South West Pharmacy Research Network

Annual Innovation Day, Tuesday 21st October 2025

Venue: E5 Bristol (aka Elim Church), 3-15 Jamaica Street, Bristol BS2 8JP

Supported by South West Central Regional Research Delivery Network and NHS England

Morning Programme

9.30	Registration and Refreshments
10.00	Welcome (Matthew Jones)
10.05	Embracing the squiggly path: a journey through pharmacy, research and inclusive leadership? (Hadeel Mohamed)
10.45	Community pharmacy: RAPID IMMUNE TEST study, examining point-of-care testing for acute upper respiratory tract infection (Andrew Turner, Emily Brown and Jonathan Campbell)
11.15	Refreshments and networking
11.45	General practice: the Improving Medicines use in People with Polypharmacy in Primary Care (IMPPP) study (Rupert Payne and Simon Strange)
12.15	Hospital pharmacy: the BCMAPS study, which is examining the impact of bar code medication administration (Aseel Mahmoud and Mandy Slatter)
12.45	Lunch

Afternoon Programme

13.15	Poster Talks
14.00	Workshops (choose one) Workshop 1: Improving the Quality of Quality Improvement (Kevin Gibbs, University Hospitals Bristol and Weston NHS Foundation Trust) Workshop 2: Research Delivery Network strategic funding - developing ideas to unblock research in pharmacy (Chris Voisey and Kelly Spencer, South West Central Regional Research Delivery Network)
15.10	Refreshments and networking
15.40	Summary, prizes and looking to the future (Matthew Jones)
16.00	End of the day

Contents

Foreword

It is my great pleasure to welcome you to the South West Pharmacy Research Network Annual Innovation Day 2025. This event has become a cornerstone of our mission to foster collaboration, share ideas, and inspire pharmacy professionals across our region to engage with research. Over the past year, our network has continued to grow and thrive. We are a vibrant community of over 300 members representing every sector of pharmacy—community, primary care, hospital, academia—and every stage of the research journey, from those taking their first steps to experienced researchers. Our regular journal clubs and webinars provide spaces for learning and discussion, while our newsletter and Microsoft Teams hub have become a go-to resource for sharing ideas and finding collaborators. We recently launched our Directory of Expertise, which you can access on Teams to find new collaborators and mentors.

All this work has been noticed by people in other parts of the country, and over the last year we have been pleased to share our experience with colleagues from other regions and professions. Of course, we continue to engage with the NIHR Incubator for Pharmacy Professionals and recently submitted a response to the UK Pharmacy Research Advisory Group , ensuring that our region plays a key role in shaping the future of pharmacy research.

This year marks an exciting milestone with the formation of our new organising committee, which will help steer the network's activities in a more sustainable and strategic way. The committee comprises:

- *Matthew Jones – Chair*
- *Tom Kallis – Communications Lead*
- *Victoria Ling – Membership Engagement Lead*
- *Susie Gage – Online Events Lead*
- *Natasha Hamilton and Wes Hughes – Innovation Day Lead*

Their energy and ideas will be vital over the coming three years and we are very grateful to them for stepping forward. Most of the committee are here today, so do introduce yourself to them and share your suggestions.

Today's event would not have been possible without the dedication of our Innovation Day organising committee. My sincere thanks go to Aseel Mahmoud, Mary Carter, Charley Hobson-Merrett, Ilhem Berrou, Jenny Scott, Tom Kallis, Simon Strange, Stuart Spicer and Ya-Hui Liang. Your hard work and creativity have ensured a programme that is both inspiring and practical.

Thank you for coming today and being part of this journey. Your enthusiasm and commitment are what make this network so special. Together, we are building a culture of research that will improve patient care, strengthen our profession, and create opportunities for all.

Enjoy the day!

Matthew Jones
Chair, South West Pharmacy Research Network

Full Programme

All sessions will be in the main auditorium at E5 unless otherwise indicated

Time	Session
09:30	Registration, refreshments, networking and posters
10:00	Welcome Matthew Jones (University of Bath and Chair of SWPRN)
	Keynote address
10:05	Embracing the squiggly path: a journey through pharmacy, research and inclusive leadership Hadeel Mohamed: PhD Researcher at the University of Bradford, Deputy Head of Clinical Pharmacy and Education Lead at South and East Leeds GP Group, Research Lead for the Primary Care Pharmacy Association, committee member for the Primary Care Academic Collaborative, and member of the Primary Care Expert Advisory Group (RPS)
	Delivery of multi-centre pharmacy research studies
10:45	Community pharmacy: the RAPID IMMUNE TEST study, which examined point-of-care testing for acute upper respiratory tract infection Andrew Turner and Emily Brown (both University of Bristol), and Jonathan Campbell (Old School Pharmacy Fishponds, Bristol)
11:15	Refreshments, networking and posters
11:45	General practice: the Improving Medicines use in People with Polypharmacy in Primary Care (IMPPP) study Prof Rupert Payne (University of Exeter) and Simon Strange (Avon and Wiltshire Mental Health Partnership NHS Trust)
12:15	Hospital pharmacy: the BCMAPS study, which is examining the impact of bar code medication administration Aseel Mahmoud (Imperial College Healthcare NHS Trust) and Mandy Slatter (Royal United Hospitals Bath NHS Trust
12:45	**Lunch** (provided), networking and posters
13:15	Poster talks - 3 minute presentations in front of each poster
	Workshops
14:00	**Choose one from the below** Workshop 1 (Champion Hall): Improving the Quality of Quality Improvement (Kevin Gibbs, University Hospitals Bristol and Weston NHS Foundation Trust) Workshop 2 (Training Suite 1): Research Delivery Network strategic funding - developing ideas to unblock research in pharmacy (Chris Voisey and Kelly Spencer, South West Central Regional Research Delivery Network)
15:10	Refreshments, networking and posters Matthew Jones (University of Bath and Chair of SWPRN)
15:40	Summary of workshops, prize presentation and next steps

Funding

This event is funded through the generous support of the South West Central Region Research Delivery Network, and NHS England. The South West Pharmacy Research Network is a collective endeavour across multiple organisations and individuals. Our innovation days would not be possible without the external funding provided by local stakeholders. We are deeply grateful for the support our funders have provided to make our 2025 innovation day possible.

Information stands

We are delighted to welcome the following organisations to our Innovation Day:

- Society for Academic Primary Care (SAPC)
- Pharmacy Workforce Development South (PWDS)
- South West Central Research Delivery Network
- SWPRN – research prioritisation and directory of expertise projects

Each organisation will have a table of information downstairs at the back of the auditorium and representatives will be on hand to answer any questions you may have.

Social media

If you're a social media user, please help us publicise the network by sharing news of the day using the hashtag #SWPRN25. The South West Pharmacy Research Network has a social media presence on:

- LinkedIn
- X (formerly known as twitter)
- Bluesky
- Substack

Please do find and connect with us on the social media platform of your choice!

Posters

During the day, the delegates' posters will be displayed at the back of the auditorium, downstairs. These posters describe many types of project, including research, audit, service evaluation and quality improvement. Some may describe final results, research proposals or projects that are ongoing.

There will be a very short talk from the author of each poster starting at 13.15. Please do take time to look at the posters - your interest will be very encouraging for the researcher!

Poster abstracts are presented on pages 9 - 45 of this programme.

Poster prizes

During the day, a team of judges will view all the posters and decide on first and second place winners in the following categories:

- Best poster from a healthcare organisation
- Best poster from a university or college
- Most visually attractive poster
- Delegates' choice*

Prizes (online vouchers) will be sent to first & second place winners after the Innovation Day.

*We will be asking all delegates to vote for their favourite posters, to decide the winners of the delegates' choice prizes. Please look out for QR codes around the venue that will take you to the voting form and make sure you vote by the end of lunch.

Poster abstracts

Poster 1: Medicines Information Needs Following Bariatric Surgery

Author(s): Danielle Wigg; Matthew Jones; Nikoletta Fotaki

Introduction:

Obesity represents a significant threat to global public health, with an estimated 29% of adults in England being classified as people with obesity, with a BMI (Body Mass Index) of 30 or more (1). Bariatric surgery is regarded as the most effective treatment option for people with obesity, with the two main types of bariatric surgery being Roux-en-Y gastric bypass (RYGB) and laparoscopic sleeve gastrectomy (LSG) (2). Multiple changes to formulations and post-operative dosage form manipulation may lead to increased medicines information needs and medication-related issues following bariatric surgery, compared with the general population.

Aim:

To explore how patients' medicine information needs change from pre-surgery to one-year post-bariatric surgery and if these needs are currently met.

Methods:

The study was conducted at North Bristol NHS Trust, which provides primary and revisional bariatric surgery to the residents of Bristol, South Gloucestershire and North Somerset. Data was collected from participants (inclusion criteria: listed for bariatric surgery (RYGB and LSG), fluent in English and are routinely managed on long-term medication), at their routine outpatient appointments at approximately the following time-points: pre-operative assessment; 4-6 weeks; 3 months; 6 months and 12 months post-surgery. A self-administered online and paper survey was developed, containing an adapted version of the Satisfaction with Information about Medicines Scale (SIMS®-BAR) and the Medication Adherence Report Scale® (MARS), which was included for criterion validation. The developed tool was designed to be self-administered and was completed by the individual participants to avoid bias. SIMS®-BAR was scored using criteria established by Horne et al for SIMS®, with a higher score indicating increased satisfaction with medicines information following bariatric surgery and with a maximum score of 17. MARS®-5 is designed to incorporate a 5-point Likert Scale (total score 5-25), with a high score indicating higher adherence to regular medication post-bariatric surgery.

Results:

To date, complete data at time 0 are available, with 162 participants recruited pre-surgery. The participants recruited identified predominately as female and White British (83.95% and 87.04% respectively), with a mean age reported of 45 years (range 24-65 years). At time 0, the median reported SIMS®-BAR was 16 (IQR: 12; 17; min: 5; max: 17). Spearman's rank correlation was performed between SIMS®-BAR and MARS-5® at time 0, with a Spearman's rho of 0.14 ($p = 0.08$).

