Jersey General Hospital Pharmacy Review

Client: Jersey General Hospital

Date of Report: 7/7/24

Reviewers: Martin Keble

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West Hertfordshire Teaching Hospitals NHS Trust

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West Hertfordshire Teaching Hospitals NHS Trust

1. REPORTER

Martin Keble and Phil Southworth

2. DURATION OF REVIEW

3 days on site 4th-6th June 2024 with further off-site review of documents between 1st -15th June.

3. METHODOLOGY

A pre-review questionnaire was sent to all pharmacy staff and was completed by 26 members of staff. The reviewers spent 3 days conducting interviews and workshops with both pharmacy staff and external stakeholders. More than 25 hours of face-to-face feedback was received from over 30 members of the pharmacy department, including representatives across all staff groups. Every member of staff was offered the opportunity to meet the reviewers, and this was used by multiple members including ex-staff members who wanted to contribute to the review. Key external stakeholders were interviewed and included senior management from HCS as well as the Minister for Health.

Written information reviewed included UK wide pharmacy benchmarking data, Freedom to Speak up reports, Amicus report, current draft business plan/priorities, Quality Improvement (QI) report on clinical pharmacy services, and current/proposed pharmacy structures.

4. INTRODUCTION/BACKGROUND

Jersey General Hospital has 219 beds and provides services that would be found in a typical UK district general hospital service, albeit on a smaller scale.

The hospital pharmacy department is an intrinsic part of healthcare on the Island. The department has 53 Whole Time Equivalent staff, WTE; encompassing pharmacists, technicians, assistants, and administration staff that provide a wide range of services. These include dispensing services for all in-, out- and discharge patients, a clinical ward-based service to patients in the hospital to ensure the safe, effective and economic use of medicines, purchasing and distribution of all medicines for patients who use HCS services (more than 4000 lines handled), and the individual production of chemotherapy for cancer patients plus intravenous feeding bags in a specialist aseptic unit.

Additionally, staff within the department support key enablers for safe medicines management across the organisation such as the Electronic Prescribing and Medicines Administration (EPMA) system, medicines governance/management and staff training and development.

The department dispenses around 800 items each working day (16000-18000 over a month), with 150-250 people attending the outpatient pharmacy. Prescriptions are screened by a pharmacist before assembly and then dispensing and checking by trained staff. Most medicines provided from the hospital pharmacy will be newly commenced/adjusted for a patient (repeat prescriptions should normally be dispensed by a community pharmacy after

a GP prescription). Medicines may need ordering before dispensing. Processes in the hospital dispensary are more complex than most community pharmacies due to the nature of patients and medicines involved, with frequent need for discussions with a prescriber to ensure each prescription is safe and appropriate. Medicines counselling is conducted by a pharmacy technician or a pharmacist.

Community pharmacies can process hospital prescriptions. Patients will, however, be charged a private prescription fee. This is because hospital prescribers do not have access to the Health Insurance Fund, which is administered by Government of Jersey Customer Local Services (under the Health Insurance Law).

These arrangements contribute to the significant workload of the department. There has been external media publicity with long queues for prescriptions of more than two hours reported (45 minutes is published expected waiting time). The Health Minister has also commented on the waiting times in Parliament. The decision to close the outpatient pharmacy at weekends was taken to support the service and staff but has contributed to some adverse media attention. It was felt that the impact would be limited as clinics are not open at weekends.

Pharmacy is a heavily regulated activity; responsibilities extend into some novel areas of particular interest to Jersey including the licensing for the cultivation of medicinal cannabis, which could become a significant business for the Island.

Prior reviews have been conducted within the department- including from Amicus and a QI review of the clinical pharmacy service. The reviewers were informed that there been multiple contacts to the Freedom to Speak Up (FTSU) Guardians.

The reviewers, experienced chief and deputy chief pharmacists in UK hospitals, were asked to come into the pharmacy department as “fresh pairs of eyes.”

