PM Healthcare
PROGRESS THROUGH PARTNERSHIP

JOURNAL

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

Winter 2026 | Issue 15

Highlights:

Workforce and Wellbeing

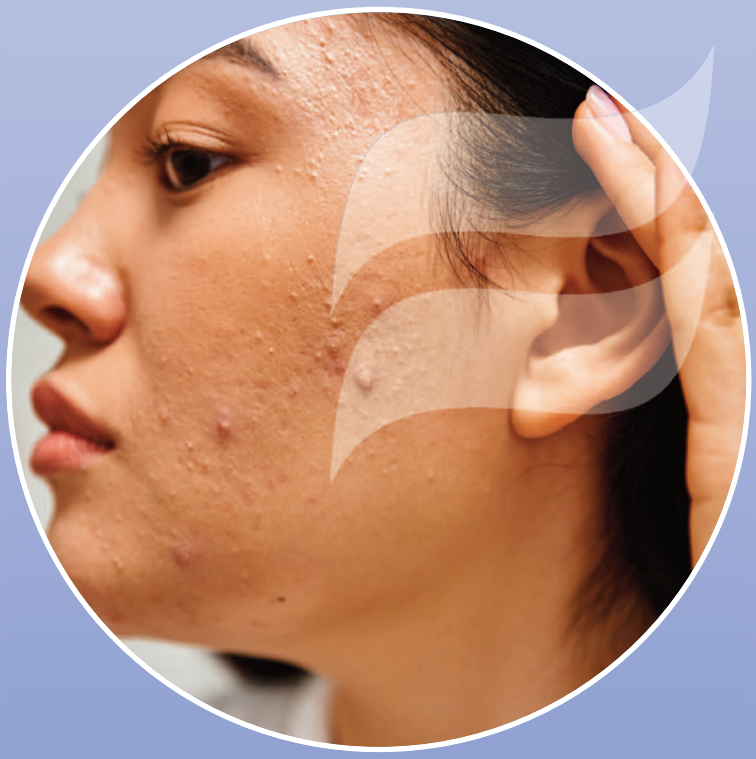
The Professional's Blind Spot: Why Trauma-Informed Care Starts With Recognising Your Own

Rachael Lemon

Medicines

Review of the prescribing of oral antibiotics for the treatment of acne vulgaris by general practices across one Integrated Care Board

Motta M, and Wilcock M.



Scan the QR code to access Prescribing Information.
This communication is intended for UK healthcare professionals only.
Information for Adverse Event Reporting can be found at the end of this document.

Discover savings of up to **29%** - only by prescribing

Zyduco® XL[1-6]

Mesalazine 1200mg Gastro-Resistant Prolonged-Release Tablets

zydus Pharmaceuticals UK

Zyduco® XL[1-6]

- Bioequivalent to Mezavant® XL[3]
- Significant cost savings for both CCGs and ICBs[4-6]
- Zyduco® XL is readily available through all mainline wholesalers
- Robust supply chain to allow continuity of supply for prescribers and patients
- Additional 120 Tablet Pack Size offering savings of 29%[4-6]

Price per 60 tablets		Potential Cost Saving using Zyduco® XL
Mezavant® XL 1200mg	**Zyduco® XL 1200mg***	
£42.95	£31.35	£11.60
		27%

Price per 120 tablets		Potential Cost Saving using Zyduco® XL
Mezavant® XL 1200mg	**Zyduco® XL 1200mg***	
£85.90	£60.95	£24.95
		29%

Only by prescribing Zyduco XL[1,2,4-6] by brand can you unlock savings on mesalazine gastro-resistant prolonged release for your CCG and ICBs

Contact us to find out more:
Email: sales@zydusuk.com Phone: 01530 432398

Data correct as per prices listed online for 1200 mg preparation(s), accessed Mar 2025.[5-6] *For cost comparison purposes, "cost per 60 units" was calculated by dividing the published cost per number of tablets to gain individual tablet cost, then multiplying by 60.[4-6] For cost comparison purposes, "cost per 120 units" was calculated by dividing the published cost per number of tablets to gain individual tablet cost, then multiplying by 120.[4-6] For Mezavant® XL £42.95 per 60 tablets is equivalent to £0.72 per tablet.

Indications: Indicated for the induction and maintenance of clinical and endoscopic remission in patients with mild to moderate, active ulcerative colitis[1] **References**: 1. Zyduco® XL. Summary of Product Characteristics. https://www.medicines.org.uk/emc/product/100638/smpc [Accessed March 2025] 2. Mezavant® XL 1200 mg. Summary of Product Characteristics. https://www.medicines.org.uk/emc/product/6154/smpc [Accessed March 2025] 3. Data on File (D1). Zydus Pharmaceuticals UK Ltd. [Bioequivalence data] 4. Data on File (D2). Zydus Pharmaceuticals UK Ltd. [Cost Calculation Tool] 5. https://dmd-browser.nhsbsa.nhs.uk/ [Accessed March 2025] 6. https://www.drugtariff.nhsbsa.nhs.uk/#/00883669-DC/DC00883665/Home [Accessed March 2025]

Date of Preparation: December 2025 Code: ZUK/ZXL/ADV/25/12/01

Contents

PM Healthcare
PROGRESS THROUGH PARTNERSHIP

As a reader of PM Healthcare Journal, stay connected by following us on Linkedin and discovering our new blog (https://www.pmhealthcare.co.uk/blog/)

We regularly post commentary and opinions on pharmacy, the NHS and healthcare across the UK, and also updates on articles and features in PM Healthcare Journal. Join us on social media to keep up to date with:

- Updates on PM Healthcare events, webinars and activity
- The latest developments in all pharmacy sectors
- ICS and ICB developments
- Issues affecting medicines optimisation and the supply of medicines
- The sharing of ideas and viewpoints on healthcare
- Best practice and shared expertise

Do you have an idea for an article or an area that you think we ought to be covering in the Journal?

If you have an idea for an article that you would like to discuss then please get in touch to see if we can include it in the Journal.

We are very keen to support healthcare professional who want to write about:

- Their experiences working in pharmacy and the related professions
- Examples of best practice
- Ideas and innovations that have improved patient care
- Clinical studies and papers that are of interest to a HCP audience, with a focus on pharmacy
- ICS/ICB-led initiatives in pharmacy, medicines optimisation and management
- System changes and reforms that have improved patient care locally and are capable of being scaled up
- Career development stories that will inspire the next generation of pharmacy graduates
- Opinions and commentary from those delivering services

These are just a few of the areas that are of interest to our readers and that contribute to our objective of bringing you insightful and relevant content that translates into best practice and practical application.

Please contact me with ideas at:

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

Editorial

As we step bravely into 2026 we could be forgiven for experiencing a sense of healthcare déjà vu.

The challenges in the NHS persistently run hot and remain very much the same – workforce shortages, long waits and relentless pressure on emergency care. These have become the backbeat of a system still under pressure, despite talk of recovery and reform. And we have yet to get to the bottom of ICS/ICB mergers, as operational changes take effect but the required system-changing legislation is still being decided.

For pharmacy and other sectors, pressures are not abstract but show up every day in busier dispensaries, waiting lists, busier wards and more complex patients, many of whom find accessing services increasingly difficult.

A major milestone this year will be newly qualified pharmacists graduating as independent prescribers, a development that may be transformative at a time when access to primary care services is stretched. This new opportunity must be offset by the reality of many pharmacies struggling, especially in the community setting where expectations are high but support may not be forthcoming. Asking pharmacy to do more is one thing, resourcing it properly is another.

In our first Journal of 2026:

- The National Pharmacy Association provides an expert and insightful article on the opportunities and challenges facing the community pharmacy sector.
- In 'Lift and Shift', Gloucestershire Hospitals NHS Foundation Trust and Sciensus Pharma describe how their collaboration led to efficiencies and savings in the use of biosimilars.
- South-West London ICB explains how it has pioneered a holistic digital strategy that has optimised patient outcomes for high-cost drugs.
- A review of the prescribing of oral antibiotics for the treatment of acne by general practices across one ICB outlines the impact of incentivising practices to identify and review patients to ascertain if management was in line with NICE guidance.
- Dr. Priya Kumar, GP Partner at Kumar Medical Centre, describes how it implemented the Johns Hopkins ACG® System to redesign urgent care and QoF processes to address patient complexity and population health more effectively.
- And Rachael Lemon advocates that pharmacists need to be properly trained and have their own wellbeing supported when they provide care for patients who have experienced trauma.

As ever, our objective is to provide you with insights that translate into examples of best practice and real-world experience. If you have an idea for an article that you would like to share, then please get in touch.

Link to the latest Journal here: https://www.pmhealthcare.co.uk/journals/ and to our new blog here: https://www.pmhealthcare.co.uk/blog/

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

The Future of Community Pharmacy in England

Henry Gregg and contributors from the NPA executive team

About the NPA

The National Pharmacy Association is the representative voice of independent community pharmacies across the UK and a key provider of services to the wider community pharmacy sector, including education and training. More than half of pharmacies are family owned and run, small to medium sized organisations - the large majority of which are NPA members. The NPA has been at the heart of the community pharmacy sector for over 100 years.

Website: https://www.npa.co.uk/

The long history of community pharmacy

Community pharmacy has served people conveniently and effectively for generations and is now relied upon more than ever.

It's been a story of constant change. The founders of the National Pharmacy Association, over 100 years ago, could hardly have imagined what today's pharmacists are doing to keep people well and save lives.

Would they have foreseen pharmacy-based vaccinations, remote consultations, pharmacist prescribing and being part of a supply chain that stretches around the globe?

Covid-19 rapidly accelerated numerous developments in pharmacy business and practice. Pharmacies became the default first port of call for many people unable to get a convenient face to face appointment with their GP during the pandemic. Pharmacists are now advising on a wider range of illnesses and making interventions more typically associated with doctors and nurses.

Looking to the future

Looking to the future, pharmacies need to be progressive and modern, while at the same time being true to the historic values of pharmacy as a personal, caring profession.

The National Pharmacy Association therefore wants to see tech-enabled community pharmacies, better integrated with other health services, operating efficiently as neighbourhood health and wellbeing centres, providing excellent patient care and recognised as 'the front door to the NHS'.

There are short and long term opportunities across many spheres of service provision, from public health (including vaccinations), minor illness, urgent care and long term conditions.

> **"Our own research report, published this year by the York Health Economic Consortium (University of York), showed that community pharmacists could save the NHS billions of pounds and improve patient outcomes, given further investment in medicines checks. Experts gathered in Westminster in November, to discuss the findings. By expanding the role of community pharmacy in medicines optimisation, we can generate substantial opportunity cost savings for the NHS while simultaneously improving health outcomes for patients."**

Other NPA reports this year have described in detail the opportunities to improve women's health and to reduce health inequalities. *'Our Mission to Tackle Health Inequalities'* follows a meeting chaired for us by Professor Maggie Rae, former President of the Faculty of Public Health. It is both a commitment by community pharmacy to help tackle health inequalities and an appeal for targeted investment by the Government and local commissioners.

Calling for bold action that builds on interventions we know work well, the report cites smoking quits, sexual health, vaccinations and health checks as areas for growth. It concludes: "Collectively, we are on a mission to tackle health inequalities, which for too long have been allowed to fester in society and failed the people who need help the most."

The prospect of much more widespread independent prescribing capacity from this year could significantly accelerate the process of turning this vision into reality.

The NPA sees independent prescribing as an essential element of the future clinical offer in community pharmacies. It allows pharmacists to provide complete solutions to patients, rather than having to refer elsewhere and prolong the episode of care. People can enjoy a more convenient service in relation to treating acute illness and managing long term conditions.

The move for all newly qualified pharmacists to be independent prescribers could mark a stepchange, if there are widespread opportunities to apply prescribing skills within properly funded services.

Financial barriers

All this may look rather out of reach for a typical community pharmacy in England, struggling to make ends meet. Current financial pressures cast doubt on the sustainability of the network, after years of cuts.

More than 1,400 pharmacies have closed in a decade and most are now running at a loss. Despite recent positive moves on the funding front, NPA surveys show many pharmacies are teetering on the brink; they need more support if they are to survive and achieve their full potential. It's clear that the scale of the challenge this government has inherited is enormous.

Urgent action is required to stabilise pharmacies and to realise opportunities for reform and service improvement. To secure the future we all want, there needs to be renewed investment from government and the NHS.

The NPA has welcomed a new parliamentary report into the future of community pharmacy in England, which makes a series of recommendations to support pharmacies and their patients.

This timely paper from the All Party Pharmacy Group in parliament (*The Future of Community Pharmacy in England, November 2025*) amounts to a rallying cry for action to save the nation's community pharmacy network, which has so much to offer patients and the wider healthcare system.

The APPG is very clear about the importance of closing pharmacies' funding gap and reforming our broken NHS contract. With this report, MPs are calling for prompt action to get community pharmacy off its knees and into a position whereby we can deliver on the 10 Year Health Plan for England.

The APPG lays out the stark current reality of financial gloom and workforce pressures. Yet their report is not a counsel of despair – it describes how a properly supported pharmacy network can be an enormous force for good in our communities, now and long into the future.

Resilience of independent pharmacies to survive

Despite the enormous financial pressures, independent pharmacies are leveraging their local relationships and community knowledge to stay strong in the market.

Their willingness to go the extra mile to provide personalised care and clinical services also seems to be helping their position.

Although independents, including independent multiples, are adaptable and resilient, that doesn't mean they are guaranteed to withstand continued underfunding. They need a much improved contractual settlement to help them survive and thrive in the near and long term.

Health Tech - a disrupter

The future also demands that we move swiftly to adopt new technologies in our pharmacy business and practice – as the world moves on and sweeps old certainties away.

With the disruptive advance of Artificial Intelligence, the long term future may be determined by developments in tech that are beyond the thinking of most current policy makers and investors.

> **"The NPA has recently entered into a range of business partnerships with tech providers, to ensure that the national chains don't steal a march on forward-thinking independents, for example in relation to patient apps."**

At the same time, there are certain enduring values that people cherish. For example we know from our own surveys that 80% of people say it is important to have face-to-face contact with their pharmacist. Community pharmacy's face to face, no appointment necessary offering is something to prize and we must never lose the human touch in health care.

10 Year Health Plan for England – opportunities

The 10 Year Health Plan for England presents a strategic opportunity for the community pharmacy sector.

Ministers are right to want to shift resources to primary care and community services. Investing those resources in NHS Community Pharmacy will deliver a major return on that investment at pace.

Investing in pharmacies would drive the shift of our NHS away from a model geared towards late diagnosis and treatment, to a model where more services and preventative interventions are delivered in local communities.

Meanwhile, the Health Secretary has promised to "tackle the social determinants of health, halving

the gap in healthy life expectancy between the richest and poorest regions in England". The NHS community pharmacy network, though markedly depleted by real terms cuts of recent times, still provides the most significant community outreach in the health system.

Investing in the local NHS pharmacy network will cut primary care waiting times during this Parliament and make meaningful progress towards ending the 8.00am scramble for a GP appointment faced by millions of people – as well as relieving pressure on the country's busy hospitals.

Meanwhile successive NHS-commissioned reviews have pointed to a greater role for community pharmacy in prevention, mental health and tackling the 'big killers' including heart disease and cancer. The Health Select Committee concluded that "community pharmacy has vast amounts of untapped potential and additional services could be delivered".

Many pharmacies are already reinventing themselves as neighbourhood health hubs, just as they rapidly reinvented themselves as the 'front door to the NHS' during the covid pandemic.

However, community pharmacy needs investment and contractual reform to unleash its full potential and become the fundamentally change-making solution it can be.

In our view, it is a sensible ambition to aim to shift more NHS support into community settings, in line with the 10 Year Health Plan. This can make healthcare more convenient for patients and much better value for taxpayers.

The community pharmacy network must be a key part of this transformation.

The investment needed to turbo-charge community pharmacies is very modest compared to the overall NHS budget and can bring swift returns.

So, the NPA is pressing for the pharmacy service developments outlined in the plan to be properly funded - and for serious contractual reform that ensures pharmacies are financially sustainable.

Here are some of the things the NPA is advising our members in England to do, following publication of the 10 Year Plan, to prepare their pharmacies for the journey ahead:

1. Examine and if necessary re-tune your skill-mix, to take into account the clinical direction laid out in the 10 Year Health Plan. Above all, get yourself, or members of your team, qualified as an independent prescriber.

2. Update your premises so that it is a suitably clinical environment for providing a range of NHS services. Think about your consultation room(s) and also whether the rest of the pharmacy is uncluttered. Also consider whether all the (non-medicinal) products that you have displayed for sale are really suited to a clinical, healthcare environment.

