I1: How to develop a business plan for clinical pharmacy services?

Expansion of already existing clinical pharmacy services or implementation of new services is important to ensure both that all patients that need pharmaceutical care receive it, and that optimal outcomes from medication use are achieved. In settings with limited financial resources it may be difficult for pharmacy directors to justify to financial decision makers the hiring of additional hospital pharmacists for clinical services expansion. Such justification will usually require not only evidence that the economic benefit of the proposed services will be in excess of the new costs, but also thorough research and planning. A well-developed business plan, complete with a clear mission and objectives, an analysis of the opportunity and need, a description of the service proposed, and an accurate estimate of both the costs and clinical/economic benefits (including a return on investment analysis), arranged in a convincing and professional way, could be the solution!

I2: Developing and implementing deprescribing guidelines

Deprescribing is the process of tapering, stopping, discontinuing, or withdrawing drugs, with the goal of managing polypharmacy and improving outcomes. Clinicians typically attempt to taper or stop agents on the basis of clinical experience and judgment, rather than using an approach guided by evidence.

Polypharmacy and inappropriate medication use among older adults are known to contribute to adverse drug reactions, falls, cognitive impairment, noncompliance, hospitalisation and mortality. While deprescribing—the act of tapering, reducing or stopping a medication—has been shown in small studies to be feasible and relatively safe, clinicians continue to find it difficult to stop medications. Barriers include difficulty making decisions to stop medications (both from the clinician and patient perspective), worry about stopping medications started by others, limited knowledge about how to stop medications, and concern about medication withdrawal effects. In addition, clinicians feel pressured to prescribe according to clinical guidelines but recognize that such guidelines are rarely based on evidence from studies in older populations and rarely address modifying clinical targets with advancing age or care goals.

Innovative approaches are needed to address these barriers in order to limit the negative impact of polypharmacy on our older population. Such approaches should facilitate decision-making about stopping a medication and provide clear recommendations for tapering and monitoring impact to ensure safety and effectiveness of the process. To achieve this, the Ontario (Canada) Ministry of Health and Long-Term Care has supported the systematic development and testing of a series of evidence-based guidelines for deprescribing.

This 90 minute workshop will introduce pharmacists to resources and tools that facilitate deprescribing – the dose reduction or stopping of medications that may be causing harm or no longer be of benefit. These include new deprescribing guidelines as well as online resources. Participants will work in pairs and small groups using cases to develop deprescribing plans. Findings from recent work using community engagement as a strategy for implementing deprescribing initiatives will facilitate discussion about practical challenges and solutions.

I3: Pharmacy practice research - designing your study

Starting research, in a small or large scale, without proper planning, without a pilot study, with vague methodology and a non-described, ineffective intervention should not be allowed – as it is a waste of resources, disheartening and will not take the evidence base forward. Guidance should be sought and taken into consideration. The intervention should be implemented and running smoothly before being evaluated. The researchers should be humble and ready to change their view points – yet stubborn in the pursuit of getting the work done.

In this interactive session the presenters will guide the participants through the hard but rewarding task of designing an original research study in pharmacy practice, with tips and recommendations, warning examples – in a cheerful spirit of sharing ideas and experiences.

Student programme - Developing an individualised pharmaceutical care plan – How can this be achieved by the hospital pharmacist?

Over 20 years ago Hepler and Strand published a seminal paper on the philosophy of pharmaceutical care (Hepler and Strand, 1990), defined as: "....responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life." Different models of pharmaceutical care have evolved but generally they involve a systematic process which is patient focussed and underpins a robust and professional philosophy of pharmacy practice. As part of this process, the pharmacist needs to co-operate with the patient and other members of the multi-disciplinary team to design, implement and monitor a therapeutic plan. To standardise and aid the hospital pharmacist in conducting the process in an organised way and to ensure maximum use of the pharmacist's skills, guidance on a systematic approach has been drawn up in Scotland (CRAG, 1996). This is a stepwise approach which results in formulation of a pharmaceutical care plan for an individual patient, identifying potential and actual care issues with associated actions to resolve and prevent the issues. This workshop will provide participants with an introduction and overview to the systematic approach. It aims to facilitate the development and application of knowledge and skills that relate to pharmaceutical care practice using an interactive, hands-on approach.