5. REVIEW OBJECTIVES

- To perform a review of Pharmacy services within Jersey General Hospital and make suggestions of any quality improvement projects that could be undertaken.
- To review the Clinical pharmacy team and its function and makeup.
- To review Leadership structures and the impacts of change as they have occurred.
- To review dispensary functions and any immediate areas for improvement.
- To review external factors that may unduly influence the function of the hospital pharmacy.
- To review the workforce, recruitment and the effects on function of the pharmacy.
- To review cultural aspects within pharmacy and their effects on the function of pharmacy as a whole.
- To make comment on any unique factors identified that influence workforce. Recruitment, service and culture in pharmacy.

6. EXECUTIVE SUMMARY

The reviewers, experienced chief and deputy chief pharmacists in UK hospitals, were asked to come into the pharmacy department as “fresh pairs of eyes”. There had been adverse comments from some current and former staff members, which had been raised internally and externally. The feedback from staff had included multiple contacts with Freedom to Speak up Guardians and negative comments made in staff/department surveys. In addition, concerns had been raised from patients and external sources about the waiting times for prescriptions to be dispensed, which has attracted some media attention.

The reviewers were on site for three days in June 2024 talking with most pharmacy staff employed, some external stakeholders and several former staff. Staff were invited to complete a survey of the positive and negative aspects of working in the department. Staff were found to be dedicated, honest and open in communication. Some staff showed signs of being upset and angry at the previous and current position including with leadership teams. Some staff were sceptical that this review would effect change and “nothing changed from the others”.

The review report is arranged in six main themes of culture, structure/staffing levels, workload, education and training, external factors and general.

During most staff interviews and discussions, the culture, and behaviours of staff in the department were consistent themes. No exact timescales for the development of any unwanted cultural and behaviours could be clearly identified. However, based on the information seen and heard in the review it was felt by the reviewers that the issues described had not acutely developed over the past few years, but were more longstanding. More recently though, staff felt that the situation was not improving, instead getting worse leading to the current scenario in the department. Staff said they felt dismissed/not listened to and there was unjust culture with confidential information sometimes shared and HR policies not being followed regularly. They also felt there was an overall lack of communication and poor visibility of senior leaders within the department. High levels of vacancies, turnover and union activity were fed back as being present for a number of years. The staffing issues and union activity have been reported as across the grades.

Recommendations include a focus on developing an open culture of continuous improvement where staff are empowered to shape the culture of the department, and the services it provides. Communication and engagement need to improve with regular and varied discussions amongst teams, and with section/department leaders. A ‘You said, we did’ approach should be considered to feedback from regular Be Heard surveys (or alternative feedback mechanism) to ensure staff see action on feedback.

There is no validated, evidence-based, template for pharmacy structures available in the UK (or internationally) for any area of pharmacy services. Most staffing models have developed over time, with additional posts being added as funding available without any overarching co-ordinated workforce approach. The views expressed were from the experience of the reviewers and comparisons with UK benchmarking. The department has staffing shortages with limited resilience, due to the cultural and local issues as such the cost of living and unique

aspects on working on an Island. There are themes of staff not consistently doing jobs/tasks that would be more appropriately done by others. Several examples are given to reconsider.

For many years (i.e. during the last two post holders tenure), the Chief Pharmacist for the hospital has been expected to lead and manage the hospital service as well as the external pharmacy demands described. The demands on the role have also increased in the last few years (internally and externally). This is unmanageable and almost certainly to have contributed to some of the issues for example a lack of time to engage with staff appropriately in the department described throughout this report. The transition to divide the historic demands of this role into separate roles is a sensible, albeit overdue, approach to ensure the appropriate senior leadership roles are in place for the Island.