3. Think about how to develop and maintain positive relationships with your local GPs, who, under the Plan, are likely to retain a central position in NHS commissioning and delivery (and referrals into services including community pharmacy).

4. Consider whether automation of routine tasks could free up pharmacist time for clinical care.

5. Satisfy yourself that your knowledge and skills are up to date in relation to the long term conditions that the Plan hints will need pharmacist input: this includes treatment of obesity, high blood pressure, high cholesterol, screening for risk of cardiovascular disease and diabetes.

We do recognise that some of these steps require a financial investment – which is a big ask given the current state of pharmacy finances in England.

What's more, the future of community pharmacy is by no means entirely in our own hands as a sector. It has frequently been noted that there is a system-wide undervaluing of pharmacy's clinical role – which regards pharmacy as transactional rather than clinical.

This was admitted by former Health Secretary, Matt Hancock, who told the Covid-19 Inquiry this year that community pharmacists were treated as an 'afterthought' and identified a 'lack of enthusiasm' within NHS England senior management to resource the sector adequately.

Ultimately we see the future of community pharmacy across the UK as an integrated, clinically-focused service, successfully balancing NHS and private provision – and thriving.

Conclusion

As noted at the top of this article, anyone visiting their local pharmacist a century ago would have encountered a very different scene to a modern pharmacy. It's a racing certainty that change will continue into the future.

As for the NPA, we see it as our duty to help drive community pharmacy even further forwards; to help the sector continue its evolution as a patient-facing health and wellbeing service, to meet the ever-changing needs of the UK population and to secure the sector's position as a core component of primary care and public health.

Change is inevitable, and desirable, but rarely easy. That's why the NPA is providing practical, actionable advice on how to make our members' pharmacy businesses stronger today and resilient for the big changes that are coming. Our Future Pharmacy Network has detailed guides to business change, setting up private and NHS services, and a wealth of exclusive insight into what the public wants and needs from pharmacy.

The future is going to be clinical - given the necessary investment, substantial and sustained. It's going to be about integrated, patient-facing and community-based services, married to medicines supply. Patient groups have consistently called for an expansion of pharmacy services, as have many other key stakeholders.

By playing to their strengths as accessible clinicians, independent pharmacies can grow together as the beating heart of community-based healthcare in the UK.

The picture in Scotland, Wales and Northern Ireland

Many of the challenges and opportunities in England are similar elsewhere in the UK, and that includes acute problems with workforce capacity. However, the issues are substantially different in some ways.

This short description from the NPA's manager in Northern Ireland gives one point of comparison:

The biggest challenge for community pharmacy in Northern Ireland continues to be the mounting financial pressures due to long-term underfunding, exacerbated by increasing costs.

It is acknowledged that the current contract and application of the English drug tariff means that many face an uncertain future.

There are also challenges posed by the slow roll out of an integrated digital system across primary care and the delays by the Pharmaceutical Society NI in establishing a register for pharmacy technicians.

There are many opportunities for the sector, especially within the DoH new Neighbourhood Model of Health as part of Health Service reset measures. With an increase in access to Pharmacist Independent Prescribers there is a significant opportunity to improve patient's access to care.

‘Lift and Shift’: A collaboration between the NHS and Sciensus Pharma, Biosimilar Switch

Authors:

Idris Bobat, Lead Pharmacist Homecare & Medication Safety, Gloucestershire Hospitals NHS Foundation Trust (GHFT).

Idris is the Lead Pharmacist for Homecare and Medication Safety at Gloucestershire Hospitals NHS Foundation Trust.

He has a passion for optimising homecare pathways and processes, working as champion for the South West Homecare collaborative. Working with homecare providers, Idris has helped lead and innovate biosimilar/generic transitions via homecare.

Debbie Goodwin, Head of NHS Service Development, Sciensus Pharma.

Debbie Goodwin is the Head of NHS Service Development at Sciensus, working in collaboration with the NHS to support the delivery of innovative solutions that add value to the NHS and the patients.

Debbie is passionate about working with the NHS to deliver scalable solutions that align to NHS priorities. This reaches from clinically led solutions, to the development of digital enhancements that benefit both NHS and patients.

Susan Gibert MRPharmS Ind Pres., Director of Customer Experience, Sciensus Pharma.

Susan is the Director of Customer Experience at Sciensus Pharma. She represents the clinical homecare sector on the Royal Pharmaceutical Society Hospital Expert Advisory Group (RPS HEAG) and is a Director of the National Clinical Homecare Association (NCHA). Prior to joining Sciensus she managed clinical homecare services in an NHS Trust, in regional procurement and nationally as the chair of the National Homecare Medicines Committee (NHMC).

Susan is passionate about clinical homecare medicines services and would like the NHS to maximise the benefits that can be realised by improving patient access to medicines whilst prioritising medicines optimisation initiatives.

(Acknowledgement of kind permission from RxInfo for the reproduction of graphical illustrations included in this report.)

Introduction

With the advent of biosimilar medicines, the NHS has been able to achieve millions of pounds in savings each year by switching patients from an originator product to a biosimilar.[1]

Biosimilar medicines tend to be less expensive than the originator biologic medicine, due to the lack of necessity for the biosimilar product revenue to fund the original research costs for that molecule. NHS England (NHSE) estimates over five years from 2024-29 there is a potential £1bn to be saved from the uptake of biosimilars.[2]

However, such switches can come with a huge administrative burden. Administrative functions can delay (and in some cases prevent) an efficient switch programme from taking place. Given that timely and efficient switches offer the maximum opportunity to release savings there is a risk that the NHS is missing an opportunity not to realise the maximum savings afforded by biosimilars due to intensive administrative processes. Sciensus Pharma has collaborated with hospitals in the UK, supporting switches over the past several years. With the wealth of expertise, foresight and innovative attitude within Sciensus these switches have become progressively more sophisticated, automated and efficient.

Learnings taken from three of the most recent biosimilar and generic switches for fingolimod, dimethyl fumarate and tocilizumab, culminated in a joint project with Gloucestershire Hospitals NHS Foundation Trust (GHFT) for a recent ustekinumab switch.

This collaboration facilitated a much faster, more efficient switch to biosimilar ustekinumab leading to additional savings to the hospital of £500k as the switch was carried out over 3 months rather than 6 months.

"Gloucestershire Hospitals NHS Foundation Trust (GHFT) is an acute secondary care provider in Gloucestershire comprising of two large hospitals, Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH). The two hospitals are approximately eight miles apart in their respective city/town."

There are over 900 inpatient beds, with the trust employing over 8,000 staff and the acute trust provides services to a population of over 700,000.

The Trust has two onsite pharmacy departments, one at each acute hospital. There are over 250 pharmacy staff members cross-site. The Trust has a dedicated pharmacy homecare team/department who are responsible for care of over 7,000 homecare patients.

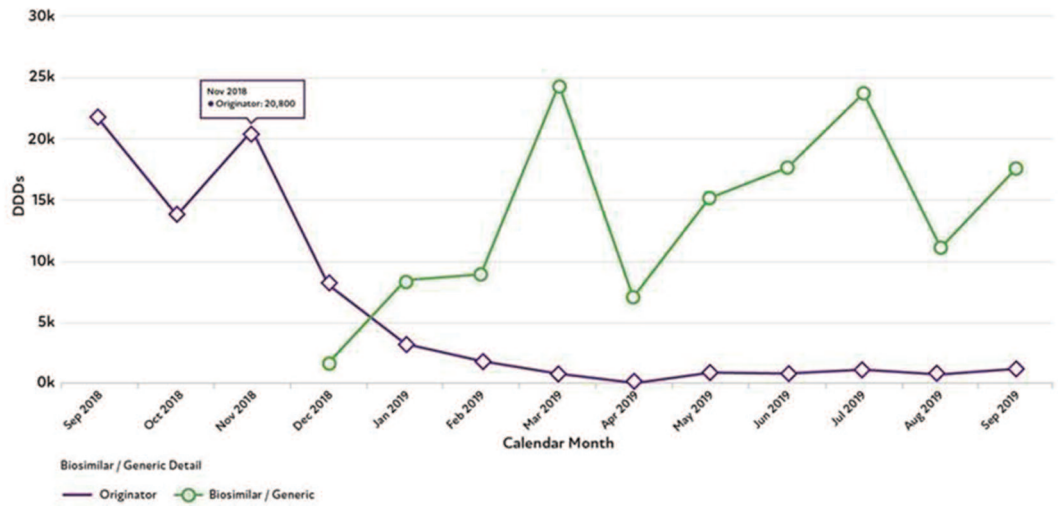
Background

In 2018, adalimumab was one of the first biosimilars to be subject to high volume patient switching. At the time there were approximately 60,000 patients taking the originator brand who were switched to one of the adalimumab biosimilar products. This switch involved many patients having to attend an additional hospital out-patient appointment for a clinical review as well as the completion of new prescriptions and homecare registration documents. The additional appointments and documentation added an additional administrative burden and cost to the NHS process, as well as inconvenience for the patients.

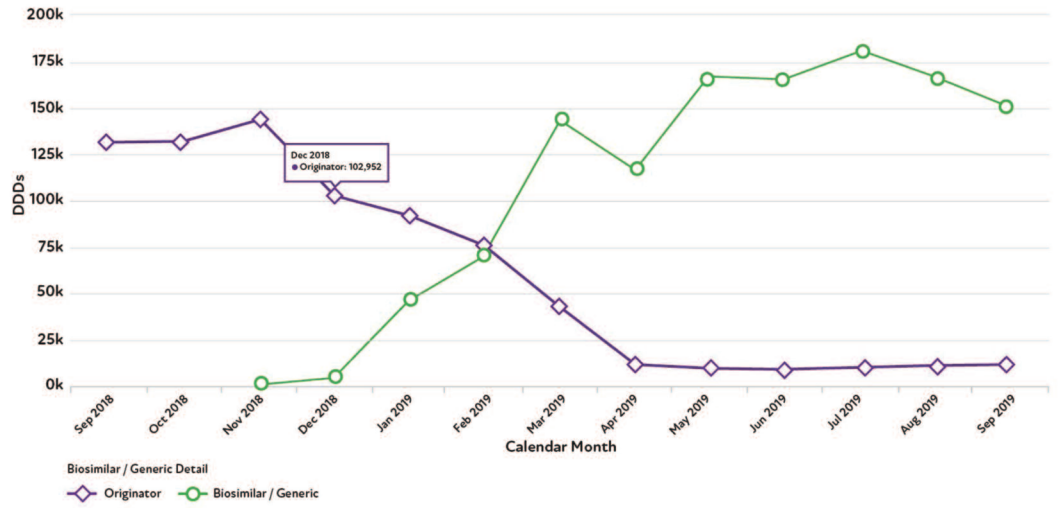
At the time, Sciensus Pharma were providing a homecare medicines service to approximately 90% of the total adalimumab population. With meticulous planning, the UK wide switch was carried out safely over an extended period of approximately 18 months. As expected, this switch occurred more slowly than subsequent switches as confidence in biosimilar medicines had not yet been established. Despite these restrictions, the NHS still saved an estimated £300m from this switch.[3,4]

Sciensus worked with GHFT and other South West Trusts as part of the regional homecare contracts, to ensure the needs of the NHS were met and transition to biosimilar occurred as safely and efficiently as possible.

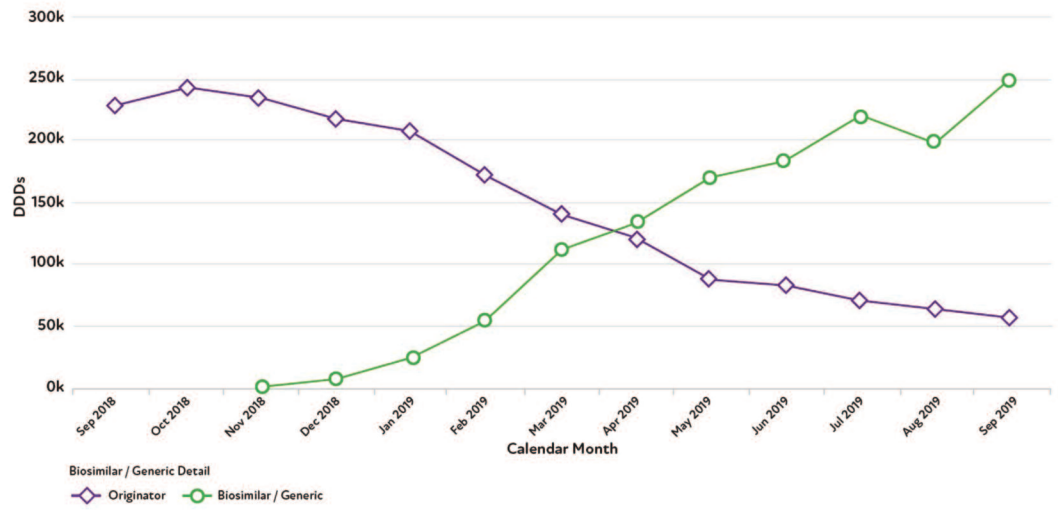
The graphs below show the uptake of biosimilar adalimumab at GHFT, the South West region, and Trusts in England that are a similar size and type to GHFT.



GHFT adalimumab switches



South West adalimumab switches



National adalimumab switches from hospitals of a similar size and type to GHFT

These graphs demonstrate that switching >90% patients took approximately 9 months to complete nationally and 3- 4 months for GHT and other Trusts within the South West.

Switching from originator products to biosimilars has now become routine for both clinicians and patients, but the administrative burden for the NHS clinical teams, Pharmacy Homecare teams and homecare providers remains.

The evolution of automated lift and shift

The table below summarises how learnings from switches were used by Sciensus to increase the efficiency of the next planned switch. Not only were the switches progressively more automated and more efficient, but the savings were realised earlier for the NHS whilst at the same time requiring less resource.

The earlier the switch is implemented; the more recurrent savings can be realised for the NHS.

Switched molecule	Brief description	Process	Number of patients	Timeframe	NHS switch resource costs	Saving to Gloucestershire Hospitals NHS FT (£)
Fingolimod	No digital enhancement. No change of homecare provider.	NHS submitted Shortened prescriptions for the originator and then re-wrote and submitted new prescriptions for the generic.	80	6 months planning. 3 months for full switch.	Duplication of effort by NHS prescribers and pharmacy homecare teams: **Clinicians** Supply of shorter duration prescriptions Supply of new prescriptions. **Pharmacy Teams** Clinical validation of additional prescriptions Additional Purchase Order Numbers (PON) raised.	£100k per month. No additional savings were realised as this switch was carried out over the expected duration.
Dimethyl Fumarate	Annotated prescriptions. No change of homecare provider.	Sciensus annotated prescriptions written for the originator so that a generic could be supplied. The prescribers' intention was clear, and permission sought from NHS Chief Pharmacist.	150	<2 months for full switch.	Provided prescribers intention/decision to switch list of agreed patients. Permission from Chief Pharmacist to annotate prescriptions.	GHFT incentivised by NHSE as part of IPOC scheme. Switch compared to average switch rate. Over £400k savings.

Switched molecule	Brief description	Process	Number of patients	Timeframe	NHS switch resource costs	Saving to Gloucestershire Hospitals NHS FT (£)
Tocilizumab	Hybrid Pharmacist Non-Medical Prescriber pilot Lift and Shift. Change of homecare provider from incumbent to Sciensus.	Originator prescriptions submitted to incumbent homecare provider. Hard stop for the supply of originator by incumbent homecare provider. From an agreed date Sciensus wrote all continuation prescriptions for the biosimilar. Prescriptions sent electronically from Sciensus to NHS Hospital for signing using e-sign type system and the returned to Sciensus via e-sign system.	110	All patients switched from chosen day.	Provided prescribers intention/decision to switch list of agreed patients. Agreement from NHS Chief Pharmacist for Sciensus to use their own IPs to write prescriptions for the biosimilar. **Clinicians** 2 or 3 prescribers - NHS hospital resource required to sign all biosimilar prescriptions via e-sign. **Pharmacy Teams** Clinical validation of additional prescriptions. Additional Purchase Order Numbers (PON) raised.	Cost avoidance of £250k per month was achieved with the efficiency of this switch. Switched at speed.
Ustekinumab	Automated Lift and Shift model with Full Non-Medical Prescriber support. Change of homecare provider from incumbent to Sciensus.	Originator prescriptions submitted to Sciensus. From an agreed date: Sciensus system automatically populated new prescriptions for each patient for the biosimilar. Patients were automatically switched from the incumbent homecare provider to a new contract on the Sciensus system. Robust governance in place to ensure that patients who required clinical training, were offered this training.	210	All patients switched from chosen day.	Limited additional NHS resource required once new service is agreed, contract signed, and switch process is put in place.	Total estimated saving £2m per annum. Additional £500k for a quicker switch realised in the first year.

