IN THIS ISSUE:

- Redesigning Hospital Pharmacy Out-of-Hours Services: A Service Evaluation Pilot
- Survey Of Job Satisfaction And Future Intentions Of Community Pharmacists In Wolverhampton, England
- Consultant Pharmacist, Respiratory And Sleep Medicine
- Bonnie And Clyde
- A Change Of Thought
AIM OF THE JoPM
The aim of the JoPM is to play an influential and key part in shaping pharmacy practice and the role that medicines can play. The JoPM provides a vehicle to enable healthcare professionals to stimulate ideas in colleagues and/or disseminate good practice that others can adapt or develop to suit their local circumstances.

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Readers are encouraged to comment upon and discuss items about pharmacy practice.

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Authors of articles discussed in correspondence will be given the opportunity to respond.

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Published by: Pharman Limited, 75c High Street, Great Dunmow, Essex CM6 1AE
Tel: 01371 874478
Homepage: www.jmedopt.com
Email: pharm@pharman.co.uk

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# CONTENTS

## BEST PRACTICE IN PHARMACY MANAGEMENT

### Redesigning Hospital Pharmacy Out-of-Hours Services: A Service Evaluation Pilot

*James Musk, Liz Jamieson, Tim Hills and Guy Wilkes*

122

### Survey Of Job Satisfaction And Future Intentions Of Community Pharmacists In Wolverhampton, England

*Amandeep Johal, Dr Hana Morrissey and Professor Patrick Ball*

132

## FACE2FACE

### Consultant Pharmacist, Respiratory And Sleep Medicine

*Gráinne d’Ancona*

147

## MANAGEMENT CONUNDRUM

* Bonnie And Clyde*

150

## LEADERSHIP

### A Change Of Thought

157
There is an increasing demand for clinical hospital pharmacy service (e.g. medicines supply, dispensing discharge medications for TTOs and responding to medicines information enquiries) to be provided on a 24-hour basis. Such services may be needed on more than one site within a Trust. The issue here is to determine the most appropriate way in which this can be provided - whether from on-site or ‘remote’ arrangements. The article in this edition evaluates two service models to determine a preferred approach that overcame problems with a stock picking process and remote location for one of the sites that would have been unresolvable without significant cost. The solution was specific for the circumstances described but the process and issues will be of interest to those involved in developing out-of-hours services locally.

There have been many changes to Community Pharmacy services in recent years. Dispensing remains a core activity but the move has been to provide more direct patient services. This is likely to increase rather than decrease in the future. How do Community Pharmacists perceive this new role? Is it something they embrace – or something that they face with trepidation? A helpful survey of job satisfaction amongst Community Pharmacists is reported in this edition. Although the scale of the survey was limited to a questionnaire to 27 Community Pharmacists in 20 pharmacies in the Wolverhampton area, it provides some useful pointers. It is heartening to note that the greatest sources of job satisfaction come from interactions with patients and professional clinical services. The level of remuneration was the least satisfying aspect of the questions asked. 77% of participants wanted to work in community pharmacy on exit from University. At the time of the survey 59% indicated that they would continue to work in a community pharmacy setting, 15% wanted further training in pharmacy, 11% wanted to re-train in another career, 7.5% wanted to move into hospital and 7.5% wanted to move into industry or other employment. This would seem to reflect a relatively satisfied profession overall with a stable core for Community Pharmacy. Further and more extensive surveys will be important to continually assess job satisfaction as the profession develops its patient services role.

Continuing in the vein of developing patient-facing pharmacy services, our Face2Face provides an inspirational example of such a role. This post, which straddles primary and secondary care, involves the provision of three outpatient respiratory clinics (Interstitial Lung Disease (ILD), COPD, severe asthma) and participation in respiratory virtual clinics at GP surgeries to offer support in the management of patients with lung disease and breathlessness. What is described here serves as a superb role model for others who wish to develop in their career and specialise in a therapeutic area. A must read!

What happens when a husband and wife team who work in the same department end going through a divorce? It is a most difficult time for the couple personally but can also impinge on other team members and the department in general. What can you, as a pharmacy manager or staff member, do to alleviate any difficulties. Our commentators give some sound, practical advice that applies not just for the particular situation described but will resonate for any situation when difficulties between staff members occurs.

Change is a constant – but how do you handle it, whether as a manager or a member of staff. Do you look for the positives – or let the negatives ‘get you down’? The Leadership section will provide you with some top tips to lead and manage change within your organisation.

**READERSHIP FEEDBACK**

If the JoPM is to continue to publish material that you would find interesting and helpful in your practice, it is clearly important that readers feedback their views. There are various ways in which feedback is currently obtained but, with effect from this edition, a short SurveyMonkey questionnaire that will take just a couple of minutes to complete will be available for each edition.
WOULD YOU LIKE TO PUBLISH YOUR WORK IN THE JoPM?

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Resilience is a key skill for all pharmacists to have, especially in the face of increasing demands from patients and colleagues alike. In this, our 13th academy series, we will look at what it takes to be resilient as an individual and as a team (including MDTs) within the NHS, in order to deliver enhanced organisational performance and patient care.

This workshop should appeal to pharmacists of all disciplines and levels and will be delivered by Pharmacy Management’s leading trainer, Tom Phillips, who has successfully delivered our previous academies. We have received exceptional feedback every time. The day is based around a highly interactive mix of theory and practical application to your own situation, allowing for the exchange of ideas and experiences with colleagues and trainers alike.

Previous academies have been a phenomenal success with average feedback scores rating each academy topic as predominantly excellent or very good. Places at each workshop are limited to a maximum of 30 participants, so book your place early to avoid disappointment.
ADVANCE NOTICE

Autumn series of Pharmacy Management Academy Meetings

Building resilience to improve organisational performance and patient care

Make sure you save the date in your diary for your nearest meeting!

Thursday 5th October  
Thursday 12th October  
Thursday 19th October  
Wednesday 1st November  
Tuesday 7th November  
Thursday 16th November  
Tuesday 28th November  
Wednesday 29th November  
Tuesday 5th December  
Thursday 7th December  

North London  
Cardiff  
Manchester  
Stirling  
Gateshead  
Birmingham  
Gatwick  
Leicester  
Bristol  
South London

Further details and the topic will follow on the Pharmacy Management website at www.pharman.co.uk.

https://www.pharman.co.uk/pm-leadership/pm-academy
Redesigning Hospital Pharmacy Out-of-Hours Services: A Service Evaluation Pilot

James Musk, Deputy Divisional Lead Pharmacist for Surgery and Clinical Support; Liz Jamieson, Advanced Practitioner for Critical Care; Tim Hills, Lead Pharmacist for Antimicrobials and Infection Control: Nottingham University Hospitals and Guy Wilkes, Managing Director of Hospital Pharmacy Services Nottingham Ltd.
Correspondence to: james.musk@nuh.nhs.uk

Abstract

Title
Redesigning Hospital Pharmacy Out-of-Hours Services: A Service Evaluation Pilot

Author List
Musk J, Hills T, Wilkes G, Jamieson E.

Introduction
A service evaluation pilot was conducted over a seven month period (November 2014–June 2015) to assess two different models for the delivery of out-of-hours clinical pharmacy services, and ensure continued quality and efficiency. This was deemed necessary due to the ever increasing demand placed upon a twenty-four hour clinical pharmacy service in a large acute Trust, and the requirement for a new location for out-of-hours pharmacy services due to unsurmountable issues with the current location.

Method
Over a fourteen week period, Hospital Pharmacy Services Nottingham Ltd (HPSN) provided the inpatient dispensing of medicines out-of-hours, whilst Nottingham University Hospital (NUH) pharmacists continued to retain the professional and clinical aspects of the service (HPSN model). This model was then compared to a dispensing service model which involved relocation to pharmacy stores at the Queen’s Medical Centre campus, utilising NUH dispensing staff alongside NUH clinical pharmacists (NUH model).