Participants will be provided with materials to take home following the workshop for application to and development of their own practice.

Audio and Video presentations from the Vienna Congress are now available via the EAHP website www.eahp.eu

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CONGRESS VENUE

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Boulevard de la Croisette
06400 Cannes, France

SYNERGY EVENTS

10 YEARS OF BIOSIMILARS - WHAT HAVE WE LEARNED?
(Supported by an educational grant from Amgen)
Wednesday, 22 March 2017 - 11:30 am to 1:00 pm
Room: Théâtre Claude Debussy

ANTICOAGULANTS – SHOW ME THE EVIDENCE
(Supported by an educational grant from Bayer)
Wednesday, 22 March 2017 - 2:00pm to 3:30pm
Thursday, 23 March 2017 - 9:00am to 10:30am
Room: Auditorium K

GOOD MORNING PHARMACISTS!
CASE STUDIES - ANTIMICROBIAL RESISTANCE
Thursday, 23 March 2017 - 7:30am to 9:00am
Room: Théâtre Claude Debussy

POSTER AWARD

Encouragement prize for investigators.
The best abstracts/posters – with regards to aspects like originality, scientific quality and practical applicability – will be awarded with 3 prizes amounting € 750, € 500 and € 250. The Poster prize nominees will be requested to give an oral presentation on 22nd or 23rd March. The winners will be announced at the closing ceremony on 24th March 2017. Winners must be present to win.

REGISTRATION

The registration fees are set as follows:
Registration Fee before 1 December 2016 € 600.
Registration Fee beginning 1 December 2016 € 700.
Registration Fee beginning 1 February 2017 € 800.
Registation Fee Young Professional at 50% of the regular rate.
Registration Fee Student € 110.
Registration fee includes access to all sessions, the opening reception, the exhibition, lunches on Wednesday and Thursday and coffee/tea during official breaks.
Registration fee includes VAT according to French law.

CONGRESS & EXHIBITION ORGANISERS

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CANCELLATION POLICY

Cancellation of individual or group registrations received before 1 January 2017 will be refunded (less € 100 per registration, bank and administration charges per participant). For groups a maximum of 15% of the Registrations may be cancelled before 1 January 2017 (less € 100 per registration, bank and administration charges per participant). No refunds can be made after this date but substitution is always accepted.
All cancellations or changes must be made in writing to EAHP via email: registration@eahp.eu

NOTE: PLEASE DO NOT SEND INDIVIDUAL REGISTRATION FORMS FOR GROUPS OF DELEGATES.

HOTEL ACCOMMODATION

VOYAGES C. MATHEZ
DMC & PCO - Nice - Cannes - Marseille - Paris - Monaco
4, Av Georges Clemenceau, 06 000 Nice, France
Tel: +33 (0) 4 93 82 68 82
Note that all hotel accommodations will be made through the EAHP website via a link to the housing bureau. All payments, changes and cancellations for hotel accomodations will be handled directly by Voyages C. Mathez.

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The European Association of Hospital Pharmacists represents more than 19,000 hospital pharmacists in 35 European countries and is the only European association of national organisations representing hospital pharmacists at European and International levels.

The European Association of Hospital Pharmacists (EAHP) is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education

EAHP appreciates the continued support of Bayer, Amgen and Pfizer - Platinum Partners.

KEYNOTE 1: NEW MEDICINES AT ANY COST?