Fingolimod

The fingolimod switch was started in December 2022. The 'traditional' approach was taken whereby the NHS submitted originator prescriptions with a shorter duration, so that as soon as an alternative fingolimod brand was available, a prescription for the more cost-effective brand could be supplied.

Switching using this process requires considerable additional NHS resource, both for the writing of the shorter prescriptions for the originator product as well as the re-writing of a second prescription for the generic by the prescribing clinician. Pharmacist clinical validation is required for both prescriptions followed by raising of a Pharmacy Purchase Order Number (PON) by the pharmacy homecare team on the pharmacy computer system. Given the same number of deliveries would occur, there is no extra resource required for the invoice processing stage.

"This results in a slow paced switch and a manageable workload for the NHS clinical and homecare teams. Whilst savings are generated it is at a reduced rate due to a slower rate of uptake of patients receiving the biosimilar."

Process evolution for subsequent switches

Starting from a place of reflection following the fingolimod switch, Sciensus and GHFT took the decision to discuss the simplifying of the process for the upcoming dimethyl fumarate (DMF) switch and ongoing future biosimilar switches (tocilizumab, adalimumab additional brands). Recognising that the NHS needed support and with more switches anticipated in the future, Sciensus and GHFT joined forces. Over a period of 18 months a plan was put in place which enabled Sciensus to harness the skills of their Non-Medical Prescriber (NMP) Pharmacists to write continuation and new prescriptions for the switching patients.

Dimethyl Fumarate

In December 2023, for the DMF generic switch, there was no need for GHFT clinicians to supply prescriptions of shorter duration followed by a second prescription for the generic product. Using a list of current GHFT patients, and permission from the GHFT Chief Pharmacist, the hospital indicated which patients would be suitable for the alternative, and then Sciensus pharmacists annotated each current prescription in turn, so that the more cost-effective brand could be supplied as soon as the alternative DMF brand was available. This pilot for 'Lift and Shift' was carried out not only for GHFT but for a number of trusts within the South West working as part of the regional homecare working group.

Compared to the 'traditional' approach, this collaborative approach results in a reduced need for additional time for NHS clinicians and pharmacy homecare teams. Clinicians need to be able to verify the list of current patients and indicate which are suitable for the alternative product but no additional prescription writing or other resource is necessary.

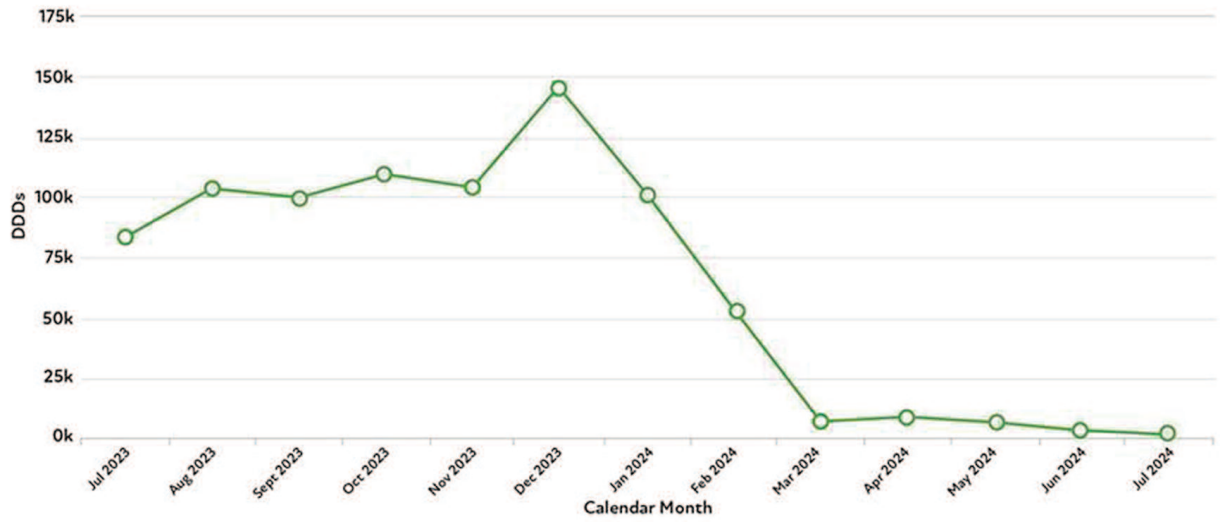
Dimethyl Fumarate cost saving

The graphs below show usage of DMF and cost savings associated with generic prescribing. It clearly shows that the pace of switch and cost saving at GHFT and South West was realised earlier in comparison to other similar size Trusts nationally. GHFT was benefitting from the maximum savings by March 2024, compared to the national savings which took until July 2024 to be realised.

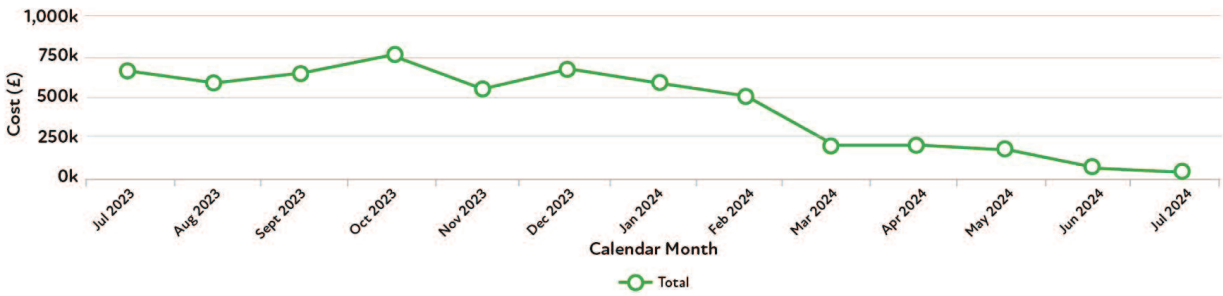
Continuous learning and development and improvement led to the next initiative.

Tocilizumab biosimilar

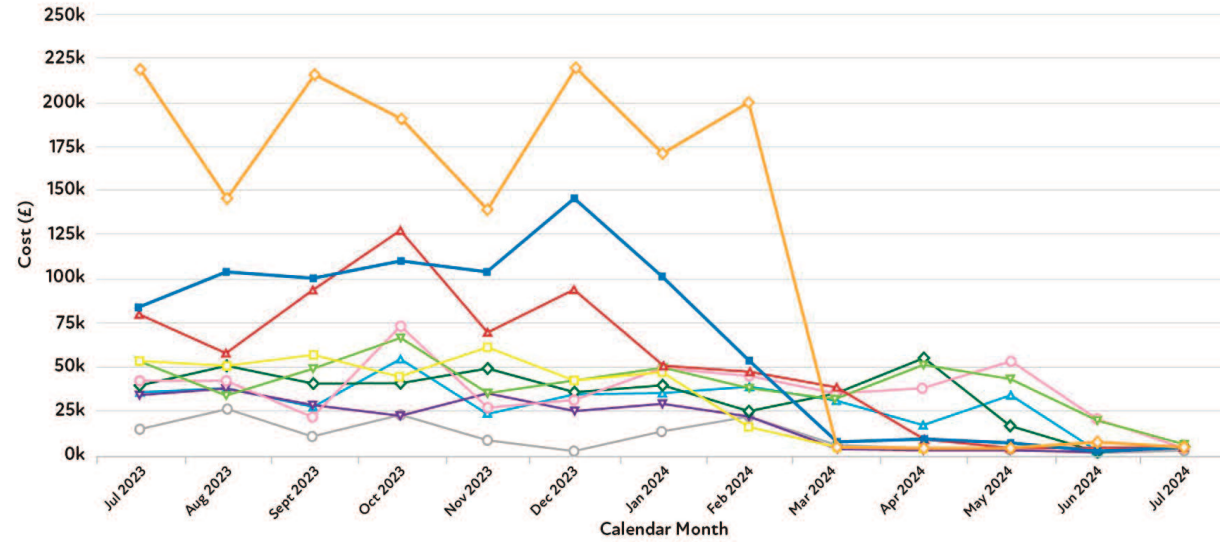
A cohort of tocilizumab patients with a different homecare provider were to be switched for both the product and the homecare provider from April 2024 onwards. The switch in product was made to utilise the most cost-effective tocilizumab product and the switch in provider to ensure the Trust was aligned to regional homecare contracts. A hard stop was put in place where the incumbent homecare provider would cease providing the service from a designated date.



DMF uptake/spend at GHFT

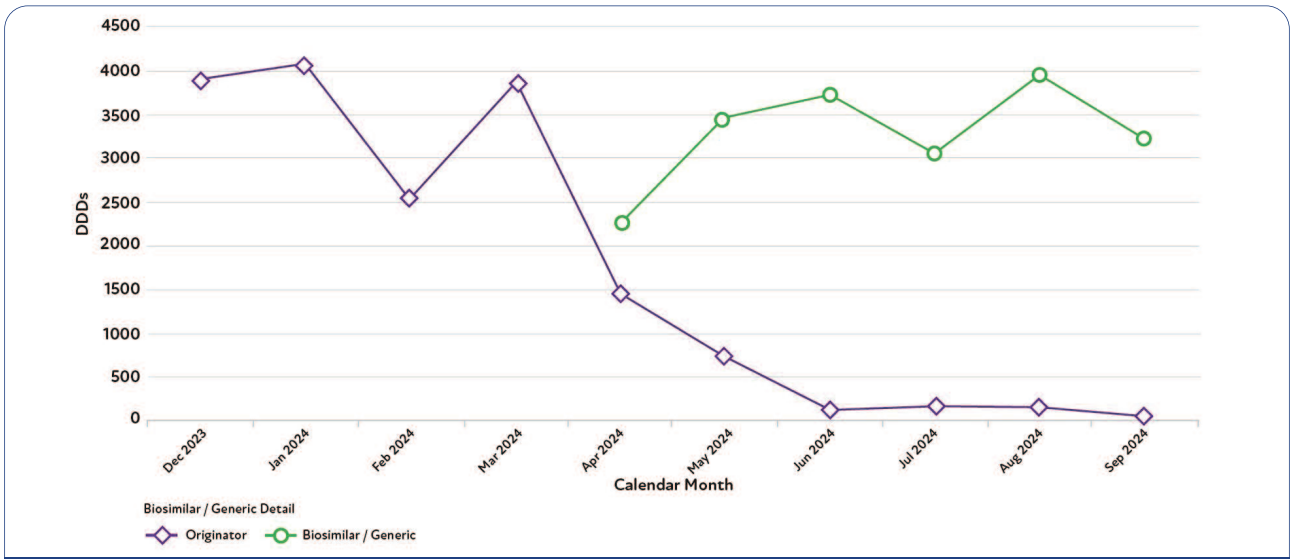


DMF uptake/spend in the South West region

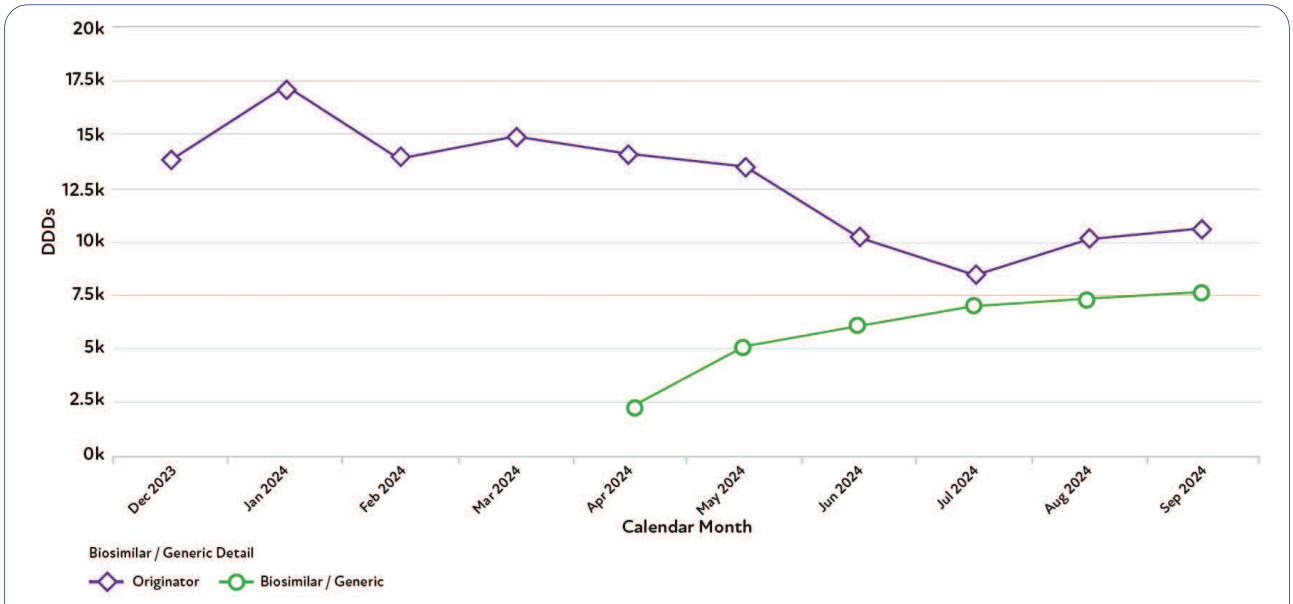


Generic DMF national uptake GHFT is the blue line with the square dots. The other coloured lines are hospitals in England of a similar size and type to GHFT.

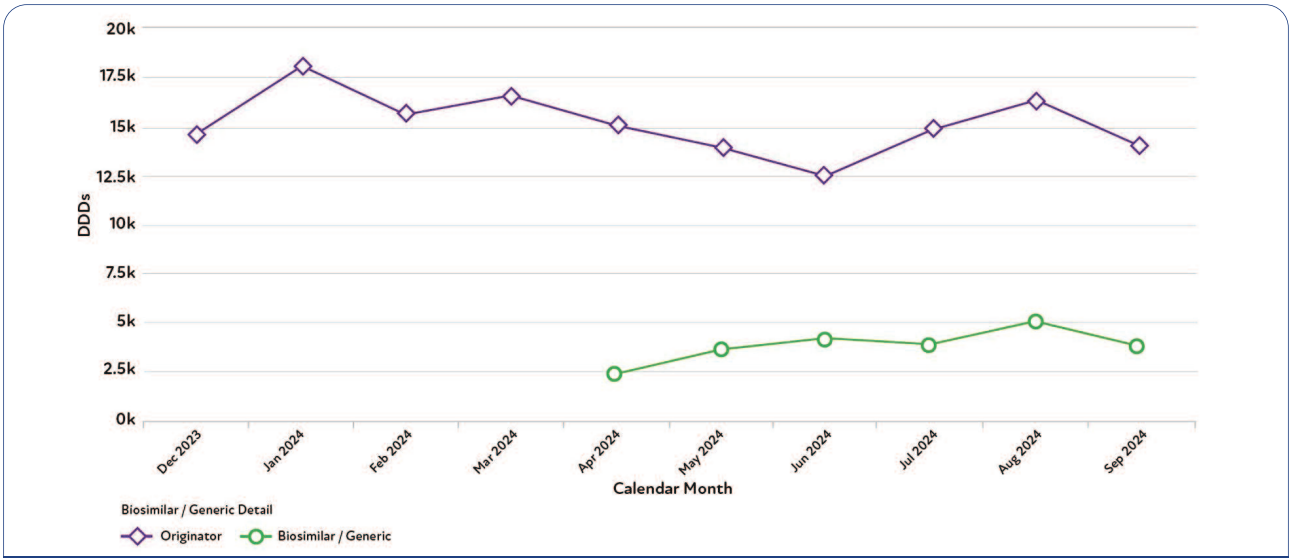
The incumbent homecare provider agreed to cease making homecare deliveries from the agreed date in March 2024, from which point a Sciensus NMP Pharmacist wrote each patient's continuation prescription for biosimilar tocilizumab. The continuation prescription was the remaining drops/deliveries left from the original originator prescription supplied to the incumbent provider. To carry out this prescribing role safely, Sciensus was sent a definitive list of patients to be onboarded to the tocilizumab biosimilar service using the verified exit data from GHFT. The Sciensus Independent Prescribers (IPs) completed all the initial biosimilar continuation prescriptions on behalf of the hospital, and these were sent electronically to 3 prescribers at the Trust. These prescribers reviewed and signed the prescriptions via E-SIGN and electronically sent them back to Sciensus.



GHFT tocilizumab uptake From April 2024 to June 2024 all eligible patients were switched to biosimilar tocilizumab. Maximum savings were achieved within 3 months of switch start



South West tocilizumab uptake. Switching to biosimilar tocilizumab started in April 2024 (GHFT data is included in this graph). By September 2024 some patients are still receiving the originator with less than 50% uptake of the biosimilar.



