for same day care.

"This week we had one referral back to us who had symptoms of tonsilitis, but the pharmacist picked up that the patient was very unwell. When I assessed her, the patient had a quinsy and needed hospital admission for treatment. General practice is struggling to manage all the demands coming its way and so doing this together in an aligned way is positive for general practice and positive for community pharmacy.

"As GPs and community pharmacists, rather than competing with each other, if we remember we're all part of the same pathway and think how we can best use our workforce, we can all get some real benefit."

Shilpa Shah reinforces this notion:

"It's about working together in a non competitive way to form local relationships. Pharmacists need to be working with all GP practice staff (not just GPs), including the receptionists and the practice manager, who play a critical role in freeing up GP appointments by sending patients to their pharmacist."

The strength of the practice/pharmacy relationship now, more so than ever before, will be the overriding factor that determines the service's efficiency and success rate, as well as the satisfaction levels of those who work there and the patients themselves.

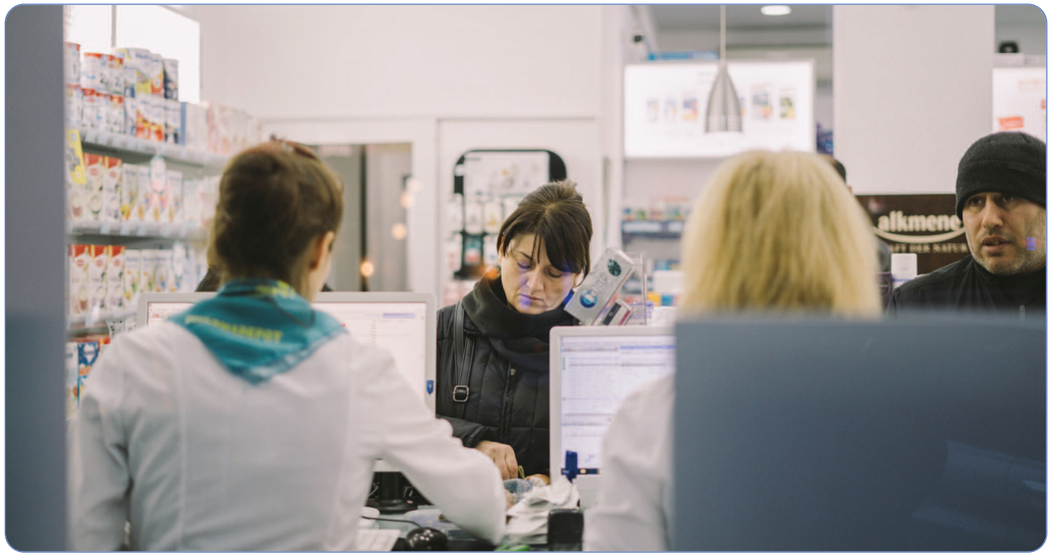
## The future outlook

Figures published in October 2023 by NHS Business Services Authority revealed there were 11,414 active community pharmacies in England — the lowest number since 2015/16. Nick Kaye, National Pharmacy Association chair and third generation community pharmacist, said:

"Even since these official statistics were compiled, many more pharmacies have closed their doors for good and the downward trend is continuing."

Whether or not more community pharmacies do close, getting on board with co-operative and effective ways of working now will provide essential foundations for the future. Should Kaye's comment of a 'downward trend' prove correct, remaining pharmacies must be primed to deal with the incoming glut of patients.





Royal Pharmaceutical Society English Pharmacy Board member Danny Bartlett shares how Horsham Central Primary Care Network was proactive in their communication following the closure of services local to them:

"We sent a message to patients with a response link saying that we were very sorry to hear their pharmacy was closing, and we'd be happy to change their pharmacy for them. We asked them to respond directly to us, telling us which pharmacy they'd like to change to. That allowed patients to make the decision there and then, and kept them in the loop so they didn't run out of medication. When closures happen, there's no easy way to deal with it, and it will be happening more in the next few years."

Findings from Community Pharmacy England's 2023 Pharmacy Pressures Survey (involving 6,200 pharmacy premises and 2,000 pharmacy team members) confirmed the gravity of the current challenges facing community pharmacies, suggesting that further closures are to be expected.