What would modern medicine these days be without medicines for disease prevention or therapy? Increasing costs of medicines entering the market and limited health care budgets, however, form a complex field of action for health care decision-makers, payers, and medicines' providers. Health care systems are challenged as the affordability of high cost medicines is jeopardized by finite financial resources. Each stakeholder group naturally has its own perceptions and goals. To exemplarily mention: Payers (e.g. hospitals, health insurances) want to limit the budget impact of new medicines as best as possible. Providers (i.e. pharmaceutical companies) aim at generating gains and achieving adequate return on investment. Finally, "consumers" (i.e. the patients) do want to receive best medicines available.
When discussing a new medicine's availability and its costs and deciding on its use, decision-makers often have to consider substantial uncertainties with regard to a medicine's true benefit at the time of market authorisation and entry. Which patients benefit the most? How safe is the medicine in real world, and what is the added value compared to already available and well-established therapies? Taken into account these uncertainties, discussions about the "justified" price and the willingness and ability of health care systems to pay "rocket-high" prices are highly relevant and necessary.

The keynote will shed light on different concepts of medicines pricing, and present approaches to quantify innovation and strategies to balance different stakeholder interests.

KEYNOTE 2: BIG DATA: HYPE OR HELP?

Health systems are forced to move in one direction: to create more value in healthcare. This means that population health should be managed more efficiently, that patient care will significantly improve and that preventive care is delivered in an efficient way. More than that cost pressure is the environment of every healthcare system worldwide making evidence-based medicine a condition sine qua non in our daily work as healthcare professionals. In the last years advances in genetics, biomedics and computing technology changed our healthcare environment and gives us the feeling that there are possibilities to fulfil the challenges to create a better healthcare system by using those data. In a SAS White Paper Big Data is defined as follows: "Big Data is a relative term describing a situation where the volume, velocity and variety of data exceed an organisation's storage or compute capacity for accurate and timely decision making".

So what is the role of Big Data in the healthcare system? To say this in first place: Big Data is not just to collect all possible data of single patients to put it together in big databases. Big Data also means that one can use those data with big data tools (meaning IT platforms) giving us the opportunity to e.g. identify at-risk patients (e.g. those who will develop a sepsis, calculated on the basis of patient history, age, gender, family history, genetic markers, drug therapy and other personalised factors), to track clinical outcomes (e.g. cancer therapy and again connected to the unique factors of patients), to measure performance and management of healthcare interventions and, perhaps most important for us, to make the right clinical decisions at the point of care on the basis of this Big Data. To get to this point the databases have to be filled with all the OMICS data, such as genomics, proteomics or metabolomics, of individual persons, have to be linked to phenotype data from clinical observations as well as data from environment, nutrition, food, drugs and also new data from e.g. gut microbiome. We can easily realise that this is still a big challenge for biostatistical analyses.

With the rise of Big Data we also face new challenges like data privacy, ownership and security, which are not yet discussed in-depth.

The keynote lecture will give an overview on the Big Data approach in healthcare systems, the possibilities, the challenges, the problems and the needs to work with.

And the goal of using Big Data in healthcare is clear: it shall improve quality and costs of health care to simple save lives.

KEYNOTE 3: INTRODUCING THE COMMON TRAINING FRAMEWORK (CTF)

The pace of change challenges healthcare systems in so far as ensuring practitioners have the necessary knowledge, skills, and attitudes to provide care.

Competency-based approaches to training, staff development and assessment are increasingly viewed as a central strategy for improving the effectiveness of those who provide care. International competency-based frameworks can also provide a pathway for mutual recognition of qualifications across countries.

The identification and application of competencies required for an effective job performance has become a complex and sophisticated endeavour. Experience with this approach has become more commonplace in business and industry.

This presentation will describe the potential benefits and risks of a competency-based approach to hospital pharmacy advanced practice.

A quality approach to the ongoing management of such a framework will also be considered. The keynote will illustrate the progress of competence-based approaches in Europe where barriers to mutual recognition of education and training systems still exist for many professions including hospital pharmacy.

LM1: Performance management - mission impossible?

Performance management, it has been said, rather than clinical pharmacy or another pharmaceutical speciality will be the imperative that shapes our future.

Increasing expectations together with a worsening economy has introduced new words into the vocabulary of the hospital pharmacist, such as efficiency, productivity, outcome and performance measures. For many this appears to be a retrospective step but the presenters will argue that in reality performance management actually develops confidence and builds careers.

