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**Introduction:** Obesity is one of the main cardiovascular disease (CVD) risk factors.<sup>(1)</sup> In primary care, pharmacists are in a unique position to offer weight management (WM) interventions. Greece is the European country with the highest number of pharmacies (84.06 pharmacies per 100,000 citizens).<sup>(2)</sup> The UK was chosen as a reference country, because of the structured public health services offered, the local knowledge and because it was considered to be the closest country to Greece geographically, unlike Australia and Canada, where there is also evidence confirming the potential role of pharmacists in WM.

**Aim:** To design and evaluate a 10-week WM programme offered by trained pharmacists in Patras.

**Methods:** This WM programme was a step ahead of other interventions worldwide as apart from the usual measuring parameters (weight, body mass index, waist circumference, blood pressure (BP)) it also offered an AUDIT-C and Mediterranean diet score tests.

**Results:** In total, 117 individuals participated. Of those, 97.4% (n=114), achieved the programme's aim, losing at least 5% of their initial weight. The mean % of total weight loss (10<sup>th</sup> week) was 8.97% (SD2.65), and the t-test showed statistically significant results (P<0.001; 95% CI [8.48, 9.45]). The programme also helped participants to reduce their waist-to-height ratio, an early indicator of the CVD risk in both male (P=0.004) and female (P<0.001) participants. Additionally, it improved participants' BP, AUDIT-C score and physical activity levels significantly (P<0.001).

**Conclusion:** The research is the first systematic effort in Greece to initiate and explore the potential role of pharmacists in public health. The successful results of this WM programme constitute a first step towards the structured incorporation of pharmacists in public's health promotion. It proposed a model for effectively delivering public health services in Greece. This study adds to the evidence in relation to pharmacists' CVD role in public health with outcomes that superseded other pharmacy-led WM programmes. It also provides the first evidence that Greek pharmacists have the potential to play an important role within primary healthcare and that after training they are able to provide public health services for both the public's benefit and their clinical role enhancement. This primary evidence should support the Panhellenic Pharmaceutical Association, to "fight" for their rights for an active role in primary care. In terms of limitations, it must be noted that the participants' collected data were recorded by pharmacists, and the analysis therefore depended on the accuracy of the recorded data, in particular on the measurements or calculations obtained. Although the sample size was achieved, it can be argued that it is small for the generalisation of findings across Greece. Therefore, the WM programme should be offered in other Greek cities to identify if similar results can be replicated, so as to consolidate the contribution of pharmacists in promoting public health. Additionally, the study was limited as it did not include a control group. Despite the limitations, our findings provide a model for a pharmacy-led public health programme revolving around WM that can be used as a model for services in the future.

## References

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## ASSESSING THE IMPACT ON PHARMACISTS' TIME BY INTRODUCING A TECHNICIAN SCREENING PROCESS FOR CLINICAL TRIAL PRESCRIPTIONS.

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**Introduction:** Various national guidance from the Lord Carter 2016 report to the NHS Long term plan have emphasised the need to transform traditional hospital pharmacy and make work streams more efficient.<sup>[1]</sup> A clinical trials pharmacist has historically validated clinical trial medicines. Whilst this is good practice for non-chemotherapy prescriptions, it is not a requirement of the Clinical Trial Regulations.<sup>[2]</sup> Interruption to validate trial prescriptions can have a negative impact on pharmacists' duty and consequently patient outcomes. With limited data available, this issue has been highlighted by anecdotal evidence. Due to the often complex requirements associated with trials, the research team are responsible for assessing the suitability of treatment. This includes checking interactions with concomitant medication, reviewing blood results and patient counselling. The clinical aspect of the pharmacist validation is therefore removed, allowing technicians to be involved in the screening of suitable prescriptions. Much is written on technicians extending their roles in the clinical setting, but this service improvement focuses on enhancing their role within the pharmacy clinical trials department.

**Aim:** To evaluate the amount of pharmacists' time saved by the introduction of technician screening of clinical trial prescriptions.

**Method:** A risk-based proforma was created and used by a pharmacist to assess clinical trial prescriptions for the suitability of screening by a Band 7 technician. Only prescriptions with pre-printed doses, no aseptic preparation or additional medicines, were approved for technician screening. The process of screening therefore only involves the checking of patient and prescriber details, allergy status and possibly a medication randomisation. The technicians underwent an in-house training including the screening of prescriptions under pharmacist supervision. A quantitative data collection tool was used to review the screening / validation of all nonchemotherapy clinical trial prescriptions received at two sites over a two-week period in September 2020. The data collection tool was piloted and all data was analysed using Microsoft Excel.