Conclusion:

Pre-bariatric surgery, the study participants reported good satisfaction with medicines information, with their needs adequately met. There is limited evidence for the criterion validity of SIMS®-BAR at this point, but the skewed distribution makes it difficult to assess and this will be reviewed when data from later time points is complete. The next steps of the study will be to analyse satisfaction with medicines information needs post-bariatric surgery and to determine if this alters with time post-surgery.

References:

Digital NHS. Statistics on Obesity, Physical Activity and Diet, England, 2019 [Available from: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/statistics-on-obesity-physical-activity-and-diet-england-2019.]

Cercato C, Fonseca FA. Cardiovascular risk and obesity. Diabetology & Metabolic Syndrome. 2019;11(1).

POSTER 2 A mixed-methods exploration of medication as a barrier to breastfeeding with intervention development

Author(s): Ms Rachel Pilgrim[1], Dr Abbie Jordan[1], Dr Sarah Chapman[2], Dr Matthew Jones[1]

[1] Department of Life Sciences, University of Bath

[2] Institute of Pharmaceutical Science, Kings College London

Introduction:

The poster will describe a PhD project that is commencing this year (so no results yet).

Breastfeeding offers significant health benefits for both mothers and infants, in addition to economic benefits. Although many medicines are not licensed for use during breastfeeding, post-marketing data frequently suggests they are safe. Yet, survey data suggests breastfeeding women are apprehensive about using medication.

A recently published systematic review has shown that women in high-income countries stop breastfeeding due to medication, even though most medicines are safe. Discontinuation rates are 2-18% in general populations, and 2-58% in those with chronic conditions. Twenty-nine medicines have been implicated; all except one are likely safe in breastfeeding. Healthcare professionals are an influencing factor. Lower education, Caesarean section, chronic conditions, less breastfeeding experience and pre-pregnancy smoking may be risk factors. Data is however limited by heterogeneity, high risk of bias and low population diversity. Very little of this data is UK-specific (1).

Aim:

To explore decision-making around breastfeeding while taking medication in the UK and use this information to design an intervention to reduce the prevalence of medication-related breastfeeding discontinuation or non-initiation.

Methods:

Phase 1: Mixed-Methods Surveys

Three hundred pregnant women across three UK regions will be recruited. Data will be collected using surveys pre-birth and at 1, 3, 6, and 9 months postpartum. Quantitative data will measure rates of discontinuation or avoidance due to medication, including safe versus unsafe drugs, temporary withholding, and medication avoidance. Qualitative data will explore influencing factors using the Theoretical Domains Framework. Medications will be classified for breastfeeding safety using Hale's and LactMed guidelines.

Phase 2: Semi-Structured Interviews

Twenty women will be selected from phase one to capture diverse experiences with medication-related breastfeeding decisions. Interviews will explore support, advice, decision-making factors, emotional responses, and care satisfaction, using the Theoretical Domains Framework and Theoretical Framework of Acceptability. They will be conducted flexibly, in-person or remotely, with sessions accommodating childcare needs and interpreters if required. Interviews will be audio-recorded, transcribed verbatim, and analysed thematically to provide in-depth understanding of influences on medication-related breastfeeding discontinuation and non-initiation.

Phase 3: Intervention Development

Data from phase one and two will be used to inform an evidence-based intervention to prevent medication-related breastfeeding discontinuation. Two co-production workshops will be conducted, employing breastfeeding women as well as other stakeholder healthcare professionals to aid in design. Possible outputs may include decision aids, educational tools, monitoring, or consultation resources.

Conclusion:

Why this matters?

Understanding why women might stop breastfeeding due to medication is crucial, helping inform the design of an evidence-based intervention

Supporting women to breastfeed while taking medication could:

Improve maternal and infant health outcomes

Reduce avoidable discontinuation of breastfeeding

Empower healthcare professionals to give confident, evidence-based advice

References:

Pilgrim R, Kwok M, May A, Chapman, S., Jones MD. The effect of medication use on breastfeeding continuation: a systematic review with narrative synthesis. Int Breastfeed J. 2025;20:59.

POSTER 3 Evaluation of NHS England Foundation Trainee Pharmacist Supervisor Support Webinars

Author(s): Jaina Nyame (NHS England Workforce, Training and Education)

Introduction:

In January 2021, the General Pharmaceutical Council introduced revised Standards for the Initial Education and Training of Pharmacists (1), bringing significant changes to foundation training. To support supervisors and employers, NHS England Workforce, Training and Education Pharmacy Team - South West (NHSE) delivered five virtual webinars covering key aspects of the reforms. After each session, participants were invited to complete a feedback survey to assess the effectiveness of the training.

Aim:

To assess the effectiveness of NHSE webinars in supporting supervisors and employers to implement the revised foundation training standards. Specific objectives were to evaluate participant satisfaction with content, delivery, and relevance; identify the most valued aspects of the sessions; gather suggestions for improvement; and determine additional training needs to inform future support provision.

Methods:

A post-workshop feedback survey was developed and administered using Microsoft Forms. The survey consisted of structured items to capture participants' satisfaction with workshop content, delivery, and relevance, along with open-ended prompts for qualitative suggestions and future training needs. The survey was distributed at the end of each webinar via a QR code and through follow-up email to maximize response rates.

Results:

Respondent demographics are shown in Table 1. Most rated the workshops positively: 94% for topic relevance and timing, 91% for content and resources, 88% for facilitator clarity, 82% for engagement, 79% for handling questions, and 76% for encouraging participation. Key benefits were peer learning (30%), clear presentation (12%), and resource signposting (12%). Suggested improvements included condensing content (12%), addressing administration issues (6%), and adding practical examples (9%). While 64% felt training needs were met or planned, additional requests included case studies, mentorship training, and a "back to basics" session for non-pharmacist supervisors.

TABLE 1 – respondent characteristics

Respondent characteristics	Number of respondents
Designated Supervisor (DS)	3
Designated Prescribing Practitioner (DPP)	13
Designated Supervisor (DS) and Designated Prescribing Practitioner (DPP)	7
Education Lead	6
Education lead and Designated supervisor	4
Community sector	5
GP sector	10
ICB sector	1
Hospital sector	14
Did not disclose sector of practice	3

Conclusion:

The webinars were effective in supporting supervisors' understanding of the revised foundation training standards, with high satisfaction across content, delivery, and relevance. Peer learning and resource signposting were particularly valued, while suggestions highlighted the need for more practical examples and content tailoring for non-pharmacist supervisors. The findings will inform future sessions, which will address identified gaps and incorporate requested topics. Ongoing evaluation will ensure the support offer continues to meet evolving training needs.

References:

General Pharmaceutical Council (GPhC), 2021 Standards for the Initial Education and Training of Pharmacists

POSTER 4 Research Proposal: Medicines associated with falls requiring Urgent Community Response (UCR) attendance

Author(s): Tom Gregory (UWE)

Introduction:

1 in 3 people aged over 65 falls every year (1), resulting in over 220,000 emergency hospital admissions and healthcare costs of up to £4 billion (2). Polypharmacy, defined as taking ≥ 5 medicines, is one of the main risk factors for falls, and if modified, can prevent falls. While extensive literature exists on the fall risks of individual medicines, little is known about how polypharmacy contributes to the risk of falls.

Aim:

This study aims to assess how different combinations of medicines affect the risk of falls among people attending the UCR service. UCR is a community service provided by a Rapid Response service within Somerset where patients require intervention following a fall but may not necessarily require a hospital admission.

Methods:

The proposal will record the list of drugs (as individual chemical entities) prescribed at the time of the UCR attendance to patients. This data will be recorded and linked to an anonymised patient identifier to record multiple attendances to the same patient. Data will be collected over a full year to eliminate any seasonality in results, but it is likely that a shorter pilot would be used to test methodology. The UCR attendance will be used as a marker for patient groups at increased risk of falls (and indeed have had a fall) to support clinicians to review high-risk combinations of medicines rather than simply to focus on specific groups of medicines.

Intended Outcomes:

This research proposal aims to further the existing evidence base around medicines increasing the risk of falls and to attempt to identify and quantify the increased risk which combinations of drugs may pose. This will also allow improvements in the quality of care, moving from reacting to falls to proactive and anticipatory review of medicines to prevent falls, and allow the development of screening tools to support decision making for clinicians.

Although falls are multifactorial, further understanding of medicines risks can improve the safety of prescribing and may lead to cost savings for health services.

References

1. Sharma S, Fida S, Soriano F. Impact of Polypharmacy on falls risk in elderly (>65years)-

A Balancing Act | British Geriatrics Society [Internet]. Bgs.org.uk. 2024. Available from:

https://www.bgs.org.uk/impact-of-polypharmacy-on-falls-risk-in-elderly-65years-abalancing-act

2. GOV.UK. Falls: Applying All Our Health [Internet]. Gov.uk. 2022. Available from: https://www.gov.uk/government/publications/falls-applying-all-our-health/fallsapplying-all-our-health

POSTER 5 Development of network guideline, using rivaroxaban for primary thromboprophylaxis, in children with a Fontan circulation

Author(s):

S Gage, Paediatric Pharmacist, Bristol Royal Hospital for Children,

C Danielsen, Paediatric Pharmacist, Noah's Ark Children's Hospital for Wales,

J Gibb, Paediatric Cardiac Registrar, Bristol Royal Hospital for Children,

K Parsons-Simmonds, Paediatric Cardiac Nurse Specialist, Noah's Ark Children's Hospital for Wales

Background

The Fontan procedure or total cavopulmonary connection was first described in 1971 by Francis Fontan, a French cardiac surgeon. The aim of the Fontan operation is to secure reliable systemic and pulmonary blood flow in patients with only one functional ventricle, ensuring that only deoxygenated blood goes to the lungs and oxygenated blood is pumped to the body. People with a Fontan circulation are at risk of developing blood clots, so life-long anticoagulant therapy is required.