What markers could be used that positively affirm to a hospital pharmacist that the work they are doing on a daily basis could be regarded as being well done? That the tasks they perform add value, that they possess the appropriate competencies and training. Furthermore if an individual feels under pressure, this can sap confidence, the cause could be a competency issue, a lack of relevant training or a lack of managerial support; how can the cause be identified? Performance management supports both individuals delivering services and those responsible for managing them.

By introducing a Quality Management System (QMS) into a Pharmacy department it will reduce and eventually eliminate non-conformance to standards in the most cost effective, supportive and efficient manner and it gives a way in which to achieve a consistent and efficient service.

LM2: Hospital accreditation: aim or means?

Healthcare is a hard business and therefore hospitals want to differentiate themselves from other competitors. This can be done by transparently comparing their services and outcomes. Their strive for offering the best care for the patient resulted in a continuous improvement of quality of care and patient safety. This can be achieved by implementation of evidence based medicine, clinical pharmacy, clinical decision support, risk assessments, critical appraisal of operating procedures, open communication on medication mistakes, ... and finally this mindset becomes a way of life.

To objectivize this level of quality and safety often an external peer assessment process is used. This can be done by the government or a qualified association such as JCI, Qmentum, ... In the USA over 95 % of the hospital are accredited for years while Europe is welcoming an accreditation wave.

As medication and medical devices are involved in most therapies the hospital pharmacist, as expert of the medication management, plays a key role in achieving the accreditation. They have to start thinking of risk analysis, analysis of incidents, creative achievable solutions, quick wins and sustainable improvements. However, they must keep in mind that accreditation is not the goal but the tool to introduce a culture of continuous improvement of quality and safety.

LM3: In search of the value of automation

Reducing medication errors, improving quality and controlling the integral costs of the medication distribution process remains of the utmost importance. In securing a closed loop hospital pharmacists rely on methodologies like Failure mode and effects analysis, lean management and business process redesign. Automating (parts of the) medication distribution process seem obvious. High investment sums and implementation difficulties on the other hand raise new managerial topics which to be dealt with. The value of automation can be identified and calculated on different domains such as: medication safety, medication use, medication spillage, inventory costs, staffing capacity, patient and staff satisfaction and the speed or flexibility of the process. Dealing with the many stakeholders in the hospital, the pharmacist has to 'sell' these benefits to account for the investment, implementation and operational costs.

With a positive balance in the business case for automation hospital pharmacists play a crucial role in the process, project you might call it, towards the optimal solution.

This process can be divided in four stages: decision making, procurement, implementation and operations. All stages require a specific approach to success.

LM4: Falsified medicines directive - did they forget the hospital pharmacy?

Trade of fake and substandard medications are not only an economic threat for the pharmaceutical industry but also a growing safety issue for patients. Reports show a varying proportion of falsified medicines ranging from less than 1 % in developed countries up to 60 % in developing countries. A difference is also noted between drugs delivered by a pharmacist and medications offered on the internet. But also the length and type of supply chain has its impact as the risk does nearly not exist when directly bought from the manufacturer or a trusted wholesaler versus a non-trusted party.

The European Commission responds to this problem with awareness campaigns for patients and healthcare professionals but also with pharmacovigilance programs and the publication of the Falsified Medicines Directive. This latter has to be implemented in national legislation of the European member states within 3 years and allows the dispensing pharmacist to check the medication package in a central repository.

A commendable initiative but does it cover all the risks and is the burden worth the benefit or are there alternatives available: let's cast a critical eye.

I1: Health technology assessment as a tool for decision making at central and local levels

Due to economic constraints, the introduction of the use of new technologies in health care (e.g., new molecular entities, medical devices, organisational models) need a thorough and structured evaluation of their effectiveness, safety, economic and ethical impact. In many countries this structured approach is performed at central level, generally by the national or regional approval agencies. In this process, some countries have applied what is called "managed entry agreements", which require some form of reimbursement/ discount when the drug is not effective as expected.