Investment is required in operational and strategic roles to support pharmacy services in the Hospital and on the Island; the addition of the strategic roles cannot be to the detriment of the operational patient care roles. We feel as a temporary/short-term support, given the good digital progress of the department, remote locum workers should be employed that can help reduce the operational burden of staff onsite. They will not be able to 'replace' an on-site member of staff but can deliver significant parts of the workload that releases on-site staff to focus on appropriate activities. This is in addition to further training, and associated training support posts, being introduced to support current services and the development of a future staffing pipeline.

Operational and clinical workload demands are significant and contributing factors include some practices to improve within the hospital, needing executive support to influence some consultant practice, and further external factors of medicines arrangements on the Island. This has contributed to the hospital medicines spend being higher than UK benchmark averages. Specific opportunities exist including within clinical, digital, operational and aseptic services for detailed reviews of current processes. The space from which services operate needs to be reviewed for current and future requirements.

There has been a lack of management development, and resilience within the department over a number of years. It is possible that this is a result of significant challenge put on managers by successive senior managers within the service, leading to breakdown, resignation of postholders, or refusal to apply for managerial roles.

Staff reported that education and training was often limited by daily service pressures. There is a need to develop an education and training strategy for all staff.

Staff commented on the recently introduced mandatory resilience training sessions. It is understood that these sessions were well intentioned to assist staff in coping with the demands including dealing with members of the public and other service users. Most staff that we spoke with, or submitted survey comments, were not positive about the sessions in terms of time out of the busy day attending and found limited value from the tools and techniques provided.

Some external factors are within the gift of the hospital to change; including consultants to cease prescribing for private patients, instead prescriptions to be taken to community

pharmacies. In time, further development/expansion of the “white list” through legislation amendments to support prescribing and dispensing of some further medicines closer to patient homes. It is anticipated that investment in strategic and operational pharmacy services will support these developments. Setting up a process of registering, and reviewing, high-cost medicines to demonstrate patients meet NICE or other locally guidance would have operational and finance benefits for the health system.

Development of a pharmacy/medicines strategy at Trust/Island level for the next three- five years would be an opportunity to engage staff in co-production. This offers a visible ‘reset’ and an initial stepping stone towards a culture of continuous improvement where staff are empowered across the department. There is an opportunity to involve staff in the design phases for the new hospital and to ensure pharmacy is adequately resourced in terms of space considering likely changes to patient therapies and treatments.

Further investment is also required to complete roll out of Pyxis electronic storage to all wards in the hospital and realise the intended security and patient safety benefits. There is a need to develop medicines governance/assurance to assist in demonstrating compliance with relevant standards/legislation.

Line Managers need to be trained in the use of relevant HR policies and make sure staff are aware of policies and kept up to date with any changes. This is anticipated to support the informal and formal ways of working with staff and likely to reduce the level of union activity. Mentoring and coaching opportunities are an opportunity to involve/empower staff and provide tools to develop compassionate leadership.

7. CONCLUSION

The dedication of pharmacy team is an overall positive but there are shortfalls in the department that need the strength and collective wisdom of the team to improve.

8. PRINCIPAL MATTERS OF CONCERN

These have been arranged into six main themes of culture, structure/staffing levels, workload, education and training, external factors and general.

Recommendations exist for all themes (54 in total arranged as short, medium and long term). Some require investment and others a change of approach.

9. REVIEW FINDINGS AND RECOMMENDATIONS

9.1 CULTURE

A key theme of the information review, including the previous FTSU reports was the culture of the department. External HR measures were reviewed:

- Staff turnover rate reported in benchmarking in 2023 was slightly lower than the UK average (15.8% versus 18.1% average) and was unusually low in 2022 (4.5% versus 17.21% average).
- Vacancy rates varied between different staff groups/seniority but were notably higher overall for pharmacy than the UK average (2023, 18.5% vs. 12.8%).
- Staff sickness rates reported are lower than the UK average (2023, 1.9% vs. 4.6%; 2022, 2.83% vs. 4.68%).

The Be Heard Survey results were requested and supplied; they were from the office of the Medical Director which encompasses Pharmacy so difficult to draw any firm conclusions.

