Hospital Pharmacy Transformation – an overview

Ann Jacklin
Professional Lead
Hospital Pharmacy & Medicines Optimisation Project
NHS Productivity and Efficiency Programme

DH – Leading the nation’s health and care
Hospital pharmacy was recognised as `a clinical workforce’

‘Hospital pharmacy services and the optimisation of medicines are *intrinsically interwoven* and from a value perspective can’t be separated’

“Hospital pharmacy….primary function…..work closely with *patients*, doctors and nursing staff to….choose, prescribe and *monitor clinical outcomes* of medicines….’
The Transformation

2014
HoPMOOp
Medicines £6.0 billion
Hospital Pharmacy £0.7 billion

2016
HPTP
Medicines £6.7 billion
Hospital Pharmacy £0.7 billion
Based on…..

- 7,000 pharmacists working with clinical pharmacy technicians to deliver values and outcomes from £6.7 billion pa medicines working with:
  - >110,000 doctors
    - Of whom >73,000 junior doctors
  - >400,000 nurses
  - For >100,000 inpatients a day

- Evidence that:
  - Clinical Pharmacy (including medicines reconciliation) delivers a return on investment of £5 for every £1 invested from
    - Reduced dose omission
    - Reduced length of stay (2 days)
    - Reduced admissions (9 -16%)
    - Increased time to readmissions (20 days)
    - Reduced medicines costs
    - Reduced errors on discharge (25% - <1%)
# Key to transformation - Carter Clinical and Infrastructure Definitions

<table>
<thead>
<tr>
<th>CLINICAL SERVICES</th>
<th>VARIABLE INFRASTRUCTURE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICINES OPTIMISATION</strong></td>
<td><strong>SUPPLY CHAIN</strong></td>
</tr>
<tr>
<td>1 Patient facing: ward pharmacy; medicines reconciliation; medicines discharge; prescribing; Out-patient and Pre-Admission Clinics; specialist Pharmacists; medicines administration and support</td>
<td><strong>E&amp;T</strong></td>
</tr>
<tr>
<td>2 Organisational Assurance: Medicines Safety Officer; Governance role of Chief Pharmacist; Audit Programmes</td>
<td><strong>ADVISORY SERVICES</strong></td>
</tr>
<tr>
<td>Store/distribution and procurement; Aseptic; Production QC; Dispensing; Homecare</td>
<td><strong>R&amp;D</strong></td>
</tr>
<tr>
<td>Training provided to Pre-Registration Pharmacists and Technicians; NVQ Assistant staff; Post-Registration Pharmacy staff</td>
<td><strong>SERVICES TO EXTERNAL ORGANISATIONS</strong></td>
</tr>
<tr>
<td>Medicines Information; Formulary</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials; Departmental Research</td>
<td></td>
</tr>
<tr>
<td>Community; Mental Health; Hospices; Prisons; Care Homes; GPs</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2.14 – Hospital pharmacy services shown as clinical or infrastructure. On average 55% of pharmacy time is spent on infrastructure services.
Pharmacy Infrastructure services

Lord Carter said:

• Can be delivered more efficiently
• Are subject to stark variation
• ..are most efficiently delivered…..through…..collaboration or shared service…..local, regional, national
• Need not be delivered by NHS employed staff

Lord Carter didn’t say:

• Are not valued
• Are not essential
• Are not required
• Don’t require expertise
Clinical Pharmacy Services

Lord Carter said:

• Acute trusts must ensure their pharmacists and clinical pharmacy technicians spend much more time on clinical pharmacy services than on infrastructure activities

He also said:

• …more clinical pharmacy staff…..deployed…..working more closely…..with patients, doctors , nurses and independently….    
• To deliver optimal use of medicines……informed medicines choices….secure better value…..drive better outcomes…..contribute to 7 day services….    

He didn’t say:

• Current clinical services meet needs either in volume or in ‘scope’
Improved patient outcomes

Principle 1
Aim to understand the patient’s experience

Principle 2
Evidence based choice of medicines

Principle 3
Ensure medicines use is as safe as possible

Principle 4
Make medicines optimisation part of routine practice

Patient-centred approach

Aligned measurement & monitoring of medicines optimisation
HPTP Landscape

Executive leadership

NHSE – MO, Right Care Spec Com. SPS RMOC

Professional Bodies (RPS, GHP, APTUK)

CQC – MH metrics and data packs NHS Benchmarking survey

trade bodies and suppliers (ABPI, BGMA HDA)

HEE CPPE

National Information Board - NHS Digital Medicines Strategy; DM+D; FMD; Scan for Safety

PMSG NPSG CMU

HPTP Programme & Board

Chief Pharmaceutical Officer (SRO) – NHSI Director of Pharmacy

Programme Management & Delivery Team

136 Acute Trusts – HPTP plans; collaboration; MH metrics

NHSI – Carter implementation role (all projects)

DH – 7 Day Service, MPI, Rebalancing,
Integration into Business as Usual

Failure

Success
Theory to practice the HPTP way…

Assume non of this is new

‘Pick’ a topic (serendipity)

Find the experts

Pick their brains

Bring ‘em together

Establish the shared goals

Priotise through alignment to HPTP

Watch the magic happen
Advice to trusts

April 2016

➢ Identify the Executive Director to be responsible for your HPTP
➢ Make contact with Strategic Planning Leads in your local health economy
➢ Discuss with colleagues, potential “collaboration footprints” or “collaborative partnerships” on hospital pharmacy services infrastructure.
➢ Review progress on actions relating to medicines arising from the interim Carter report published in June 2015
➢ Map the elements of your current service (eg. onsite, outsourced, shared)
➢ Map current clinical services against the seven elements of medicines optimisation in the Royal Pharmaceutical Society model
➢ Review local digital roadmaps to ensure that requirements for EPMA, DM +D, FMD and Scan for Safety (GS1& PEPPOL) are taken into account

May 2016

➢ Digital Road maps to include possible need for pharmacy system upgrades;
  ➢ DM&D June 2016
  ➢ FMD Feb 2019
  ➢ Scan4Safety
Context

With thanks to Andrew Davies