In others, everything is left at the hospital level, a process known as "hospital based HTA".

In any case, some level of evaluation needs to be performed at the local level in order to reach a decision to include or not the new technology in clinical practice.

Hospital pharmacists are involved in the process, given their task in new technologies evaluation for the inclusion in the formulary or medical device positive list, and in the monitoring of the correct use and outcomes.

I2: Leadership and the art of predicting the future of healthcare

In current business and economy scenarios, hospital pharmacy is facing major challenges to fulfil its mandate to provide medicines due to repeated disruptions of the supply chain and shortages of any kind. Regardless as to whether such situations could have been avoided by early and proper actions such as key account management, future behaviour of hospital pharmacy managers should ensure a high degree of compliance to the mandate and accountability for the patients' interest. Efforts invested in the evaluation of indicators of change, scenarios, and trends as well as in the strategic planning will prevent tiresome troubleshooting and major deviations from effective task fulfilling in future practice. Hospital pharmacy managers should timely construct the framework of indicators of change and analyse their interrelationship. By doing so, they may recognise more readily patterns which deviate from linear developments and anticipate future inconvenient circumstances. A decision taken within a net of interrelations may induce several consequences on the whole framework. Simulation of decision taking and of personal stakeholder constellation is one of the most delicate challenges hospital pharmacy managers will face in the area of organisational development and business reengineering. This seminar will further address data mining options, evaluation of added values and scaled advantages, as well as emerging opportunities and threats.

I3: New roles for hospital pharmacists - pushing the boundaries

It is rare for a genuinely new role for pharmacists to be created and on the few occasions that they have come into being, it usually starts in one or two locations and then spreads slowly across the profession, over many years.

New roles seldom originate from high up in the health service hierarchy.

This seminar will outline one such rare instance, the development of Advanced Clinical Practice (ACP), a practice of clinical pharmacy which goes beyond the current concept.

Pharmacists from concept through pilot to creation, across the health service in England in four short years.

PH1: Immuno oncology - new possibilities in the fight against cancer

It has been known for many years that the immune system has potential for the specific destruction of tumours with no toxicity to normal tissue. It also has long-term memory that can prevent cancer recurrence.

However, cancer progression is often accompanied by immune suppression: tumours change normal immune regulation to their advantage. The expansion of tumour antigen-specific helper and cytotoxic T cells is prevented, and the production of proinflammatory cytokines and other factors is promoted, leading to the accumulation of suppressive cell populations that inhibit immunity.

Advances in the past 30 years are leading to novel immunotherapeutic approaches for the treatment of cancer. Tumour immunity may be enhanced by blocking inhibitory pathways and inhibitory cells in the tumour microenvironment (e.g. antibodies against cytotoxic T-lymphocyte-associated antigen-4, programmed death 1 or its ligand programmed death ligand 1). Also the specificity of antitumor immunity can be enhanced by inducing the expansion of T cells and antibodies directed to well-defined tumour antigens (e.g. cancer vaccines).

These approaches are already showing a substantial impact on some patients with advanced, previously untreatable, malignancies. It is time for hospital pharmacists to understand the promise and pitfalls of this new approach, which may change cancer treatment in the near future.