During most staff interviews and discussions, the culture, and behaviours of staff in the department were consistent themes. The Amicus report provided similar responses. No exact timescales for the development of any unwanted cultural and behaviours could be clearly identified. However, based on the information seen and heard in the review it was felt by the reviewers that the issues described had not acutely developed over the past few years, but were more longstanding. More recently though, staff felt that the situation was not improving, instead getting worse leading to the current scenario in the department. The key concerns that the staff repeatedly highlighted and provided lived experiences and examples of included:

- Feelings of being dismissed/not being listened to by senior managers for a number of years when trying to either raise concerns or suggest ideas for improvement. Often staff felt 'passed off' with inappropriate points. Staff meetings were seen as "one way". This has resulted in feelings of not being able to speak up or listened to (and in some situations led to concerns raised to the FTSU guardians). Some staff were sceptical that this review would effect change and "nothing changed from the others".
- Staff reported punitive measures being in place if they were off sick. Staff reported that were "sickness managed" otherwise and therefore came to work on occasions when they did not feel well.
- Lack of visibility of the Chief Pharmacist and lack of accessibility to this role as well as other senior members of the department. The longstanding demands on senior leaders is almost certainly a contributory cause.
- A fragile senior leadership team with the department with key posts covered in an interim nature for prolonged periods of time.
- Multiple situations where policies, procedure, and processes were not applied in a fair and just manner.
- A culture of 'keeping things within pharmacy' and a reluctance for issues and concerns to be highlighted or discussed outside of the pharmacy department.

- Lack of recognition (and reward where possible and appropriate) for the good work the pharmacy team and individuals within are undertaking.
- Lack of feedback to staff, for example outputs and outcomes of the Amicus review.
- HR policies not being followed consistently.
- Lack of transparency in general communication, processes, and outcomes.
- Staff roles and responsibilities/opportunities being described prior to accepting roles being markedly different to actual situation once started.
- Confidential information about individual staff members being known by staff members with no necessity to be aware of sensitive information.
- Unusually increased union involvement in internal pharmacy management situations (which would not usually warrant union involvement).

9.1.1 Recommendations

Short term (3-6 months)

- Focus on developing an open culture of continuous improvement where staff are empowered to shape the culture of the department, and the services it provides (**ongoing recommendation**).
- Introduce a local, authentic recognition approach to recognise the valuable work of individuals in the department.
- Conduct an external positive communication/media campaign on the value of the pharmacy department and services it provides.
- All current and future Job Descriptions should be kept in a publicly accessible space that all staff are aware of.
- Review of weekly department meeting and other communication mechanisms to improve communication of messages to the whole pharmacy department.
- Introduce monthly coffee with the Chief Pharmacist for all new starters and any established staff as requested.

Medium term (6-12 months)

- Introduce monthly Improvement Board for pharmacy department-open to all staff to be members. Representatives from across the department meet to discuss, review, implement improvement ideas.
- Implement 'You said, we did' approach to feedback from regular Be Heard survey (or alternative feedback mechanism) to ensure staff see action on feedback.

Longer term (12-24 months +)

- Continue to embed an open culture of continuous improvement where staff are empowered to shape the culture of the department, and the services it provides (**ongoing recommendation**).

9.2 STRUCTURE/STAFFING

9.2.1 Structure

There is no validated, evidence-based, template for pharmacy structures available in the UK (or internationally) for any area of pharmacy services. Most staffing models have developed organically over time, with additional posts being added as funding available without any overarching co-ordinated workforce approach. UK benchmarking data is used to try and help compare resourcing, but interpretation is confounded due to the diversity in organisation structures and the services they provide. The suggestions offered below are based on the reviewers' experience and understanding of other structures, rather than a validated blueprint of pharmacy structures. Some recent changes to the structure and staffing have been put in place (or are in progress related to external feedback and reviews of the department and HCS). In response to Op Crocus, an Immunotherapy lead role was created. Seven new operational roles have been mentioned as being created to support the operational pressures on the department, but the reviewers found it difficult to ascertain these exact posts, where they are in the structure, and where they are in the process of recruitment. There are further external drivers that HCS and the department need to consider. For example, the Royal College of Emergency Medicine position statement on Pharmacists and Pharmacy services in the Emergency department identify the clear need for additional pharmacy staff.