With 96% of pharmacy owners facing significantly higher costs than last year and many operating understaffed, but at the same time 92% reporting a significant increase in requests from patients unable to access general practice, the eye of the storm may be a way off yet, but it is coming. And when it comes, those who survive through to the other side will be the ones who are the most resilient, innovative, training-focused and whose relationship and communication with GP practices are the strongest.

## Further Reading

**Working collaboratively in an ICS: freeing up opportunities in community pharmacy**
Exploring the opportunities for greater collaborative working between community pharmacies, primary care networks and federations within ICSs. Read the NHS Confederation article here.

**CPCS service specification**
The service specification describes the requirements for provision of the service and it is essential reading for all pharmacists providing the service.

**CPCS Toolkit for pharmacy staff**
The toolkit provides further information on the CPCS for pharmacy teams, including materials which can be used to brief team members on the service.

**Registering for CPCS**
Pharmacy owners can register to provide the CPCS service via the NHSBSA Manage Your Service (MYS) portal.

# Migrating the IMOG away from an APC

**Hemant Patel,** *FRPharmS, BSc (Pharm), MSc (iPres), MSc (Healthcare Leadership)*
*Director of Medicines and Clinical Policy, Black Country ICB .*

## Background

Integrated care systems (ICSs) are partnerships that bring together providers (NHS trusts) and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population.

**"The formation of the Black Country Integrated Care System (ICS) was in place by July 2022. This provided an opportunity to realise our vision of working collaboratively at an ICS level with secondary care and other stakeholders to improve the health and wellbeing of our local population."**

To realise system-wide priorities, reduce variation and implement a shared strategic approach for medicines optimisation, we established an Integrated Medicines Optimisation Group (IMOG) for the ICS. The aim being to drive forward system-level working and leadership across the Black Country for Medicines Optimisation, ensuring robust governance processes are in place, as well as consideration around the organisational membership. They will also need to define formulary processes (e.g. management of drug applications, publications, and formulary harmonisation) and the impact on other committees.

The ICS IMOG replaced the existing four separate legacy area prescribing committees (APCs) in Dudley, Wolverhampton, Walsall, and Sandwell.

## Introduction and purpose

The IMOG serves the local community by improving the safe and effective use of medicines and improving cost effectiveness across the health economy. It is responsible for medicines optimisation within available resources at a healthcare system organisational level. It does this by deciding which medicines are recommended for use locally, and by supporting the implementation of evidence-based advice on the best use of medicines.

The IMOG oversees the use of medicines, transformational plans and system-wide approaches. It will consider the national workstreams such as those defined by the regional medicines optimisation committee (RMOC) for local implementation and will be responsible for several key medicines optimisation elements, including to:

- Enhance healthcare system-level working between organisations to enable improved medicines optimisation for patients
- Consider the national workstreams and recommendations from the RMOC and national specialist groups for local implementation
- Provide assurance in relation to the safe use of medicines across primary and interface care
- Consider patient experience in relation to medicines and make recommendations across the ICS for member organisations
- Lead the development of a joint formulary in relation to primary care and commissioning budgets across the ICS. (Processes and principles agreed for the joint formulary will be defined in the Black Country ICS IMOG Policy)
- Undertake medicines horizon scanning to forecast developments in medicines related healthcare and support the introduction of new medicines


- Provide a framework to endorse medicines related guidelines with clinical networks to support better use of medicines
- Ensure that health equity and health inequalities are continuously reviewed and addressed as part of the IMOG functions to improve population health and management
- Provide a forum for the review of the current evidence and provide evidence-based recommendations to support the managed entry of new medicines, or new indications for existing medicines into the Black Country health economy
- Support a consistent approach to managing the shared care of appropriate medicines across the interface between primary care and secondary/tertiary care organisations
- Provide a forum for the review of alerts, guidance and locally collated information with regard to the safe use of medicines in order to support a consistent approach to managing medicines safety issues and provide assurance to individual organisations
- Consider medicines procurement across Black Country health economy to deliver a best value programme.
- Develop and recommend a framework to measure achievement on quality indicators in commissioning

The group is accountable for medicines optimisation at healthcare system level, delivering functions and duties delegated by the Black Country ICS. The IMOG oversees and develops the best use of medicines across the healthcare system and involves membership from NHS and wider organisations to a system-wide understanding of medicines optimisation.

