WHITE PAPER

PM consultancy
Progress through partnership

Lord Carter of Coles has recently delivered his independent report, snappily entitled "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations". While there has been a lot of coverage of the report as a whole, we wanted to concentrate on what it could mean for pharmacy. Although Lord Carter restricted his comments to English acute hospitals, we think that there are wider lessons that can be drawn.

Let us begin with Lord Carter's letter to the Secretary of State that introduces the report.

1. **All trusts should … grasp the use of their resources more effectively, the most important of which is their people.**

This is an important message, because pharmacy is largely a knowledge industry. Too many managers see pharmacy as just a synonym for dispensing, whereas Carter is clear that the mechanical aspects of service should be separated from those areas where the knowledge held by pharmacists can be used to good effect. In short, pharmacists' time should be concentrated where it does most good for patients.

This is not only relevant to the acute sector. It could, for example, apply to the embedding of pharmacists in GP surgeries. If their role is merely administrative—reviewing notes, for example—then we will be falling into exactly the same trap that Carter identifies. Pharmacists add most value when they speak directly to patients.

One of the biggest consumers of pharmacists' time, especially at managerial level,

is meetings. We believe that every organisation should periodically audit the meetings it holds or attends to ask some key questions:

- Why are we holding it?
- What are its aims?
- What are its outputs?
- Is it serving the purpose for which it was created?
- If so, could it do so more efficiently?

Many pharmacists now attend time management training and aim to use their time more productively. There is a lot to commend in this, but sometimes people are very conscious of their own use of time yet disregard the demands they place on the time of subordinates. Readers who attended the PM Academy series on lean thinking will immediately spot that this process must lead to waste, because the subordinates' time is not being used efficiently.

So what's the opportunity here? We would say that Carter has given every manager the authority to examine the pharmacy team's use of their time and to challenge any activity that is not clearly serving the needs of patients. This should be a proactive review. For most hospital pharmacy departments, saving a couple of hours per person per week is as good as getting a new member of staff.

2. We must endeavour to reduce and rationalise the plethora of reporting burdens currently placed on providers by commissioners and regulators.

Most of us spend a lot of time completing forms. Carter's complaint is that sometimes people have to report the same data in two ways because different authorities want it for their own purposes. For example, a report of a clinical error may be reported in one way, but if it happens to involve a controlled drug some hospitals require a report on a different form.

Moreover, some data collections appear to have no purpose. Nobody is going to use them in any way that benefits a patient. For example, a trust required community nurses to complete a timesheet showing when they arrived at and left a patient's home. The idea was to show how much time was spent travelling, but since the managers concerned had no idea how they could change this, whatever the data showed, they stopped collating the data. However, the collection went on for some time after the purpose was lost.

Another example is the collection of blood glucose levels. There is an obvious usefulness in this if the patient is regularly seeing a clinician, but it is not unusual to be presented with six months' readings at an appointment. One of our advisers attended a diabetic patients' group at which the question was asked "Why do you ask me to ring you if my blood glucose exceeds X when every time I do you tell me to take it a few more times in case it's a fluke?"

Again, we believe that Carter is giving us all the authority to question how and when data are collected, to assure ourselves that there is a purpose to the activity and to look for ways of streamlining data collection. Nobody is going to come to pharmacy suggesting that they need fewer data. It is for pharmacy to grasp the nettle and suggest improvements itself. Comparing our local demands with our peers is a good way to bolster our arguments.

3. **Delayed transfers of care for patients out of the acute hospital setting…[result] in sub -optimal use of high acuity clinical resources and delays to treatments for other patients.**

We can generalise this finding. Treating a patient anywhere except the best setting results in sub -optimal care and waste. Community pharmacists need to be better at identifying which patients need to be referred, but they are not alone. A number of services have faced criticism for failure to refer appropriately—and NHS111 has also been criticised for under-referring.

We need to ensure that all pharmacy services have clear guidelines on appropriate referrals. We will be holding a satellite on this topic in relation to diabetes at the JoMO/UKCPA national meeting on Medicines Optimisation in Diabetes on 17th May (see www.pharman.co.uk/events).

4. **Trusts should therefore ensure more clinical pharmacy staff are deployed – working more closely with patients, doctors, nursing staff and independently – to deliver optimal use of medicines, make informed medicines choices, secure better value, drive better patient outcomes, and contribute to delivering 7 day health and care services.**

There are two elements to this increased deployment. The first is that we ensure that pharmacists spend more of their day in front of patients, but it was also clear that there is a wide variation in the establishment levels of Trusts when it comes to clinical pharmacist numbers. Some Trust managements have been tardy in developing this role but now Carter has made it very clear that clinical pharmacists can make better use of resources and thereby cover the cost of their deployment.