National tocilizumab uptake from hospitals of a similar size and type to GHFT. Similar picture to South West with more savings yet to be realised

Importantly, as the duration of the original prescription had not been altered, prescriptions were still in line with patients' bloods and clinical appointments, ensuring minimal impact to patients and clinical teams.

The speed of switch graphs below clearly demonstrate that tocilizumab biosimilar uptake was rapid and faster than either the South West region as a whole and faster than comparator Trusts of similar type and size in England.

It is worth noting that the switch of Tocilizumab regionally and nationally has been hampered by supply disruptions of the only biosimilar available. (GHFT, as one of the first trusts to go with transition to biosimilar, was fortunate to then have limited stock ring-fenced for patients who had transitioned already.)

Ustekinumab Automated lift and shift

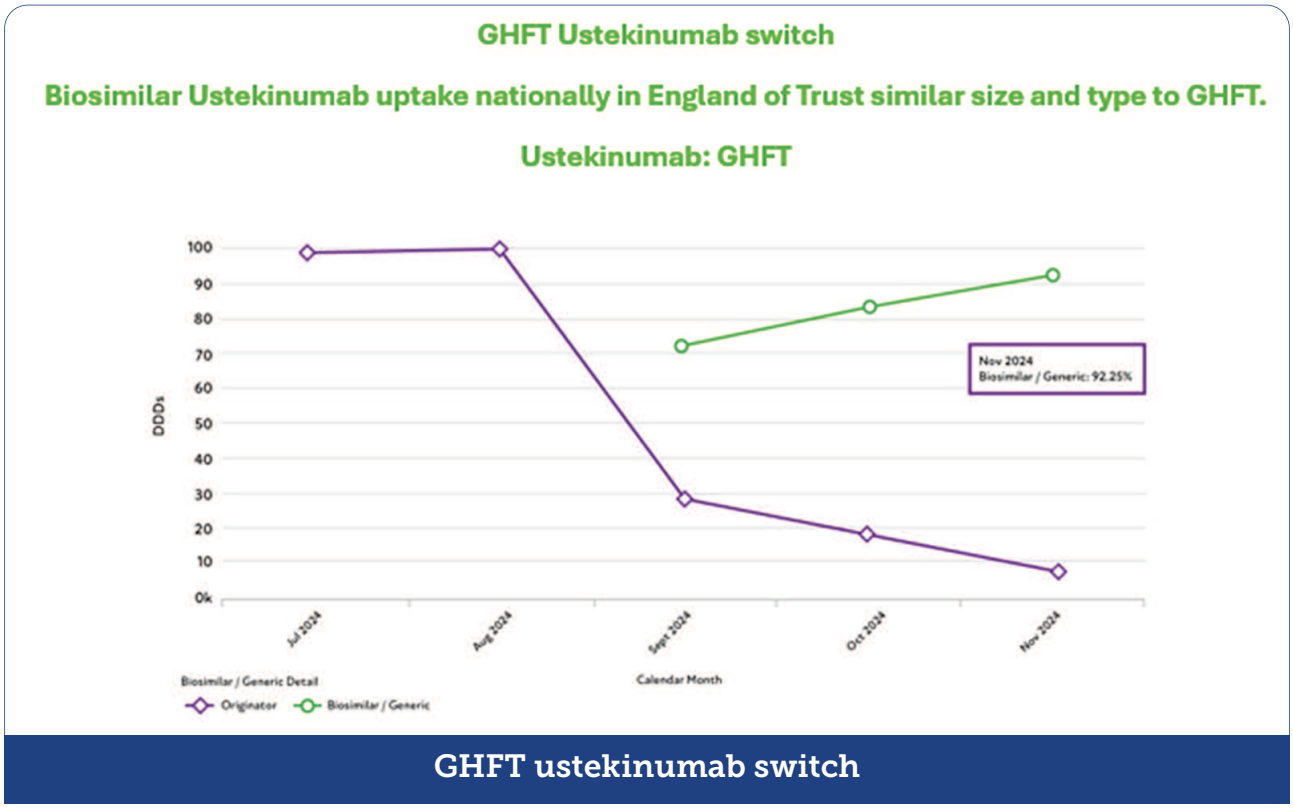
With experience from the DMF and tocilizumab switches, the process was further enhanced and the ustekinumab switch was the most sophisticated. Like tocilizumab, GHFT supplied patient exit data from the incumbent provider to Sciensus following an already established governance process that takes into consideration Information Governance and data sharing. At the launch of ustekinumab biosimilar, Sciensus was able to use an automated process which automatically pre-populated prescriptions for the GHFT patient cohort that would be switched to the biosimilar.

Following a comprehensive risk assessment, a robust process was put in place that allowed GHFT to identify the list of patients who would be switched to the biosimilar. Patients were informed of the change and patients were encouraged to access training on the new device from the Sciensus clinicians. A robust process was put in place at Sciensus to ensure that patients who required a clinical training visit were offered a suitable appointment.

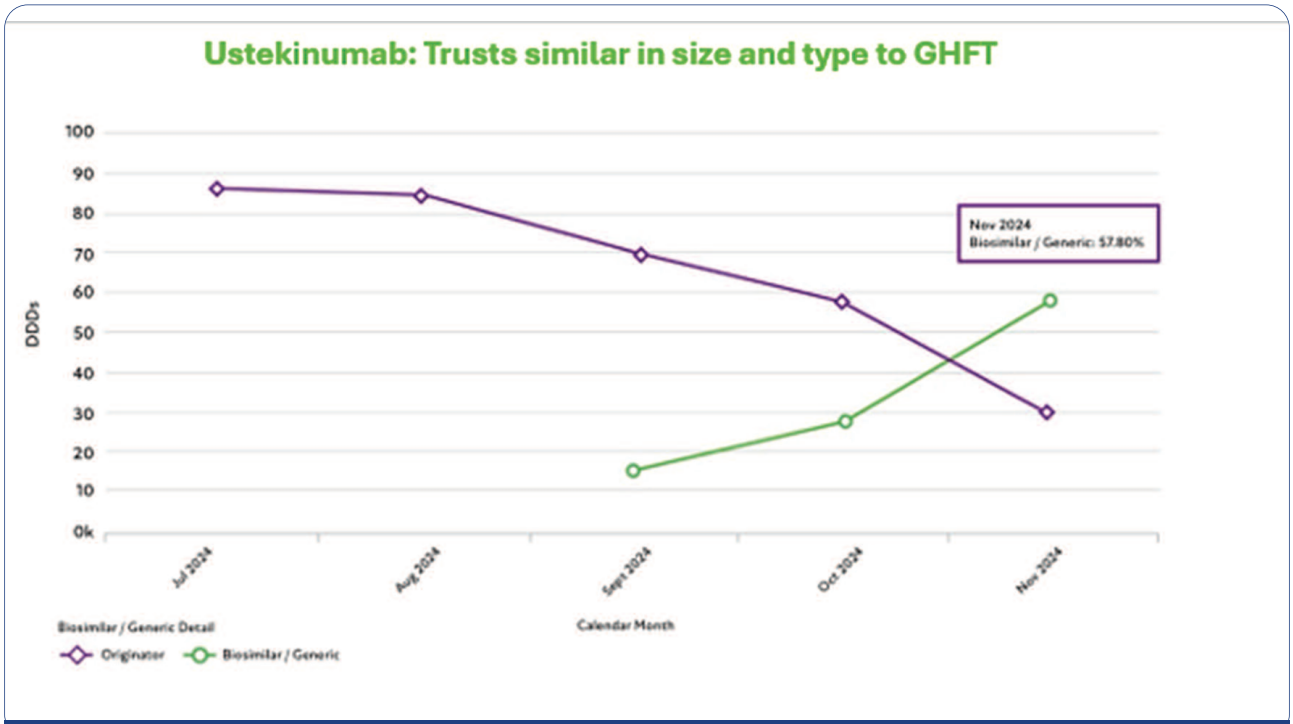
Blood test results and other clinical assessments were carried out and verified by GHFT prior to the GHFT patient list being sent to Sciensus. All new continuation prescriptions for the biosimilar were pre-populated using the Sciensus digital solution and then were clinically screened and signed at Sciensus by Sciensus Non-Medical Prescribing Pharmacists.

This approach required minimal additional resources from the NHS. The NHS clinicians do need to carry out the pre-switching preparations with their patient cohort, allowing them to raise concerns or questions about their change in medication. Blood tests and any other required clinical assessments were completed by the NHS, and the patient data was verified. All other additional steps in the switch process were completed by Sciensus.

Ustekinumab is a therapy which is routinely administered every 8 to 12 weeks and prescription durations ranging from 6 to 12 months. Historically, transitions would occur on prescription expiry and therefore switch of such therapy could take 6 to 12 months. By utilising the new embedded 'Lift and Shift' and NMP prescribing process, savings were achieved from day 1 (September 2024) of launch of biosimilar and a significantly fast paced switch. This has led to GHFT releasing an additional £500k savings.



GHFT ustekinumab switch



Biosimilar ustekinumab uptake nationally in England of Trusts similar size and type to GHFT

The graph above shows by November 2024, 92.5% of ustekinumab use at GHFT was of biosimilar ustekinumab (remaining 7.5% is where biosimilar is not licensed in UC use). In comparison, similar size Trust to GHFT nationally, 52.8% of ustekinumab use was biosimilar.

Purchase Orders

From a pharmacy homecare team perspective, a certain amount of flexibility is required when switching as the product delivered would not match the product on the original Pharmacy Purchase Order. There is a need for the pharmacy computer system to either accept amendments to Purchase Orders, or a mechanism for the pharmacy homecare team to be able to cancel the original Purchase Order and then raise either a prospective or retrospective Purchase Order for the new product.

Where there is no change to the homecare provider, Sciensus can provide a report which details the number of instalments remaining on the original prescription, so that hospitals can raise a prospective Purchase Order for the remaining instalments of the new product. Where this is not possible, the NHS hospital would raise a retrospective Purchase Order on receipt of the invoice.

The amendment of, or re-creation of the Purchase Orders for the alternative product does require some additional work for the Pharmacy Homecare Team. It is important to note that the value of the original and new Purchase Orders would not exceed the value of the original Purchase Order.

Metrics

In addition to the reduction in drug spend generated by early switching, there are considerable time savings for NHS hospitals when the homecare provider prepares the new prescriptions. Clinician prescribing time is saved which in turn means an eradication of the duplicated clinical validation of the new prescriptions by the NHS Pharmacy teams as shown in the table below. Patient safety is also an important factor for consideration, Sciensus monitored patient reported missed and delayed doses and recorded a reduction in this metric.

The Future

Taking learnings from each switch and maximising efficiency, GHFT and Sciensus are in a position where robust processes were well embedded. For any subsequent switches, this process will no longer be limited to Gloucestershire Hospitals but any NHS hospital wishing to take advantage of this enhanced service will be able to do so.

Governance

It is worth noting that all other biosimilar switching guidelines have been followed. Patients were fully informed of their intended switch. The decision to switch was taken by the prescribing clinician at GHFT with the patient being part of that decision making process. The clinicians' intention to switch their patient cohorts was clear and processes to ensure communication with patients including obtaining patient consent were followed at all times. For all of the above scenarios, permission was sought from NHS GHFT Chief Pharmacist.

Collaborative approach

Along this journey Sciensus and its NHS partners have listened to each other. Pathway design has been an iterative process, with minor changes along the way. The concept was tested at each stage of the process by the Sciensus Pharmacy Operations team. This initiative was implemented only when the safety of each step in the process

Brief description	Time taken: per prescription or for 1 patient	Time saved for 650 patients
Prescription generation	3 minutes	32.5 hours
Clinical validation	2 minutes	21.7 hours
Purchase Order creation	2 minutes	21.7 hours

had been thoroughly tested and deemed safe. A 'build the concept, test the concept' approach was taken.

Subsequent Biosimilar Adalimumab Lift and Shift

With one of the adalimumab biosimilar manufacturers pulling out of the UK market in 2024, NHS hospitals were obliged to switch all of their patients away from the affected product to an alternative. Without this service offering from Sciensus the short-notice administrative burden on the NHS would have put patient safety at risk. Sciensus provided support to 28 Trusts by annotating the original prescription with an alternative product for a total of 9,000 patients.

Managing Supply Disruptions Lift and Shift

With the recent recognition of the burden on NHS resource that is required to safely manage the number of medicine supply disruptions in the homecare medicines sector, being able to support the NHS to switch patients to an alternative medicine is advantageous.[5] In these instances, beyond communicating the prescriber's intention for a list of patients who are to be provided with an alternative medicine, the NHS has very little interaction. Sciensus can reliably provide the prescribing and supply capability to the NHS.

Advantages of Automated Lift and Shift

- Time saved for the NHS – prescribing, clinical validation and administration burden

- Reduction in NHS resource, staff can carry on with Business As Usual (BAU) activities while the switch carries on in the background
- Multiple switches can be realised simultaneously
- Prescriptions are received by the homecare provider via internal processes only, allowing for instantaneous transmission of prescription to verification (screening) stage
    - Prescriptions take an average of 2 weeks from prescribing to receipt at a homecare provider
    - Hospitals using the Sciensus Connect Portal have visibility of the prescriptions for their patient cohort in almost real-time
    - The Sciensus Connect Portal allows for prescription tracking 24/7
    - The Sciensus Connect Portal allows hospitals to track deliveries to verify savings realised
- Reduction in the number of late prescriptions
    - Avoidance of patient missed and delayed doses due to late prescriptions
- Stock management – deliveries can be timed to ensure that original stock is used up
- Savings accessed in a timely manner due to efficiencies and speed of switching
- Non-Medical Prescribing Pharmacists – use their skillset which helps retention and attrition
- Streamlined processes – aids resource utilisation
- Generic and biosimilar manufacturers benefit from more efficient switches and earlier entry to the market
- Planned switching can be used to manage UK stock/supplies as required volumes of medicines can be estimated in advance
- Demonstrates good practice to the clinical homecare industry
    - Robust processes maintain patient safety whilst improving efficiency
    - Homecare providers are recognised innovators, driving service excellence

References

1. NHSE National medicines optimisation opportunities 2024/25, 7 October 2025, NHS England. https://www.england.nhs.uk/long-read/national-medicines-optimisation-opportunities-2023-24/
2. Procurement Distribution Interest Group November Symposium, Session, NHSE Medicines Value and Access, November 2024, Guild of Healthcare Pharmacists. https://www.ghp.org.uk/pdig-november-2024/
3. NHS set to save record £300 million on the NHS's highest drug spend, 26 November 2018, NHS England. https://www.england.nhs.uk/2018/11/nhs-set-to-save-record-300-million-on-the-nhss-highest-drug-spend/
4. 'Switching to 'best-value' generics and biosimilars saved the NHS £294m in 2018/2019, figures show', 04 September 2019, Pharmaceutical Journal. https://pharmaceutical-journal.com/article/news/switching-to-best-value-generics-and-biosimilars-saved-the-nhs-294m-in-2018-2019-figures-show
5. Medicine Shortages: Solutions for Empty Shelves, November 2024, Royal Pharmaceutical Society. https://www.rpharms.com/medicinesshortages

South-West London's Digital Transformation in High-Cost Drugs: Optimising Patient Outcomes Through Real-World Data

Brigitte van der Zanden (Deputy Chief Pharmacist)

After graduating as a pharmacist in the Netherlands, Brigitte developed a distinguished career in hospital pharmacy and primary care in the UK.

She has a background in hospital medicines information and was a PCT Chief Pharmacist, before taking on a regional Lead commissioning pharmacist role. She has extensive experience managing locally commissioned high-cost drugs (HCDs), a responsibility she has held since this commissioning concept was introduced. Throughout her career, she has been recognised for driving innovative system improvements in both primary and secondary care.

Brigitte is currently Deputy Chief Pharmacist with a focus on medicines value and productivity for the SWL Integrated Care System.

Brigitte van der Zanden: https://uk.linkedin.com/in/brigitte-van-der-zanden-bba41541

Vinty Amin (Head of Medicines Optimisation)

Vinty is an innovative pharmacist with expertise in medicines optimisation and a cancer specialist background. She is an independent prescriber, NICE associate, and co-author of research publications in The Journal of Oncology Pharmacy Practice and the British Journal of Pharmacology.

Experienced in different clinical specialties including primary care, she became the SWL commissioning pharmacist in 2019 and has significant knowledge of cost-effective models including cost modelling for the Nightingale London. She has led service improvements and developed various SWL HCD patient pathways.

Currently, Vinty is the Head of Medicines Optimisation for SWL Integrated Care Board, where she strives for excellence and is committed to improving quality, medicines' value, productivity, and reducing inequalities in patient care.