Results
The pilot demonstrated that the utilisation of HPSN dispensing services was cost-effective and sustainable. The NUH model provided a comparable quality of service but relied upon temporary staffing measures. Overall, the NUH model was deemed less cost-effective and unsustainable over a longer period. Furthermore, whilst challenges identified with the HPSN model were resolvable during the duration of the pilot, the NUH model required significant investment to overcome challenges related to location and work environment suitability, which was not immediately possible.

Conclusion
Overall, the results of the pilot demonstrated the quality and efficiency of the service models employed were comparable, with variations in dispensing error rates noted but considered insignificant. The final decision to employ the HPSN model (and HPSN dispensing services) aligned with the NUH Pharmacy Department strategy to centralise and streamline the medicines supply chain. The aim of this strategy is to optimise efficiency and cost-effectiveness as recommended within recent NHS medicines optimisation agendas.

Keywords: On-call pharmacy service model, out-of-hours pharmacy dispensing, dispensing efficiency, dispensing quality, dispensary relocation.

Background
Nottingham University Hospitals (NUH) NHS Trust pharmacy department provides inpatient clinical pharmacy services to 80 wards and approximately 1,700 beds. These beds are split across two hospital sites; Queen’s Medical Centre (QMC) Campus and Nottingham City Hospital Campus. Out-of-hours pharmacy services are provided to both sites each day between 17:00 and 00:00 hours by junior pharmacists based on the QMC campus, with senior pharmacist support provided remotely. From 17:00, two dispensary based pharmacists remain on site working until 22:00 and 00:00 hours respectively. Between 00:00 and 09:00 the designated on-call pharmacist responds to calls remotely and is available to return to work if urgently required.

“The majority of the out-of-hours service workload involves medicines supply, dispensing discharge medications for TTOs (‘To Take Out’) and responding to medicines information enquiries.”
During 2014, the on-call service responded to 74 calls a night on average, in comparison to 67 in 2013 and 56 in 2012. The majority of the out-of-hours service workload involves medicines supply, dispensing discharge medications for TTOs (‘To Take Out’) and responding to medicines information enquiries.

In 2012, out-of-hours pharmacy services relocated to a satellite dispensary attached to a medical admissions wards at Queen’s Medical Centre. Since this relocation a number of issues were identified with the service following a formal risk assessment. These were:

- a lack of technical management of the dispensary as only used out of hours and at weekends. This led to poor stock control and rotation, resulting in a lack of stock availability and significant financial loss for the department
- inadequate space and facilities to promote safe dispensing and ensure appropriate storage and segregation of medicines
- a lack of environmental temperature control resulting in significant financial loss due to unusable stock
- an absence of any technical support staff after 19:00 hours on weekdays and 17:00 hours at weekends and bank holidays. During periods of heavy workload (particularly during winter pressures) this required junior pharmacists to work overtime and senior support staff to return to work to facilitate dispensing of medicines with overtime cost implications for the service.

As a result of difficulties in addressing the inadequacies of the out-of-hours service, the possibility of alternative service models was explored. NUH established Hospital Pharmacy Services Nottingham (HPSN) Ltd. as a private, wholly-owned subsidiary company of NUH in 2012 to manage its outpatient and Emergency Department Pharmacy dispensing services. The decision was taken to pilot a service model with HPSN providing out-of-hours dispensing services, whilst NUH pharmacists continued to provide clinical aspects of the out-of-hours service (HPSN model). The NUH model utilised NUH dispensing and clinical staff to provide the out-of-hours service from QMC Pharmacy stores (relocation of the service).

**Pilot aim**

To determine which service model represented the best possible service considering patient safety, efficiency and cost-effectiveness as equally important indicators of service quality.

**Method**

To enable a direct comparison between the services, two fourteen week pilots were conducted. The first was between November 2014 and February 2015 from

<table>
<thead>
<tr>
<th>Monday - Friday</th>
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<td>17:00-19:00</td>
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<td>21:00-00:00</td>
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**Figure 1: HPSN Model staffing – above staff covering inpatient dispensing only.**

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability of HPSN to supply controlled drugs for inpatients (no wholesaler’s licence)</td>
<td>NUH pharmacists to dispense controlled drugs</td>
</tr>
<tr>
<td>HPSN staff unable to enter NUH stockholding premises</td>
<td>NUH staff to complete stock transfers from stores to HPSN</td>
</tr>
<tr>
<td>Unable to transfer part-pack stock from NUH to HPSN (as a wholesale dealer)</td>
<td>NUH pharmacists dispensed part-packs directly from NUH stock within the satellite pharmacies.</td>
</tr>
<tr>
<td>Not cost-effective for HPSN to stock all high cost drugs that may be required out-of-hours (i.e. immunoglobulins, digifab)</td>
<td>Agreement that NUH will stock high cost drugs and transfer to HPSN stock as required</td>
</tr>
<tr>
<td>Lack of any inpatient dispensing procedures</td>
<td>HPSN adapted NUH dispensing procedures</td>
</tr>
<tr>
<td>Maintaining ‘arms-length’ separation of NUH and HPSN organisations</td>
<td>Developing clear and separate workflows with designated responsibilities for staff</td>
</tr>
</tbody>
</table>

**Figure 2: Logistical challenges associated with Model A, and their solutions**
the HPSN outpatient dispensary based at QMC (HPSN model). The second was conducted between March 2015 and June 2015 from QMC Pharmacy Stores using NUH staff only (NUH model).

**HPSN Model - HPSN outpatient dispensary**
As part of this service model, HPSN employed additional dispensing staff between 17:00 and 00:00 hours. HPSN already employed staff between these times to cover emergency department (ED) dispensing seven days a week; however additional staff were required to cover inpatient dispensing. Dispensing staff were segregated into inpatient and outpatient dispensing teams to ensure appropriate separation and flow of inpatient and ED/outpatient dispensing. The addition of undergraduate pharmacy students as dispensary assistants (employed by HPSN) and newly qualified pharmacists as accuracy checkers (employed by NUH and cross-charged to HPSN) compensated for the increased workload associated with inpatient dispensing out-of-hours as summarised in Figure 1.

Prior to the pilot numerous logistical challenges were identified with the HPSN model, and were addressed with the solutions shown in Figure 2.

As previously discussed, NUH identified the requirement for additional dispensing staff for the out-of-hours service to improve efficiency and cost-effectiveness (via reduced pharmacist overtime claims). Due to the short-term nature of each pilot, NUH were unable to recruit additional dispensary staff on a short-term basis. Consequently, the support staff model employed by NUH relied upon additional voluntary shifts from existing members of staff. The staff skill mix employed by NUH during the pilot was not the ideal skill mix that was identified for an improved service long-term. The accuracy checking shift was completed by newly qualified pharmacists or a locum accuracy checking technician. Dispensary assistant shifts were completed by a mixture of levels of NUH technical staff. Staffing levels for the NUH model are summarised in Figure 3.

Prior to the pilot, numerous logistical challenges presented with the NUH model, which were addressed with the solutions shown in Figure 4.

**Key Performance Indicators**
In order to evaluate the effectiveness and quality of the two service models, a number of key performance indicators (KPIs) were agreed (Figure 5). These KPIs were identified by various stakeholders and senior members of the pharmacy team within the Pharmacy Operations Group at NUH based upon service requirements and targets. The target dispensing time of 15 minutes for clinically urgent medications was selected as NUH medicines policy requires the administration of clinically urgent medications Monday - Friday

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<tr>
<th>Time</th>
<th>checker 1</th>
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<tr>
<th>NUH Pharmacy Stores QMC</th>
<th>NUH Pharmacy Stores QMC</th>
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**Figure 3: NUH model staffing - covering inpatient dispensing out-of-hours**

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wholesale dealer's licence and part pack dispensing</td>
<td>Part packs of medication generated were recycled into NUH pharmacy satellite dispensaries</td>
</tr>
<tr>
<td>Inability to dispense monitored dosage systems (MDS) from pharmacy stores</td>
<td>MDS dispensed from pharmacy satellites</td>
</tr>
<tr>
<td>No controlled drugs within pharmacy stores</td>
<td>Temporary CD cupboard installed</td>
</tr>
<tr>
<td>Large area storing medicines – inefficient picking process</td>
<td>None identified</td>
</tr>
<tr>
<td>Reduced accessibility to ward based staff (due to remote location of Pharmacy stores)</td>
<td>None identified</td>
</tr>
<tr>
<td>Safety of lone-working staff</td>
<td>Security staff visit at timed intervals to ensure staff safety</td>
</tr>
</tbody>
</table>