The Island of Jersey offers unique challenges with respect to a pharmacy structure that can meet the needs of the pharmacy services:

- Regulatory and professional functions related to the laws and regulations governing the Island.
- Development of Island wide strategy and approaches to optimise the use of medicines in all areas (including community pharmacy services, GP surgeries, etc).
- Management of an acute hospital (and associated mental health and community) services with the pharmacy providing the support required.

Historically, the Chief Pharmacist for the hospital has been expected to lead and manage the hospital service as well as the external pharmacy demands described above. This is not manageable and is likely to have contributed to some of the issues described throughout this report. The transition to divide the historic demands of this role into separate roles is a sensible, albeit overdue, approach to ensure the appropriate senior leadership roles are in place for the Island.

However, in terms of staffing structure numbers the overarching size of the population must be considered and reflected in an appropriate staffing structure. Due to this, some roles, particularly at a senior level will be required to cover multiple functions and support service delivery.

Specific feedback on the current/proposed pharmacy structures

Comments made below and on the suggested structure diagrams are based on the reviewers' experience and knowledge of other pharmacy structures. Some roles that have been suggested as not required may require reconsideration as further funding is available.

However, comments made considering a need for prioritisation of key roles as will require additional funding.

Chief Pharmaceutical Structure consideration

- Remove Deputy chief pharmaceutical officer post.
- Remove senior professional advisor-transformation.
- Remove specialist pharmacist digital (further team expansion will be required at some point).
- Add in senior professional advisor-antimicrobial stewardship.
- Change reporting line of Head of Pharmacy Workforce Development, Education and Training to Associate Chief Pharmaceutical Officer – Medicines Optimisation.
- Move Consultant pharmacist Mental Health into HCS structure reporting to Associate Director of Pharmacy-Clinical Services.
- Rename Chief technician as Senior Advisor for Pharmacy Technicians.
- Rename Research and Administration officer as Pharmacy Personal assistant to reflect role more appropriately.

HCS structure considerations

- Introduce junior to senior progression posts for pharmacists.
- Consultant pharmacist mental health should sit in this structure to be able to support clinical activities where necessary.
- Introduce full-time lead MI/formulary role (currently very small part of mixed role)
- Lead digital pharmacist and technician both required as a minimum to support digitalisation requirements of HCS.
- Rotational pharmacist management can be via individual managers, but overall development needs to be co-ordinated by Education and Training pharmacist lead.
- Invest in haematology/oncology pharmacist.
- Limited senior technicians-invest in lead medicines optimisation technician to manage other medicine optimisation technicians.
- Lead technician for training should be managed by lead pharmacist for training (training team).
- Consider pharmacy assistant supervisor responsible for support and development of pharmacy assistants.
- Consider resource requirement related to activity based on Royal College of Emergency Medicine position statement on Pharmacists and Pharmacy services.

9.2.2 Staffing

There is no validated pharmacy staffing model for hospital pharmacy resourcing, with many factors influencing staffing levels. Instead, information available through benchmarking can help understand a service's activity and skill mix relative to peers. In UK benchmarking, overall, the total pharmacy WTE per 100 beds is slightly below the UK average (2023, 19.4 WTE vs. 21 average). Compared to the UK average, this consists of a lower number of pharmacists per

100 beds (2023, 6.1 WTE vs. 8.8), but a higher number of technicians (2023, 9.5 WTE vs. 7.8), and a slightly lower number of assistants (2023, 3.8 WTE vs. 4.6).