## Recognising change is required

There are significant quality, safety and financial risks associated with the failure to optimise the use of medicines and there is an expectation that ICBs will ensure there are appropriate governance arrangements in place to support the delivery of local, regional and national priorities for medicines optimisation. It is also important that there are effective routes for the oversight and escalation of emerging issues and concerns.

What became clear was that these criteria simply replaced those of the existing APCs, resulting in the agenda being dominated by the same items that a typical APC undertook. Principally this was

assessing formulary applications, shared care agreements, stipulating the RAG status to current medicines and NICE technology appraisal guidance medicines.

A gap was identified that was not being met by this group, consisting of senior leaders across the Black Country having little or no time to:

- Consider a strategic plan for medicines optimisation
- Consider the governances or assurance required
- Provide sufficient challenge to existing prescribing and medicines management and whether we were delivering against our wider strategy or individual strategic goals

Having recognised this, we were able to ask:

- How assured is the new group that we were maximising opportunities to improve patient outcomes, safety, efficiency, support evidence-based medicine and reduce health inequalities?
- How do we benchmark against others across the country?
- How are we delivering against regional or national targets?

## Now and in the future

We clearly require those important aspects that historically were managed by APCs to continue, and locally these will be managed by the inception of a joint formulary group (JFG). The JFG will manage the role of legacy APCs, including formulary harmonisation process and ratification.

The outputs will be reported to the IMOG for information only. Where there are decisions that cannot be made by the group, such as when funding requirements exceeds delegated limits, or where there are commissioning elements that need to be addressed alongside the decision, these will be reported to the IMOG for consideration.

The IMOG will now become the strategic, oversight and assurance group, with appropriate representation to view the issues beyond organisational boundaries and instead system-wide. There will be elements that need to be escalated higher up into relevant boards or committees, where there is a requirement to seek assurance, funding, and to gauge where a proposal sits within the priorities of the ICS. The JFG began operation in July 2023, and from September it began to receive formulary applications and shared care agreements.

The IMOG now resembles a strategic board, which will be utilised to push the medicines optimisation agenda, challenge its own performance and that of its constitute partners as well as providing the assurance required by the system and NHS England.

One of the first tasks for the group was to select the Medicines Optimisation Opportunities as set out by NHS England. The agenda including items such as prescribing and spend oversight, with the ability to undertake deep dives into areas of interest. Ensuring key subgroups were formed and had workplans signed off by IMOG helped to provide the group with assurances and build credibility across the system.

The role of the IMOG now includes:

- Overseeing and providing assurance on progress against the delivery of national programmes for medicines optimisation and pharmacy integration across the Black Country, including the NHS Long Term Plan and the Primary Care Access Recovery Plan
- Identifying and managing key risks associated with the delivery of the national programmes, escalating issues as necessary, including oversight of arrangements for the aseptic preparation of medicines and co-ordinating an approach to medicines shortages that impact on patient care
- Supporting the establishment and development of effective system governance and clinical leadership arrangements for medicines optimisation and pharmacy integration

The requirement to migrate the IMOG into a strategic, oversight and assurance group has allowed the group to build credibility with the system by providing the ICS with the level of governance and assurance it requires. The new IMOG now is able to devote sufficient time to make system-wide medicine optimisation decisions.





# Resilience

**Ivan Hollingsworth**,
*Director, Centric Consultants.*

Ivan founded Centric Consultants in a bid to tackle 'culture-washing' and support business leaders to build strong, sustainable, high-performing teams based on trust and psychological safety.

A former elite athlete and award-winning fundraiser, Ivan brings his lived experience of how culture and trust affect mindset when it comes to reaching goals.

After 16 years working in senior roles in the pharmaceutical industry, Ivan combines his in-depth research and knowledge with on-the-ground experience of a wide range of different team dynamics, both in the private and public sector. He creates an inclusive, open and engaging atmosphere tailored to individual or team dynamics and shares strategies and tools that can be applied right away.

## What is resilience?

How many times have we heard people say, "The kids of today seem to lack resilience" or, "We need our employees to be a little more resilient"? In recent years, resilience seems to be one of those words that is being increasingly used to put down a person or group who aren't conforming to a modern-day, false narrative of how we need to be brave, strong, or bulletproof, which in my opinion has got to the point that it has become toxic.