**Figure 4: Logistical challenges associated with the NUH model, and their solutions**
### Key Performance Indicator

<table>
<thead>
<tr>
<th>Safe and accurate dispensing</th>
<th>Dispensing error rates within the national average (0.02%-2.7%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritisation of clinically urgent medications</td>
<td>100% of clinically urgent items to be dispensed within 15 minutes of clinical screen.</td>
</tr>
<tr>
<td>Efficiency of dispensing discharge prescriptions</td>
<td>95% of discharge prescriptions to be dispensed within 2 hours of clinical screen (existing NUH pharmacy target).</td>
</tr>
<tr>
<td>Cost-effective</td>
<td>Most cost-effective service model preferred.</td>
</tr>
</tbody>
</table>

#### Figure 5: Service model targets for pre-determined key performance indicators.

*Please attach to drug chart/ward slip/TTO*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Ward</th>
<th>Pt. initials</th>
</tr>
</thead>
</table>

*Pharmacist to complete*

- Time screened
- No. of items required

*Dispenser to complete*

- Time screened
- Stock obtained from satellites
- Items required

*Checker to complete*

- Labelling error
- Dispensing error
- Delay (with reason)

#### Figure 6: Data collection proforma

*On-call data collection*

- If TTO - time Dr. signed off on NOTIS
- Critical item
- Inpatient item
- CD request
- Ward stock

- Mpharm
- ATO/Technician
- Pharmacist

- No. of items
- No. of satellites

- Time all items checked
- Technician
- Pharmacist
medications within an hour of prescribing; therefore a pharmacy dispensing time of 15 minutes allows for this target to be met.

Data collection
Data was manually collected at the point of screening and dispensing by pharmacy staff members carrying out those specific tasks, using a specifically designed proforma as documented in Figure 6.

Results
Audit data relevant to the KPIs was collected during the middle four weeks of each pilot to allow for a period of acclimatisation – data collection over a longer period was considered unrealistic due to the time intensive nature of data collection. As demonstrated within Figure 7, both models performed comparably and experienced a similar workload volume over the course of the respective fourteen week pilots. Urgent medication requests were processed with comparable efficiency (51% v. 48% dispensed within fifteen minute target) as were discharge medication requests (93% v. 92% dispensed within two hour target). One clear differentiator between the two service models was the projected annual pharmacist overtime cost associated with each - £2,122 for the HPSN model versus £5,665 with the NUH model.

As summarised in Figures 8 and 9, a higher internal dispensing error rate was reported using the HPSN model (3% v. 1%); however, the rate of errors leaving the pharmacy department and therefore reaching patients and clinical areas was higher with the NUH model (0.2% v. 0.5%).

Discussion
The KPIs investigated were considered appropriate measures of service quality for the following reasons:

Safe and accurate dispensing
NHS England have identified medication errors as a key patient safety area for improvement, which

<table>
<thead>
<tr>
<th>KPI</th>
<th>HPSN Model</th>
<th>NUH Model</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total items dispensed</td>
<td>953</td>
<td>864</td>
<td>0.09</td>
</tr>
<tr>
<td>Internal error rate (internal = detected by checker)</td>
<td>3%</td>
<td>1%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>External dispensing error rate (external = left dispensary)</td>
<td>0.2%</td>
<td>0.5%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Total urgent medication requests</td>
<td>70</td>
<td>40</td>
<td>0.21</td>
</tr>
<tr>
<td>Urgent medication dispensing in less than 15 minutes</td>
<td>51% (3 – 135 mins)</td>
<td>48% (4 – 83 mins)</td>
<td>0.34</td>
</tr>
<tr>
<td>Total TTOs dispensed (discharge prescriptions)</td>
<td>115</td>
<td>172</td>
<td>0.04</td>
</tr>
<tr>
<td>TTO dispensing in less than 2 hours</td>
<td>93% (9 – 271 mins)</td>
<td>92% (2 – 179 mins)</td>
<td>0.37</td>
</tr>
<tr>
<td>Frequency of inadequate stock availability at point of dispensing</td>
<td>4%</td>
<td>3%</td>
<td>0.29</td>
</tr>
<tr>
<td>Estimated pharmacist overtime cost per year</td>
<td>£2,122</td>
<td>£5,665</td>
<td>-</td>
</tr>
</tbody>
</table>

“One clear differentiator between the two service models was the projected annual pharmacist overtime cost associated with each - £2,122 for the HPSN model versus £5,665 with the NUH model.”
was also highlighted by the Francis enquiry. Providing a pharmacy service that upholds the ‘five rights of medicine administration’ comes under this initiative, therefore dispensing error rates represent a key indicator of the quality of the service.

Whilst analysing dispensing error rates, it is worth noting that there was a statistically significant difference in internal dispensing errors with the NUH model performing favourably. These ‘internal’ dispensing errors were detected prior to the medications leaving the dispensary. ‘External’ error rates (dispensing errors that left the department) and reported safety incidents were collated from official NUH incident reporting over the fourteen week duration of each pilot. During this period, four were reported whilst the service was provided using the HPSN model - two events related

![Dispensing Error Rate Graph](image-url)

**Figure 8: Dispensing error rates that were detected within the department (internal errors) and that left the department (external errors)**

![External Errors Table](image-url)

**Figure 9: The type of external dispensing errors that were reported with each model**
to a delay in treatment, one related to incorrect directions on a medication, and one related to an incorrect form of a medication. In contrast, six incidents were reported whilst the service was provided using the NUH model - one delay in treatment, two related to a supply of an incorrect form of a medication, two related to incorrect directions for a medication, and one medication supplied with an incorrect patient name.

There were low numbers of external dispensing errors reported for both models during the pilots, which were within national averages. Although more were reported with the NUH model (6 versus 4) it is difficult to draw any firm conclusions from this data due to uncertainty surrounding consistency of external error reporting rates and the relatively short duration of each pilot. It should be noted that no patient harm resulted from these reported errors.

In addition, the NUH model employed a locum pharmacy technician with no prior NUH experience whilst HPSN dispensary staff had negligible previous experience of inpatient dispensing, which may explain the higher internal error rate. It is expected that the error rate would improve with further experience in inpatient dispensing. Due to the small differences in quality and efficiency of the two models, it was deemed that these aspects of the service were comparable.

Prioritisation of clinically urgent medications

The NPSA alert from 2010 highlights the significant adverse consequences of delayed and omitted medications, and Trust medicines policy states that critical medicines must be administered within an hour of being prescribed. The results for urgent medication dispensing demonstrate no statistical difference in the quality or efficiency of the two service models.

Discharge prescription turnaround time

As documented in the QIPP initiative (Quality, Innovation, Productivity and Prevention) and Carter report, the NHS is targeting billions of pounds in productivity and efficiency savings. Facilitating timely discharges via efficient dispensing comes under this initiative and is a continuing key performance indicator for NUH pharmacy services - the NUH Pharmacy service is assessed by the Trust board and directors against a target dispensing time of 2 hours. The results for discharge medication dispensing demonstrate no statistical difference in the efficiency of the two service models.

Appropriate stock management

As described above, the NPSA alert from 2010 identifies that delayed and omitted medications can impact significantly on a patient’s quality of care. Furthermore, the Carter report of 2016 highlights effective medicines stock management as an integral factor in efficiency savings. The results for frequency of inadequate stock at the point of dispensing demonstrate no statistical difference in the efficiency of the two service models.

Cost-effective

With the QIPP initiative and Carter report in mind, the ability to provide a cost-effective service without compromising on quality and efficiency is a crucial consideration. Factors such
Although the pilots were conducted over a four week period for each pilot.

- Data collection relied upon staff completing audit forms at the time of screening, dispensing and accuracy checking. It is recognised that data may not have been recorded during the busiest periods due to time constraints, and therefore data collection was not comprehensive.

