

ROUNDTABLE

REWIRING THE

Experts wrestled with expanding the role of hospital pharmacists and the potentially huge impact of outsourcing services in a debate over the future of hospital pharmacy. Ingrid Torjesen listened in

The pressure on secondary care pharmacy services has increased dramatically over the past 20 years. A wider range of complex medicines, shortening length of stay and more patients taking several regular medicines has caused dispensary workload to escalate. While the introduction of robots has taken some of the strain of dispensing, the rising drug bill and requirement to make efficiency savings have thrown specialist pharmacist services into the spotlight.

In the autumn, a group of pharmacy experts gathered in London to discuss how specialist pharmacy services could evolve to benefit patients, NHS organisations and the NHS as a whole – and what role the private sector could play in this.

The meeting began with the chair Dr John Coakley, medical director at Homerton University Hospital Foundation Trust, asking the group to outline the major factors impeding progress in medicines management.

The proportion of the NHS drugs budget spent by hospitals had risen over the past few years from 20 per cent to around 33-35 per cent (around £4bn per year), said Allan Karr, chair of the National Homecare Medicines Committee. Meanwhile, the number of hospitals had fallen dramatically, meaning “each buying point now is applying more and more money”.

Pharmacy in most hospitals was still seen as “a Cinderella service” supporting clinical teams, he explained, and was expected to find the same 3-6 per cent saving as other support services under trusts’ cost improvement programmes. He said this hit pharmacy particularly hard for two reasons: pharmacy dealt with



such a significant amount of money; and the best way for pharmacy to make long term efficiency savings was through medicines optimisation, which meant reviewing pathways rather than crude budget cuts.

Minimising errors

Aaron Cummins, chair of the Foundation Trust Network’s finance directors forum, said that, apart from cutting drug spend by 6 per cent through negotiating better prices and improving procurement, trust boards should also focus on improving pharmacy patient safety and quality.

This meant reducing serious incidents, medication errors and patient complaints. As most complaints were related to the end of the patient journey – often delays in discharge and getting home – the spotlight often fell on pharmacy and the speed prescriptions were dispensed. But, he emphasised, it was not always pharmacy that was a blocker.

Medication errors and serious incidents were most likely to occur when a patient’s care was transferred from one sector to another, Ian Costello, chief

pharmacist at the Royal Marsden Hospital, pointed out.

Mr Cummins said agreeing a standard interface language and a standard way of recording across primary and secondary care and other services was “a bit ambitious”. “We need to find some way of recognising that the problem is interfacing information and sharing.”

As patients’ medicines were no longer dealt with just by secondary and primary care, the NHS legal framework – rules, regulations and governance principles – needed to be redesigned, Mr Karr argued, both for services that already existed, such as homecare and outsourced outpatient services, as well as new services.

For example, the opportunity for community pharmacy services to deliver homecare medicines to a local pharmacy rather than a patient’s home raised a huge number of governance issues, he said.

Dr Coakley asked the group what changes in secondary care pharmacy would have the most impact in terms of medicines management.

Ron Pate, secondary care pharmaceutical adviser to the department of medicines management at Keele University, said polypharmacy was a growing problem and that pharmacist prescribers could have an important role in reducing it. There were large numbers of elderly patients taking 10 or more medicines, and when someone was over 80 they were not all essential, he explained. “We can reduce that down to about three or four medicines. Make it manageable for the patient.”

Chris Calkin, chair of the Healthcare Financial Management Association’s



ROUNDTABLE PARTICIPANTS

Dr John Coakley (chair) medical director, Homerton University Hospital Foundation Trust
Chris Calkin chair of the Healthcare Financial Management Association’s policy committee, retired finance director at University Hospital of North Staffordshire, and part time lecturer at Keele University.
Ian Costello chief pharmacist, Royal Marsden Hospital
Aaron Cummins chair of the Foundation Trust Network’s finance directors forum, and finance director, Mid Staffordshire Foundation Trust
Dr Chris Green director of pharmacy and medicines management, Countess of Chester Foundation Trust, and chair of the UK Clinical Pharmacy Association
Allan Karr chair of the National Homecare Medicines Committee, and pharmacy business manager, University College London Hospitals Foundation Trust
Ron Pate secondary care pharmaceutical adviser to the department of medicines management, Keele University, a consultant to the NHS and the pharmacy industry, and author of *Outsourcing hospital pharmacy outpatient dispensing services – challenges and opportunities*
Scott Savage chief pharmacist, Kettering General Hospital Foundation Trust
Pete Shergill head of strategic services, Lloydspharmacy
Sally Taber director, Independent Healthcare Advisory Services