Email: swlhcd@swlondon.nhs.uk

Joe Coates (Lead Pharmacy Technician)

Joe started his career in secondary care and held several posts at Dartford and Gravesham NHS Trust, where he first became involved in homecare and HCDs. Joe worked briefly in a managerial role at The Royal Marsden NHS Foundation Trust before moving into a commissioning role at NEL CSU working across the London region. In 2022, Joe began his current role in South West London ICB as Lead Pharmacy Technician with a focus on form design and optimising functionality of the HCD platform used across the region.

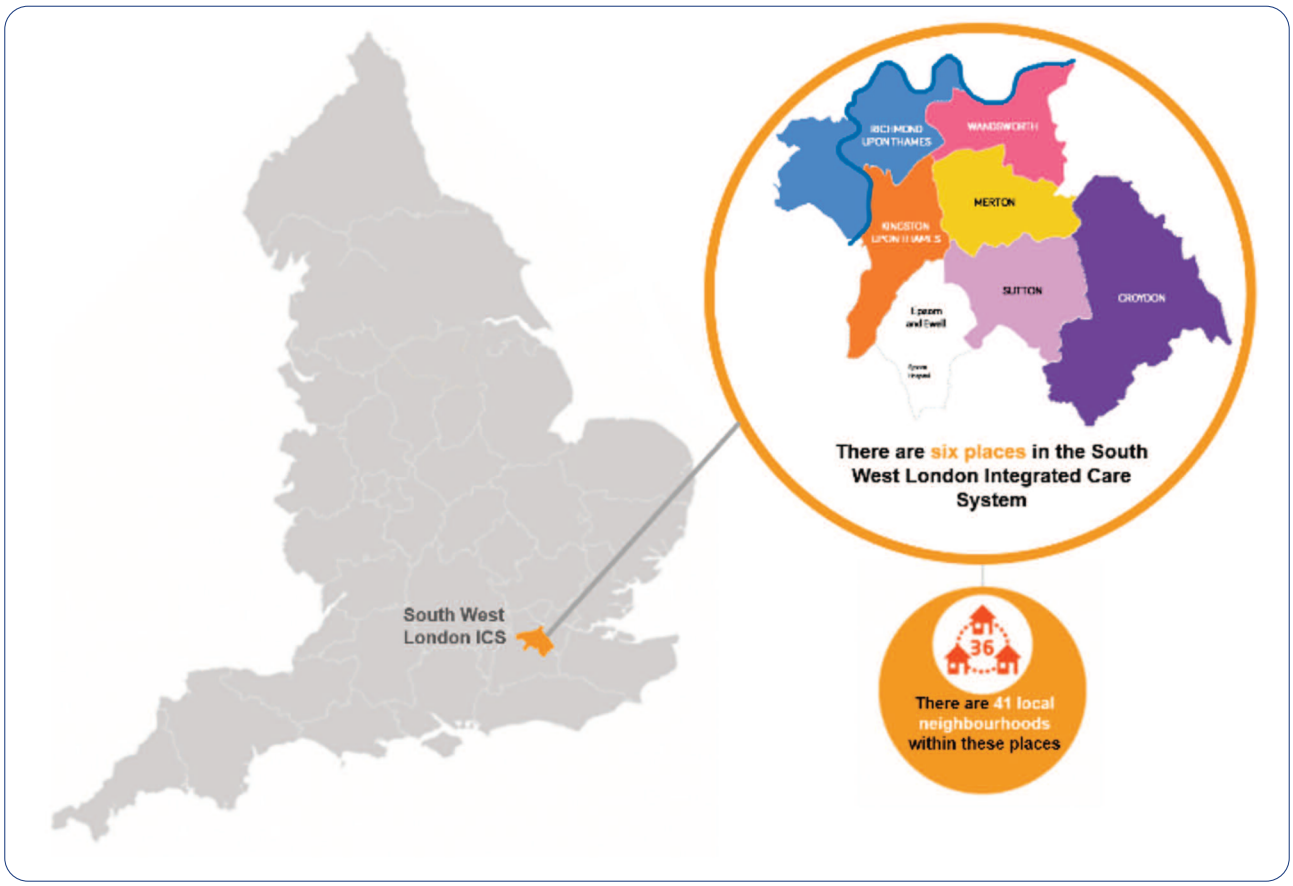
Joe Coates: https://uk.linkedin.com/in/joe-coates-2aa2861b4

Neha Patel (Lead Pharmacy Technician)

Neha has been a dedicated NHS pharmacy technician since 2001. With 13 years of hospital experience at King's College Hospital, she worked as the Medicines Finance Lead. This role involved HCD reporting and managing the homecare service. In 2017, she transitioned into commissioning with Southwest London CSU, now ICS, where she has played a key role in streamlining processes for HCDs.

Recently she has led the simplification of HCD application forms, improving efficiency and accessibility for the SWL Reform project. Looking ahead, she is focused on implementing regular audits to build a comprehensive real-world data portfolio, supporting evidence-based decision-making.

Neha Patel: https://uk.linkedin.com/in/neha-patel-1874235b



South-West London Integrated Care Board

SWL ICB: https://uk.linkedin.com/company/south-west-london-ics

HCD email: swlhcd@swlondon.nhs.uk

Project Summary

South-West London Integrated Care Board (SWL ICB) has pioneered a holistic digital strategy to optimise patient outcomes for high-cost drugs (HCDs). By transforming the HCD data platform (Blueteq®) from a prior approval tool into a live clinical audit and benchmarking system, SWL has addressed unwarranted variation, improved clinical decision-making, and enhanced medicines optimisation across multiple hospital Trusts. This project demonstrates how digital innovation, automation, and collaborative clinical engagement can drive measurable improvements in patient care, cost-effectiveness, and system-wide learning.

Introduction

Managing HCDs presents ongoing challenges for the NHS, including variation in prescribing practices, administrative burden, and the need for robust outcome data to inform commissioning decisions. SWL ICB identified opportunities for

digital transformation aimed at standardising prescribing, automating data validation, and enabling real-time clinical audit. The project brought together multidisciplinary teams from four acute hospital Trusts, with the shared goal of improving patient outcomes, reducing variation, and supporting evidence-based practice.

Current Situation and Opportunities

The SWL ICS maintains a dynamic portfolio of HCD pathways (currently 16), each regularly updated to reflect new NICE technology appraisals, drug price changes, and local commissioning decisions. SWL pathways are implemented through the HCD data platform. Prior to this initiative, SWL's HCD processes were largely manual, with repetitive data entry and significant time spent on validation and screening. The lack of objective outcome data hindered evaluation of treatment effectiveness and pathway development. By leveraging digital tools, SWL shifted from reactive, administrative processes to proactive stewardship focused on "doing things right first time for patients." The new approach enabled patient outcome-based audits, enhanced identification of unwarranted variation, and facilitated the collection of realworld outcome data to improve patient care.

Portfolio of HCD pathways
Rheumatoid arthritis
Ankylosing Spondylitis & Non-Radiographic Axial Spondyloarthritis
Psoriatic Arthritis
Wet Age-related Macular Oedema
Diabetic Macular Oedema
Macular Oedema secondary to Retinal Vein Occlusion
Choroidal Neovascularisation (CNV) associated with pathological myopia
Psoriasis
Migraine (Chronic & Episodic)
Inflammatory bowel disease (Crohn's Disease & Ulcerative Colitis)
Atopic dermatitis
Postmenopausal osteoporosis
Idiopathic Thrombocytopenic Purpura (ITP)

Participants, Organisation, and Location

South West London Integrated Care System (SWL ICS) brings together 6 places, four acute hospital Trusts alongside mental health and specialist partners. The SWL Integrated Care Board (ICB) Medicines Optimisation Team coordinates efforts across these organisations to optimise HCD management for the region.

The project was led by SWL ICB in collaboration with hospital Trust pharmacy and clinical teams, commissioners, finance and public health.

Innovations and Key Changes

The reform of SWL's HCD processes marked a significant shift from manual, labour-intensive workflows to automated, digitally validated systems. Previously, clinical teams completed forms that required manual screening and assurance checks by the ICB. Now, advanced programming validates 80–90% of entries automatically by requiring mandatory completion of all fields before submission, with automated alerts ensuring disease scores are entered within specified ranges. Calculated fields reduce manual input, and information transfer between initiation and continuation forms avoids duplication. Enhanced reporting enables digital

auditing of all captured information, and iterative development ensures continuous feedback and improvement. Regular data feeds, drawn from HCD forms completed at specific time points, enable active monitoring for variation and inform system-wide decisions. Accuracy depends on the requestor's input, with data accuracy improved through automated form functionality and consistent data capture.

Measurable Outcomes and Impact

Quantitative Outcomes	Result	Impact
Data entries digitally validated	80-90%	Time saving through reduction in manual checks, repeated data entry, manual calculations.
HCD forms auto-approved	94%	Rapid treatment access while retaining manual review where clinical judgment is required.
Number of HCD pathways on platform capturing outcomes data	16	System-wide clinical audits to identify variation in clinical practice, highlight areas for improvement.
Cost savings (single MDT case)	£5,000/year	Virtual multi-Trust MDTs enabling consistent, peer-reviewed decisions across four Trusts, reducing unwarranted variation in access and treatment, and building a real-world outcomes repository to inform future strategies. Cost savings reflect the difference between the drug requested and the MDT-approved alternative.
Regional savings (5-year plan)	£15 million	Efficiency savings enhanced by proactive pathway development and implementation, encouraging increased use of originator drugs with upcoming patent expiry before switching to biosimilar.

Following implementation we held face-to-face engagement meetings with each Trust using a standardised questionnaire (which was sent out beforehand) to gather stakeholder feedback with the following key outcomes.

Qualitative outcomes from stakeholder feedback	Description
Ease of use	Forms easier to use, reduced screening time.
Compliance	Improved internal compliance checking.
MDT communication	Enhanced inter-Trust collaboration.
Patient outcomes	Right medicine first time, reduced delays.

SWL's commitment to continuous improvement is reflected in its audit plan, which was developed and prioritised with acute Trusts. Audits focus on benchmarking drug selection, monitoring trends in drug use, and patient outcomes across disease states. Audit results inform both local commissioning decisions and broader system learning. This

systematic approach ensures that quality assurance and value optimisation remain central to medicines management.

Specific Examples of Impact

1. Multi-Trust MDT for Treatment-Resistant Patients

A major innovation has been the introduction of a virtual multi-Trust multidisciplinary team (MDT) process for patients who have failed to respond to three or more prior treatments. Managed via the HCD data platform and MDT group email, this process facilitates peer review and supports smaller hospital Trusts, reducing variation in practice. An audit of 28 requests for patients who had failed three biologics found that 15 out of 16 patients with outcome data responded positively to further treatment, providing assurance to the local governance committee and supporting evidence-based commissioning. 7 MDT requests were declined, or the proposed treatment was changed by the MDT.

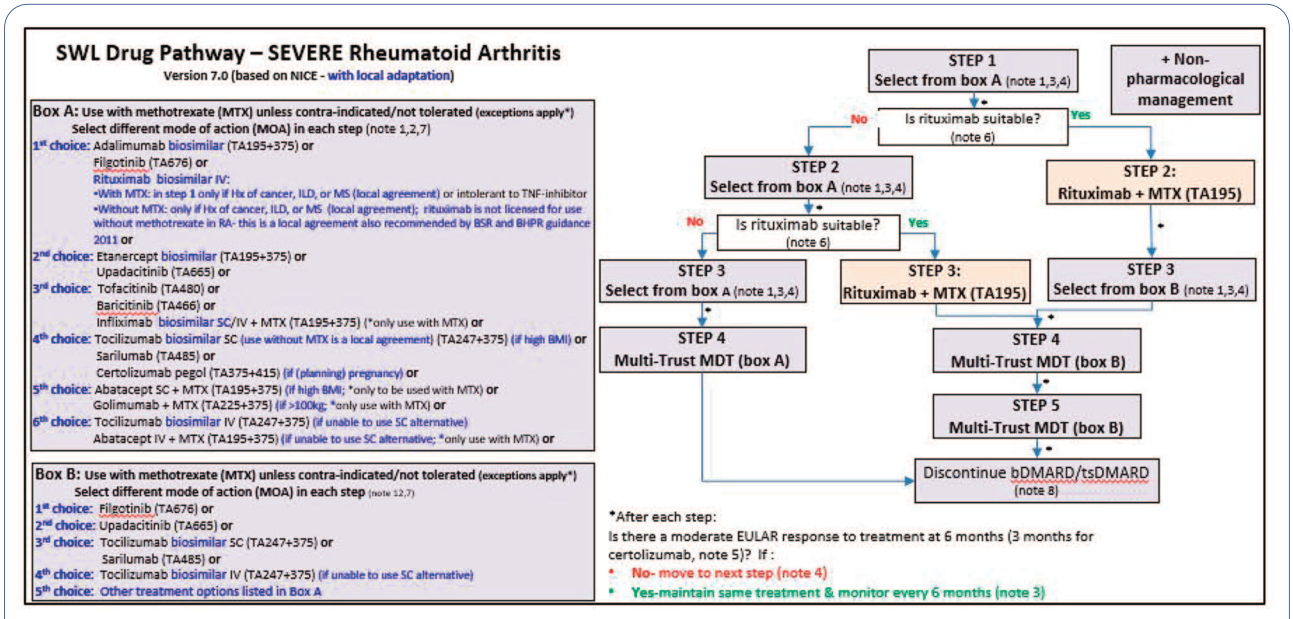


Figure 1: Example SWL Drug Pathway including virtual MDT process - Severe Rheumatoid Arthritis

2. Vedolizumab Dose Escalation Audit

SWL ICB allowed vedolizumab dose escalation for three months in cases where no alternative treatment was available. An audit of 18 requests revealed variable success rates and differences in practice between Trusts. For patients with outcomes, 7 switched to alternative treatment soon after dose escalation, 2 continued for 8 months and required further escalation, and 8 outcomes were not yet known at the time of audit. As a result, all dose escalation requests are now processed through the multi-Trust MDT to promote consistency. Although practice and clinician perception varied, the number of vedolizumab dose escalation requests subsequently reduced by approximately 50% annually.

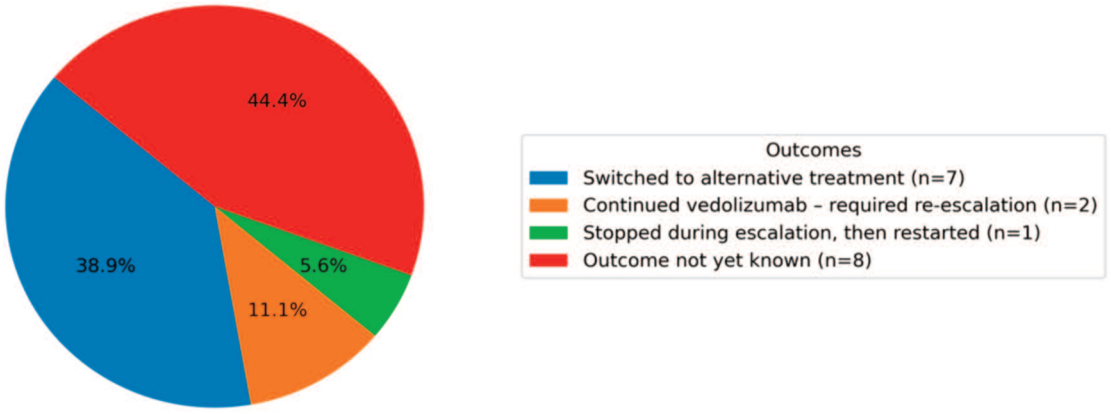
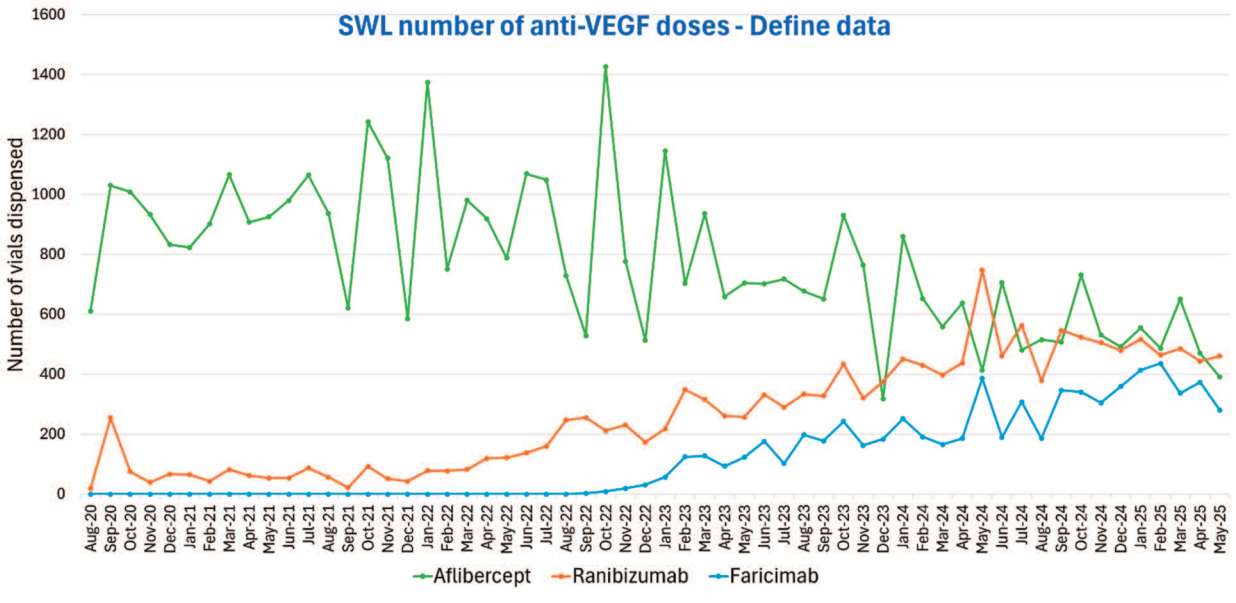


Figure 2: Outcomes of Vedolizumab Dose Escalation Audit

3. Driving Efficiencies in Ophthalmology

Audit data has driven efficiencies in ophthalmology, particularly in the use of anti-VEGF therapies. By promoting the use of ranibizumab and closely monitoring injection frequencies, SWL managed to keep anti-VEGF expenditure stable despite a growth in patient numbers. Audits showed that most patients responded equally well to ranibizumab or aflibercept, allowing for extended treatment intervals and significant system savings. Faricimab tended to have a higher injection frequency as in SWL it is used for patients with a suboptimal response to other anti-VEGFs.