Situation

Across our Congenital Heart Disease Network (CHDN) there are 107 patients with Fontan circulations on warfarin, with an average additional 8 patients annually. Warfarin monitoring requires regular significant costs of INR monitoring; multidisciplinary team time managing the results, cost of Coaguchek® machine, testing strips, inpatient management, when initiating warfarin and subsequent admissions, when results are significantly out of range. In many cases, being on warfarin adversely affects patients and their families' quality of life.

There is huge variability and a lack of consensus internationally regarding anticoagulation regimens. The American College of Cardiology details the use of novel oral anticoagulants and acknowledges their use in children for thromboprophylaxis with Fontan circulations (1). Rivaroxaban is a direct factor Xa inhibitor and is licensed in the United Kingdom (U.K.), from term neonates, for treatment and prevention of venous thromboembolism. The UNIVERSE study evaluated the use of rivaroxaban in children with Fontan circulation (2). It demonstrated similar safety and efficacy profile to that of aspirin. It is licensed in the United States for use as thromboprophylaxis in children 2 years and older, who have undergone the Fontan procedure. It's main advantage is that it doesn't require routine monitoring.

Rivaroxaban was proposed as an alternative to replace warfarin as the first line anticoagulant for primary thromboprophylaxis in Fontan patients within the CHDN. An interprofessional meeting was held between level 1 and level 2 cardiac centres: involving pharmacists, cardiologists, cardiac nurse specialists (CNS) and haematologists. A guideline and patient information leaflet were developed and edited with feedback shared to all relevant hospital and CHDN governance and special interest groups, including the Paediatricians with an expertise in Cardiology.

Conclusion

Since approval of the guideline, existing warfarin patients around the CHDN have been contacted and asked to consider a switch to rivaroxaban. Formulary applications have been written and there are ongoing discussions with General Practitioners for future shared care prescribing. Education has been provided to healthcare professionals, signposting them to the guideline and patient resources.

We are currently in the early implementation of the guideline; however, this has demonstrated an excellent example of collaborative working across professions and in the CHDN and we hope to see significant benefits soon. Being the first in the U.K. to make this change, it is an example to other CHDNs. Future work identified includes monitoring the impact of this change for patients via feedback, assessing bed days saved, quantifying the CNS resource reallocation, financial savings and sustainability impact of no testing. We aim to share lessons learnt and innovations with other CHDNs.

References:

1. Alsaied T, Possner M, Van den Eynde J, et al. Anticoagulation algorithm for fontan patients. American college of Cardiology 2023. Anticoagulation Algorithm For Fontan Patients - American College of Cardiology (acc.org) (Accessed 18 Feb 2025).

2. McCrindle B, Michelson A, Bergen A, et al. Thromboprophylaxis for children post-fontan procedure: insights from the UNIVERSE study. Journal of the American Heart Association 2021;10. https://doi.org/10.1161/JAHA.120.021765

POSTER 6: Testosterone in menopause: a review of the evidence and prescribing practice

Author(s):

Karon N Arnold (NHS BNSSG Integrated Care Board)

Richard Mellings (NHS BNSSG Integrated Care Board)

Fergus Hamilton (University of Bristol)

Introduction:

Testosterone is an important hormone for sexual and metabolic function in women, contributing to libido, sexual arousal, mood and musculoskeletal health. Levels naturally decline with age and may contribute to hypoactive sexual desire disorder (HSDD), the most common female sexual dysfunction. Despite this, research on the effects and replacement of testosterone in women is limited. No testosterone products are licensed for women in the UK, and the National Institute for Health and Care Excellence (NICE) does not strongly recommend its use. This has led to regional variation in formulary inclusion, creating inequitable access to treatment.

Aim:

To review the evidence base for testosterone use in postmenopausal women with HSDD and to examine prescribing trends, formulary positions and the potential factors driving variation in access and demand.

Methods:

A narrative review of the evidence was conducted, drawing on a 2019 systematic review and meta-analysis of 36 randomised controlled trials (RCTs) (1) and one additional RCT published since. NHS prescribing data from the NHS Business Services Authority (2) were analysed to assess trends in testosterone gel prescribing to women aged ≥40 years between 2015 and 2023. All 46 publicly available integrated care board (ICB) formularies in England were manually reviewed to determine local traffic light status for testosterone. Socioeconomic variation in prescribing was explored using practice-level Index of Multiple Deprivation (IMD) 2019 data (2).

Results:

Evidence from RCTs suggests testosterone modestly increases the number of satisfying sexual events (mean difference 0.85 per month, 95% CI 0.52–1.18) and may improve sexual desire and arousal, though data on wider health outcomes and long-term safety are limited. No licensed female-specific preparations exist, and prescribing is off-label using male formulations. Testosterone is included on most ICB formularies with amber status requiring specialist initiation, though 13 formularies do not include it. Prescribing has risen 15-fold in England over the past decade, with NHS spend increasing from £150,000 in 2015 to £2.5 million in 2023. Prescribing rates are three times higher in the most affluent practices than in the most deprived.

Conclusion:

Testosterone prescribing for postmenopausal women with HSDD has increased markedly despite limited evidence and the absence of national consensus. The lack of a licensed product, robust cost-effectiveness data and NICE endorsement contributes to variation in access and socioeconomic inequity. Testosterone should only be considered when oestrogen replacement is optimised, and further research is needed to evaluate the clinical and cost-effectiveness of women-specific testosterone formulations. Standardisation is urgently needed on national pathways and prescribing.

* **Footnote:** Since publication, the Medicines and Healthcare products Regulatory Agency (MHRA) has approved AndroFeme® Cream, a testosterone cream for postmenopausal women with HSDD on 25 July 2025 (announced 12 August 2025). It is expected to be available in the UK from 2026, although local ICBs may conduct cost analyses before its adoption across England.

References:

1. Islam RM, Bell RJ, Green S, Page MJ, Davis SR. Safety and efficacy of testosterone for women: a systematic review and meta-analysis of randomised controlled trial data. *Lancet Diabetes Endocrinol*. 2019;7(10):754-766. doi:10.1016/s2213-8587(19)30189-5
2. Ministry of Housing, Communities & Local Government. English indices of deprivation 2019. September 2019. Accessed February 2025. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

POSTER 7: Propranolol: Safer Prescribing In Anxiety Disorders

Author(s):

Parisha Kyada (Healthwest Primary Care Network)

Amy Williams (University of Bristol)

Dr. Dellel Rezgui (Bristol North Somerset and South Gloucestershire ICB)

Introduction:

Propranolol is a non-selective beta-blocker which is commonly prescribed for situational (performance) anxiety. In anxiety, Propranolol helps to manage somatic, physical symptoms, e.g. tachycardia, sweating and tremor, rather than psychological symptoms, such as worry and fear. Interestingly, it is not recommended by NICE as a treatment option for any anxiety disorders, which suggests poor evidence for efficacy. Recently, there have been growing concerns regarding Propranolol safety; under-recognised toxicity in overdose has been highlighted, especially in females under 40 years old who use concurrent SSRIs for anxiety (1).

Aim:

The initial audit aimed to evaluate local prescribing trends in primary care, documented rationale for treatments, and evidence of patient counselling around the associated risks of Propranolol use in anxiety.

The project aims to:

1. Audit Propranolol prescribing trends in anxiety disorders.

2. Understand the rationale behind initial Propranolol prescriptions with a deep dive for high-risk patients.

3. Assess the impact of education on prescribing and counselling practices.

4. Identify seasonal variations in prescription rates.

5. Establish good prescribing standards and create tools to support evidence-based practice in primary care.

Methods:

The audit included patients coded with any anxiety disorder and prescribed Propranolol between January 2024 and August 2025. Data was collected using EMIS and ePACT2 systems, focusing on repeat vs acute prescribing, prescribed quantities, and the impact of educational interventions.

Further scrutiny was applied to patients identified to be at higher risk of harm due to large, prescribed quantities of Propranolol or records of previous attempts of suicide and/or drug overdose.

Results:

The audit revealed a shift from majority repeat prescriptions to majority acute prescriptions, with a reduction in the average quantity per prescription from 56 to 28 tablets. The total number of Propranolol prescriptions for anxiety-related indications decreased. Education on safety concerns led to improved prescribing and counselling practices.

Conclusion:

The use of an educational memo to remind primary care clinicians about the potentially fatal risks associated with beta-blocker use in anxiety disorders enhanced compliance to national guidance and improved safety netting information provided to patients. An updated memo with weight-based toxicity information (2) and a safety Propranolol EMIS template are being considered to help tailor treatment even further.

Whilst Propranolol is not recommended by NICE-guidelines, clinicians are continuing to trial the medication with close follow-up as an option for panic symptoms induced by specific situations, with clear counselling to patients that this will not target the anxiety itself. So, we will continue to work with primary care teams on a wider scale to address the underlying cause.

References:

1.Gorton HC, Archer C, Algahtani T, Mughal F, Copeland CS. Involvement of propranolol in suicides: cross-sectional study using coroner-reported data. BJPsych Open. 2024 Jun 3;10(4):e127. doi: 10.1192/bjo.2024.714.

2.Williams H, Jagpal P, Sandilands E, et al. The problem of propranolol poisoning. Br J Clin Pharmacol. 2025; 1-7. doi:10.1002/bcp.70147

POSTER 8: Sex differences in a UK Idiopathic Pulmonary Fibrosis (IPF) population: analysis of the British Thoracic Society (BTS) Interstitial Lung Disease (ILD) Registry

Author(s):
Mulholland S.1,2 Dixon, G.1,2,3 Wells, M.1, White, P.4, Harding, S.5, Russell AM.6 Barratt SL1,2.
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5. Research and Innovation North Bristol NHS Trust, Bristol, UK
6. School of Health Sciences, University of Birmingham, Birmingham, UK

Introduction:
Biological sex influences the presentation, diagnosis and outcomes of many lung diseases. Understanding these differences is a step towards addressing potential inequity to improve patient care.

Aim:
Characterise a large UK IPF population by biological sex, determining differences in disease characteristics, treatment and outcomes.
Methods:
Standardised data of IPF patients enrolled into the BTS ILD registry from Jan '13-Oct '24, were categorised by biological sex and analysed for differences in baseline demographics, pulmonary function, and eligibility/uptake of antifibrotics. Kaplan–Meier log-rank test assessed sex-differences in survival, censored to 15.10.24.