SCRIPT

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The panel: (opposite page, clockwise from top left) Allan Karr, Scott Savage and Pete Shergill; (top row, left to right) Chris Calkin, Ian Costello and Aaron Cummins; middle row Chris Green, roundtable chair John Coakley and Ron Pate; and Sally Taber



policy committee, said that doctors often prescribed items to counteract the side effects of drugs the patient was already taking – and that around a third of drugs were not taken as prescribed. Often this was because some patients were taking so many, Mr Pate added.

Hospital pharmacists had an ideal opportunity on wards to find out if patients were having problems with or failing to take any medicines properly, added Scott Savage, chief pharmacist at Kettering General Hospital Foundation Trust. “They’re not going anywhere,” he said – and suggested pharmacists could “chat with these patients and then communicate that discussion [to the GP and community pharmacy] that they’re not keen on taking the yellow tablet or ... taking their inhalers twice a day”. “That’s where the value is going to be – that communication.”

However he warned of a risk of secondary care pharmacy duplicating work being done in community pharmacy through the new medicine service and medicines use reviews. Better

communication between hospital, community pharmacy and the GP was vital to avoid this and prevent a patient being taken off a drug in hospital and then having it immediately reinstated in the community.

That was what medicines optimisation was all about, said Pete Shergill, Lloydspharmacy head of strategic services – moving the pharmacist closer to the clinician as well as the patient interface and, rather than focusing on the costs of individual drugs, making sure

‘Hospital pharmacists have an ideal opportunity on wards to find out if patients are failing to take any medicines properly’

that patients were taking drugs correctly and the right drugs for them, to reduce the risk of them coming back into hospital with a medicines-related issue.

Mr Shergill pointed out that it was easy to save 6 per cent: “You stop prescribing.” He recounted a visit with a hospital pharmacy team who told him that they could not give him a fixed cost for how much they would spend on medicines because they “were not in control of that”. He had told them: “If you extend the service to more than just dispensing and supply then we can work with your clinicians [to achieve better value for money].”

Ten years ago the focus of hospital pharmacy had been on assembly and dispensing. “Robots have come in and a lot of wards now get much more access to pharmacy teams – whether it’s pharmacist prescribers or technicians who are in the hospital environment with community skills,” said Mr Shergill. “We underutilise those skills when we pull them back into the dispensing process.”

Mr Savage said pharmacy staff were often pulled back into dispensing to ensure hospitals were getting patients through A&E quickly enough and, as a result, were unable to focus on improving outcomes and potentially reducing length of stay. “People have to re-engineer their service to cope with getting the dispensing done as quickly as possible.”

Lloydspharmacy’s experience

Panel members called for specialist pharmacists to reach out to support GPs and community pharmacists with complex new medicines. Between 40 and 50 per cent of new drugs are complex biotech products



of running outpatient dispensing in Liverpool had shown that convincing clinicians to change protocols was difficult but possible, Mr Shergill said.

Regular medicines reviews and patient education were crucial, Mr Cummins agreed, but he added that electronic prescribing and medicines administration (EPMA) was also needed to identify problems that would otherwise be difficult to pick up because of variations in clinical practice.

Such systems would also reduce medication errors and incidents resulting from illegible handwriting and poor form filling. EPMA tracked medicines use electronically, was easily read and could flag contraindications and provide clinical decision support.

But Dr Chris Green, director of pharmacy and medicines management at Countess of Chester Foundation Trust, warned that electronic prescribing would not fix the quality of prescribing: "You can still prescribe rubbish if you want to prescribe rubbish."

Doctors in training caused a lot of problems when they came on to the wards for the first time, he said. "Junior doctors are not taught to prescribe properly and pharmacy teams spend inordinate amounts of time correcting junior doctors' prescribing."

Dr Green said: "We patch up problems but we don't fix the

'When you ask junior doctors what their training in prescribing is, it is actually zero'

root cause. We have clinical pharmacy services partly to improve medicines optimisation but partly because junior doctors are not trained properly."