> "Resilience as a word is too often used by well-intentioned but ill-informed individuals or by those in positions of authority and influence to exert power over others; not only is it toxic to the recipient, but it has also become weaponised in workplaces across the globe."

Resilience isn't a trait or characteristic you are born with, instead it is something you can develop and improve with the right understanding, support, and environment. It is my personal mission to detoxify and de-weaponise the word resilience, by inspiring, empowering and supporting everyone to understand what it really means in practice to become truly resilient in their own lives.

Let's start with a definition of resilience:

**Resilience is the ability to withstand adversity and bounce back from difficult life events.**

So, let's unpick this. There will be occasions in life where, on a random afternoon, 'adversity' or 'difficult life events' blindside you, leaving you completely floored. The question is whether the advice of those who have misappropriated resilience helps or hinders you when these challenges or uncertain times arise. To explain why I believe so passionately that this is not only unhelpful, but also has the potential to cause us a greater degree of pain and suffering, requires me to share a little of my personal story.

On the evening of Sunday 11th January 2009, our son Seb was born. He was our first child and like many expectant Dads, I was overwhelmed with emotion as he arrived into the world. Unfortunately, those positive emotions quickly vanished when 15 hours after Seb was born, we were following an ambulance to the Children's Heart Unit at Newcastle Hospital, to be told he had a life-threatening congenital heart defect

requiring open heart surgery.

In that moment I felt weak, helpless, and certainly not resilient! Seb's condition deteriorated quicker than expected and at just 16 weeks old he underwent emergency life-saving open heart surgery. The days and weeks that followed were the most difficult and challenging I have ever experienced, watching our precious child cling on to life, lying with more than a dozen tubes and wires attached to him, so incredibly fragile.

The good news is that over the days and weeks that followed, Seb slowly got stronger, the tubes and wires were removed and six weeks later we were able to take him home. The bad news was that Seb would require further open-heart surgery at various intervals, potentially for the rest of his life, but for now, we could at least breathe. Why am I telling you all of this? Well, I had spent most of my life with people telling me I was a strong character and with lots of resilience, and while that felt like a compliment at the time I came to realise that I had no idea why they were saying it, whether it was true and how I could control, built on and improve it.

I challenged myself to learn everything I could about resilience, enabling me to explore my existing strengths to a point that I could improve them and identifying my weaknesses so I could activate strategies that might make a difference when we found ourselves in this situation in the future. The over-riding goal was to have the capacity to support Seb and my wife, whilst also trying to ensure the cost of doing so did not result in me crumbling.

The years that followed were some of the most challenging, enriching and rewarding of my life. I gained a clearer understanding of how not only I could become more resilient but also how everyone else could too.

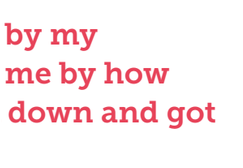
Firstly, no judgement. We're not robots, machines, or movie superheroes. If things go sideways, you get hit by that curve ball or you hit one of life's unexpected speed bumps, there is no absolute certainty if you will cope or how you should cope. Sometimes the things that you could handle yesterday, just feels like too much today. Remember, resilience is not about battling through everything, sometimes things break you and practising true resilience is about having the mechanisms and support systems in place to regroup and rebuild. To quote one of my favourite people in history:

> **"Do not judge me by my successes, judge me by how many times I fell down and got back up again."**
>
> **Nelson Mandela**

The academic world has published significantly in the field and there are several models focussed on resilience. To help structure my toolkit, I'm using the 'The Predictive 6-Factor Resilience Scale: Neurobiological Fundamentals and Organizational Application' by Pieter J. Rossouw and Jurie G. Rossouw (published in 2016) as a guide. This isn't an academic article or a review of the research. This article is written with the goal of providing meaningful tools, tips, and strategies to help you in your life today. To do this, I will use elements of research, share the insights of thought leaders, and weave in my personal journey along the way.

## What is your purpose

Personally, I found this to be the most challenging of all the areas and it took a few years to really understand my purpose in life. At times I felt like I was either defined by my job, hobbies or just like a boat drifting without a rudder. By pure chance, I watched Simon Sinek's Ted Talk (https://www.youtube.com/watch?v=u4ZoJKF_VuA) and read his book, 'Start with Why' and these two pieces of work started me on a journey of self-discovery.