**Table 1:** Effect of tailored intervention of community pharmacists on surrogate markers of hypertension and type 2 diabetes mellitus

Variable	Parameter	Mean $\pm$ SD			
		Week 1	Week 4	Week 8	
Total	SBP (mmHg)	146.72 $\pm$ 22.52	135.89 $\pm$ 18.56*	129.56 $\pm$ 17.54**	
	DBP (mmHg)	84.17 $\pm$ 15.77	80.39 $\pm$ 11.03*	80.39 $\pm$ 10.57**	
	FBG (mg/dL)	84.67 $\pm$ 16.03	97.83 $\pm$ 16.15	115.83 $\pm$ 22.48	
	W-Hip ratio	0.91 $\pm$ 0.09	-	0.89 $\pm$ 0.07**	
	BMI (kg/m <sup>2</sup> )	25.58 $\pm$ 5.67	-	26.84 $\pm$ 5.59**	
<b>Gender</b>					
Male (n=7)	SBP (mmHg)	148.29 $\pm$ 18.17	137.43 $\pm$ 15.73	133.14 $\pm$ 15.68	
	DBP (mmHg)	87.29 $\pm$ 16.17	80.00 $\pm$ 11.73	78.71 $\pm$ 9.18	
	W-Hip ratio	0.94 $\pm$ 0.07	-	0.90 $\pm$ 0.06**	
	BMI (kg/m <sup>2</sup> )	27.03 $\pm$ 7.04	-	26.96 $\pm$ 6.59	
Female (n=11)	SBP (mmHg)	145.73 $\pm$ 25.72	134.91 $\pm$ 20.85*	127.27 $\pm$ 19.00**	
	DBP (mmHg)	82.18 $\pm$ 11.14	80.64 $\pm$ 11.14	81.45 $\pm$ 11.67	
	FBG (mg/dL)	82.20 $\pm$ 16.60	92.40 $\pm$ 10.24	110.00 $\pm$ 20.26	
	W-Hip ratio	0.89 $\pm$ 0.08	-	0.87 $\pm$ 0.07	
Diagnosis	BMI (kg/m <sup>2</sup> )	26.29 $\pm$ 5.00	-	26.77 $\pm$ 5.19	
	<b>HTN (n=12)</b>				
	SBP (mmHg)	145.83 $\pm$ 26.73	137.25 $\pm$ 21.50*	130.42 $\pm$ 17.23**	
	DBP (mmHg)	84.92 $\pm$ 15.66	80.25 $\pm$ 12.02	80.08 $\pm$ 11.59	
HTN+T2DM (n=6)	W-Hip ratio	0.92 $\pm$ 0.08	-	0.89 $\pm$ 0.07**	
	BMI (kg/m <sup>2</sup> )	26.69 $\pm$ 6.55	-	26.88 $\pm$ 6.43	
	SBP (mmHg)	148.50 $\pm$ 12.13	133.17 $\pm$ 11.87*	127.83 $\pm$ 18.70**	
	DBP (mmHg)	82.67 $\pm$ 17.39	80.67 $\pm$ 9.17	81.00 $\pm$ 11.67	
	FBG (mg/dL)	84.67 $\pm$ 16.03	97.83 $\pm$ 16.15	115.83 $\pm$ 22.48	
	W-Hip ratio	0.90 $\pm$ 0.08	-	0.88 $\pm$ 0.07	
	BMI (kg/m <sup>2</sup> )	26.38 $\pm$ 3.93	-	26.77 $\pm$ 3.90	

SBP: Systolic Blood Pressure, DBP: Diastolic Blood Pressure, FBG: Fasting Blood Glucose, W-Hip ratio: Waist-to-hip ratio, BMI: Body Mass Index, HTN: Hypertension, HTN+T2DM: Hypertension and Type 2 Diabetes Mellitus, n: number. \*  $P < 0.05$  – Week 1 vs Week 4, \*\*  $P < 0.05$  – Week 1 vs Week 8. FBG data not available for males.

**Results:** A total of 89 prescriptions were received. 56 (63%) were eligible for technician screening, of which a suitable technician validated 50%.

Across both sites a total time of 360 minutes were spent validating/screening prescriptions including solving prescription related issues. Combining the time taken by a pharmacist to return from a clinical area and screening time consequently saved a total of 227 minutes of pharmacists' time.

**Conclusion:** Distributing the workload amongst trained staff saves pharmacist's time, which can be utilised on clinical and complex tasks. This does not eliminate the requirement of a pharmacist to validate prescriptions however; it reduces the frequency and streamlines the service. Further data collection is required to analyse the direct impact on patients' and any changes in the number of reported errors. A limitation to the study is the lack of data prior to implementation as a comparator. Additionally, during data collection there were no suitable technicians available at one site due to the Covid-19 pandemic, resulting in only 50% of eligible prescriptions being screened by a technician. Ultimately, this does not change the outcome; enhancing technician's roles allows pharmacists' time to be used more efficiently.

## References

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## TAILORED INTERVENTION TO IMPLEMENT THE MANAGEMENT OF HYPERTENSIVE AND TYPE 2 DIABETES MELLITUS PATIENTS IN COMMUNITY PHARMACIES – A PILOT STUDY

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