Novice prescribers

Some had never written a scrip before, then were suddenly prescribing for real patients largely unsupervised, he said. "It's crazy – you would not take your car to a garage where the lad said: 'To be honest I am not really trained to do this, but I will fix your brakes anyway.'"

Sally Taber, director of Independent Healthcare Advisory Services, recalled that when nurses became independent prescribers, there had been lack of respect for their skills from doctors, and asked whether pharmacist independent prescribers had suffered the same problem.

Dr Coakley admitted this was a problem. "I think there is a sort of bizarre departure from reality when the doctor says 'I am trained to prescribe, no one else is,' and when you ask them what their training in prescribing is, it

is actually zero. They come out of medical school and they've had no training at all."

Around 7 per cent of hospital admissions were due to drug reactions, Mr Calkin pointed out, and it was suggested that pharmacists in hospitals could reach out into the community more to support GPs and community pharmacists to reduce this and to enable more complex medicines to be prescribed outside of hospitals.

Between 40 and 50 per cent of all new medicines were complex biotech products, Mr Karr said, and the burden of prescribing them and therefore the cost had tended to be kept within secondary care. Yet patients did not want to have to travel miles to pick up their medicines so these products should really be prescribed by their GPs, he said. But, he warned, most GPs did not understand how to prescribe them and would expect to get paid extra for doing so through an enhanced service.

As this was the direction of the medicines market, complex medicines had to be addressed in GP training, and secondary care pharmacists needed to train and support community pharmacists to understand complex drugs, he said.

"We have got an enormous amount of pharmacy expertise in our hospitals and it never actually reaches out to support patients in the pathway in a primary care setting," Mr

Costello added. "There has got to be an integrated pathway and it is about using specialist resources to make the changes within the integrated pathway."

Mr Savage proposed that IT systems could be used to enable secondary care pharmacists to interact with patients requiring specialist drugs in the community where community pharmacists did not have the necessary specialist knowledge.

Mr Shergill suggested that it might make sense for community pharmacy to develop specialisms so the patient might then travel to "a pseudo-specialist centre" within a few miles of their home.

Home delivery

Dr Coakley said that an awful lot of medicines dispensed by hospitals could be delivered at home. Mr Shergill agreed, but recommended that the first prescription be filled at the hospital, where it could be managed effectively. The subsequent supply could then be delivered to the home providing the patient was competent and chose that approach, he added.

Around £1.5bn worth of drugs were already delivered through homecare to approximately 200,000 patients every year, Mr Karr revealed. The majority were expensive branded medicines but when patents expired and prices dropped, the VAT savings from homecare would evaporate, he said. "Those services then



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will be picked up by the trust if they are to be continued.”

But he acknowledged that even without VAT savings, there were a number of services for which homecare would continue, such as dialysis services, enteral feeds and total parenteral nutrition. Homecare existed in Northern Ireland, Mr Karr pointed out, where there were no VAT savings to be made.

Mr Costello explained that the development of homecare had been driven by VAT savings rather than planned, so while it would be much better for many patients if they could access their drugs through home delivery or a community-based delivery service, for some inexpensive drugs it was not financially viable. Mr Pate said it was important to remember that home delivery was not the same as homecare and to distinguish between the two.

Dr Coakley said a variety of services, from IV antibiotics to low risk chemotherapy, were suitable for homecare and it was important for commissioners to look at the value of homecare in terms of the NHS as a whole. For example, where the homecare

service was delivering nutrition, the value of the service could be prevention of hospital admissions.

Mr Shergill agreed. When the need to go to hospital to receive chemotherapy was removed, he said: “You can then start to look at how you can potentially re-engineer other parts of the pathway.”

Mr Costello warned the NHS had rushed into homecare and risked doing the same with the outsourcing of secondary care pharmacy. “It is seen as a quick financial win. It is not really being planned and the best benefits that can be achieved are not really being achieved in many cases.”

Tax benefits

Mr Calkin indicated that some hospitals had outsourced outpatient dispensing to community pharmacy companies to save VAT. While the potential to save 20 per cent in VAT would “switch on the efficiency light” for boards, Mr Cummins cautioned that this

‘Trusts doing it purely for the year one win and providing a very narrow service will find it difficult’

could be a time limited benefit if tax rules changed, so should not be the only reason to choose this approach.