Results:
Of 7177 cases, 77.8% (n=5587) were male, median age 75 years (Interquartile range (IQR) 69.5-80.5) for both sexes (p=0.83). Males were more likely to have a history of smoking (males 72.9% vs females 60.5%, p<0.001) and lower baseline median Forced Vital Capacity (FVC) % predicted (males 76.4%, IQR 66.2-86.7 vs females 78.8%, IQR 68.6-89.1, p<0.001). Whilst more males in the cohort met eligibility criteria for antifibrotics at baseline (males 54.1% vs females 47.8%, p<0.001), a larger proportion chose not to commence treatment (males 47.0% vs females 29.6%, p<0.001). Significantly, more females experienced symptoms for >24 months prior to first clinic appointment (females 40.1% vs males 36.6%, p=0.028). Female sex was associated with longer survival, for females, the 75% Kaplan-Meier survival quartile is 7.6 years (95% CI: 5.51, 9.68 years) vs 4.3 years (95% CI: 3.82, 4.78) for males (p<0.001). Male sex (HR 1.76 (95% CI 1.22-2.54), p=0.002), higher age (HR 1.042 (95% CI 1.02-1.06) p<0.001), lower baseline FVC % predicted (HR 0.98 (95% CI 0.97-0.98) p<0.001) and co-existent lung cancer (HR 9.3 (95% CI 2.86-30.24) p <0.001) were all independently associated with worse survival.

Conclusion:
This is the first UK study to use national registry data to systematically evaluate IPF disease characteristics stratifying by biological sex and highlights distinct characteristics between groups. Future clinical trials should explicitly explore sex-specific targeted interventions and analyses to optimise future IPF patient care.

Disclaimer: This publication makes use of data purchased from the BTS ILD Registry which has no responsibility or liability for the accuracy, currency or correctness of the publication.

POSTER 9 Pyxis Project: using A3 thinking methodology

Author(s):

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Introduction:

Pyxis automated medicines storage and management systems have been in use in University Hospitals Bristol and Weston on the adult general ICU (ward A600) since 2020, overseen jointly by pharmacy and nursing teams. While implementation has supported stock control, it also revealed longstanding challenges in medicines management and highlighted opportunities for improvement.

The Pyxis system is not always intuitive to use, and medications are frequently withdrawn without appropriate consideration of stock balance. As a result, the system is not realising its full potential in terms of efficiency, cost savings, and safe stock management.

Incorrect Pyxis inventories contribute to critical medicine shortages, potential patient safety risks, and significant inefficiencies. These include wasted stock, delays in care, and staff frustration. Misuse also incurs a recurring dispensing return fee of approximately £900 per month for the Division of Surgery.

Aim:

Our vision is for Pyxis machines on A600/general ICU to consistently support patient safety and care excellence. The specific goal is to reduce the wasteful dispensing return fee by 30% (around £4,000) within six months of implemented actions.

Methods:

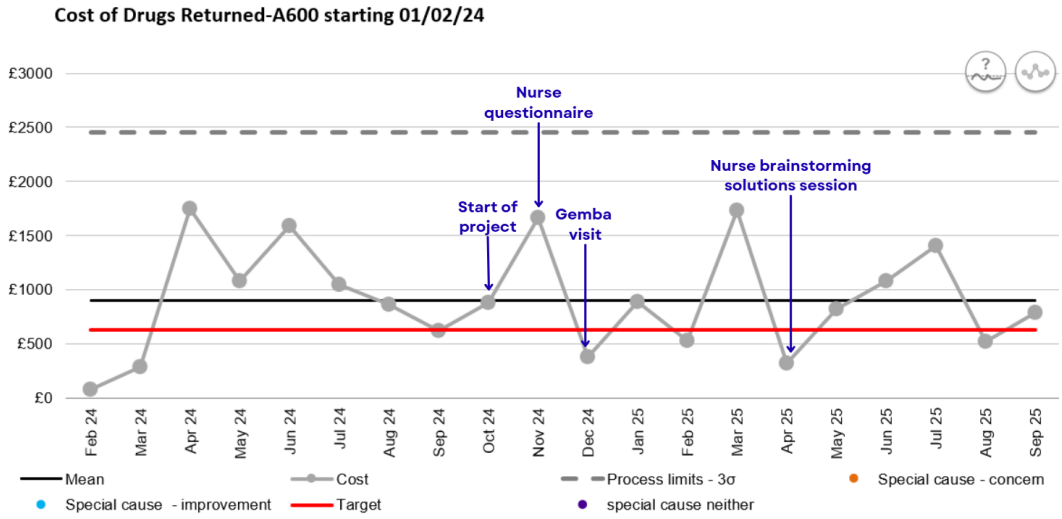
A mixed-methods approach was used, including:

- Questionnaires for nursing and pharmacy distribution teams to capture use and perceptions.
- Analysis of staff permissions for Pyxis inventory counts.
- Process mapping to identify duplication and inefficiencies.
- Review of Datix incident reports.
- Gemba visits to observe real-world workflows.

Results:

Key contributing factors were identified:

- Lack of clarity in Pyxis stock reporting (software limitations, inconsistent dosing representation).
- Inadequate training and absence of standardised refresher content.
- Medicines returned outside the Pyxis system, often due to limited staff access and unclear processes.
- Workflow inefficiencies, with nursing staff required to leave the bedside frequently.
- System challenges outside local control, such as patient acuity and limited machine space.



Interventions:

- Quick wins: Development of Pyxis usage posters and redistribution of stock to prevent overfilling and technical failures.
- Major project: Creation of a Kallidus e-learning package to standardise training and sustain competence.

Conclusion:

The review of Pyxis use on University Hospitals Bristol & Weston adult general ICU (A600) has highlighted system, process, and training barriers that currently limit the technology's effectiveness in supporting safe and efficient medicines management. By implementing targeted service improvements including immediate practical measures and the development of a Trust-wide e-learning package, the project provides a structured approach to strengthening both staff capability and system reliability. These changes are expected to reduce avoidable medication returns costs, improve stock control, and enhance the overall quality of care.

Next Steps:

- September 2025: Baseline Pyxis user survey.
- October 2025: Implementation of stock redistribution and poster campaign.
- November 2025: Initiate development of a Trust e-learning package, with planned go-live in Spring 2026.

POSTER 10: Enhance Reporting and Accountability of Pharmacy Trial Setup Performance

Author(s):

(Amy) Kit Mei Long, Liz McCullagh (University Hospitals Bristol and Weston NHS Foundation Trust)

Introduction:

Clinical trials transform scientific discoveries into effective treatments, yet setup delays remain a major bottleneck. Pharmacy teams are critical to this process – reviewing Local Information Packs (LIP) to assess capacity and capability (C&C) and developing local procedures for managing Investigational Medicinal Products (IMPs).

In the UK, median setup time for commercial trials increased from 222 days (2018) to 271 days (2021). Recruitment in England fell by 44%, and the UK's global ranking for Phase III trials dropped from 4th to 10th (1). These declines have reduced patient access to innovative treatments, resulted in significant lost income for the NHS, and diminished the UK's competitiveness in life sciences. The Lord O'Shaughnessy review identified lack of accountability as a key barrier (2). At University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), this is reflected in the absence of a standardised performance metrics reporting system, making it difficult to evaluate pharmacy trial setup efficiency, benchmark performance, or drive quality improvement.

Aim:

To develop and implement standardised performance metrics to enhance reporting and accountability in pharmacy trial setup at UHBW.

Methods

The SMART framework was utilised. A standardised data collection form was developed within the EDGE clinical trial management system to capture key performance metrics – LIP receipt, review, C&C confirmation, greenlight issuance – retrospectively (November 2023 – November 2024) and in real-time (November 2024 – May 2025).

Three methodologies supported the project:

Process Mapping: Visualised the pharmacy trial setup workflow and defined key metrics.

Model for Improvement: Guided two Plan-Do-Study-Act (PDSA) cycles – first to pilot the form using retrospective data, then to implement it across all Pharmacy Trials Unit (PTU) staff. Data were analysed in Excel to evaluate performance against the established Key Performance Indicators (KPIs).

KPIs: Benchmarks were established using internal data and external references (Southampton NHS team, NIHR delivery KPIs).

Results:

Four performance metrics were defined and captured via EDGE:

Time to receive LIP

Time to review LIP

Time to confirm C&C

Time to issue greenlight

Retrospective data from 35 trials across six specialities showed average setup times of:

LIP receipt: 41 days

LIP review: 32 days

C&C confirmation: 68 days

Greenlight issuance: 77 days

Three KPIs were introduced, with an adjusted timeline for Bristol Haematology and Oncology Centre (BHOC) trials due to complexity:

LIP review within 30 days

C&C confirmation within 60 days (85 days for BHOC)

Greenlight issuance within 30 days

A traffic light dashboard (Green ≥80%, Amber 60–79%, Red <60%) showed amber performance for LIP review and C&C confirmation in non-BHOC trials, and red for BHOC C&C confirmation and greenlight issuance overall. Real-time data collection is ongoing.

Conclusion:

The EDGE form has improved consistency and visibility in pharmacy trial setup performance. The dashboard enables benchmarking and highlights areas for improvement. Next steps include investigating delays, addressing resource and training gaps, strengthening stakeholder collaboration, supporting funding bids, attracting sponsors, and promoting EDGE usage through reminders and training.

References:

O'Shaughnessy J. *Commercial clinical trials in the UK: the Lord O'Shaughnessy review – final report*. London: HM Government; 2023 [updated 26 May 2023; cited 2025 Sep 19]. Available from: https://www.gov.uk/government/publications/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review-final-report

Office for Life Sciences, Department for Science, Innovation and Technology, Department of Health and Social Care. *Life sciences sector data, 2023*. London: HM Government; 2023 [published 13 Jul 2023; cited 2025 Sep 19]. Available from: https://www.gov.uk/government/publications/life-sciences-sector-data-2023

POSTER 11: South West Pharmacy Research Network (SWPRN) – Directory of Expertise Survey Findings

Author(s):

Miss Teresa Chan (Royal United Hospitals Bath)

Dr Jenny Scott (University of Bristol)

Ms Mandy Slatter (Royal United Hospitals Bath)

Dr Matthew Jones (University of Bath)

Introduction:

Workforce engagement in research is an NHS priority as research-active organisations have better patient outcomes (1). However, a UK survey found that pharmacy professionals remain underrepresented in research (2).