PH2: The elderly at risk: reducing medications safely to meet life's changes

Polypharmacy is common among older patients and often comes with an increased risk for negative health outcomes such as adverse drug reactions, drug-interactions, nonadherence, functional and cognitive decline, falls and higher healthcare cost. In responding to polypharmacy - related harm, a new term has entered the medical lexicon: deprescribing. The term deprescribing is used to describe the comprehensive process of tapering, stopping, discontinuing or withdrawing drugs, with the goal of managing polypharmacy and improving outcomes. A systematic and patient-centered deprescribing process comprises several steps: compile comprehensive medication history; identify potentially inappropriate medications; assess each medication for eligibility to be discontinued; prioritise medications for discontinuation; monitor, support and document. Deprescribing is not free from harm, and potential adverse consequences of medication withdrawal (return of a medical condition, or other adverse drug withdrawal reaction) should be considered. Most of the harms of deprescribing can be minimised with proper planning, monitoring and with reinitiation of the medication if the patient's condition returns. Barriers to deprescribing include fragmented care among multiple prescribers, ambiguous or changing care goals, uncertainty about the benefits, harms of continuing and discontinuing specific medications, fear of adverse effects, community and professional attitudes toward more rather than less use of medications, and limited consultation time.
Deprescribing requires coordination of health care providers and pharmacists can contribute to all steps of systematic deprescribing process. Different levels of pharmacist's involvement is present in different countries. As such, we need to plan organizational models where the contribution of the pharmacist can have the maximum impact.

B1: Merging in pursuit of excellence - does it really work?

Mergers among hospitals and healthcare organisations have been on the rise for several years now. The new healthcare organisation is then expected in theory to improve efficiency, access to care, and quality of care, and may lower costs.

During a merger, no part of an organisation is immune from change. The challenges for hospital pharmacist emerge in every area and function (i) at the collective level, in terms of culture, behaviours, priorities, outcomes (ii) at the individual level, the organisational changes may lead to job restructuring, layoffs, and changes in the administration of patient care. Pharmacy staff facing a merger may feel stressed, feared, and uncertain.

When a merger occurs there are a few issues any manager should address:

Are the outcomes well defined and understood in the new context?

Are the behaviours clear in terms of the culture of the parties involved in the deal and the culture necessary to deliver the post-deal outcomes?

Are the drivers of the desired behaviours well understood, prioritised and designed appropriately?

Is there an effective change-management program planned?

This seminar will present and discuss the issues and outcomes of merging organisation with the views of Medical Director and a chief-pharmacist.

B2: Managing patients' own drugs in the hospital – empowering patients by redesigning pharmaceutical care

Patients transitioning from the hospital to home are at an increased risk of medication errors. Patients with discrepancies in their medication list have more hospital re-admissions than patients with a correct medication list. Discrepancies can be due to in-effective medication reconciliation at admission or discharge, substituted drugs during hospital stay or adherence issues not revealed during hospital stay.

Medicines reconciliation is conducted by doctors, nurses or pharmacists. In many cases there is no clear owner of the process. No standardised process exists and in many situations the patient is not well- positioned to provide an accurate medication list at admission, as opposed to later during their stay.

During hospitalisation, approximately 40% of a patient's medication is being substituted according to the hospital's formulary. Substitution of drugs may be carried out because of different brands or different strengths in the hospital drug supply. Although this approach is considered as effective and safe, substitution may have downsides with respect to medication safety, patient satisfaction and financial impact. Although medication substitution seems to save money at first sight, staff and medication costs are also involved in order to organise the substitutions.

From a patients' perspective, substitution should most likely be discouraged. Not only are patients at higher risk for medication errors during hospital stay, they may also be confronted with drugs that patients are unfamiliar with. Consequently, patients' engagement in their treatment may be altered.

Adherence to drug regimes is often hard to recognise. Adherence is approximately 50 % of prescribed medications. The ability to understand instructions and handle packages are two examples of adherence problems that are not often asked about.

This is supported by the fact that while patients receive care in hospitals, they often assume a passive or dependent role. On discharge, patients (and their family members) are abruptly expected to assume a significant self-management role in their medications, often with little support at home.

This seminar will focus on a new concept of pharmaceutical care delivered during a patient's admission, in which patient's engagement and self-administration of medication are key elements. This concept has been tested in several (academic) hospital settings, and was supported by the Dutch Ministry of Health. We'll present the background of this concept, the first findings as well as a toolbox on how to implement this strategy.

B3: The growing role of hospital pharmacists in the outpatient setting

Clinical pharmacy services in the outpatient setting have experienced great changes in the past years and it looks like they will only continue to expand. Hospital pharmacists working in the ambulatory care scenario have become experts in the treatment of solid tumours and haematological malignancies with oral drugs, HCV infection with direct-acting antiviral agents, multiple sclerosis with recently marketed oral treatments, etc., and the pipeline is full of new options that will probably continue to be high-cost and complex.