Organisations either had to have an exit strategy in case of changes to the tax rules, he added, or recognise other benefits, such as reduced waiting times, improved information sharing, improved patient experience or reduced admissions. A change to the VAT rules is unlikely as it would require a change to EU legislation.

Mr Shergill said: “Trusts... doing it purely for the year one win and providing a very narrow service will find it difficult .. Those who have taken advantage of the market situation and are doing it in a strategic way will benefit in the long term. There are trusts out there... looking for five and ten year partners and who recognise that, as a foundation trust, you want to get care closer to home but equally hold on to the revenue.”

The services could be controlled by the foundation trust but delivered through numerous partners in primary

care or the intermediate care setting, he explained. He described two examples of such multidisciplinary service approaches that Lloydspharmacy had been involved with. The first delivered cardiovascular risk screening to 10,000 men over the age of 40 in Birmingham during the evenings or weekends. Some patients were seen at GPs’ surgeries that agreed to remain open in the evenings when security costs were covered, and others were seen at sports grounds, such as football stadiums.

“We had the lowest ‘do not attend’ because they were being followed up by text. We were finding patients who had not been to the GP in 10 years,” he said. The second service was a bowel screening initiative where patients were seen in both the community and hospital environment.

Mr Cummins asked whether there was evidence to demonstrate non-financial benefits of outsourcing outpatient pharmacy in secondary care.

Mr Shergill said

How to improve customer satisfaction with NHS pharmacy services was a major talking point. Panel members acknowledged the private sector's expertise in this area, suggesting that the NHS could benefit from this by either working in partnership with the private sector or trying to learn from it



Lloydspharmacy always carried out patient surveys after the service had been outsourced to them, and sometimes before, to demonstrate patient satisfaction. The two areas these surveys highlighted were reduced waiting time and an improved environment, he said.

Mr Karr wanted to know whether the reduced waiting times were the result of the staff the service was outsourced to dispensing faster. Mr Shergill replied that they resulted from staff being focused on outpatient dispensing because they did not have other competing work priorities.

Mr Pate said that some hospitals had opted to set up a subsidiary company for outpatient dispensing rather than outsource – and had invested part of the financial savings they had made into new staff and new facilities to improve the patient experience. So it was not outsourcing per se that improved patient experience, he said.

Those trusts got to keep all the profit in-house but, Mr Pate admitted, missed out on the commercial expertise that the community pharmacies had and their distribution network. “There is definitely more customer focus from the community pharmacy. The way the hospitals that have done the in-house service have tried to address this is to recruit community pharmacy people.”

‘The profession and NHS have to decide what the role of the pharmacist is in the modern world’

Mr Savage agreed that one of the advantages of involving community pharmacies was they were used to striving to achieve real customer satisfaction. That satisfaction was essential as community pharmacy relied on repeat business, he explained: “Repeat business coming back for that experience.”

Mr Shergill said there were different solutions for different trusts. It was a matter of what the trust's strategy for the next five to 10 years was – would they welcome a partner to support them or did they think they had the capability in-house to achieve the potential gains?

“One of the benefits of having a commercial partner or outsourcing is something else that the sector is wrestling with, which is access to good quality and affordable capital for investment in either facilities or IT,” Mr Cummins said.

“Central monies are now drying up and surpluses and margins at trust level are small, so actually signing up with a

commercial partnership, whether it's pharmacy outsourcing or something else, does give access to that.”

Mr Pate, who has written a review of the benefits and drawbacks of outsourced pharmacy services, said he had been surprised that there were no examples of a mixed economy arrangement where a community pharmacy did the home delivery and support, and a subsidiary of the trust was responsible for outpatient dispensing in-house.

Mr Karr said individual trusts and the NHS as a whole had to think carefully about how they took pharmacy contracting forward. He likened the situation to a chess game, where every potential consequence needed to be considered. “What you don't want to do is to lose what is working very well and saving the trust a significant amount of money,” he said.

Drug company worries

Some independent pharmacy providers had homecare companies and wholesalers – a fact that worried some pharmaceutical companies and had already led to changes in distribution arrangements, Mr Karr said. For example, Pfizer had moved from a fairly open distribution arrangement to a single distributor. “They are the people that give the discounts and the concern is that if this escalated we would certainly

need to see what the impact would be in hospital prices.” Pfizer had done this because they were concerned about a “grey market” – the loss of product from the UK to overseas, Mr Karr said: “In many cases, certainly within the hospital sector within England, the prices of their drugs are lower than in Europe.” But he admitted that there was no evidence that any UK product had ended up overseas.