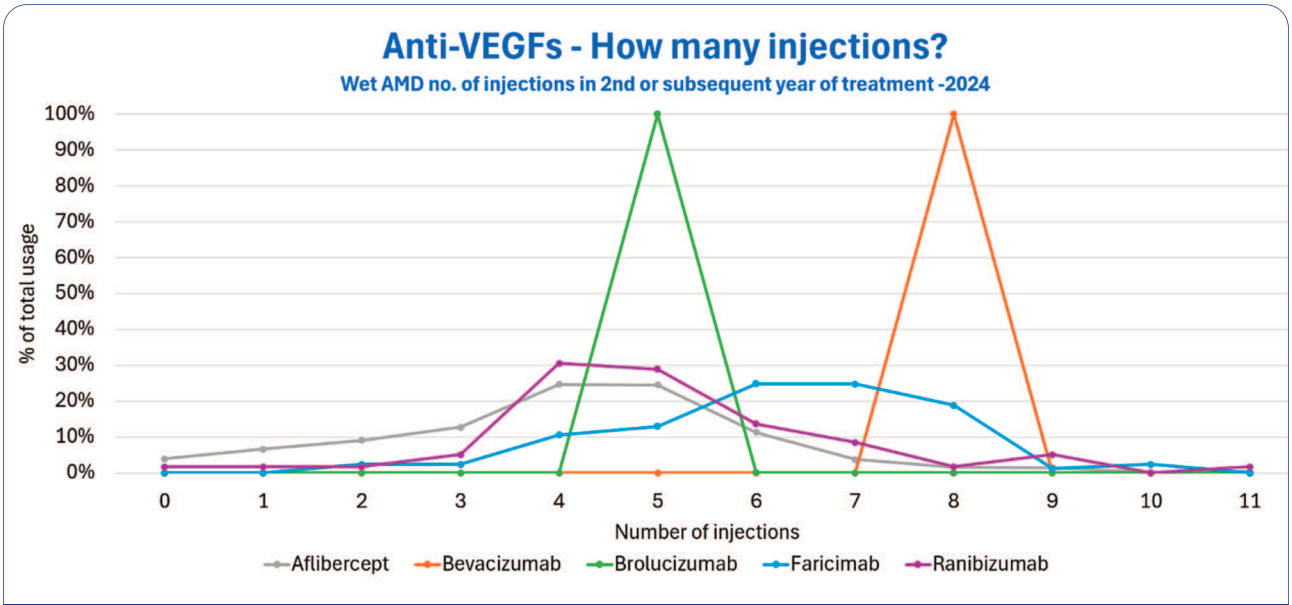


Figure 3: Anti-VEGF Injection Frequency and Usage Trends in SWL

4. Outcomes for Eyes with Vision ≥ 6/12

An audit focused on the use of bevacizumab in eyes with vision better than 6/12 found that 82% of eyes maintained vision above this threshold for at least one year. This outcome data supports local commissioning recommendations for using lower-cost anti-VEGF agents in this patient group.

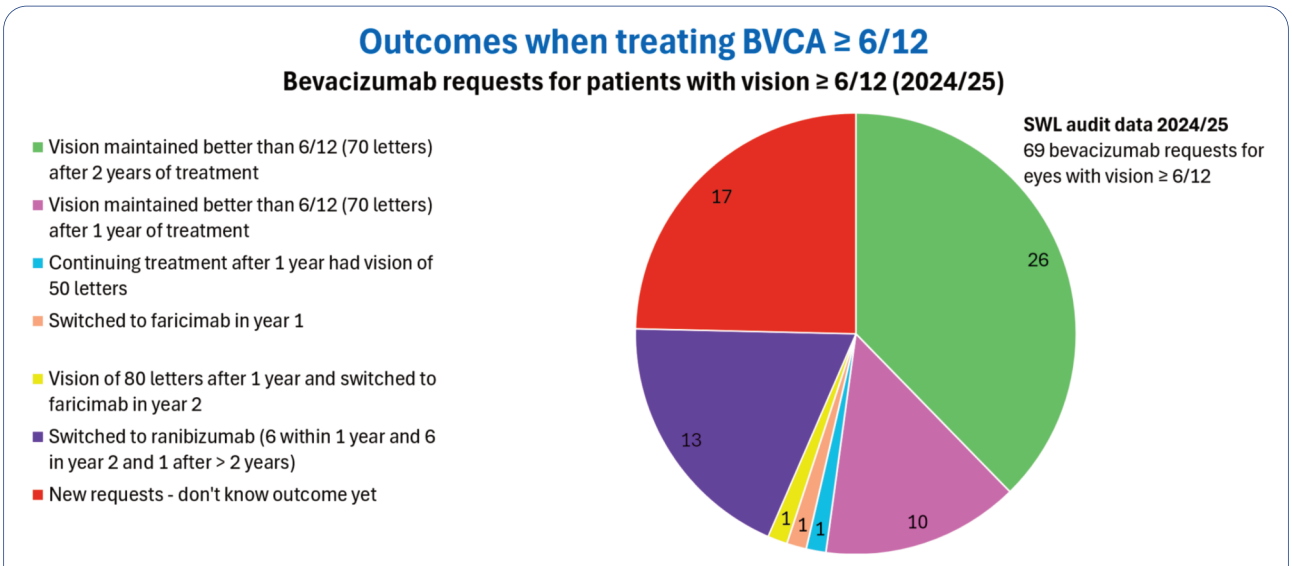


Figure 4: Outcomes for Eyes with Vision ≥ 6/12 Treated with Bevacizumab

5. Addressing Cost and Variation—Risankizumab Audit

A live example of using audit data to address cost and variation is the ongoing risankizumab audit. Triggered by significant cost growth in two Trusts, unlike the other two Trusts, the audit revealed variation in practice and bypassing of more cost-effective options. The findings prompted closer scrutiny of HCD data forms and discussions with clinical teams, demonstrating the system's ability to respond rapidly to emerging issues.

Lessons Learned and Recommendations

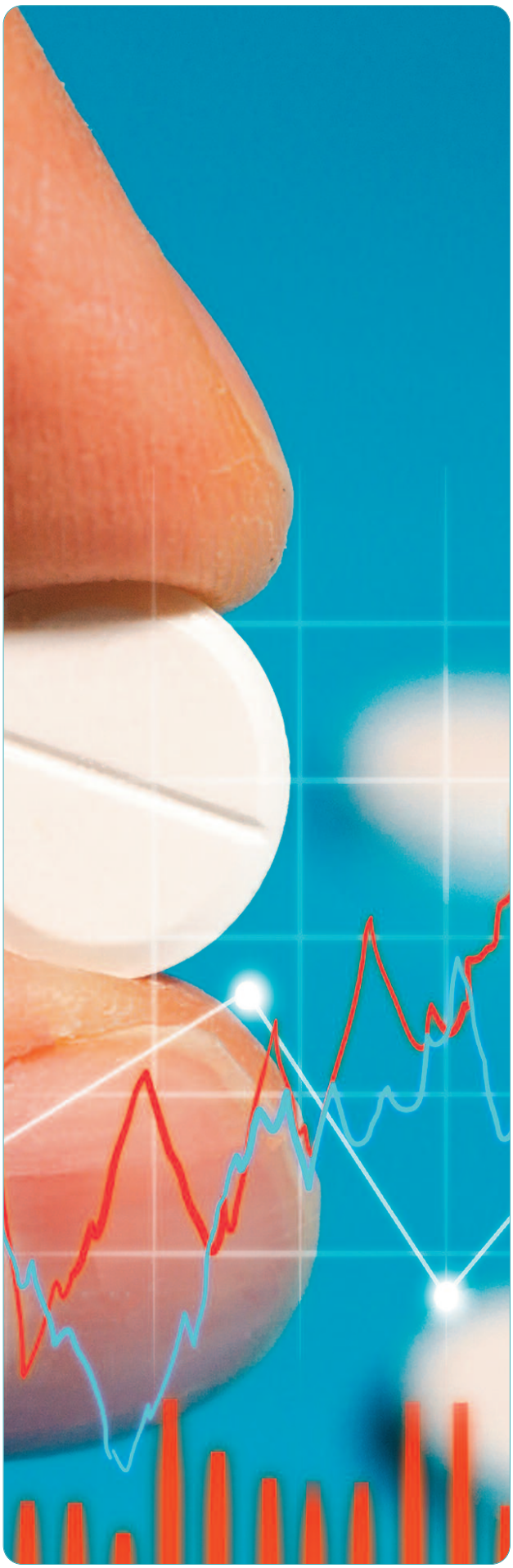
Transforming the HCD data platform from a static approvals database to a dynamic, audit ready system has fundamentally changed medicines optimisation in SWL. Automation reduced manual workload, improved data quality, and enabled rapid access to treatment. Continuous stakeholder engagement proved critical for successful digital transformation, while automation and validation enhanced efficiency and data quality. Real-world data enabled evidence-based pathway development and commissioning, and the MDT model enhanced clinical scrutiny and equity, especially for complex cases.

For other organisations considering similar initiatives, the SWL experience highlights the value of using existing platforms in innovative ways, prioritising stakeholder engagement and iterative development, focusing on outcome-based commissioning rather than administrative compliance, and sharing documentation and training resources to support replication. We learnt that identifying a clinician champion for each speciality helps to promote clinical leadership, ownership and consistent engagement across the system. This should be underpinned by a transparent and collaborative approach to communication, ensuring that information, learning, and decisions are shared effectively with all relevant stakeholders.

Replicability and Scalability

Looking ahead, SWL's digital processes offer a scalable model for other regions seeking to improve population health and healthcare value.

The project uses a nationally available platform and standardised documentation. Training materials, process guides, and templated forms are available to support adoption by other organisations. The model has already attracted interest from other Integrated Care Systems, NHS England and Wales, demonstrating its potential for broader impact. This work is included as a case study on NHS England's 10-Year Plan website under the Analogue to Digital shift. Case study link: NHS England — London » Analogue to digital.



The future vision includes upscaling SWL's approach to national or regional pathways, leveraging advanced programming for consistent data capture, and integrating real-world audit data on both financial and patient outcomes. We have started exploring linking HCD data with hospital and primary care data to identify priority medicines optimisation areas with a focus on patient health outcomes and reducing health inequalities.

Conclusion

South-West London's digital transformation of HCD management has delivered measurable improvements in patient outcomes, cost-effectiveness, and system-wide learning.

By leveraging automation, real-world data, and collaborative clinical engagement, the project provides a replicable model for medicines optimisation nationally. Key benefits include reduced variation, enhanced clinical decision-making, and significant cost savings.

Other organisations can adopt similar approaches by focusing on stakeholder engagement, iterative development, and outcome-based commissioning. The lessons learned from SWL's experience offer valuable insights for future digital health initiatives.

Acknowledgements

- SWL HCD Assurance Task and Finish Group
- SWL Reform Steering Group
- SWL HCD MO team (past and present)
- SWL HCD and Pathway Group members (past and present)
- Surrey Heartlands ICB

Review of the prescribing of oral antibiotics for the treatment of acne vulgaris by general practices across one Integrated Care Board

Motta M, Wilcock M,
Medicines Optimisation Team, Cornwall and Isles of Scilly Integrated Care Board.

Introduction

Acne vulgaris is common, affecting nearly all adolescents and adults at some time in their lives. Acne is not a trivial disease and can lead to enduring scarring, hyperpigmentation, emotional, physical, educational, and psychosocial costs. Depending on the severity of the acne (mild to moderate or moderate to severe), national guidelines typically recommend non-antibiotic topical treatments, such as benzoyl peroxide, or a topical retinoid/adapalene, or a topical combination product containing antibiotics.[1,2,3] Systemic treatments include oral antibiotics and, for women with polycystic ovary syndrome, co-cyprindiol or a combined oral contraception.[1] To reduce the risk of antibiotic resistance, oral antibiotics should be used alongside topical non-antibiotics, be reviewed at 12 weeks, and considered for continuation for up to 12 more weeks only if their acne has improved but not completely cleared.[1] Recommended oral antibiotics are lymecycline or doxycycline, with trimethoprim or an oral macrolide as alternatives. Guidance also recommends effective contraception for female patients of childbearing potential receiving oral tetracyclines, and referral to a specialist where appropriate.

Most acne treatment in the UK is provided in general practice, though from a 2018 study GPs expressed uncertainty about the use of topical treatments for acne, and had some unawareness of guidance suggesting that antibiotic use in acne should not exceed 3 months.[4] Acne is a major contributor to antibiotic exposure among young people, and, prior to the NICE guideline,[1] long courses of oral antibiotics were reported as being common, with one study in 2022 showing that 44.5% of people with a new acne diagnosis received a prescription for long-term antibiotics.[5,6]

This study examined the impact of incentivising general practices across Cornwall to identify and review patients currently prescribed oral antibiotics for the treatment of acne to ascertain if management was in line with NICE guidance. The review was prompted by data showing that lymecycline prescribing in Cornwall and Isles of Scilly Integrated Care Board (ICB) was amongst the highest in England, and for 12 months to August 2023 over half of the patients had received lymecylcine treatment for 24 weeks or longer, increasing the risk of antimicrobial resistance. Furthermore, both lymecycline and minocycline are 'watch' antibiotics; that is, broader-spectrum antibiotics with higher resistance potential and are first or second choice antibiotics indicated for a limited number of infective syndromes and whose use should be carefully monitored.[7,8]

Method

For 2024/25, GP practices were offered via the Prescribing and Medicines Optimisation Scheme (PMOS) a payment and instructions on the review process required. The target cohort was patients who had received an oral tetracycline-like antibiotic in the prior 4 months. A structured reporting template was provided for completion for quantitative results and practices were also asked to add free text relating to how their results would bring about any process change in the practice. Data were collated and analysed using Microsoft Excel. As a clinical audit, this study did not require ethics approval.

Results:

Forty-seven (87%) of 54 practices returned their data, identifying 711 patients (60% female) who received tetracycline-like antibiotics, the majority of which (80.6%) were for lymecycline (Table 1). The number of patients reported by the 47 practices ranged from 2 to 59. Of the 711 patients, 309 (43.5%) were recorded as overdue for review after 3 months and 269 (37.8%) overdue for review after 6 months of therapy. Concurrent topical treatment was recorded as not being prescribed for 292 (41.1%) patients. Of the 427 female patients, 259 (60.7%) were not prescribed effective contraception with 141/259 (54.4%) not offered contraception and 118/259 (45.6%) were offered but it was refused or unnecessary. There were 152 (21.4%) patients who were either managed with specialist input or referred and awaiting specialist advice.

Lymecycline	573 (80.6%)
Doxycycline	89 (12.5%)
Oxytetracycline	37 (5.2%)
Minocycline	9 (1.3%)
Tetracycline	3 (0.4%)

Table 1. Choice of antibiotic (n = 711)

All forty-seven practices provided feedback on proposed changes to be made to processes for oral antibiotic prescribing in acne and the key themes, from 50 suggestions, are shown in Table 2.