Keeping up to date on evidence-based treatment guidelines and selecting with the physician the right treatment option for each patient is becoming a common practice for pharmacists. Access to these drugs on occasions will also need special involvement of the hospital pharmacist and can be a critical step that will play an important part in the success of the treatment plan. Once the drug is available, providing counselling on potential adverse events, avoiding interactions with other treatments, educating patients on the importance of adherence, monitoring response and appearance of toxicities, recommending dose adjustments, or even the end of treatment when the patient meets stop criteria are some, but not all, of the clinical activities in which hospital pharmacists are engaged with patients that are not in the hospital's "controlled environment".

But will we be able to manage these growing roles without changing the way we do things?

Finally, the patient's individual needs should be analysed to understand the limited resources we have and how to get the most out of them in terms of health outcomes. It may be needed to switch to a new model that is centred in an active patient, instead of the traditional treatment-centred model, and even clinical services may need to be offered in a different degree among patients treated with the same drug based on each patient's necessities.

W1: Quality management: the road to excellence

In this workshop themes discussed in the Seminar entitled Introduction to Quality Management Systems (QMS) will be explored further using the medium of case studies and delegate participation. Attendance at the seminar isn't a prerequisite for this workshop.

Using case studies we will explore what markers could be used that positively affirm to a hospital pharmacist that the work they are doing on a daily basis could be regarded as being done well and that the tasks they perform actually add value, that they possess the appropriate competencies and training. If an individual feels under pressure, this can sap confidence, the cause for this could be a competency issue, a lack of relevant training or a lack of managerial support; how can the cause be identified? Performance management supports both individuals delivering services and those responsible for managing them.

Increasingly words such as efficiency, productivity, outcome and performance measures are finding their way into the vocabulary of the hospital pharmacist. For many this appears to be a retrospective step but in this workshop it will be shown that in reality performance management can be a positive tool in the hospital pharmacist's toolbox and actually helps to develop professional confidence and builds careers. Quality management can be seen as a friend not a task master!

W2: The art of writing an abstract

Scientific abstracts cover the main points of a study and its results. They represent condensed and clearly structured summaries that allow the reader to understand the most important aspects (e.g. study rationale, methods, results) at a glance. The task of writing an abstract can be challenging, and several pitfalls may lead to impaired quality or even rejection of the abstract. First impression matters!

In 2016, 318 submitted congress abstracts (35,77%) were rejected by the scientific committee of EAHP due to various reasons. Hence the current workshop will, among other things, address common pitfalls related to creating abstracts for EAHP and congresses in general.

The workshop is dedicated to ambitious hospital pharmacists who plan to submit a high-quality abstract for future congresses, want to improve their abstract writing skills and want to reduce the risk for abstract rejection.

W3: A quick guide to successful publication

Reporting original research in journals, through scientific papers in standard format needs a training that will overcome the barriers that face pharmacists.

An original paper is 'The first disclosure containing sufficient information to enable peers to assess observations, repeat experiments, and evaluate intellectual processes (are the conclusions justified by the data?)'.

Briefly, it's a question and its answer. The author must consider 4 questions: What was the question? (the introduction); How did you design the study? (the methods); What did you find? (the results); What does it mean? (the discussion). For most journals an original paper has 3500 words, 3 to 6 illustrations. The title should be a message (with the main results?). The formatting, the references, and other items (authors, contributors, disclosure, acknowledgments, contributors, funding) should be adapted to the journal.

The choice of a journal and the cover letter are the first step before submitting. Journals follow ethical guidelines, but their functioning varies among journals.

The technology and the business model (open access?) have greatly changed the system.

Social networks tend to comment papers after publication, and influence practices, such as retractions by editors.

This seminar will present and discuss the issues of writing and publishing an original paper; it will list the key messages to save time and win the 'game'.