Aim:

The aim of the Directory of Expertise, utilising the SWPRN, is to foster research collaboration and mentorship among pharmacy professionals in the South West (SW).

Methods:

Building on the findings from a SWPRN members survey (2024), a new survey was developed with the SWPRN network leads to learn more about the members' views on collaboration and mentorship between experienced and research-curious members of the network. Part 1 of the survey asked for basic information about the members i.e. geography and profession. The data from part 1 created the “SWPRN Directory for Network Leads”. Part 2 explored participants' interests for collaboration, research methodology and clinical areas/research topics of interest. Individuals consenting to Part 1 and Part 2 were included in the “Directory of Expertise”.

Results:

Response rate from a cohort of 294 participants contacted was 32% (93 responses). Of 93 respondents, 90 were included in the SWPRN Directory for Network Leads and 88 in the SWPRN Directory of Expertise. The survey captured participants across all SW ICBs and other ICBs (Oxfordshire and London) with72% (71) pharmacists, 8% (8) Other health researchers (Pharmacist (2); academics (2); Not specified (2)) and 4% (4) nurses.

Participants’ main role: secondary care, 42% (37); universities, 22% (20); primary care, 12% (11); NHS regional or national role 9% (8); in other health-care environments or combined roles, 15% (13)

Network interests

Table 1: Participants’ collaboration interests within the Network

Collaboration interests	Number of participants (%)
Collaboration in audit, QI or research projects	71 (21%)
Peer review of research funding applications, abstracts or draft papers	34 (10%)
Providing one-off support	49 (14%)
Receiving one-off support	41 (12%)
Providing mid to long-term support i.e. mentoring	27 (8%)
Becoming a mentee	24 (7%)
Participating in research projects	57 (16%)

Conclusion:

The Directory of Expertise can be a stepping stone for research development opportunities. The results highlight keen interest in collaboration and mentorship for research among network members, with 15 accesses since its launch. The longer-term goal of the directory is to support the pharmacy profession in research activities and leadership roles in the future, ensuring that healthcare interventions meet patients' needs and preferences. The Directory is active and will be continuously updated monthly. Overall, Pharmacists made up 72% of respondents, mainly from secondary care and university settings, reflecting a need to reach underrepresented groups, such as primary care pharmacists.

References:

1. England N. NHS England» Maximising the benefits of research: Guidance for integrated care systems [Internet]. England.nhs.uk. 2023 [cited 2025 Jul 30]. Available from: https://www.england.nhs.uk/long-read/maximising-the-benefits-of-research

2. England N. NHS England» Report of a UK survey of pharmacy professionals' involvement in research [Internet]. www.england.nhs.uk. Available from: https://www.england.nhs.uk/long-read/report-of-a-uk-survey-of-pharmacy-professionalsinvolvement-in-research

POSTER 12 Pilot for Implementation of a pharmacist led Direct Provocation Test (DPT) clinic for low-risk patients with 'Penicillin Allergy Label' (PAL) at Gloucestershire Hospitals NHS Foundation Trust.

Author(s):

Delyth Ahearne (Lead Antimicrobial Pharmacist), Carys Hoskins (Lead Surgical Pharmacist), Dr Kay Chidley (Consultant Anaesthetist), Gloucestershire Hospitals NHS Foundation Trust

Introduction:

From Business Intelligence (BI) information, an average of 12.8% of Trust inpatients have a PAL. However, fewer than 10% of patients labelled with a penicillin allergy are truly allergic (1). Previous studies have found that DPT can safely be completed by non-allergy specialist staff (2). A county wide group, Action Group to Improve Penicillin Allergy Documentation, was formed in January 2024, from this a pilot for a pharmacist prescriber led DPT clinic was developed and implemented in February 2025.

Aim:

Key objectives include-

1. Production of method for risk assessment of patients for DPT clinic, within Trust guidance on 'Penicillin Allergy De-labelling in Adults', based on previous research and PEN-FAST score.

2. Production of key documents to support DPT clinic e.g. patient information leaflets.

3. Implementation of a pilot pharmacist prescriber led DPT clinic, within the surgical pre-assessment area with facilities and staff trained and equipped to manage potential anaphylaxis.

Methods:

Following planning (Fishbone analysis, GANTT) and risk assessment-

1a. The notes of patients awaiting surgery with a PAL were gathered and an initial assessment of history and potential exclusions completed using Sunrise EPR, JUYI, SCR and paper medical notes.

1b. Appropriate patients were approached through a telephone consultation. Patient information (via Accu-Rx message) was sent and additional questions completed, after consent gained.

1c. Low risk patients (PEN-FAST 1-2) were invited to DPT clinic, written consent obtained and given a dose of amoxicillin 500mg orally or index drug. Patients were observed for 60 minutes with observations at baseline and 20-minute intervals.

Results:

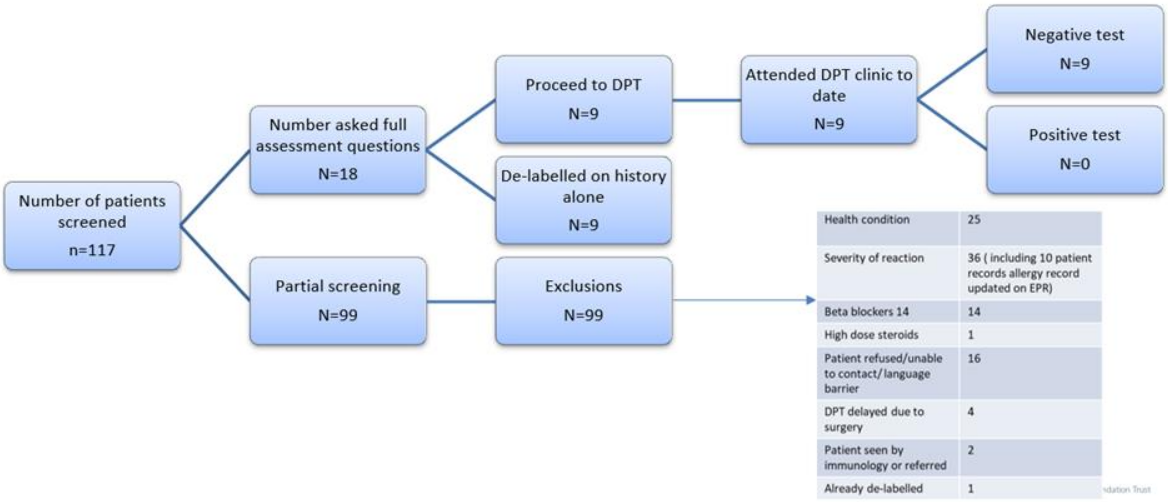
Key objectives were completed

1. A paper risk assessment form was produced for the pilot.

2. Key supporting documents were produced and approved in relevant governance groups.

3. A pharmacist led DPT clinic pilot was completed, results can be seen in Figure 1.

Figure 1



Conclusion:

As in Figure 1, 9 patients attended DPT clinic and were de-labelled, and 9 patients were suitable for de-labelling on history alone. Conversion rate from screening to de-labelling was 15%.

8 out 9 patients completed a patient survey following their DPT clinic. 100% were extremely satisfied with the overall service at the clinic and 100% of respondents were very or extremely happy to take a penicillin-based antibiotic in the future.

Future work involves creating an electronic patient assessment form linked to Trust EPMA system.

References:

1.Royal Pharmaceutical Society (RPS) Penicillin allergy checklist. Available at: https://www.rpharms.com/recognition/all-our-campaigns/antimicrobial-resistance-stewardship/penicillin-checklist (Accessed: 16 September 2025).

2.Savic, L., Ardern-Jones, M., Avery, A., Cook, T., Denman, S., Farooque, S., Garcez, T., Gold, R., Jay, N., Krishna, M.T. and Leech, S., 2022. BSACI guideline for the set-up of penicillin allergy de-labelling services by non-allergists working in a hospital setting. Clinical & Experimental Allergy, 52(10), pp.1135-1141.

POSTER 13 Workplace, burnout and mental wellbeing evaluation of pharmacy staff.

Authors:
Wing Hei Mak1, Mandy Slatter2, Kiran Channa2, Tim Rennie1.
1University of Bath, 2Royal United Hospitals Bath NHS Foundation Trust.

Introduction:
Healthcare professionals, particularly within the NHS, face elevated levels of work-related stress, which has been linked to burnout and diminished mental health. Although previous research has explored these dynamics in broader healthcare settings, there is limited data specific to pharmacy staff. Given the critical role pharmacists and their colleagues play in patient care, understanding the impact of workplace factors on their wellbeing is essential. This study investigates how variables such as job role, work section, stage of career, and working hours correlate with burnout and mental health among pharmacy staff at a secondary care NHS Trust.

Aim:
This study aimed to quantitatively evaluate burnout and mental wellbeing among pharmacy staff at a secondary care NHS Trust, and to qualitatively explore their perspectives on workplace improvements. The goal was to identify key determinants of job dissatisfaction and psychological strain and propose data-driven recommendations for improving workplace satisfaction and mental health.

Methods:
A cross-sectional survey was conducted among pharmacy staff using an online survey platform. The survey incorporated standardised instruments: the Royal Pharmaceutical Society (RPS) Workforce and Wellbeing Survey (1) and the Oldenburg Burnout Inventory (OLBI) (2). Responses were collected anonymously over one month from a sample of 43 staff members (~1/3 response). Quantitative data were analysed using SPSS with Kruskal-Wallis and Mann-Whitney tests, while qualitative data were thematically categorised.