Sinek explains that most people or organisations know what they do, some have a good understanding of how they do it, but very few know why they do it. The months that followed were a rollercoaster of thoughts and emotions, as I explored the answer to that 'simple' question for myself – *What is my why?* The exercise that had the most profound impact on me was imagining what I hoped those who know and love me might write in my eulogy when I'm no longer here.

I spent some time examining what kind of life I wanted to lead and by imagining that I could track back to the present day and start to live with that purpose front of mind. Finding my purpose provided me with a compass point, a North Star, and a deeper sense of who I am, what I care about and the life I wanted to lead. If you asked my Mum (who unfortunately passed away when I was 26), she would have said all I did was unearth what was already there. The process I went through makes me think of the Michelangelo quote, "Every block of stone has a statue inside it, and it is the task of the sculptor to discover it". My purpose was always there, I just had to be prepared to chip away at the stone to release it.

Having completed this exercise and having clarity of my purpose enabled me to better cope with adversity, whether that is the major life-changing trauma of losing a loved one, Seb's surgery or those curve balls that comes out of the blue. It provided a hopeful sense for the future and a reason to persist. For those who might be interested, my purpose is: **To inspire, empower and support people to thrive.**

Does this mean every day I achieve my purpose, no it certainly does not! But what it does give me is a meaningful goal, a reason to persist and, when I do go off track, I can quickly bring myself back to that compass point.

## Meaningful connection

Depending on your personality, upbringing, and environment, you could find this element to be easier or much harder to fathom. Having a supportive social network is powerful in times of adversity, but if you wait until you need people most, then the emotional glue will not be strong enough to provide the support you most need.

When faced with significant challenges I tended to go inward and rarely asked for help. I think this is partly a result of conditioning (believing vulnerability is weakness), not wanting to burden people and because I have always been told I am strong, so why would I need help? This all changed when I watched Brené Brown's groundbreaking Ted Talk The Power of Vulnerability

(https://www.ted.com/talks/brene_brown_the_power_of_vulnerability?language=en) and devoured her book Daring Greatly.

By understanding that vulnerability is in fact a sign of strength and can transform your relationships, we open ourselves up to opportunities for meaningful connection at a deeper human level. This opened my mind and heart to the realisation that those closest to me wanted to help me. It wasn't a burden to them, and they would do anything to help me navigate difficult life situations.

There will be times in your life when those difficult

life events will simply be too much for you to cope with alone, and it is in these moments that your support networks become crucial – it feels at times like they literally carry you when you are broken. This is why breaking the myth that resilience is about strength is so important, because it is only a result of our vulnerability that we can ask for help.

## Building your perseverance and developing your grit

If there is any aspect of resilience I did have, this was probably it. My 'grit' is part nature and part nurture. As someone for whom things have never come easily, I have always had what Carol S. Dweck (Professor of Psychology at Stanford University) would refer to as a growth mindset. As I previously said, I had no idea why I was so tenacious or where my persistence came from, so I felt helpless to build and improve it.

It was the discovery of Angela Duckworth's (Rosa Lee and Egbert Chang Professor of Psychology at the University of Pennsylvania) research around Grit that illuminated this entire area for me and provided the framework, to become even 'grittier'.

Duckworth explains that grit isn't about talent or luck but:

> **"Is about having what some researchers call an 'ultimate concern'—a goal you care about so much that it organises and gives meaning to almost everything you do. And grit is holding steadfast to that goal. Even when you fall down. Even when you screw up. Even when progress toward that goal is halting or slow."**

Duckworth states: Grit = Passion + Perseverance (for a long-term meaningful goal).

We can break this down even further into the four areas below:

1. Interest – Enjoying what you're doing, intrinsically motivated and curious
2. Practice – Engage in focussed practice and set clear goals
3. Purpose – A belief your work matters and improves the lives of others
4. Mindset – A belief our skills are malleable and can be improved

## Developing your self-compassion

This area is my most recent to focus on and feels like the most emotionally challenging. The default when life doesn't go as planned, is normally fight, flight, or freeze – the engagement of the ancient evolutionary part of our brain, the amygdala. This has led me on more than one occasion to make poor decisions and most definitely not feel or demonstrate resilience.