- Calculations of staffing costs utilised during the pilots are unlikely to fully represent the long-term service costs, due to the use of a sub-optimal skill mix and temporary staff during the pilots. Therefore, the cost-effectiveness comparison is reliant upon projected costs.

- NUH’s long-term departmental objectives and strategy align with Lord Carter's recommendations to maximise streamlining and efficiency in the medication process and centralise medication dispensing locations. All stakeholders and participants during the pilots were aware of NUH’s strategy which may have affected data collection due to the potential for bias.

**Conclusion**

Overall, the results of the pilot demonstrated the quality and efficiency of the service models employed were comparable, with variations in dispensing error rates noted but considered insignificant. Although limitations were identified with both models, these limitations were considered more manageable and far less significant than the identified constraints and risks with the preceding service model. The limitations identified with the HPSN model were resolvable during the short duration of the pilot; in contrast, the inefficient stock picking process and remote location for the NUH model were unresolvable without significant cost to the department (e.g. installation of automated dispensing system within stores) which was considered inappropriate at this time.

Furthermore, other key considerations included the sustainability of the service model and long-term cost-effectiveness. It was recognised that the HPSN service model was more aligned with the department's long-term goal to maximise streamlining of the medication process and increase efficiency. As documented by Lord Carter, the 'Hospital Pharmacy Transformation Programme’ recommends exploring opportunities to outsource services wherever appropriate, improving service efficiency and reducing unnecessary spending on hospital pharmacy services – the projected cost savings associated with NUH's redesigned service model aligns with these objectives.

It should be noted that the HPSN model is based upon experience of a service where clinical aspects of the hospital pharmacy service are completed by NUH employed clinical pharmacists, working in partnership with HPSN dispensing staff; this continues to provide the basis of the NUH out-of-hours clinical pharmacy service model to date. Although many NHS Trusts have already considered and employed outsourcing outpatient dispensing with varying degrees of success, NUH Pharmacy Department believe that their unique out-of-hours service model may be of interest to other NHS Pharmacy Departments re-evaluating their dispensing services.

**Declaration of interests**

The authors have nothing to declare.

“It was recognised that the HPSN service model was more aligned with the department’s long term goal to maximise streamlining of the medication process and increase efficiency.”
NUH Pharmacy Department believe that their unique out-of-hours service model may be of interest to other NHS Pharmacy Departments re-evaluating their dispensing services.

REFERENCES

COMING TO A TOWN NEAR YOU IN 2017 - A PHARMACY MANAGEMENT EVENT FOR MEDICINES

JoMO-UKCPA
National Diabetes Workshop
10 October 2017, London

Biosimilars - how will pharmacy manage the challenge?
In partnership with UKCPA and British Oncology Pharmacy Association (BOPA)
1 November 2017, London

Pharmacy Management National Forum Workshop
10 November 2017, London

Pharmacy Management Academy
See details for the next programme elsewhere in the Journal.

Details from jgriffiths@pmmmarketaccess.com
75c High Street, Great Dunmow, Essex CM6 1AE
Tel: 01371 874478
Homepage: www.pharman.co.uk
Email: pharm@pharman.co.uk

Further information relating to these events will be added onto the Pharmacy Management website events page which can be found using the QR code.
Survey Of Job Satisfaction And Future Intentions Of Community Pharmacists In Wolverhampton, England

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Abstract

Title
Survey Of Job Satisfaction And Future Intentions Of Community Pharmacists In Wolverhampton, England

Author List
Johal A, Morrissey H, Ball P.

Background
In 2016, the Department of Health announced £320 million in government cuts to the pharmacy sector. This is thought to have had an effect on patient access to services and resulted in hardship to community pharmacists, which may adversely have affected morale. There has been a significant change in the role of community pharmacists from a historic dispensing role to more clinical, patient-centred services. It is important to understand how pharmacists view the new roles and their intentions for the future.

Aim
The aim of this study was to administer a satisfaction and future intentions questionnaire specific to community pharmacists.

Methods
A mixed design questionnaire, based upon blended closed-end and free text questions was used. A convenience sample of 27 community pharmacists representing 20 Wolverhampton pharmacies was selected.

Results
This study found that patient interaction and professional clinical services are the source of greatest satisfaction whilst remuneration was the least. The proportion of pharmacists intending to stay in the community setting was 15% less than those who stated that they had intended to work in community upon graduation. The top two suggestions for increasing job satisfaction were an increase in patient service provision and closer integration into primary care.

Conclusion
Community pharmacists were particularly satisfied and motivated by the provision of patient-centred services.

Keywords: community pharmacy, satisfaction, career, pharmacists, patient care.

Introduction

The historical role of the community pharmacist in checking the appropriateness of a prescription, compounding, dispensing and labelling medications has changed considerably in recent years. The increase in original-pack dispensing and the rise of specialised extemporaneous compounding services has reduced such dispensing activities. The reclassification of a number of prescription medicines as ‘Pharmacy’ (P) medicines or general sales list (GSL), increased opportunities as independent prescribers, a shift in funding from that for dispensed items to the provision of clinical services and the upskilling of pharmacy technicians and support staff have all led to changes in the role of community pharmacists.

Given the background, it is important to understand how pharmacists view the new roles and their intentions for the future. This is important for the introduction of further developments and workforce planning.

Aim
The aim of this study was to administer a satisfaction and future intentions questionnaire specific to pharmacists. It was given to local community pharmacists to investigate their professional fulfilment and aspirations. It is important to secure an adequate community pharmacy workforce to service the expected extended opening hours and to provide patient education and the clinical services the NHS is aiming to provide to address the shortage of GPs.

Ethics
Ethics approval was obtained from the University of Wolverhampton School of Pharmacy Ethics Review Committee on 21 of November 2016.

Method and Design
This study was mixed, quantitative, qualitative and questionnaire-based. The questionnaire included pharmacist and pharmacy-related questions. The responses on satisfaction included a numerical scale from 1 to 7. The overall number of questions was kept low to minimise the time burden on already busy pharmacists.

The questions relating to satisfaction were synthesised from questions taken from a review of literature (Table 1) related to the assessment of job...
At the end of the survey, there was a free-text section that invited pharmacists to describe, in their own words, ideas they believe could make the community sector more attractive to undergraduates. The questionnaires were produced on Google™ Forms, an online tool for conducting a survey, and printed out for distribution to community pharmacies. A pack, which included an explanatory leaflet and three paper copies of the questionnaire, was prepared and delivered to each of the 30 selected pharmacies. The questionnaire link is at: https://docs.google.com/forms/d/14qr90Pg9Vwhol6Ensk5G4VJ5HfqwRtZTNzLOWMKus/edit

A list of registered pharmacy premises was obtained from the General Pharmaceutical Council (GPhC) website, current as of January 2017. The pharmacies with Wolverhampton postcodes were identified and given serial numbers. A sample of pharmacies was selected based on approaching those assigned an odd number (1, 3, 5, etc). All participating pharmacists were given a short verbal explanation on the purpose of the study and the content of the delivered pack, before being asked to fill out the questionnaire. To facilitate collection, the investigator either waited in the waiting area, returned at a pre-arranged later time or agreed that the responder return the completed survey by post.

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<tr>
<th>Satisfaction parameters</th>
<th>Literature</th>
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<tr>
<td>Relationship with management, colleagues and patients</td>
<td>Shann and Hassell (2006); Eden et al (2009).</td>
</tr>
<tr>
<td>Career progression</td>
<td>Hardigan et al (2010).</td>
</tr>
</tbody>
</table>
Data analysis

The questionnaire forms were returned to the investigator in unmarked envelopes to preserve the anonymity of the respondent whilst the information leaflet was retained by the pharmacy. Responses were given a serial number and entered onto an Excel™ spreadsheet. The demographic information was tabulated and presented as pie charts and bar graphs. The results for satisfaction on a numeric scale were analysed by calculating the mean and standard deviation (SD). The questionnaires were securely filed by the investigator and the electronic data was stored on password protected University of Wolverhampton.