Mr Cummins said: “I sit on the national procurement council and the voice of industry around how this movement in the market could splinter some of the governance they have got around supply chain and its integrity is vocal. They are saying the more points there are in the market where there are points of intervention on the supply chain introduces risk – price risk essentially.”

Mr Shergill agreed these were genuine concerns but said they were not insurmountable.

“Retail pharmacy cannot get access to hospital products because there are firewalls between systems,” he said.

But Mr Pate feared that companies would know the contract prices of the services outsourced to them and use that information to their advantage.

Mr Shergill said that, to protect the supply chain, everyone had to work together and governance arrangements should be put in place to

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separate the relationship between the pharmaceutical industry and those involved in pricing.

Mr Karr said he had concerns about the governance arrangements for homecare, outsourced pharmacy and other types of contracted services because if they were put out to tender they would be open to any qualified provider. "The existing contracted out outpatients [pharmacy] most probably are working," he said. "But it doesn't mean that if we have 100 hospitals going that way it will work. We don't know because there aren't the governance arrangements."

Ms Taber said: "Any qualified provider who is serious is hardly going to go into it with governance systems that aren't there because they are not going to be in business very long."

Mr Karr responded that pharmacy was used to managing products and had little experience managing services. "You need skills to manage external services," he said. "We need to have a contract manager to ensure that the specification is drafted and it's appropriate and doesn't contain loopholes." Although not many trusts currently had those positions within pharmacy, those roles could be developed. But he feared that trusts would take shortcuts and opt not to employ contract managers.

Mr Cummins pointed out that



all foundation trusts and most NHS trusts would already have experienced contracting teams, finance teams and commercial legal support: "The performance management of the contract side of the commercial element should sit within the corporate functions."

He added that the public sector had to learn lessons from private finance initiatives which had been drafted with private companies with very clever legal departments and decide: "What kind of person do we need in the corporate functions if outsourcing and private sector partnerships are the future strategy for either pharmacy services or the NHS?"

As the meeting drew to a close, Dr Coakley asked the group where secondary care pharmacy should go from here.

Mr Calkin said the profession and NHS had to decide what the role of the pharmacist was in the modern world, and whether that included helping to reduce

prescribing errors and hospital admissions. "Then we can start to determine what kind of services we want and then how we provide those," he said, which could mean a mix of private, public and joint ventures.

With the coming sea change in the commissioning landscape, Mr Cummins said it was vital to understand better what the local health economy would want before making massive structural changes to the design of services. Dr Coakley agreed changes to commissioning posed big risks in the short term. "We don't know how much is going to come top-down from the NHS Commissioning Board and how much from clinical commissioning groups," he said.

Private sector's role

In conclusion, he asked: "How can the private sector help the NHS push the boundaries of the service it provides?"

Mr Pate said that hospitals had a very clinical and patient focus, while in community pharmacy the focus was more on the customer. Bringing some of that training from community pharmacy into the hospital could achieve big improvements in attitude among staff, he said.

Dr Coakley shared a story from his local MP, who had visited his hospital recently and

complained that the same woman had been sitting on reception for 20 years and never smiled. He admitted:

"Community pharmacy is very different – the whole thing is very personalised."

Mr Cummins pointed out that, while a better patient experience was important, "we shouldn't have to buy that in to be fair." Ms Taber echoed his comments: "We don't need to buy in customer service, you just need to change your attitude, that's all it is."

Mr Costello agreed, but said that trusts could learn from the private sector. "It is about delivering things with the private sector in a better way for patients that we should be focusing on really, it's not about buying in customer service."

Mr Green revealed that the Countess of Chester Foundation Trust, where he is based, has entered into a strategic partnership with Unipart to draw on its experience of implementing lean practices and improving other workplace practices. "That's been great for our hospital, we have learnt so much from them," he said.

Mr Pate said he knew of another hospital that had worked with Formula 1 teams to improve the transfer of patients from theatre to intensive therapy units. "The speed... they improved things was dramatic so you can bring in private sector to help," he said. ●