Recall for review at 3 / 6 months	31 (66%)
Appropriate prescribing of topicals	12 (25.5%)
Contraception documentation	4 (8.5%)
Referral for specialist advice	2 (4.3%)
Coding of acne in the medical records	1 (2.1%)

Table 2. Key areas of action for improvement (n = 50)

Discussion

This study found a lack of adherence to NICE guidelines surrounding use of concomitant topical therapy, review of patients on oral antibiotics and provision of contraception. The feedback received from the practices points to this scheme having raised awareness of the guidelines and, hopefully, the implication of antimicrobial resistance may improve the need for a timely review of antibiotic prescribing in particular.

The literature describes various audits of primary care compliance with the NICE guidance on acne management.[9,10,11,12] A 2023 audit of 102 patients in a single practice identified a lack of adherence to NICE guidelines surrounding choice and duration of therapy, with 90.2% of patients receiving longer than 6 months of oral antimicrobial therapy.[9] A smaller 2024 audit of 39 patients, undertaken in Cornwall, likewise found overall low compliance with the NICE guidelines.[12] Similarly, another audit in a primary care setting reported critical gaps in prescribing practices.[11] However a 2023/24 audit of an online prescribing service found very high compliance with NICE guidelines for duration of oral antibiotics and concomitant topical treatment.[10] In this digital setting they reported that 99% of 361 cases were not prescribed oral antibiotics for more than six months,[10] compared to our reported proportion of just over one-third (37.8%). It is unclear from the brief report how controls over prescribing duration are more effective from an online doctor than in a 'typical' general practice.[10]

"We do note that a longitudinal trend of patients who had received more than 24 weeks of lymecycline therapy (more than 180 capsules) has started to show a slight decline in recent months since the PMOS was in place (Figure 1). Furthermore, a single month's snapshot (July 2025) has Cornwall preforming marginally better than the 7 ICBs in the southwest with 25% of patients having received more than 24 weeks treatment."

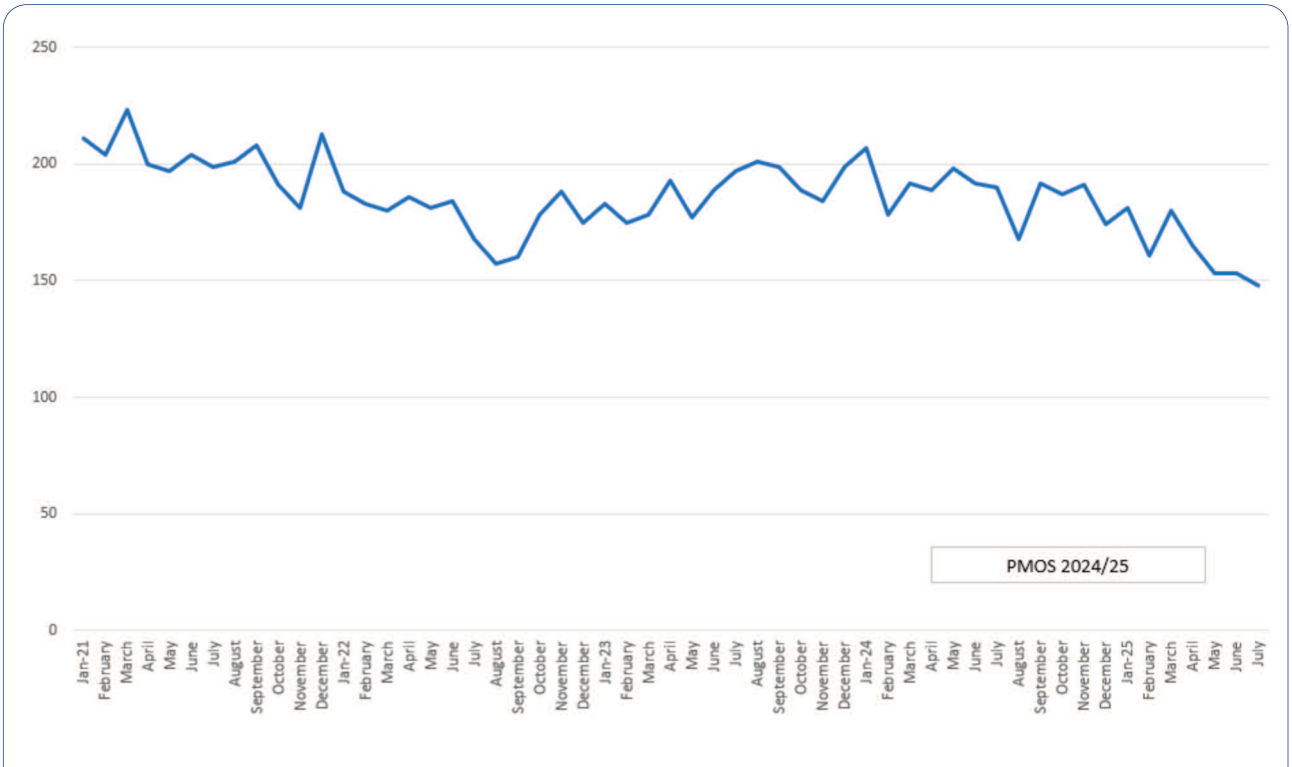


Figure 1. Unique patients in each month prescribed > 24 weeks lymecycline in the preceding 7 months

Strengths of this study include a well-defined patient cohort, and a structured data collection form aligned with national guidelines. This approach to utilising PMOS as a means of targeting a review of the national acne guidance is in line with how ICBs monitor data and use incentives, guidance and/or challenge prescribers on their behaviour to optimise antibiotic prescribing.[13] Though the Treat Antibiotics Responsibly, Guidance, Education and Tools (TARGET) resources for acne treatment were not explicitly mentioned in the review process instructions, others have shown that, in a general practice setting, these resources are effective in helping to upskill pharmacy professionals in the area of antimicrobial stewardship increasing capability and opportunity in the management of acne.[14,15] However, limitations are acknowledged. The single ICB design limits generalisability. Reporting bias by the practices may have missed information that was not recorded in the notes. We restricted the review of oral antibiotic prescribing to tetracyclines only, though other antibiotic classes are also used to treat acne. We are unsure if the small number of patients on minocycline, an antibiotic not to be used for acne in primary care, have been followed up in the relevant practices.[16] Additionally, the nature of this cross-sectional study precludes assessment of long-term patient outcomes as we looked only at process measures.

Conclusions

This study in one ICB across 47 practices shows poor adherence to NICE guidance overall. Subsequent actions outlined by general practices include more patients prescribed topical treatments; face to face reviews were organised; a default review after 12-weeks of oral antibiotics was set in GP systems; contraception documentation has improved; and practice clinical meetings to discuss the practice's own findings.

References

1. National Institute for Health and Care Excellence. Acne vulgaris: management. NG198. 2021. https://www.nice.org.uk/guidance/ng198
2. Zaenglein AL, Pathy AL, Schlosser BJ, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol 2016;74(5):945–973.e33.
3. Nast A, Dréno B, Bettoli V, et al. European evidence-based (S3) guideline for the treatment of acne — update 2016 — short version. J Eur Acad Dermatol Venereol 2016;30(8):1261–1268.

4. Platt D, Muller I, Sufraz A, et al. GPs' perspectives on acne management in primary care: a qualitative interview study. Br J Gen Pract 2020;71(702):e78-e84.

5. Lown M, McKeown S, Stuart B, et al. Prescribing of long-term antibiotics to adolescents in primary care: a retrospective cohort study. Br J Gen Pract 2021;71:e887–94.

6. Bhate K, Mansfield KE, Sinnott SJ, et al. Long-term oral antibiotic use in people with acne vulgaris in UK primary care: a drug utilization study. Br J Dermatol 2023;188(3):361-371.

7. UK Health Security Agency. UK Access, Watch, Reserve, and Other classification for antibiotics (UK-AWaRe antibiotic classification). Available online at https://www.gov.uk/government/publications/uk-aware-antibiotic-classification/uk-access-watch-reserve-and-other-classification-for-antibiotics-uk-aware-antibiotic-classification

8. Waterlow NR, Ashfield T, Knight GM. Observational study of antibiotic prescribing patterns by age and sex in primary care in England: why we need to take this variation into account to evaluate antibiotic stewardship and predict AMR variation. JAC Antimicrob Resist 2025;7(1):dlae210.

9. Williams O, Fischetti C, Power B. An audit of oral antimicrobial therapy against acne vulgaris NICE guidelines. Int J Pharm Prac 2023;(Suppl 2):ii54-ii55.

10. Bagga S, Patel N. An audit to evaluate the prescribing of antibiotics for acne against NICE guidelines in a digital setting. Int J Pharm Prac 2024;32(Suppl 2) ii18–ii19.

11. Shareef S. P049 Improving care for patients with acne vulgaris: an audit of oral lymecycline therapy against the NICE guidelines (NG198). Br J Derm 2025;193(Suppl 1):140.

12. Young A. P22 Review of antibiotic therapy (lymecycline) for the treatment of acne vulgaris in primary care. JAC-Antimicrob Resist 2025;7(Suppl 3):dlaf118.029.

13. Knowles R, Chandler CIR, O'Neill S, et al. Which interventions optimize antibiotic prescribing in primary care in England? A survey and Qualitative Comparative Analysis of NHS Integrated Care Boards. JAC Antimicrob Resist 2025;7(6):dlaf244.

14. Lakha A, Fleming N, Sonnex K, et al. Evaluating the role of primary care pharmacy technicians in antimicrobial stewardship (AMS) and acne management using TARGET resources. JAC Antimicrob Resist 2024;6(1):dlae011.

15. Sonnex K, Thornley T, Fleming N, et al. Pilot and quantitative evaluation of the TARGET acne toolkit by UK pharmacy professionals working in general practice. BMJ Open 2024;14(7):e081641.

16. NHS England. Items which should not routinely be prescribed in primary care: policy guidance. August 2025. https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/

Transforming Primary Care Through Complexity-Informed, Patient-Centred Care: The Experience of Kumar Medical Centre

Dr. Priya Kumar BEM,
Dr. Priya Kumar is a current GP Partner at Kumar Medical Centre and is recognised for her leadership in population health, digital innovation, and tackling health inequalities. She has held influential roles within Slough and Frimley ICB, including Primary Care Strategy Lead, Urgent Care Lead, and Health Inequalities Lead, shaping system-wide service redesign.

Her clinical leadership has driven initiatives such as the Multigenerational Household Project and the Wider Determinants of Health Questionnaire, alongside regional redesign of NHS 111 and the establishment of multiple urgent care centres. In 2023 she was awarded the HSJ Digital Innovator of the Year and is currently working with PPL as a national coach on the National Neighbourhood Health Implementation Programme.

Contact details: priya.kumar1@nhs.net

Introduction

Delivering high-quality primary care in socioeconomically disadvantaged and ethnically diverse communities presents profound challenges, particularly for patients with complex medical and social needs requiring personalised attention. At Kumar Medical Centre (KMC) in Slough, approximately 95% of registered patients are from global majority communities, and nearly 10% live with diabetes, a prevalence nearly twice that of the local population. This demographic and clinical context places sustained pressure on primary care services to deliver timely, equitable, and culturally responsive care.

Establishing robust urgent care pathways that accurately assess and understand patient complexity is critical to ensure patients are directed to the most appropriate service or clinician at the first point of contact. This approach reduces delays, prevents unnecessary referrals, and improves outcomes. Furthermore, conventional approaches, such as the Quality and Outcomes Framework (QoF), which schedules reviews by birth month, often fail to capture the full intricacies of patients' health profiles, resulting in delayed interventions for high-risk individuals and suboptimal utilisation of clinical resources.

To overcome these limitations, KMC implemented the Johns Hopkins ACG® System, using its Patient Need Groups (PNGs) segmentation tool. PNGs classify patients according to overall clinical and social complexity, considering the entirety of comorbidities and healthcare utilisation patterns rather than single diagnoses. The methodology assigns patients into 11 mutually exclusive, clinically meaningful segments spanning the full spectrum of health and social care needs, from those with minimal utilisation to those with multiple complex conditions and frailty. Each category represents a population with similar healthcare requirements, enabling proactive, tailored interventions. This approach represents a decisive shift from timebased scheduling to a complexity-informed, patient-centred system, supporting personalised care planning and strategic resource allocation (Johns Hopkins University, 2025).

The Challenge

KMC recognised the need to redesign both urgent care and QoF processes to address patient complexity and population health more effectively. In urgent care pathways, staff initially had limited insight into the complexity of individual patients. By integrating PNG-based information into the triage process, urgent care pathways were transformed to accurately assess patient needs, ensure safe and timely routing to the appropriate clinician or service, and maximise the likelihood of first-time effective care. This redesign was subsequently extended to QoF reviews, ensuring proactive care planning that

prioritises patients based on risk, clinical urgency, and holistic need.

Historically, QoF reviews were conducted using a uniform, birth-month-based system, distributing workload evenly without regard for patient complexity. Complex patients often required multiple appointments because clinicians were unable to adjust treatment plans or prescribe necessary medication at the first encounter. High-risk patients were not prioritised during peak seasonal pressures, increasing vulnerability to complications during winter. By redesigning urgent care and QoF processes, KMC implemented a population health approach that segments the patient population, optimises resource allocation, and ensures timely, proactive interventions for those with the highest need.

Urgent Care Pathways

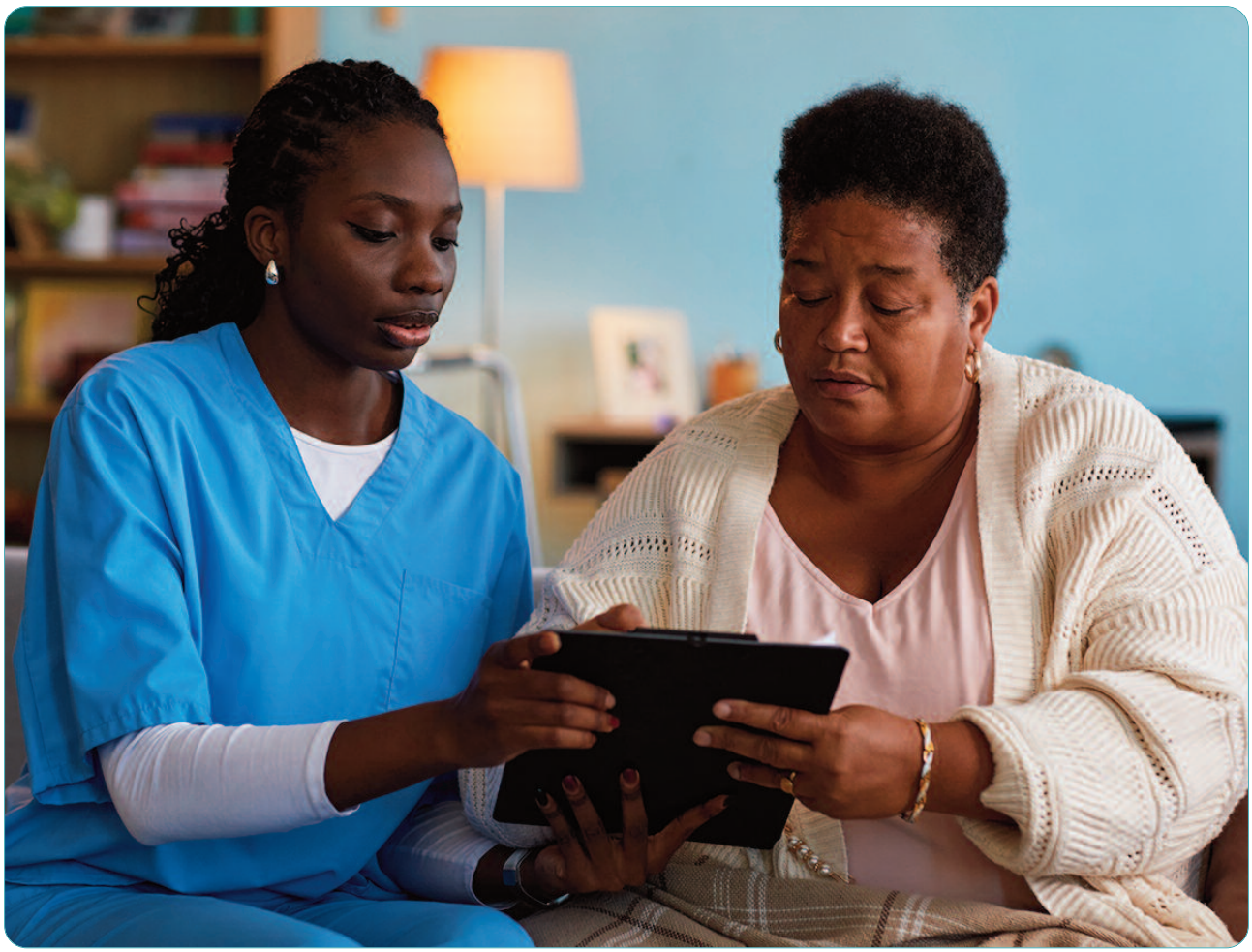
By refining our in-house triage process and optimising the use of services such as Pharmacy First, we have successfully integrated complexity-based triage into our referral pathway. This approach has allowed us to manage 75% of low-complexity patients within the Pharmacy First service, compared with just 31% of high-complexity patients. Therefore now, lower-need cases are now appropriately directed to services that meet their requirements, while patient complexity is assessed in-house by the most appropriate healthcare professionals, maximising the effectiveness of each consultation and enabling us to concentrate on delivering continuity of care for individuals with higher-complexity needs.