<table>
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<tr>
<th>Participant details</th>
<th>Percentage</th>
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<td>Ethnicity</td>
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<td>• Relief pharmacist</td>
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<td>• Locum pharmacist</td>
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<tr>
<td>• Pre-registration pharmacist</td>
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<th>Pharmacy details self-reported by pharmacists</th>
<th>Percentage</th>
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<td>• Co-op</td>
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<tr>
<td>• Internet</td>
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<td>• Department store</td>
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<td>Location</td>
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<td>• Wolverhampton</td>
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<tr>
<td>• South Staffordshire</td>
<td>11%</td>
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</tbody>
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Table 2: Demographics of participants
servers and the investigator’s password protected laptop.

Results

The researcher approached 22 pharmacies and responses from 20 (91%) were received. No responses were received from two pharmacies because both pharmacy managers indicated that they did not have the time to complete the survey. Of the premises in which pharmacists responded, three premises provided three replies, three provided two replies and twelve provided a single response i.e. 27 pharmacists.

Demographics of participants

Demographic data collected in the survey is summarised in Table 2.
Ideal role at time of graduation

77% of participants wanted to work in community pharmacy on exit from University (Figures 1 and 2).

Two thirds of the reasons given for choosing community pharmacy roles were ‘family circumstances’ and ‘closer to home’ (Figure 3).

Satisfaction scores

Scores for satisfaction, where 1 is extremely dissatisfied and 7 extremely satisfied, are shown in Table 3 for the factors that were assessed.

Professional role

Satisfaction with the professional role was relatively high (mean 6.0): Table 3.

Professional support

Males and females equally considered professional support in areas such as other pharmacy staff (technicians) or in-house continuing professional development (CPD) as an important factor that impacted upon job satisfaction (mean scores 5.6 vs 5.7) with the youngest demographic feeling the most supported compared to 36-45 years (mean scores 6.3 vs 5.0). The greatest contrast was between the 25-35 age group relief pharmacist (scored 7.0) and independent contractors (scored 4.0): Figure 4.

Workload

Male and female satisfaction levels with workload was low (mean scores 4.8 vs 4.9). Older age groups were less satisfied with workload (36-55 age group scored 4.0 vs. 25-35 age group scored 5.2). The least satisfied by occupation role classification were pre-registration pharmacists from age group 25-35 years (scored 1.0) whilst the most satisfied were relief pharmacists at the same age group (scored 6.0): Figure 5.

Convenience of location or commuting

As with other items, male satisfaction was less than female (mean scores 5.9 vs 6.1). The 46-55 years of age were the most satisfied (scored 6.5) whilst 35-45 years the least (scored 4.7): Figure 6.

Management and Regulation

Male satisfaction was lower compared to female satisfaction, with 22.2% of males being moderately or extremely unsatisfied with the management and current pharmacy regulations. The two older age groups were more satisfied with this aspect of work (36-55 years, scored 6.0). The most satisfied (scored 7.0) groups were pharmacy managers in pharmacies owned by a single organisation, whilst most dissatisfied (scored 1.0) were pre-registration pharmacists at multiple pharmacies owned by a single proprietor: Figure 7.

Hours worked

Male satisfaction was lower than female (mean scores of 5.1 vs 5.9). Contractors were the most satisfied with the current community pharmacy roles (scored 7.0), with pharmacy managers also scoring relatively highly (scored 5.9). Pre-registration students in the 25-35 years group were the least satisfied (scored 2.0). As for those who are employed as part-time or on flexible hours, 50% were extremely satisfied as opposed to 29% of full-timers: Figure 8.

Patient Interaction

Patient interaction was reported to be the most satisfying aspect overall (mean of 6.4).

This was the most satisfying item for all respondents with all age groups (mean score of 6.0 or greater for both males and females). Contractors from the 36-45 age group, pre-registration pharmacists from the 25-35 age group and relief pharmacists from the 25-35 age group were particularly satisfied with this item (score 7.0): Figure 9.
### Table 3: Score of satisfaction where 1 is extremely dissatisfied and 7 extremely satisfied

<table>
<thead>
<tr>
<th>Responder</th>
<th>Professional role</th>
<th>Professional support</th>
<th>Workload</th>
<th>Compensation</th>
<th>Convenience of location or commuting</th>
<th>Management and Regulation</th>
<th>Hours worked</th>
<th>Patient interaction</th>
<th>Section for non-prescription products</th>
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</tr>
<tr>
<td>26</td>
<td>3</td>
<td>2</td>
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<td>2</td>
<td>3</td>
<td>2</td>
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<tr>
<td>27</td>
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<td>4</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

**Mean**: 6.0, 5.4, 4.9, 4.3, 6.1, 4.6, 5.7, 6.4, 4.7, 5.3
Sale of non-prescription products
This item was the least satisfying with a mean of 5.0 for males and 5.4 for females. Pre-registration pharmacists were the least satisfied in having this section included in the pharmacy they worked in (scored 4.3) and pharmacy managers were the most satisfied (scored 5.8). Of all ages, the 35-55 years age group were the most satisfied (scored 5.5): Figure 10.

Control over the pharmacy practice
Both male and female mean satisfaction scores were low (5.4 and 5.8). The 25-35 years age group were the most satisfied with the level of control over their practice (score 5.8). Pharmacy managers had higher satisfaction levels (scored 6.1) than all others. Part-time pharmacists were less satisfied than those employed full time (scores of 5.2 vs 5.8): Figure 11.

Future intentions to practice in community pharmacy
Out of all participants, 59% indicated that they would continue to work in a community pharmacy setting, 15% aimed for further training in pharmacy, 11% wanted to re-train in another career, 7.5% wanted to move into hospital and 7.5% wanted to move into industry or other employment: Figure 12.

The proportion of pharmacists intending to stay in the community setting was 15% less than those who stated that they had intended to work in community upon graduation.

Improvements to community pharmacy
Participants were given the option to select all applicable options which they believe can improve the community pharmacy sector. They were asked to add free text comment for any other options which were not listed. Of the suggested improvements options to community pharmacies, the one that resulted in the highest percentage (41%) was to improve funding for clinical services: Table 4.

When age groups were compared, the age group of 25-35 years in both genders were the group showing most interest to change the current practice model, in all listed options: Figures 13 and 14.
Figure 5: Satisfaction regarding workload by professional role and age

Key: X-axis scale; 1, extremely unsatisfied to 7, extremely satisfied.
Key: PR, pre-registration; LP, locum pharmacist; PM, pharmacy manager.

Figure 6: Satisfaction regarding location/convenience/commute by professional role and age

Key: X-axis scale; 1, extremely unsatisfied to 7, extremely satisfied.
Key: PR, pre-registration; LP, locum pharmacist; PM, pharmacy manager.
Figure 7: Satisfaction with regulation and management by professional role and age

Key: X-axis scale; 1, extremely unsatisfied to 7, extremely satisfied.
Key: PR, pre-registration; LP, locum pharmacist; PM, pharmacy manager.

Figure 8: Satisfaction with hours worked by professional role and age

Key: X-axis scale; 1, extremely unsatisfied to 7, extremely satisfied.
Key: PR, pre-registration; LP, locum pharmacist; PM, pharmacy manager.
Figure 9: Satisfaction with the level of patient interaction by professional role and age

Key: X-axis scale; 1, extremely unsatisfied to 7, extremely satisfied.
Key: PR, pre-registration; LP, locum pharmacist; PM, pharmacy manager.

Figure 10: Satisfaction with non-prescription sales section by professional role and age

Key: X-axis scale; 1, extremely unsatisfied to 7, extremely satisfied.
Key: PR, pre-registration; LP, locum pharmacist; PM, pharmacy manager.
Figure 11: Satisfaction with control over pharmacy practice professional role and age

Key: X-axis scale; 1, extremely unsatisfied to 7, extremely satisfied.
Key: PR, pre-registration; LP, locum pharmacist; PM, pharmacy manager.

Figure 12: Future career intention by Gender

Key: CP, community pharmacy; FS, further study in pharmacy; TI, transfer to industry; TH, transfer to hospital; NC, re-train for new career.
Free text box comments

There were 19 (70%) responses to this section. The responses were split up into eight themes which emerged during data analysis: Table 5.