Results:
Less than half of participants rated their mental health as good or very good. Pharmacists reported the highest mental health ratings, while pharmacy technicians and assistants showed poorer mental health and higher burnout scores. Clinical services staff exhibited better mental health compared to those in operations and cancer services. A statistically significant inverse correlation was found between burnout (both exhaustion and disengagement) and mental health. Key burnout drivers included staff shortages, lack of autonomy, poor management support, and workplace discrimination or harassment. Notably, staff who considered leaving their role or profession had significantly worse mental health and higher burnout. While burnout scores did not significantly differ across stages of career or working hours, full-time workers and those newer to the profession tended to report worse outcomes.

Conclusion:

This study confirmed a strong negative relationship between burnout and mental health among pharmacy staff, with clear variation based on job role and departmental section. High burnout and poor mental health were significantly associated with workplace dissatisfaction, absenteeism, and intent to leave the role. Qualitative responses highlighted urgent needs for better leadership engagement, flexible work arrangements, recognition, and increased staffing. These findings mirror existing literature on burnout in pharmacy settings and reinforce the NHS's strategic priority to safeguard staff wellbeing. However, the limited sample size and overrepresentation of certain roles (e.g., pharmacists) suggest the need for broader studies. Implementing targeted interventions based on staff feedback could improve morale, reduce turnover, and enhance patient care outcomes.

References:

(1) Burns C. RPS launches latest Workforce Wellbeing Survey. Pharmaceutical Journal. 2022 Sept 20;309(7965).

(2) Demerouti E, Bakker AB. The Oldenburg Burnout Inventory: A good alternative to measure burnout and engagement. Handbook of stress and burnout in health care. 2008 Jan;65(7):1-25.

POSTER 14 Gender Diversity in the Independent Prescribing Curriculum

Author(s):

Mx Sorrel Beverley-Evelyn Kavanagh MPharm, PgDip, IP, FHEA

Introduction:

Almost 60% of trans individuals avoid accessing healthcare due to fear of transphobia, and 70% report being negatively affected by transphobic attitudes and behaviours in healthcare settings (1). Healthcare training providers are well positioned to upskill the healthcare workforce to improve the care provided to members of this vulnerable community.

Aim:

We attempted to develop bespoke training for healthcare professionals and training providers to improve their understanding of the needs of trans people and how to deliver care sensitively and respectfully to this underserved patient group.

Methods:

We carried out a scoping activity to identify relevant guidance, inclusivity frameworks and practical approaches to support healthcare training providers and clinicians providing care to trans individuals. We used lived experience to shape our scoping activity and articulate its key findings and conclusions.

Results:

Although several guidelines and case studies have been developed in the higher education sector, their recommendations are not routinely visible or clearly transferrable to healthcare training. This may explain the lack of understanding and confusion commonly reported by healthcare staff. Our findings informed the development of bespoke training to support diverse healthcare professionals undertaking independent prescribing training. The training was positively received by students and educators.

Conclusion:

Training for healthcare professionals may improve the quality of care delivered to trans people. Bespoke training provides a basic starting point which offers rich opportunities to identify and evaluate novel approaches for future practice.

References:

1. TransActual. Trans Lives Survey 2021: Enduring the UK's hostile environment [Internet]. Available from: https://transactual.org.uk/wp-content/uploads/TransLivesSurvey2021.pdf [accessed 17 April 2024]

POSTER 15: Training Experiences of Foundation Year Overseas Qualified Pharmacists and Designated Supervisors in the South West of England: A Service Evaluation

Author(s):

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Ireland, Helen (Pharmacy Workforce Development South, Bristol, BS2 8HW, UK)

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Thakkar, Kandarp (3 University Hospitals Plymouth NHS Trust, Plymouth, PL6 8DH).

Introduction:

Overseas qualified pharmacists can apply for GPhC registration through the Overseas Qualified Pharmacist Assessment Programme (OSPAP). This entails a one-year post-graduate diploma, followed by a foundation training year (FTY) signed off by a designated supervisor (DS), and passing the registration assessment. Many have worked as pharmacists prior to commencing OSPAP and have a different registration journey to UK pharmacy graduates. National recruitment data shows an increase in OSPAP students for FTY: 8.5% of applications (249/2922 applications) in 2023-24, from 1.1% (27/2485 applications) in 2019-20 (1). In 2024-25, 22% (32/143 FTY posts) are OSPAP trainees on a National Health Service (NHS) England-commissioned training programme in the South West of England.

Aim:

We aim to understand the lived experience of FTY OSPAP pharmacists in the South West and their DSs. This will be achieved through exploring the OSPAP FTY experience, exploring the DS experience and elucidating any insights of good practice that can be shared.

Methods:

In December 2024 invitations to participate in this service evaluation were sent to all NHS England-funded posts enrolled on a current FTY and all DSs across the South West (Gloucestershire, Bristol, Wiltshire, Somerset, Dorset, Devon & Cornwall). An interview schedule was created employing the NHS England Safe Learning Environment Charter and in January 2025 one-to-one semi-structured interviews were conducted and transcribed over video call to understand the lived experiences of both trainees and DSs (2). The anonymised transcripts (names, pronouns and locations removed) were then analysed using human and AI (Google Notebook LM) interpretive approaches to construct a thematic coding analysis. Quotes were identified to highlight coded themes and draw conclusions. This project was reviewed by University Hospitals Bristol and Weston NHS Foundation Trust's head of clinical audit and effectiveness and classified as service evaluation not requiring ethics approval.

Results:

OSPAP trainees (n=7) recognised the different strengths they brought to their training programme and wanted to have their prior experience recognised by their supervisors. OSPAP trainees feel that the South West FTY is preparing them for registration and practice, one

commented "The programme overall will train well-rounded pharmacists, so I'm quite confident in that". DSs (n=7) recognised that this group of trainees had incredible drive and motivation while noticing that complex situation communication skills, knowledge of NHS structures and reflective practice can be lacking. The DSs also acknowledged their own gaps in understanding the OSPAP registration journey.

Conclusion:

This service evaluation recommends trainees' individual strengths and weaknesses are fully assessed at the start of the FTY, by both trainees and DSs, and training plans constructed adopting the NHS England Safe Learning Environment Charter (2). DS insight into the OSPAP experience could be improved by recruiting former OSPAP trainees into supervisor roles and providing more new DS training. We received no responses from community-based trainees or DSs; the lack of their insight is a limitation. The themes highlighted can inform and direct training and support for OSPAP trainees and DSs as well as serve as the basis for research.

References:

1. NHS England, 2024. Evaluation of Trainee Pharmacist National Recruitment 2019-2024. Available at https://london.wtepharmacy.nhs.uk/national-recruitment/evaluation/. Accessed 29 November 2024.

2. NHS England, 2024. Safe Learning Environment Charter- what good looks like. Available at https://www.england.nhs.uk/publication/safe-learning-environment-charter-what-good-looks-like/. Accessed 26 June 2024.

POSTER 16 Patient-Centred and Preventive Health and Social Care Through Community Pharmacies: Implementation Barriers in Pharmacy First Services.

Author(s):

Dr Salma Sultan, Lecturer/Module Lead Health and Social Care, Cecos London College, Bradford Campus.

Introduction:

Community pharmacies across the UK are increasingly recognised as vital access points for delivering patient-centred and preventive health and social care. NHS launched pharmacy first services in January 2024, due rising workload and GP waiting time which further cause inequalities. The Pharmacy First Services were launched on the foundation of Community Pharmacist Consultation Services (CPCS) continuation of 10 year NHS plan. Pharmacy First Services, empowered community pharmacist to offer treatment and consultation of six minor illness within community pharmacy without further delay of GP waiting appointments under NHS funded treatments.

As pharmacists assume greater responsibility in frontline healthcare, understanding the barriers that limit effective implementation is crucial to ensuring high-quality care, system efficiency, and equity in health outcomes.

Aim:

As pharmacists assume greater responsibility in frontline healthcare, understanding the barriers that limit effective implementation is crucial to ensuring high-quality care, system efficiency, and equity in health outcomes.

Methods:

A qualitative approach was adopted to investigate the experiences of community pharmacists delivering PFS under CPCS within initial stage of implementation during 2024. Community pharmacist who were delivering PFS in community were recruited through purposive and snowball sampling from diverse background within UK community pharmacy. Total Fourteen community Pharmacists were recruited for semi structured interviews.

Interviews were recorded and transcribed through Microsoft Team. Moreover, interviews were analysed by using Braun and Clarke's six-step thematic analysis framework to identify recurring patterns and emerging insights. Themes such as technological readiness, clinical training, operational workflows, and interprofessional communication were identified.

Results:

Thematic analysis uncovered three core implementation barriers. First, technological limitations significantly hindered service efficiency. Pharmacists reported slow response times and login issues with the Pharma Outcomes platform, compounded by problems accessing digital tools for physical assessments (e.g., otoscopes). Second, operational constraints included insufficient infrastructure, staff shortages, limited private consultation spaces, and

poor integration with GP referral systems. The abrupt rollout left many pharmacists underprepared, affecting their ability to deliver safe and seamless care. Third, clinical training was often inadequate. While pharmacists welcomed their evolving role in preventive care, many lacked confidence in performing examinations and managing complex cases. Despite these challenges, participants reported enhanced professional identity, strengthened patient relationships, and reduced pressure on local GP practices. Some also described the services as opportunities to address public health inequalities by improving access for underserved populations.

Conclusion:

PFS and CPCS represent transformative shifts in UK primary care by leveraging the accessibility and trustworthiness of community pharmacists. These services have the potential to improve patient outcomes, promote early interventions, and reduce unnecessary GP visits. However, their success relies on overcoming systemic barriers. Investment in robust digital infrastructure, standardised and practical training programs, and improved GP-pharmacist collaboration is critical. Furthermore, recognising and expanding pharmacists' role in delivering integrated health and social care will not only enhance service quality but also support broader NHS objectives of reducing disparities and promoting health equity across communities.

References:

1. Anderson C, Sharma R. Primary health care policy and vision for community pharmacy and pharmacists in England. Pharmacy Practice (Granada). 2020 Mar;18(1).

2. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology. 2006 Jan 1;3(2):77-101.

POSTER 17 Crossing the battlelines: perspectives on why and how we should continue researching antidepressant deprescribing.

Author(s):

Sarah Jones (University of Bristol)

Introduction:

The body of literature about antidepressant withdrawal effects has been steadily growing in both the lay and scientific press over the last decade. The issue is now much better recognised and researched. Clinical guidelines have been updated to better reflect the risks of withdrawal effects. Clinicians are advised to be alert to the fact that withdrawal effects may occur, that they can be severe and that they may be mitigated by slower medication reductions. However, there is still a lack of consensus about the incidence and severity of these withdrawal effects, which is linked to larger disagreements about the overall utility of antidepressant treatment. Publications on this topic can presented in a relatively combative style, with personal critiques of individual researchers appearing on social media. This presents challenges for both prescribers and patients when interpreting research to make decision about antidepressant deprescribing in clinical practice.

Aim:

To design a research protocol for a prospective observational, mixed-methods study investigating antidepressant deprescribing in primary care, informed by a variety of perspectives from patients, clinicians and researchers.

Methods:

The protocol development has involved interviews with patients and clinicians alongside reviewing both scientific and lay literature, networking with other researchers and regular supervision.

Results:

Protocol development is nearing completion, with a plan to submit for ethical approval by the end of 2025. The study will combine patient and prescriber interviews with qualitative data collection from patients as they undertake their antidepressant reduction.

Stakeholder discussions combined with consideration of the existing standardised data collection instruments has led to the development of a novel approach to collecting data about antidepressant withdrawal experiences. These new questions will be combined with the existing standardised instrument the Discontinuation-Emergent Signs and Symptoms (DESS) scale.

Conclusion:

Patient and clinician representatives reported frustrations due to a lack of nuance in the design and reporting of research about antidepressant withdrawal effects and existing literature consistently identifies a lack of research which is representative of the broad patient population taking long term antidepressants. The aim of this project is to help address both of these issues

by providing quantitative and qualitative data reflecting the experiences of a diverse group of patients undertaking antidepressant reductions.

References:

1. Moncrieff J, Hobday H, Sørensen A, Read J, Plöderl M, Hengartner M. et al. Evidence on antidepressant withdrawal: an appraisal and reanalysis of a recent systematic review. Psychological Medicine 2025;55. https://doi.org/10.1017/s0033291725100652

2. Kalfas M, Tsapekos D, Butler M, McCutcheon R, Pillinger T, Strawbridge R. et al. Incidence and nature of antidepressant discontinuation symptoms. JAMA Psychiatry 2025;82(9):896. https://doi.org/10.1001/jamapsychiatry.2025.1362

POSTER 18 "I feel a bit almost stuck, because I wanna get off it 'cos I don't like the side effects, but and then, almost feels it's going to be super dangerous to get off it." Experiences of people coping with antipsychotic sedation and fatigue

Author(s):

Charley Hobson-Merrett (University of Plymouth and Lancaster University)

BACKGROUND

Internationally, an increasing number of people are prescribed antipsychotics. Prevalence rates of tiredness related side effects (e.g., tiredness, sedation, fatigue, excess sleep) in long-term antipsychotic users are unclear both within and across different antipsychotics and different mental health diagnoses. However, these side effects are distressing, and reduce people's ability to socialise, work and maintain relationships. There is little evidence regarding how to successfully manage or cope with these side effects.

METHODS

10 people who are prescribed antipsychotics long-term for a mental health problem and experience tiredness related side effects were interviewed about their experiences coping with these side effects. Data were analysed using interpretative phenomenological analysis, first creating personal experiential themes for each participant and then looking across cases to create group experiential themes.

RESULTS

Four group experiential themes were created: "It's what I do. It's part of me now. It's like second nature": the experience of TRSEs and responses to TRSEs becoming a part of one's life; "I've made a choice in my life that I want to be happy, I want to be mentally well and if that means I have to sacrifice some things, then I have to sacrifice some things": the experience of prioritising one element of one's life over another; "I used to self-harm, which is not the best strategy": the experience of utilising detrimental management strategies and coping responses; "There's an acceptance that I can't change it": the experience of coping with unmanageable TRSEs via acceptance.

CONCLUSION

Clinicians, including prescribers and pharmacists, should be aware that coping with tiredness related side effects of antipsychotics may become part of a person's life, causing them to downplay the impact of these side effects. Despite this, coping with tiredness related side effects is burdensome to antipsychotic users. Users' perception of a lack of choice, and frustration and fear in balancing side effects against symptoms, impedes their ability to have empowered and honest conversations about side effect management with clinicians.

POSTER 19 The association between timely medicines reconciliation and length of stay at an NHS hospital: a retrospective cohort study

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Introduction:

NICE recommend that medicines reconciliation (MR) should be completed within 24 hours of hospital admission (1). Various pressures have led a reduction in MRs completed within this time (2). There has been little research into whether completion of MR within 24 hours results in improved patient outcomes.

Aim:

To determine if there is an association between time taken to complete MR and patient length of stay (LoS).

Methods:

Retrospective cohort study using electronic patient record data from the Royal United Hospital, Bath. Eligible admissions related to patients aged 18+ admitted as inpatients October 2023-October 2024 with complete data in their record. Data were extracted by hospital staff, deidentified and supplied to the researchers. LoS was the number of days between the recorded admission and discharge times. MR time was the number of hours between the recorded admission and MR completion times. Various patient/admission characteristics were also extracted. A Cox proportional-hazards model was used to investigate the association between LoS and MR time, controlling for patient/admission characteristics.

The study was assessed as having low potential to do harm, reviewed and given a favourable opinion by proportionate review at the University of Bath on 9th October 2024 (number 6915-7722).

Results:

28,777 admissions were eligible. 54.8% were female patients. 60.5% were patients aged ≥61 years. 83.0% were patients of white ethnicity. 29.0% had no recorded conditions and 44.7% had 1-5 existing conditions. Most admissions were under the care of medical (40.6%) or surgical (33.7%) specialities. There were fewer admissions on Saturdays and Sundays (12.0% and 11.6%) than on weekdays (14.0-16.5%). 44.8% of MRs were completed within 24 hours and 11.2% within 24-48 hours. No MR was recorded for 34.5% of admissions. Median LoS was 2.4 days (interquartile range 1.0-7.1).

Compared with an MR time of ≤24 hours, increased MR times were associated with a longer LoS, demonstrated by a reducing hazard ratio (HR) for the risk of discharge: HR=0.779 (95%CI: 0.747-0.813) when MR time=24-48 hours; HR=0.756 (95%CI: 0.716-0.799) when MR time=48-72 hours; HR=0.607 (95%CI: 0.565-0.653) when MR time >72 hours. However, non-completion of MR was associated with a shorter LoS (HR=6.286, 95%CI: 6.069-6.509). Median LoS (interquartile range) varied with MR time: <24 hours=3.9 days (1.8-9.1); >24 hours=6.8 days (3.9-13.2); no MR=0.7 days (0.3-1.2).

Increasing age and number of existing conditions, some ethnicities and specialities, and Friday admissions were associated with longer LoS. Female sex, other specialities, and Tuesday and Wednesday admissions were associated with shorter LoS.

Conclusion:

Completion of MR within 24 hours continues to be challenging. Faster completion of MR was associated with a shorter LoS. The shorter LoS associated with non-completion of an MR may relate to patients discharged very quickly and before a pharmacy visit could attempt MR. Limitations include use of data from only one hospital, data quality (e.g. coding of ethnicity and existing conditions), and non-availability of data on patients' number and type of medicines. Finally, causal inferences cannot be drawn from these associations, so findings should be interpreted with caution.

References:

1. National Institute for Health and Care Excellence. NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015.

2. Lipanovic D. Reconciling medicine review targets with hospital workforce challenges, Pharm J, 2024;312(7984).

Venue information

Our venue is E5 Bristol (aka Elim Church), 3-15 Jamaica Street, Bristol BS2 8JP, close to the Bristol Royal Infirmary and Cabot Circus, NCP Bristol St James Barton and Trenchard Street car parks. Bristol Temple Meads is 30 minutes walk away.

CAR-PARKING OPTIONS: A city church means city traffic! Don't be late as you don't want to miss out. There is limited parking around the church.

BUS/COACH: Bristol bus and coach station is approximately a 5 minute walk away from the church. You can also catch the 70/71/75/76 bus which will drop you off in Stokes Croft – a 5 minute walk from the church.

TRAIN: The closest train station is Bristol Temple Meads – you can catch the number 8/9 bus which will drop you off in the centre of Bristol. The centre of Bristol is approximately a 10 minute walk away.

Quiet spaces are available all day in the Parents' Lounge and the back garden. Please don't use these spaces to makes calls or hold conversations, as we wish to keep them as quiet spaces for delegates who need a break.

Venue website: https://elimbristol.org/

Food and drink

Food will be served throughout the day at the back of the auditorium, both upstairs and downstairs. Halal, Vegan, Gluten-free and Dairy-Free options will be available and will be served upstairs.

09:30: Drinks and Pastries

11:15: Drinks and Biscuits

12:45: Lunch: sandwiches, crisps, quiche, falafel, cake, fruit

15:10: Drinks and Snacks

Contributors' biographies

Emily BROWN

Dr Emily Brown is a GP and Research Fellow at the University of Bristol, with experience working at the interface of clinical General Practice, academic research and the commercial sector. Her research focuses on the use point-of-care tests in primary care to inform antibiotic usage for respiratory and urinary infections

Johnathan CAMPBELL

Jonathan Campbell, is a community pharmacist currently working with the SW RRDN as a "Community Pharmacy Research Fellow" to scope and support the delivery of research within community pharmacy. As a pharmacist with over 30 years experience, Jonathan has been a Superintendent Pharmacist for multiple pharmacies, a Pharmacy Contractor, Associate Director of Prescribing / Medicines Management across Bristol and Wiltshire, and Associate Director of Pharmacy at North Bristol Trust.