Being self-aware and having a positive attitude motivated me to dig deep and led me to explore the concept of self-compassion. First researched by Kristin Neff (Associate Professor of Educational Psychology at the University of Texas at Austin), self-compassion refers to being supportive to oneself when in pain or experiencing suffering. Much like vulnerability, I think self-compassion is something we can all struggle with, perhaps perceiving it as weakness, self-pity, or self-indulgence. It is my belief that compassion is a crucial element of humanity and is fundamentally about reducing someone else's suffering. The question is whether we believe we are worthy of showing ourselves the same compassion or not.

Neff broke self-compassion down into three components: self-kindness, common humanity, and mindfulness.

### 1. Self-Kindness

Being warm and understanding toward ourselves when we suffer, fail, or feel inadequate. The simple exercise I use for this is to imagine what you would do or say if a loved-one or close friend was struggling. My guess is the tone, words, and emotions used might not be the same as those used in our own heads when we are struggling or have failed.

### 2. Common humanity

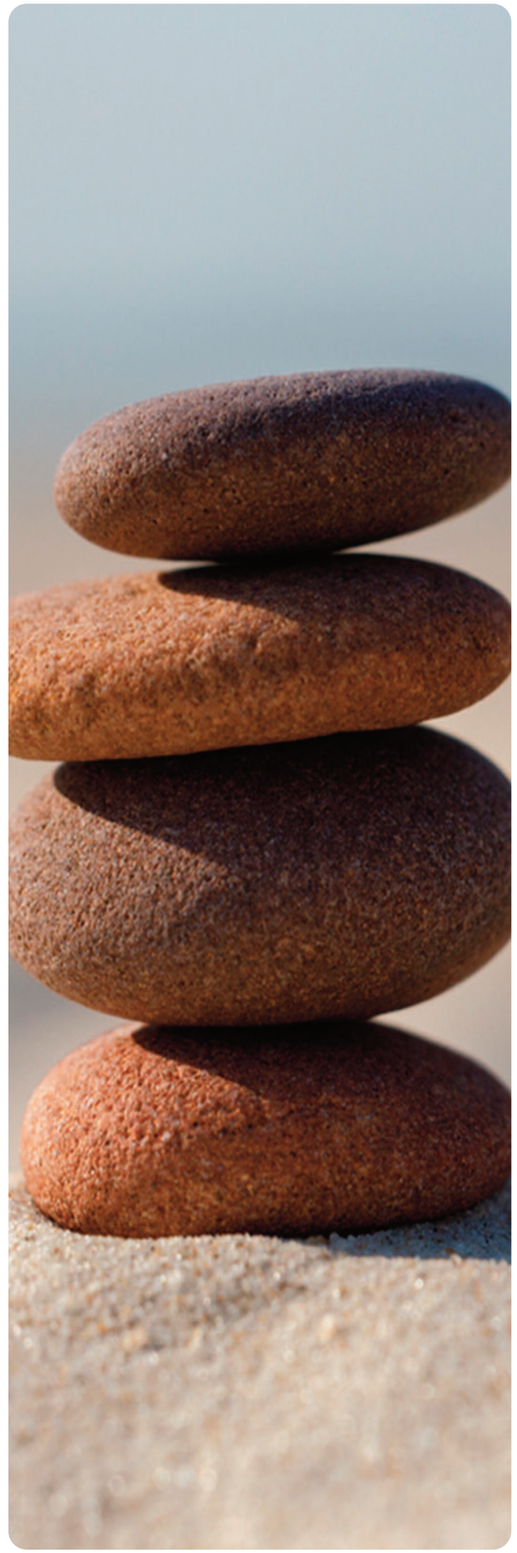
Often when we make mistakes, fail or struggle, we can feel a sense of isolation, it can feel as if we are the only person struggling or making a mistake. Recognising humans are all mortal, vulnerable and imperfect enables us to shift from that state of isolation and self-pity to sharing with a trusted friend or colleague.

### 3. Mindfulness

This is a non-judgmental, receptive state where you can observe your thoughts and feelings without trying to deny or suppress them. In certain circles the term 'mindfulness' has become a bit of a buzzword, which has led some to either being confused by its actual meaning or feeling it is excessively soft and flowery.