Discussion

The survey was well understood by participants.

The sample had a high proportion of younger female pharmacists of ethnic minority background, which may not reflect the national workforce.

Patient interaction was the most fulfilling of the items. Increased funding for clinical services and extended professional roles were the most suggested improvements to be made in community pharmacy, which agrees with Grindrod and Seston. This may be driven from fulfilling the utilisation of their clinical skills and knowledge taught in the undergraduate pharmacy education courses, which are not currently fully utilised in the prescription dispensing process. The move to hospital pharmacy was considered by the younger age group even when they were satisfied with their current career (7.5%). This was confirmed by Hardigan and Silverthorne; the authors concluded that those who are ‘career orientated’ will consider the move to the hospital sector despite being satisfied in their current role in community pharmacy to seek greater professional development and career advancement opportunities.

In this study, hospital pharmacy was the choice of female pharmacists whereas males selected pharmacy contractors, which agreed with the finding of Willis. Older pharmacists were less likely to consider a change of sector. This may be due to ‘job embeddedness’ such as links

### Table 4: Suggested changes to community pharmacy by gender

<table>
<thead>
<tr>
<th>Option</th>
<th>Number of responses from females</th>
<th>Number of responses from males</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve funding for clinical services</td>
<td>14</td>
<td>8</td>
<td>41%</td>
</tr>
<tr>
<td>Regulate opening hours</td>
<td>5</td>
<td>1</td>
<td>11%</td>
</tr>
<tr>
<td>Improve waiting areas for patients and customers</td>
<td>3</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Regulate work-load</td>
<td>7</td>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>Time set aside for personal administration/lunch/clinical services/CPD</td>
<td>7</td>
<td>4</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Figure 13: Suggested improvements to community pharmacy by age groups in females
to community, perception of fit and perception of loss should they change; all of which concur with Mitchell. Grindrod suggests that pharmacists prefer providing services, which agrees with the finding in this study.

Differences in satisfaction with control of working practice mirrored those found by Magirr and Gidman with managers having greater satisfaction than trainees and full-time staff more satisfaction than part-time staff. This may be explained by organisational structure with employed pharmacists feeling a greater autonomy to make clinical and organisational decisions than part-timers, locum and pre-registration pharmacists.

The negative comments regarding not wanting to continue in community pharmacy are important as those are the reasons that frequently lead to community pharmacists changing sector or profession.

**Study Limitations**

There were a number of limitations to this study, which reduces its generalisability. The small sample size and reduced geographic distribution of the study produced a cohort that may not be fully representative of the national pharmacy workforce. The questionnaire will need to be validated in different cohorts to confirm that it is robust. The inclusion of questions on the number of years since graduation, ethnicity and previous career changes were overlooked.

**Conclusion**

Community pharmacy remains attractive for a substantial number of pharmacists who find meaning and satisfaction in their role as medicine experts, business owners, health care workers and managers.

There is obvious dissatisfaction with the lack of opportunities to provide patient-centred services. A younger workforce has a different expectation of their role and are prepared to leave the community pharmacy sector to move into hospital, industry or re-train for another career if opportunities for skills development and clinical skills utilisation are not available.

The development of clinical services may enable community pharmacies to provide a similar work environment to that in hospital pharmacy, which may attract more pharmacists to remain in the sector. As hospital pharmacy positions are limited, reforming the community pharmacy sector to be more attractive may also contribute to the retention of

“Community pharmacy remains attractive for a substantial number of pharmacists who find meaning and satisfaction in their role as medicine experts, business owners, health care workers and managers.”

---

**Figure 14: Suggested improvements to community pharmacy by age groups in males**

<table>
<thead>
<tr>
<th>Aspects of Change</th>
<th>Males 46-55</th>
<th>Males 36-45</th>
<th>Males 25-35</th>
<th>Males &lt; 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time set aside for personal administration/lunch/clinical services/CPD/</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Regulate work-load</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve waiting areas for patients and customers</td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Regulate opening hours</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Improve funding for clinical services</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of Responses
pharmacists in the profession if they become more satisfied with their community pharmacy role.

Community pharmacists must take the opportunities presented from the development of extended roles to confirm the contribution they can make and the added value it can bring to healthcare. It is essential for the profession to evaluate new roles and obtain evidence of benefit; only then will the NHS be prepared to consider providing additional resource.

**Practical implication:**

This project shown that pharmacists are interested and motivated by patient-centred services and opportunities for professional development.

As the sample population was small and limited to the Wolverhampton area, a larger study will be required before the finding can be deemed representative of the profession.

**Declaration of interests**

The authors have nothing to declare.

**Funding**

Self-funded.

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**Table 5: Themes identified regarding respondents’ suggestions to make community pharmacy more appealing to undergraduates**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Statements</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial benefits and security</td>
<td>• Better salary than NHS sector</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>• Better funding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Better funding to support all areas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stop docking pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pay should be increased - current pay not representative for pharmacists of pressure and responsibility in daily job</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Scheme should be introduced privately/separately for car hire/rental/loan specifically for pharmacist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Job security</td>
<td></td>
</tr>
<tr>
<td>Negative views towards the profession</td>
<td>• Would not recommend it</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• Retrain in another career or start in a new field</td>
<td></td>
</tr>
<tr>
<td>Change in work patterns</td>
<td>• More sociable hours</td>
<td>1</td>
</tr>
<tr>
<td>Interprofessional collaboration</td>
<td>• Earlier introduction into GP practice</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• More GP interaction</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>• More services to provide</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• New expanding roles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To provide further services to show not just about dispensing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• It’s best to get on with it and provide the services because that makes the career interesting</td>
<td></td>
</tr>
<tr>
<td>Patient interaction</td>
<td>• More patient-centred</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• Offer more patient interaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• More about patient care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• We need to interact with patients more and not consider them just a number</td>
<td></td>
</tr>
<tr>
<td>Curriculum changes</td>
<td>• Learn business</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• More experience in different environments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Option of independent prescribing as part of course</td>
<td></td>
</tr>
<tr>
<td>Regulatory and representation</td>
<td>• Less paperwork targets</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• Continue the professional representation at national level i.e. PSNC and government</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


Question:
What is your job title?

Answer:
Consultant Pharmacist, Respiratory and Sleep Medicine, Guy’s and St Thomas’ NHS Foundation Trust and Clinical Lecturer, Kings College London.

What are your main responsibilities/duties?
I run three outpatient respiratory clinics (Interstitial Lung Disease (ILD), COPD, severe asthma) and participate in respiratory virtual clinics where I go to GP surgeries and offer support in the management of patients with lung disease and breathlessness.

To whom do you report and where does the post fit in the management structure?
My line manager is the Associate Chief Pharmacist - Clinical Services, but my objectives are set by the Clinical Lead physician for respiratory medicine.

How is the post funded? Is the post funded on a non-recurring or recurring basis?
My post is in two portions, one delivering a service and funded by GSTT (0.6WTE), the other to and by two local CCGs (Lambeth and Southwark) at 0.4WTE. The post is substantive.

When was the post first established?
The post was established as a Principal Pharmacist position in Oct 2015, then made a consultant post a year later.

Are you the first post holder? If not, how long have you been in post?
Yes, I am the original!

What were the main drivers for the establishment of the post and how did it come about?
As an NHS England designated specialist centre for severe asthma and ILD, and having the largest sleep centre in Europe, there was recognition in GSTT that there were gaps in the service around medicines use that would be best filled by a pharmacist.

I had been at the Trust for nine years as the Principal Pharmacist for acute medicine, and always had a particular interest in respiratory medicine, so I had a lot of input into the purpose of the post and what the post holder should deliver.

With the current funding structure, the clinics I run attract an outpatient tariff, so the post easily pays for itself. With respect to the primary care portion, the value realised from the medicines optimisation and clinical support to GPs and practice nurses drove the bid. I’m lucky that the CCGs I work with have a track record of re-investing significant proportions of any drug saving in high value interventions and service delivery.