Additionally, a recent QI analysis identified the limitations of the current resource available to provide adequate clinical pharmacy services. Multiple staff referred to having their dispensing efficiency reviewed by comparison to an extrapolation of a Drug tariff figure of items per hour. However, use of this figure is not appropriate in the opinion of the reviewers due to the difference in complexity of prescriptions and it does not consider factors such as the volume of telephone calls and other distractors dispensary staff must manage.

The clinical pharmacy service was difficult for the reviewers to assess as at this time the department had evoked a business continuity plan which had severely restricted the clinical pharmacy service to the hospital. This was due to resourcing levels and to the protect the operational supply function of the department. Staff raised concerns about the patient care aspects of this decision. Prior to the business continuity plan, based on 2023 UK benchmarking average (and the 2022 HCS reported figures), the level of pharmacist clinical support per 20 beds (clinical pharmacy staffing comparator) was the same as the UK average (0.6 WTE vs. 0.6 average), as was technician support (0.5 WTE vs. 0.6). The reported percentage of pharmacist time spent on clinical activities was below the average (2023, 69% vs. 77%), however the percentage of pharmacy technician time spent on clinical activities was above the average (2023, 61% vs. 52%). The percentage of inpatient beds visited by a clinical pharmacist was below the UK average (2023, 53% vs. 65%), and had decreased (2022, 73% vs. 75% average).

During the review, the clinical service was severely impacted with most clinical technicians relocated to the dispensary, and pharmacists serving multiple wards remotely with a very limited supply service. Through discussions, it was clearly recognised this situation was imperfect and generated some risk that was difficult to mitigate (risk described as high on the Corporate Risk Register).

Across the UK, pharmacy services are facing difficulties with recruitment and retention. This is multifactorial but includes the increasing number of roles that pharmacists (and technicians) are desired for including GP surgery and wider primary care roles. Staff reported that leaving interviews were not being routinely completed, which could provide further timely feedback for managers to improve retention. Jersey faces some additional challenges being an Island, and with local challenges such as the affordability of life as an Islander (common theme reported by staff of all levels).

From the review feedback, observations, and interviews, there were issues identified with roles and responsibilities across the department. Some of this can be resolved through sharing of Job Descriptions (highlighted previously), and some through focused work to ensure the right person is doing the right job. There were clear examples of staff doing tasks that would have been more appropriate by a different member of staff with the appropriate skill mix e.g. the reception hatch being managed by pharmacy assistants, and porter deliveries being conducted by pharmacy assistants.

The aseptics unit operates under Section 10 of the Medicines Act; there is supervision from a pharmacist with competence and technical expertise in Good Manufacturing Practice within

a small space in the department. The unit prepares custom made chemotherapy for outpatient chemotherapy patients and some inpatients prescribed individual feeding nutrition bags (most patients receiving ready prepared nutrition bags). There is currently one pharmacist (interim) and other technical staff. There is some other pharmacist cover available within the department although the service remains fragile. 2023 benchmarking demonstrated significantly lower staffing levels within the unit compared with the UK averages (0.8 WTE staff in post / 100 beds vs. 1.4WTE, and a vacancy rate of 78.4% v 12.2%). The unit has space constraints and would not be fit for future anticipated service changes e.g. introduction of gene therapies. There is no electronic Quality Management System (QMS).

9.2.3 Recommendations

Short term (3-6 months)

- Ensure additional recently approved resources (7 posts) provide operational roles to manage operational pressures.
- Appoint appropriate dedicated support staff for pharmacy-specific staff e.g. 3 x pharmacy receptionists, 2 x pharmacy porters.
- As a temporary/short-term support action, employ remote locum workers that can help reduce the operational burden of staff onsite. They will not be able to 'replace' an on-site member of staff but can deliver significant parts of the workload that releases on-site staff to focus on appropriate activities.
- Implement leaving interviews for all staff with feedback provided to managers (with Human Resources).