5. **There was significant variation in medicines stockholding.**

This is an area in which pharmaceutical industry colleagues could make a big difference. Contracts that allow for stock drawdown via wholesalers on an “as required” basis will make a big difference to a Trust’s stockholding. Indeed, it could be argued that such arrangements are worth something and should be factored into the tendering process. Given the wholesaler service in most of the UK, there is little reason to have high buffer stocks. With supply chain management occupying 45% of pharmacy staff time, any initiatives from suppliers that drive this percentage down will free staff for clinical duties. It would be interesting to see some pilots and share the results of such initiatives, and we would be happy to receive such reports for our Journal of Pharmacy Management.

6. **Use of partners to deliver some services**

Carter argues that services such as outpatient dispensing can be delivered by third parties. That is undoubtedly possible, though he may have underestimated the complexity of managing such arrangements. However, there is clearly a case for saying that acute Trust pharmacies should concentrate on their clinical function. It must also be noted that where outpatient supply is contracted out, patient choice should be preserved

7. **A Hospital Pharmacy Transformation Programme (HPTP) should be developed at local, regional and national levels. To ensure all trusts achieve the model hospital benchmarks, trusts will need to have agreed plans by April 2017**

This is perhaps the most ambitious part of the pharmacy section of the report. A number of elements will appear in the HPTP:

- more clinical pharmacy staff are deployed on optimal use of medicines (ensuring that more than 80% of trusts' pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits)
- delivering 7 day health and care services
- adoption of digital information systems such as electronic prescribing and medicines administration systems (EPMA),
- consolidating medicines stock-holding and modernising the supply chain to aggregate and rationalise deliveries to reduce stock-holding days from 20 to 15, deliveries to less than 5 per day and ensuring 90% of orders and invoices are sent and processed electronically
- improvement of high cost drugs coding within trusts' NHS reference cost returns.
- reducing the medicines bill through best choices and from actively monitoring market developments, such as the launch of biosimilar products.

The report clearly envisages that biosimilars should be widely adopted. However, it has ignored a debate that has been bubbling for a little while. Some pharmacists have argued that the setting of a patient's care may be driven by differences in drug pricing between the community and hospitals rather than by clinical need, and that the best way to remove such perverse incentives is to bring hospital purchasing prices within the scope of a revised PPRS and create unified prices. Carter appears to have taken for granted that this will not happen. Companies with products challenged by biosimilars will need to devise a strategy acknowledging that the price is likely to be forced down quicker than previously expected.

The first step in implementing this section must be a clear understanding of where a Trust stands already. Some Trusts have made substantial progress in some of these areas.

The industry can assist in stockholding by producing packs of appropriate size so that handling is minimised and accommodating electronic ordering and invoicing—most companies already do, but one or two are lagging.

8. Community pharmacy providers may be willing to take on discharge medication dispensing, supported by NHS clinical pharmacy services

This will have to be handled carefully. Given that the most common cause for complaint in most Trusts is that discharge medicines are not received in a timely way (usually due to late ordering) it may be necessary to correct that issue first before attempting to introduce another organisation to the system. However, it would not be surprising if chief executives reading the report seized on this as a first step that needs to be completed.

9. Opportunities for taking a national or regional approach to collaboration and re-design also exist in the manufacturing and preparation of bespoke medicines in hospitals

In some health communities these manufacturing units are being approached by CCGs to take on the production of specials that fall outside the Drug Tariff as a means of controlling spiralling costs. A more systematic approach to that might be possible.

ACTION GRID	
TOPIC	[NOTES FOR LOCAL IMPLEMENTATION]
Review the use of staff time, particularly in their commitment to meetings	
What proportion of your pharmacists' time is patient-facing?	
For each report or data capture, check why it is being collected, who receives it, and whether they are doing anything useful with it.	
Do you audit what proportion of your patients are being treated in the best setting for them?	
Do you need help to create a business case for more clinical pharmacists? If you've been successful in obtaining more, are you prepared to share the arguments you used?	
What is your current stockholding? Can your team suggests steps to reduce it? How many packs require to be broken down to more appropriate units before use and can the manufacturer be persuaded to adjust their pack sizes accordingly?	
Are you making best use of partnership arrangements to deliver services?	
Comparing with peers, how would you assess your own Trust's use of IT? Where are the key areas for improvement?	
Dispensing for discharge is a major source of patient dissatisfaction. Have you gathered data on performance to inform future steps?	
Are there activities that you currently undertake that would be better performed at a regional, sub-regional or national level?	

PM consultancy

Progress through partnership

PM consultancy is the arm of Pharmacy Management that provides tailored services to the NHS and to the pharmaceutical industry.

To contact us, please call or email Katie Fraser:

01747 829501

katie.fraser@pharman.co.uk

Pharmacy Management

75c High Street
Great Dunmow
Essex CM6 1AE
Tel. 01371 874478
Email pharm@pharman.co.uk
www.pharman.co.uk