What have been the main difficulties in establishing/developing the post to its current level?
The process of having the position recognised as a consultant post was a challenge. Not because the job did not reflect the ethos of such a title, more that it wasn’t necessarily a priority. I had almost reached the point of giving up, but my physician colleagues kept on pushing – they wanted it even more than I did!

What have been the main achievements/successes of the post?
Having a post that straddles primary secondary and tertiary care gives a unique perspective and offers the opportunity to bring sectors together. The greatest achievement of this is in being co-chair of our Responsible Respiratory Prescribing group and agreeing an asthma and COPD guideline across six CCGs and four acute Trusts! I hadn’t properly understood the phrase ‘herding cats’ prior to this! In the 18 months since I have started, I have also grown the team to 0.8WTE 8a pharmacist for ILD and 1WTE for sleep medicine, with plans for many more pharmacist led clinics.

What are the main challenges/priorities for future development within the post, which you currently face?
Offering so many clinics is a fantastic way of delivering patient care, and this is the post’s raison d’être, but it doesn’t leave much room for other important consultant roles, for example professional leadership and research.

While physicians review their job plans annually and change PAs (planned activities, where one PA is a half day per week) based on local need and personal areas of interest/development, Agenda for Change (AFC) does not allow such...
flexibility and that’s frustrating. Fantastic opportunities arise, but often they simply have to be absorbed into an already busy schedule or missed because there isn’t ‘backfill’ for the time. I think there is also a need to better articulate the progression within consultant posts from 8b-d i.e. what takes you to the next tier and what make these posts career positions that grow and change in a similar way as the physician consultant posts do.

What are the key competencies required to do the post and what options are available for training?

Most of my training has come from doctors! I have been extremely lucky in my pharmacy career to spend time with incredibly supportive, clinically excellent and forward thinking medics. Witnessing first hand their interactions with patients, discussing the thought processes behind decisions (mine and theirs!) and working with them to provide care for individuals patients has been invaluable.

One problem with hospital pharmacy, is the relentless pace of problem spotting and solving; we rarely get the chance to reflect on the outcomes of the interventions we make and seldom get to build a rapport and really get to know patients. I think that is a real shame as it is one of the most motivating parts of my jobs. Having someone come back and tell me how much better they are gives you a glow like nothing else! Of course, things don’t always go to plan but there is a satisfaction that comes from having built the rapport and developed a relationship with the patient (and often their carers) such that they can come back and tell you that thinks aren’t right too. I look forward to hearing the phrase “I didn’t tell the doctor this, but…”

Working with GPs has sometimes been a challenge – I have seen them think and occasionally voice “who is this pharmacist advising me on what I should do with my patients”, but that too can bring about great satisfaction. When someone starts sceptical (openly disappointed that I am unaccompanied by a physician colleague even!), and you offer support and advice that they recognise as useful, then thank you for it, is a real buzz. It blurs traditional (in my opinion obsolete) professional barriers and encourages everyone to appreciate that our training provides varying and, often times, invaluable perspectives, including that multi-disciplinary working provides exceptional patient care. One of our greatest achievements was being welcomed back with tea and biscuits at a notoriously difficult practice. No greater compliment than being asked back, never mind being fed!

How does the post fit with general career development opportunities within the profession?

The majority of NHS interventions involve medicines, many of these are provided in outpatient settings, yet we continue to focus our attention almost exclusively on inpatient services. We want to put the patient at the centre of what we do, but we don’t use the clinical expertise we have developed through years of hospital training to support patients outside our hospital walls. I don’t really see how we can progress as a profession without taking on more of these kinds of roles.

How do you think the post might be developed in the future?

There should be more dedicated time for research and evaluation. It is important to investigate and publish the value of these roles to encourage development of similar roles elsewhere.

What messages would you give to others who might be establishing/developing a similar post?

You can’t do this on your own, you need at least one supportive and encouraging colleague with you. In my experience, consultant physicians are excellent ‘critical friends’.

Do you have any Declarations of Interest to make and, if so, what are they?

I have received payment for providing education sessions and advice and been supported to attend clinical meetings by AstraZeneca, Boehringer Ingelheim, Chiesi, GSK, Napp, Novartis, Pfizer and Teva.
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MANAGEMENT CONUNDRUM

Bonnie And Clyde

Carey Whitecoat thought something unusual must have happened when her friend Janet Donit, Chief Pharmacist at Metropolis NHS Trust, suggested getting a takeaway coffee and sitting in the park.

“I need some advice,” Janet explained, “but it’s a really sensitive issue. And I remembered you telling me once about an incident you had to deal with involving two of your staff members one Christmas.”

Carey looked a bit alarmed - the Christmas Party incident was not something she wanted to revisit. It had left her with a major headache to sort out.

“Is this the relationship thing?” she asked.

“I can’t name names, and you don’t know them anyway, so let’s just call them Bonnie and Clyde. Clyde is a pharmacist in my department and Bonnie is a senior technician, and they’ve been married quite a while.”

Janet took a sip of coffee to gather her thoughts.

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Janet took a sip of coffee to gather her thoughts.

“‘It seems they’re getting divorced and it’s all got very messy and spiteful. Their personal life is not really any of my business and I’ve told them both to leave that at the door when they get to work. A couple of the other technicians did, however, come to me last week and said that the department is suffering because people feel expected to take sides or support one or the other. Of course, more of them work with Bonnie than with Clyde, but Clyde is more senior. And it doesn’t help when two of your team aren’t speaking to each other.”

“Have you discussed it with your HR team?”

“I have, but they’re focussed on what you might call the disciplinary stuff. They didn’t have much to offer about how I get the staff to work together. That’s what I was hoping you might have some ideas about. If I get it wrong it could make things worse - and you did such a good job on that Christmas Party thing.”

I don’t think I did, thought Carey, but I’m glad others think so.

What would you say if you were asked? How do you manage workplace relationships?

Commentaries

John Terry,
Head of Pharmacy,
Neath Port Talbot Hospital
Email: john.terry@wales.nhs.uk

These situations are notoriously difficult to manage. Emotions run high and the simplest, and normally most straightforward domestic events in Bonnie and Clyde’s marriage can be clouded by a jaundiced view of the situation. This can often be embellished by either party to gain favour with colleagues. Neither party will want to lose face, especially with colleagues, many of whom they will have known for years. Where sensitivities from Bonnie and Clyde’s relationship are discussed with colleagues there is often credibility in each individual’s point of view. The result can be staff feeling very uncomfortable with having to agree/disagree or be subjected to having to choose a particular side. The uncomfortableness of these situations can put staff in an awkward position, consequently having a dramatic effect on staff performance, departmental atmosphere and even morale.

Having worked with both Bonnie and Clyde for quite some time, Janet Donit will have an insight into their personalities, their degree of openness and how they have managed the stresses and strains of working in a department together as a married couple. This can often lead to conflict with colleagues over departmental decisions, annual leave, etc and there must have been occasions when elements of tension have crept into their objectiveness. Both will have felt somewhat uncomfortable at some point in their relationship where there has been conflict between departmental and marital priorities.

Although an old management cliché, one approach here is ‘to begin with the end in mind’. In this instance that means...
being mindful of Bonnie and Clyde’s feelings and the charged emotions both will experience but also the need to minimise the effect on each individual’s work performance, that of colleagues and the department.

Janet will need an open and honest discussion with both Bonnie and Clyde - this may be done collectively or as individuals dependent on their personalities. Clarity is vital, Janet will have to be explicit and make it clear that she is not there to take sides, but to listen to their concerns and help them through this traumatic period. Exhibiting sensitivity and empathy for Bonnie and Clyde in this manner will make them feel they are not alone going through this without departmental support and that she appreciates how difficult the situation must be for both of them.

Janet will then have the platform to outline her management responsibilities, principally to ensure that a safe, effective service is provided by the department. As professionals they should be reminded to put the patient at the centre of everything they do. Any personal conflict thrown up by the divorce that creates work difficulties can be discussed with Janet directly. She will then be in a position to plan working arrangements to avoid further deterioration of any flashpoint situations. Janet must explain that colleagues cannot be embroiled in any conflict as the strength of the service is in the pharmacy team, which ultimately delivers a first-class patient focussed service. Janet Donit should ask Bonnie and Clyde to reflect on how their behaviour could have an adverse affect on the service and, in particular, on colleagues within the department. Ultimately, they will both be mindful to respect Janet’s position, continue to work professionally and cause minimal disruption to departmental working life.