Mary CARTER

Mary is a research fellow at the University of Exeter. She has worked on a range of research studies, and has experience of qualitative investigations, surveys, systematic reviews and randomised controlled trials. Her PhD, awarded by University of Bath, focussed on the role of general practice-based pharmacists. She is currently investigating the impact of pharmacy roles on continuity of care in general practice.

Kevin GIBBS

Kevin has been a hospital pharmacist for 41 years and currently manages a Team providing clinical, informatics and clinical trials services to the Bristol Royal Infirmary. His particular interests are medication safety and continuous quality improvement. He has been involved in clinical audit for 30 years and is a founding member of the Trust's Quality Improvement Faculty.

Charley HOBSON-MERRETT

Charley is a research fellow at the University of Plymouth, working within the primary care research group and the peninsula applied research collaboration. She has experience as a research methodologist, and is a co-applicant on a number of successful NIHR funding applications. Charley has expertise in exploring causation via realist evaluation and synthesis, understanding experience via Interpretative Phenomenological Analysis, collating data via embedded ethnography (researchers in residence) and synthesising existing evidence via systematic reviewing. She has contributed to designing and undertaking service evaluations, randomised controlled

trials, and process evaluations, and has a burgeoning interest in linked data sets. She works in mental health research, and has undertaken research looking at how to live well whilst taking antipsychotic medication. Charley is also interested in other areas where medication use interacts with wellbeing, including chronic pain and fatigue, and antidepressant deprescribing.

Matthew JONES

Matthew is Senior Lecturer in Medicines Safety, Medicines Information and Pharmaceutical Aerosol Science in the Department of Life Sciences at the University of Bath. He is also chair of SWPRN. His research career began with a PhD in respiratory drug delivery at the University of Bath, which was followed by similar work at UCL School of Pharmacy. He then worked as a medicines information pharmacist for before moving to his current post. Consequently, his current research considers two distinct areas: 1) medicines information and medicines safety, particularly how the design of clinical guidelines can cause or prevent medication errors; 2) how the formulation of inhaled medicines can be improved by measuring and controlling the force of adhesion between their microscopic particles.

Tom KALLIS

Tom is a clinical pharmacist and Wellcome-NIHR Doctoral research fellow at the University of Exeter. He is interested in how clinical pharmacists make decisions in the context of clinical uncertainty when reviewing polypharmacy in primary care. He is a holder of the 'PhD for Primary Care Clinicians' NIHR fellowship and was one of the first pharmacists to be awarded this grant nationally. Tom has methodological expertise in conversation analysis, qualitative interviews and evidence synthesis. He qualified from King's College London and started his career in community pharmacy, before moving into general practice and later completing an MSc in Clinical Pharmacy Practice. Alongside his academic role, Tom maintains his clinical practice part time at Saltash Health Centre.

Ya-Hui LIANG

Ya-Hui is the Lead Pharmacist for Adult Critical Care & ECMO at University Hospitals Bristol and Weston NHS Foundation Trust. She has worked a number of NHS tertiary centres in the South West since 2013. Passionate about patient-centred care and multidisciplinary collaboration, she brings a wealth of experience from working in fast-paced, complex clinical settings.

Beyond clinical practice, Ya-Hui is deeply committed to nurturing growth within the pharmacy profession. She is particularly enthusiastic about creating space for individuals and teams to build confidence, develop new skills, and take an active role in quality improvement and research. Through this work within SWPRN, Ya-Hui hopes to empower more pharmacy professionals to contribute to research that shapes the future of healthcare.

As part of the conference organising team, Ya-Hui is excited to help bring together pharmacy colleagues and researchers to share ideas, showcase innovation, and inspire greater engagement with pharmacy research across all areas of practice.

Aseel MAHMOUD

Dr Aseel Mahmoud is a Health Services Researcher in the Pharmacy department at Imperial College Healthcare NHS Trust (ICHT) and a Postdoctoral Research Fellow in the Health and Community Sciences Department at the University of Exeter. Her work is focused on the development and evaluation of health interventions, medication safety and has a particular interest in the use of digital health interventions.

She completed her PhD in 2022 at Liverpool John Moores University, during which she developed a community pharmacy-based intervention to improve asthma care and management. She has worked on projects funded by the NIHR, including the DREAM, RecoverED and FLEXI projects. She is currently a member of the NIHR Patient Safety Research Collaboration (PSRC) and a lead qualitative researcher of a realist mixed-method evaluation of the impact of barcode medication administration on patient safety (BCMAPS) as part of her role at ICHT. She has been awarded a career development fund from the NIHR School of Primary Care Research (SPCR) at the University of Exeter to develop and submit a grant application for a project that aims to improve medication adherence in older people with COPD using digital health interventions in primary care which builds on her PhD project.

Hadeel MOHAMED

Hadeel is a senior pharmacist prescriber with experience across hospital and general practice settings. She is Deputy Head of Clinical Pharmacy and Education Lead for a GP Federation in Leeds and previously held the role of Polypharmacy Programme Clinical Lead for Health Innovation Yorkshire & Humber. Hadeel founded ENIGMA, a mentoring scheme that supports female pharmacy professionals from ethnically diverse backgrounds in developing leadership skills, which has now expanded nationally to include all sectors.

She is in the final stages of completing a PhD at the University of Bradford, focusing on medication self-management in older patients during the hospital-to-home transition. A

passionate advocate for the pharmacy profession, Hadeel is a member of the RPS Primary Care Expert Advisory Group, Research Lead for the Primary Care Pharmacy Association (PCPA), and committee member for the Primary Care academic CollaboraTive (PACT).

Mandy SLATTER

With over 30 years clinical pharmacy experience in primary and secondary, Mandys current role is Pharmacy Practice Research Lead at RUH, Bath. Focused on developing capacity and capability in research across the whole department encouraging curious questions, data driven improvement and collaboration with experienced researchers. Current NIHR pre application support funding. Personal research interest is Antimicrobial Resistance with a focus on management of urinary tract infection in the emergency department – particularly diagnostic stewardship.

Rupert PAYNE

Rupert Payne is a senior academic GP and clinical pharmacologist. He undertook his medical training and PhD in Edinburgh, and subsequently held a NIHR clinical lectureship in Cambridge and clinical senior lecturer position in Bristol. He leads a programme of applied health service research focused on improving the safety and quality of medication use in primary car. He has a particular interest in improving how we measure, evaluate and manage polypharmacy, and has methodological expertise in pharmacoepidemiology, electronic health records, and data science. He is an active member of the Exeter Collaboration for Academic Primary Care (APEx).

Rupert recently led development of the Cambridge Multimorbidity Score, an increasingly widely used tool for quantifying multimorbidity using routine health records, as well as the Bristol Medication Review model, which outlines a flexible, patient-centred approach to structured medication review. He has also published on a range of other topics related to medications and health services, including deprescribing, pharmacovigilance, sustainability, continuity of care, multimorbidity, and cardiovascular disease.

Jenny SCOTT

Dr Jenny Scott is a senior lecturer at the Centre for Academic Primary Care, Bristol Medical School and a specialist pharmacist prescriber in the drug and alcohol treatment service in Wiltshire, Connect (Turning Point). Her research is focused on the reduction of drug related harm and the prevention of overdose deaths, using mixed methods. Current work which network members may be interested in includes being a co-investigator on the NIHR funded iHOST project (Improving Hospital Opioid

Substitution therapy) and the NIHR funded InBOAT trial (A Randomised Controlled Trial (RCT) of a Diazepam Maintenance Intervention versus Standard Care of Tapering Diazepam to Reduce Dependent Street Benzodiazepine Use in Adults Receiving Opioid Agonist Treatment (OAT)).

Kelly SPENCER

Dr Kelly Spencer is the Strategic Development Director at South West Central Research Delivery Network, a role he/she has held since earlier this year. Prior to joining RDN, Kelly spent nearly 20 years working in clinical research, holding a variety of leadership roles including as Head of Research at a busy acute trust, Research Manager for a research network, and trial management roles at a University sponsor.

Stuart SPICER

Stuart is a researcher in applied healthcare at the University of Plymouth Community & Primary Care Research Centre. His current role is Senior Research Fellow in PenARC (NIHR Applied Research Collaboration South West Peninsula). His research interests include mental health, chronic pain, preventative healthcare, population health, and medical statistics. He is co-leading the HOPE-AO project investigating the overprescribing of medication for chronic pain in older adults. He is developing a wider research programme in this area, investigating the overprescribing of potentially dependence forming medication in the context of health inequalities including socioeconomic deprivation. This includes how to support individuals to safely reduce unnecessary medication.

Simon STRANGE

Simon is a clinical pharmacist for Avon and Wiltshire mental health partnership NHS Trust, specializing in community mental health, veterans support and addictions. He is experienced in research design and delivery, both in primary and secondary NHS healthcare.

Andrew TURNER

Andrew is a researcher and study manager at the Centre for Academic Primary Care (CAPC) and the Centre for Applied Excellence in Skin and Allergy Research (CAESAR) at the University of Bristol. His research has focused on technology and health.

South West Pharmacy Research Network steering group

The network would not exist without the hard work of our steering group, who are drawn from as many sectors of the profession as we can manage. Thank you to all of them. Do get in touch if you would like to join the group.

- David Bearman – Community Pharmacy Devon and South West Research Delivery Network
- Ilhem Berrou - UWE and primary care pharmacist
- Victoria DiMartino - Pharmacy Workforce Development South
- Lyn Hanning – University of Bath
- Ola Howell - West of England Academic Health Science Network
- Uzo Ibechukwu - Royal United Hospitals Bath NHS Foundation Trust
- Matthew Jones - University of Bath
- Sarah Jones - University of Bath
- Anneka Mitchell - University Hospitals Plymouth NHS Trust
- Tim Rendell - Swindon and Wiltshire Local Pharmaceutical Committee and Day Lewis PLC
- Tim Rennie - University of Bath
- Jenny Scott - University of Bristol
- Anthony Sinclair- Livewell Southwest
- Stuart Spicer- University of Plymouth and PenARC
- Ellen Williams - Pharmacy Workforce Development South