Susan David (Harvard Medical School Psychologist) explained:

> **"It may be easier to understand what mindfulness is really all about by first looking at its opposite: mindlessness. Mindlessness leads us down the path of getting hooked. It's the state of unawareness and autopilot. You're not really present. It's mindfulness that allows you to notice your uncomfortable feelings and thoughts rather than be entangled in them."**



Self-awareness of my emotional state when things go wrong provided me with a choice – do I want to continue in a mindless state of fight, flight, or freeze, or do I want to switch the amygdala off and engage the prefrontal cortex (the part of our brain that deals with executive functions such as self-control, problem solving and decision making)?

My simple exercise to switch my amygdala off is 'Box Breathing'.

Breathing:

1. Inhale deeply through nose, expanding stomach for a count of four
2. Hold in that breath for a count of four
3. Slowly exhale all air through mouth, contracting stomach, for a count of four
4. Hold the empty breath for a count of four
5. Repeat four times

There are other ways that you can focus on building your resilience too:

## Health

Whilst the research around the health benefits of nutrition and exercise has been known for years, it is only relatively recently that research around sleep has identified its link to resilience.

### Exercise

I have found regular exercise to be crucial in dealing with stress and trauma, understanding its ability to switch off the amygdala, thus reducing the negative effects of stress and the positive benefits of the endorphins that are released when we exercise. It provides a sense of control, focus and at times can be deeply cathartic.

### Nutrition

The link between nutrition and overall wellbeing is not new. When we consume high levels of sugar, dietary fats, and alcohol we know the negative impacts on our health and therefore the detrimental effect on our resilience.

### Sleep

The field of sleep is an area which until recently was not deeply understood. However, thanks to the work of Matthew Walker (Professor of Neuroscience and Psychology at the University of California, Berkeley, and Founder and Director of the Centre for Human Sleep Science) and colleagues, this is no longer the case.

Walker found that study participants who slept in-between stressful experiences reported feeling differently. MRI scans showed significant reduction in the amygdala reactivity and a real engagement of the prefrontal cortex after sleep, which had a positive impact on emotional reactions. Participants who remained awake across the day, without the chance to sleep, showed no such benefits to emotional reactivity over time.

Walker suggests four Tips for Better Sleep:

1. Avoid caffeine and alcohol before sleep. If you do have caffeine in your diet, then pay specific attention to the half-life of caffeine. The result of this means I will not drink caffeine past 1pm, which has really helped the quality of my sleep
2. Avoid taking naps during the day
3. Regularity – go to bed and wake up at the same time every day (even weekends)
4. Keep cool (67° f) – the body needs to lower its core temperature by 2-3° f to fall and stay asleep

## Thriving or growing through adversity

The main theme within this area is how we go about reframing negative situations. Very few people enjoy it when things going wrong, especially if there is an emotional component. That emotional response is rarely helpful and can lead us into a state of reacting (fight, flight, or freeze), rather than responding.

My strategy is:

1. First acknowledge something has gone wrong
2. Press pause
3. Remove myself from the specific environment and literally step-back
4. Activate Box Breathing
5. Shift my perspective, create options, and choose my next steps wisely


As with many of these areas, there are crossovers and situations that will require different strategies, from seeking help/guidance, more significant stress management techniques (such as exercise), or a good night's sleep.

Personally, this is an area that I must constantly remind myself about and work on. Don't beat yourself up or berate yourself when you are less than perfect, it's not a race and there are no winners. Be kind and show yourself some self-compassion.

## Conclusion

I started this article explaining that my motivation was to understand resilience and feel empowered to build my own, so when the day came that Seb would require further surgery I would be better able to cope. On Monday 11th July 2022 that day came.

In the 13 years that had passed, I had been on a journey of self-discovery, development, and growth. Yet in the moment we were told his date for surgery had come, having to kiss him goodbye in the operating theatre or seeing him post-surgery in paediatric intensive care, broke me. Does that mean it was all for nothing? No, it doesn't. It reflects the real world and the fact that at times those difficult life events are just too much for anyone to cope with.

What those 13 years gave me is an unwavering belief in my purpose, the development of my self-compassion that meant I didn't judge or beat myself up anymore, the belief I did indeed possess grit, the understanding of how to reframe this difficult situation, ask friends for help when I didn't have the strength to continue, and a broader understanding of how my health and well-being would contribute to bouncing back.

I don't think I will ever stop on this journey of self-discovery, development, and growth. The crucial element is, I now understand what needs to be done, how important it is and the realisation that we can all become more resilient.

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