What is the model hospital pharmacy department?

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Difficult to quantify/measure . . .

• Many variables: technology, geography, available workforce, local priorities/opportunities, etc.
• One size doesn’t fit all
• Increasingly complex
  – Multidisciplinary; not just pharmacy department
  – Cross organisational/integrated; not just hospital
• Lots of metrics but limited use in isolation
Pharmacist skill mix

Pharmacist skill mix (average)  Pharmacist skill mix (submission)
Flow: supporting discharge
Omitted medicines: supporting nurses

- Significant difference between the Intervention (A) and the Control (C) groups in terms of unacceptable omitted doses
- 1 in 5 versus 1 in 100
- ARR = 17.4%

<table>
<thead>
<tr>
<th>(A) Pharmacy Assistant supporting Nurse</th>
<th>(C) Single Nurse on Control Ward</th>
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</thead>
<tbody>
<tr>
<td>% Patients with UOD</td>
<td>1.2%</td>
</tr>
<tr>
<td></td>
<td>18.5%</td>
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Conceptual difference between effectiveness & efficiency

Effective
- Doing the ‘right’ things
- Adds value
- Transformational
- Radical

Efficient
- Doing it ‘right’
- Reduces costs
- Transactional
- Incremental
Effective

• Doing the ‘right’ stuff e.g.
  – Clinical; adds value to patient care; value seen external to service; judged using important clinical outcomes; typically required 365 days of the year
  – Pharmacists prescribing routinely for all inpatients; medicines review as part of medicines reconciliation process; other clinical roles; facilitating discharge; operating across and into primary care; clinic roles; requires basic examination skills and other advanced clinical skills
  – Technical staff in patient facing roles including; managing patient’s own medicines, drug administration (including IVs), drug history taking, pre-operative assessment clinics, counselling, transfer of care
Effective

• ‘Wrong’ stuff?? (‘variable infrastructure services’)
  – In-house procurement, supply and logistics (versus automation/centralisation/outsourcing)
  – In-house manufacturing/aseptic services (versus outsourcing/regional scale of operation)
  – Prescription validation/medicines ordering (versus EPMA, order sets, standardisation of supply)
  – Outpatient dispensing (versus treatment recommendation forms)
  – On-site discharge dispensing (versus over-labelled ward stock medicines/adopting whole health systems to medicines supply)

Note: in each example a case could be made for this being the ‘right’ thing to do.
Efficient

• ‘Right’ scale
• ‘Right’ numbers of staff
• ‘Right’ AfC band
• ‘Right’ mix of technical and clinical staff (multidisciplinary)
• Using technology where it helps
• Balancing act – patient needs; service needs; staff’s needs
• Adopting human relations approach to leadership/management
  – Staff working at the boundaries of their capability (whilst being supported)
  – Job design/content e.g. responsibility, team work, patient focused
  – Staff development
  – Job satisfaction/staff motivation
  – Leads to higher performance
Questions?

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