There are probably several instances where they work together. In the short term it may be advisable to try and work through options to minimise these situations. In this way it is possible to minimise further conflict and the opportunity for a flashpoint where colleagues feel uncomfortable. The rationale for this should be explained to other departmental members. They will understand the need for this approach while Bonnie and Clyde go through this difficult and immediate period.

“Clarity is vital, Janet will have to be explicit and make it clear that she is not there to take sides, but to listen to their concerns and help them through this traumatic period.”
Good relationships are key to accomplishing success at work. Janet needs to actively work at building and maintaining relationships in the workplace and be aware and open to others’ situations. Trust, respect, support, openness and effective communication are key to promoting a positive work culture.

Working relationships have broken down in Janet’s department and are causing conflict and awkwardness. The technicians are already saying that the department is suffering. This is an extremely stressful and sensitive situation.

She needs to think about the impacts divorce can have on both Bonnie and Clyde and their colleagues such as low morale, decreased productivity, poor performance and potential mistakes. There is generally no formal policy or procedure within organisations and little acknowledgement of how difficult divorce and separation can be. Yet divorce is generally listed as one of the top five most stressful life events along with experiencing a family bereavement. It has a similar pattern of emotional response including shock, anger, denial, panic, grief and acceptance.

So, Janet needs to consider how she can not only support the couple through their divorce but also ensure that the whole team is happy and productive and feels ‘joy at work’.

Janet has already talked to the couple but now that the team is suffering she needs to ‘nip this in the bud’ and talk to Bonnie and Clyde together to ensure they understand the impact that their divorce is having on the team and what the result could be. Maybe they are caught up in their own stress and don’t even realise that others feel expected to take sides. She can be empathetic to their stressful situation but also reinforce the need for them to act in a professional manner throughout and reiterate that they do not bring their personal life into work.

Janet needs to:
- be compassionate, empathetic and supportive but not act as a problem-solver
- maintain her role as manager and not become the therapist
- be flexible to their needs e.g. work-life balance policy to enable them to deal with the issues the divorce throws up
- direct them to appropriate organisational and outside support and resources
- be a good listener but avoid giving personal advice
- keep her distance and avoid becoming the go-to person for divorce issues.

“There is generally no formal policy or procedure within organisations and little acknowledgement at how difficult divorce and separation can be. Yet divorce is generally listed as one of the top five most stressful life events . . .”
The team is already suffering, whether
Bonnie and Clyde are aware or not, so
Janet should ask the couple to jointly meet
with the team, explain their situation and
help people to understand this new phase
of their life, understand the consequences
of their divorce, apologise for any
difficulties the team has already
encountered and reassure colleagues that
they will remain professional, keep their
personal life outside work and do not
expect people to take sides.

She should also explain to Bonnie and
Clyde that, whilst she acknowledges their
personal problems, the functioning of the
team is her paramount concern. She
needs them to maintain an appropriate
work relationship and, if the team
continues to feel under pressure, she will
need to consider how and where each of
them works.

At the end of the day maintaining
good relationships is all about the
‘3 Cs’ - communication, communication,
communication!

Declaration of interests

● John Terry: Member of the Editorial
Board, Journal of Pharmacy
Management (JoPM). Personal fee
from Pharmacy Management for
writing the commentary.

● Sharon Pfleger: Member of the
Editorial Board, Journal of Pharmacy
Management (JoPM). Personal fee
from Pharmacy Management for
writing the commentary.

“. . . now that the team is suffering she needs to ‘nip this
in the bud’ and talk to Bonnie and Clyde together to
ensure they understand the impact that their divorce is
having on the team and what the result could be.”
A Change Of Thought

By Tom Phillips, lead trainer at Pharmacy Management, who has enjoyed 20 years of working with both the private and public sector, during which time he has gained extensive experience and demonstrated considerable success in management, sales, marketing and training. Tom is an excellent communicator and motivator and has designed/delivered training at all levels from trainees to directors at both a national and international level. Such is Tom’s love of training and development that, in his personal life, he is also a qualified fitness and diving instructor.

The only constant in life is change. This is true in most walks of life and especially the NHS. We all respond to change in different ways. For some of us it can be quite daunting, for others is it invigorating. Some of us embrace change with open arms. Some of us avoid change at all costs, burying our heads in the sand and hoping that the change will pass us by. In situations like these, when we finally do lift our heads we notice that the world has changed regardless.

So, we can let change happen to us, or we can make change happen for us. In most cases organisational change is inevitable, so it makes sense to look for the positives in the situation, both individually and collectively.

It makes sense to examine our own thought processes around change. Basic psychology tells us that the way we think about a situation determines the way we feel about that situation and the way we feel has a huge impact on the way we act when in that situation. If we have negative thoughts and feelings about change, we are likely to act negatively as the change takes place. If, however we look for the positives in the changing situation, we are more likely to enjoy the change. Which would you rather do?

If being part of change is challenging, leading and managing change can be even more so. However, none of us who moved in to a management or leadership role wanted an easy life, right?

Here are some top tips on leading and managing change.

- **Lead by example**
  If you are going to manage change, you need to make sure that you are thinking, feeling and acting positively. If your words say one thing, but your actions say another, your people will spot this easily and no matter how convincing you try to be, your messages will get lost. So, make sure you have the support you need to see through the change process.

- **Communicate early and often**
  One of the worst things that can happen at a managerial level is nothing. No one communicates with their staff and this leads to uncertainty. Worse still, in the absence of communication from above, staff assume the worst and start to fill in the blanks. So, communicate often, even if it is just to say that there is no news.

- **Communicate the bigger picture honestly and simply**
  People need to know why the change is happening, when it is going to happen and how it will affect them individually and collectively. When you communicate these facts, keep your language simple and honest. Avoid using management jargon such as “strategic realignment of operational personnel” which most people will interpret as “jobs are going”. People need to feel secure during change and using language that confuses them will alienate them and lead to feelings of resentment.

“If you are going to manage change, you need to make sure that you are thinking, feeling and acting positively.”
• **Allow time for one to one discussions**
  As a team leader or manager you owe it to your staff to give them time to discuss their concerns (no matter how strange these may seem) with you. Again, during these conversations be as honest as possible, even if you are delivering bad news. You may also need to allow for several one to ones with the same individual as some of us need more reassurance than others.

• **Create change champions**
  As mentioned above, some of us respond to change very positively. Identify those people in your team and organization who fit this bill. Allow them individually and collectively to become champions for the change that they are going through. Allow your change champions to have meetings with other individuals who are more reluctant about the change. It is powerful for concerned individuals to see how their more positive peers are responding to change.

• **Celebrate short term wins**
  As the change process you are entering starts to unfold, look for and celebrate examples of individuals or teams who are embracing the change and driving it through. Think about small awards at team meetings and newsletters to recognise and celebrate the change as it takes place. Even a simple verbal or written “well done” can have massive motivational impact. The other good thing about celebrating your wins is that they help to reduce any remaining cynicism in those individuals that are still resisting the change.

• **Make short term wins stick**
  Many change experts, such as John Kotter, illustrate that change fails because once the deadline for change has passed, many individuals and organisations go back to doing things ‘the old way’. As a leader or manager, we need to ensure that the new way remains the new way. This may involve rewriting SOPs, job descriptions, minimum performance standards etc. It is also a good idea to continue to review both individually and collectively, how the change is being implemented in the present day and how things could be improved in the future. We know that the world moves on at a pace, so change that has made us successful today, may be redundant 12 months from now. You and possibly your change champions need to be horizon scanning for future change opportunities.

• **Review and progress**
  Once the change process is complete you should be looking to review it and determine what worked and what you would improve next time, because there will, inevitably be, a next time.

**Declaration of interests**
Tom Phillips discloses payment for writing the article and professional fees from Pharmacy Management outside the submitted work.

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