QoF Process

Within the QoF pathway, care is tailored to patient complexity, with high-complexity individuals prioritised for earlier and more frequent appropriate appointments to optimise management ahead of winter. Lower-complexity patients are supported through digital consultations or an annual routine check-up, ensuring their care is delivered in the most appropriate and accessible mode, which has significantly improved uptake of interventions such as blood pressure monitoring. High-complexity patients, such as those with uncontrolled diabetes, heart failure, severe COPD, or asthma with PNG 9 and above, are seen directly by senior nurse specialists and GPs, while senior clinical pharmacists provide oversight to ensure safe and effective deprescribing. Lower-complexity patients are managed by junior pharmacists, aligning the skill mix with patient need. This strategic matching of consultation mode and professional expertise eliminates unnecessary intermediate assessments, enhances care delivery, and supports professional

KMC: RESULTS YEAR ON YEAR

QOF	BASELINE-2022	YR 1 - 2023	YR 2- 2024	YR-3 – 2025
% ACHIEVEMENT SEPT	67%	90%	87%	84%
% ACHIVEMENT END OF YEAR TARGET MARCH	< 67%	70%	75%	70%



development. The recent September 2025 results demonstrate sustained year-on-year improvements, with 84% of patients having been reviewed and 70% of individuals with long term conditions achieving disease control. Analysis of data over a two-year period indicates a 10% improvement in HbA1c control among the diabetic population (QoF Data, CQRS).

Embedding PNGs across the practice has increased overall capacity, enabling a stronger focus on preventive care, including health checks, vaccinations, and outreach to multigenerational households. Over the past two years, cervical screening targets have been consistently met without the need for exception reporting. Administrative and triage staff have gained confidence in their decision-making, leading to reduced burnout and improved team effectiveness. These improvements are reflected in patient experience, with a 10% increase in satisfaction scores in the 2023–24 National GP Survey (NHS Digital, 2024).

References

- Johns Hopkins University. (2025). Johns Hopkins ACG® System: Patient Need Groups (PNGs). Available at: https://www.hopkinsacg.org/wp-content/uploads/2022/08/Johns-Hopkins-ACG-System_v13.0_PNG-Overview-v080322.pdf *Johns Hopkins ACG® System*
- NHS Digital. (2024). *GP Patient Survey 2023–24.* Available at: NHS England Digital https://digital.nhs.uk/data-and-information/publications/statistical/nhse-gp-patient-survey/2024
- QoF Data, CQRS. (2024). *Quality and Outcomes Framework Achievement, Prevalence and Exceptions Data 2023–24.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2023-24


WELL
NESS

The Professional's Blind Spot: Why Trauma-Informed Care Starts With Recognising Your Own

Rachael Lemon,
Executive Coach | Honorary Member, Royal Pharmaceutical Society | NHS Leadership
Contact: Hello@rachaellemon.com

About the author

Rachael Lemon is founder of Lemon Aid Coaching & Consulting, specialising in trauma informed, neuroinclusive leadership for healthcare professionals. An Honorary Member of the Royal Pharmaceutical Society for distinguished services to pharmacy, her 20+ years of NHS leadership includes the English Pharmacy Board and strategic advisory roles across NHS England, Department of Health, and Royal Colleges. A domestic abuse survivor with specialist training in trauma informed practice and rape crisis work, she brings both lived and professional expertise to her coaching practice.

Connect on LinkedIn:
linkedin.com/in/rachaellemon-leadership-coach-mentor

Knowing What To Do

In October 2025, The Pharmaceutical Journal (PJ) published an article recommending pharmacy staff ask about sexual assault during emergency contraception consultations. The authors suggested "normalising enquiries about trauma" with a simple script.

As someone who has spent over 20 years in NHS pharmacy leadership, has completed three months of rape crisis training, and has held trauma disclosure professionally and personally, the PJ article missed out something critical: What happens if someone says yes?

Scenario

It is 2pm on a Tuesday. Your consultation room is between the diabetes clinic and the prescription collection point. A 23-year-old woman has requested emergency contraception.

You ask the question from the training. She breaks down crying and tells you she was raped two days ago.

What do you do next?

> **"The PJ article does not tell you. The two-hour online module you completed does not tell you. Your workplace policy almost certainly does not tell you."**

And here is something else that nobody talks about: You might be triggered yourself.

The Gap Between Policy and Protection

I was a high-performing NHS pharmacy leader for over two decades. National board positions, strategic planning groups and policy development. The kind of career that looks successful from the outside.

For 17 years, I was also living with domestic abuse.

Nobody at work knew. Not because I hid it particularly well, but because nobody asked the right questions. When my performance slipped, when my sick days increased, when I started flinching if someone came up behind me in the office, they documented it for performance management rather than asking what changed.

Eventually, I was pushed out. Not because I was not good at my job, but because my trauma responses made me "unreliable."

After I left, I trained in trauma-informed coaching, spent three months training with rape crisis with ongoing supervision and peer support work. Learning to hold other people's trauma without drowning in it. Learning to recognise my own triggers before they derailed me. That training taught me something crucial: Asking about trauma without knowing how to hold the answer is dangerous. Dangerous for the person disclosing, for the person receiving the disclosure, and for everyone in the pharmacy who will feel the ripple effects.

Answering a potentially traumatic question is one thing – what the pharmacy actually needs is the right infrastructure to hold the answer.

What The Policy Didn't Mention

'Ask for ANI' was a government-funded codeword scheme launched during the pandemic. Women experiencing domestic abuse could walk into a pharmacy and say "ANI", with pharmacy staff providing immediate support. It was discreet, accessible and could be used by women who couldn't safely call helplines from home.

It worked.

In 2024, government funding was withdrawn. The scheme was replaced with "Safe Spaces" - a self-service model where pharmacy staff provide a quiet room and the woman calls the helplines herself.

Notice the pattern? Active support replaced with self-service. Staff-led intervention replaced with "Here's a phone. Good luck." The burden shifted back onto the survivor. This is what happens when we build policies without infrastructure.

The weaknesses and risks in such a system are apparent:

- Recommend asking the question, but
- Don't fund the training
- Don't build the support systems
- Don't consider what happens when the answer is yes

What Being Ready Actually Requires

We may think the issue is whether or not to ask about trauma. In fact, the issue is what happens in the 60 seconds after someone discloses.

Rape crisis training takes three months minimum. It covers holding disclosure without fixing, recognising your own triggers, setting boundaries, referral pathways, and ongoing supervision requirements.

A two-hour eLearning module does not cut it.

When someone discloses trauma, you need to know exactly where to refer them. Not "Here's a helpline number" but specific, locally accessible services. Rape Crisis centres with waiting lists. ISVA (Independent sexual violence adviser) services requiring police reports. Domestic abuse specialist support with immigration restrictions. Mental health crisis teams. Legal advocacy services.

You need physical environment design. Your consultation room matters. Can the door be locked from the inside? Is there a panic button? Can someone see in from outside or hear what is being discussed? Is there somewhere comfortable to sit? Tissues readily available? Water?

You need psychological safety for staff. Who do you debrief with after a difficult disclosure? What happens if you are triggered during a consultation? Is there somewhere private you can go to regulate yourself? Do you have access to clinical supervision?

You need clear follow-up protocols. What happens after the disclosure? Do you document it? How do you ensure confidentiality? Who follows up? When?

These questions need answers before you start asking patients about trauma.

The Questions To Ask Yourself First

Before you ask a patient about trauma, ask yourself:

- What trauma am I carrying?
- What might trigger me during this conversation?
- Do I have the emotional capacity to hold someone else's distress today?
- What will I do if I react badly?
- Who can I debrief with afterwards?

If you cannot answer these questions, you are not ready. That does not make you a bad pharmacist. It makes you human.

I know from coaching pharmacy professionals that many of us are carrying trauma ourselves. For example, navigating toxic workplace cultures, bullying, racist microaggressions from colleagues and patients, performance management when you're being harmed at home, professional isolation in community pharmacy settings where you are the only qualified person and there is nobody to debrief with.

You are experiencing vicarious trauma from holding other people's distress day after day with no supervision or psychological safety net. You are told to be "resilient" when what you actually need is systemic change.

And now you are being asked to "normalise trauma enquiries" without anyone asking: What trauma are you carrying? Who is holding your distress? When was the last time someone checked if you are okay?

What Trauma-Informed Actually Means

I am part of a survivor-led initiative, building community-based early intervention. We are designing support that meets people where they are, delivered by people who understand trauma because we have lived it. Trauma-informed leadership starts with self-awareness – you cannot create psychological safety for others if you have not examined your own trauma responses. It requires ongoing training and supervision. Not one-off modules, but regular, consistent and supported learning.

> **"It also acknowledges intersectionality. For example, the immigrant woman faces different barriers than the disabled woman, who faces different barriers than the professional woman. One-size policies fail."**

It builds from lived experience. The people who have survived trauma design better systems than people who have only studied it. It also prioritises staff wellbeing - you cannot pour from an empty cup. Burnt-out, traumatised staff cannot provide trauma-informed care.

Your Strategic Position

You are positioned to do something about it – to build infrastructure before implementing policy. You understand the systems from inside. You know what pharmacy professionals actually face. You have the credibility to advocate for proper training, adequate support and realistic implementation timelines.

This is not about whether trauma enquiries matter in pharmacy. They do. This is about doing them properly. That means investing in specialist training for pharmacy staff, building psychological safety infrastructure, creating clear accessible referral pathways, designing physical environments that support disclosure, providing ongoing supervision and debriefing, and acknowledging that pharmacy professionals carry trauma too.

The Transformation Opportunity

Every gap in current practice is an innovation opportunity. The need has been identified and we are positioned to build the solution. What would it look like if your pharmacy became genuinely trauma-informed? Not just asking the question, but ready to hold the answer?

"What if you built support systems for staff who witness trauma? What if you created debriefing protocols, supervision access and psychological safety provisions that actually work?"

What if you advocated to senior leadership for proper implementation, specialist and funded training, adequate time allocation, staff wellbeing being prioritised and referral pathways established?

What if pharmacy led the way in showing other healthcare settings how to do trauma enquiry properly?

That is not just managing policy implementation – it is revolutionary leadership.

Your Action Framework

Week 1: Assess Current Reality

- Identify what training staff have actually received
- Map referral pathways (do you know where to send someone who discloses?)
- Document gaps between policy and practice

Week 2: Build Staff Psychological Safety

- Create debriefing space after difficult consultations
- Establish supervision access for staff holding trauma
- Identify who on your team is carrying vicarious trauma
- Provide support before implementing trauma enquiry protocols

Week 3: Establish Referral Infrastructure

- Connect with local Rape Crisis centres, ISVA services, domestic abuse specialists
- Understand which services are actually accessible (waiting lists, eligibility criteria, barriers)
- Build relationships before you need them
- Create simple, clear referral protocols staff can actually use

Week 4: Advocate for Proper Implementation

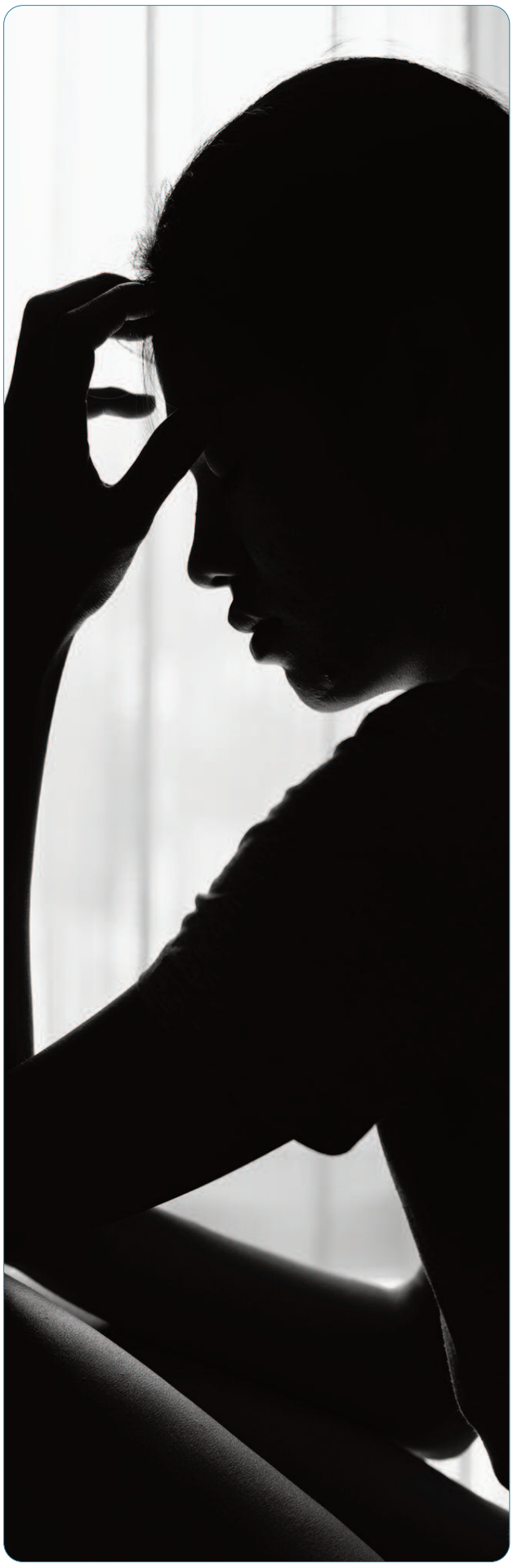
- Present findings to senior leadership
- Request specialist training (not eLearning modules)
- Secure ongoing supervision provision
- Ensure physical environment supports psychological safety

This is not about refusing to ask about trauma. It is about being ready to hold the answer when it comes.

Discussion Points For Your Team

Does your workplace have a trauma enquiry policy?

Who knows about it?



What training have staff received in holding trauma disclosure?

What psychological safety provisions exist for staff who witness trauma?

When was the last time leadership asked staff: "Are you okay?"

What would genuinely trauma-informed practice look like in your setting?

Series Overview

This is the first article in a series exploring trauma-informed leadership in pharmacy.

The next article: 'When the System Becomes the Trauma: Performance Management, Workplace Culture, and the Pharmacy Professionals Nobody Sees' examines how workplace trauma affects pharmacy professionals and what trauma-informed leadership actually looks like when systems are designed to support the pharmacy team.

For now, I will leave you with this thought: Before you ask someone else about their trauma, make sure you can hold your own.

References

1. MacKenzie, K.A., Hill, L. (2025). How to improve pharmacy services by integrating trauma-informed care. The Pharmaceutical Journal, 28 October 2025. https://pharmaceutical-journal.com/article/ld/how-to-improve-pharmacy-services-by-integrating-trauma-informed-care
2. Scottish NES TURAS. Responding to a disclosure of rape or sexual assault. Main access: https://www.rightdecisions.scot.nhs.uk/media/donbw0uy/2025-turn-to-sarcs-disclosure-v11.pdf
3. NHS England eLearning for Healthcare. Identifying and responding to sexual assault and abuse. Main access: https://www.e-lfh.org.uk/programmes/identifying-and-responding-to-sexual-assault-and-abuse/
4. Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Main access: https://www.traumainformedcare.chcs.org/wp-content/uploads/samhsa_trauma_concept_paper.pdf
5. UK Office for Health Improvement and Disparities. (2022). Working definition of trauma-informed practice. https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

(All links last accessed 12/01/26.)

PM Healthcare
PROGRESS THROUGH PARTNERSHIP

Published by Pharman Limited
The Stable Yard, Vicarage Road, Stony Stratford, Buckinghamshire MK11 1BN
Tel: 0333 800 2850 Homepage: www.pmhealthcare.co.uk Email: editor@pmpublications.co.uk