Medium term (6-12 months)

- Focus is made to increase the pipeline of future staff. This includes:
  - Increasing the number of student/Pre-Registration Pharmacy Technician places.
  - Instigating Foundation Trainee Pharmacist places.
- Introduce progression/preceptorship programme for junior pharmacists into senior rotational posts (after completing post training examinations and competencies).
  - Succession/progression planning is instigated across the department to identify who is being developed as succession for each individual role.
  - Introduce assistant supervisor responsible for support and development of pharmacy assistants.
- Develop the capacity planning for aseptic staff- including resources to enhance the Quality Management System.
- Target recruitment of further aseptics staff (especially pharmacists and consider further rotation of middle banding staff). Include QC/QA resource.

Longer term (12-24 months +)

- Introduce science manufacturing apprenticeship technician training for a pipeline of aseptic staff.

- Review the space allocated to the Unit.
- Develop a business case for an electronic Quality Management System (QMS).

9.3 WORKLOAD

The workload of any pharmacy department includes a wide variety of activities to ensure the safe and effective use of medicines across an organisation. Much of this work is not seen or captured directly, and examples include guideline and policy authorship/input, clinical advice, and review of incidents and appropriate action. Part of the challenges due to the combination of workload and staffing are linked to the lack of funding and resource to deliver a seven-day pharmacy service. This leads to additional workload over the Monday-Friday period and often results in delays resolving issues that have been generated over the weekend.

It is noteworthy that since the introduction of an electronic prescribing system (EPMA), pharmacy have described new, additional operational inefficiencies due to the workflows necessitated by the electronic system. This feedback reflects the reviewers' personal experiences, and experiences provided by other users of hospital-wide electronic prescribing systems.

9.3.1 Dispensary/operational workload

Currently, there are two significant issues facing the workload of the department: the contributors to the volume of work, and the management of the work.

The dispensing volume of the hospital pharmacy is high compared relative to the size of the hospital. This is multi-factorial but is contributed to by:

- The patient costs and charging arrangements for dispensed prescriptions both in community and the hospital (and the associated prescribed list for GPs/Heath Insurance Fund).
- Limitations of medicines that the GP can prescribe due to restrictions of the prescribed medicines list (white list).
- Lack of Shared-Care models of prescribing where GPs could take-over prescribing of appropriate medicines at a suitable point.
- Consultants providing hospital prescriptions for patients which they have seen privately and should have been given a private prescription for dispensing in a community pharmacy.
- Provision of prescriptions for medicines which are available to purchase over the counter (OTC).
- Limited use of pre-pack medication for discharges.

This has contributed to the medicines being higher than UK benchmark average (£8m/100 beds vs. £6m/100 beds).

Additionally, acutely the business continuity plans in place (severely restricted clinical service) has a negative impact on inpatient workload as 'preventable' work is not avoided due to the lack of clinical service.

A recent change in processes in pharmacy was to delay dispensing of an outpatient prescription until pharmacy were notified that the patient required it and would be collecting the medicines. This has reduced the volume of uncollected medicines, made locating prescriptions easier, and has reduced the processing volume of avoidable returns the team undertake. However, part of this change was to ask patients to telephone pharmacy to inform them they were about to collect. This has led to an additional workload of managing a significant increase in telephone calls.

The department has more recently closed the hospital pharmacy to the public at weekends in response to the current demands on the service and staff. This has created some adverse media attention in terms of weekday waiting times and convenience (although outpatient clinics are not open at weekends). This would seem an appropriate course of action given the current staffing pressures.

Observing the dispensary highlighted a cramped environment with a shortage of staff (from anticipated and witnessed demand), staff being interrupted multiple times by attending to the outpatient and inpatient hatches and taking telephone calls, having a complex system of up to 22 places to look for a prescription when a telephone call is received, a high level of medicines prepared ready for collection, and not having a system of continuous flow of work (labelling computers not in regular use).

Unnecessary delays to patients receiving their prescriptions were due to some prescribing clinicians not having telephone contact details registered with switchboard. Where a pharmacist needed to query a prescription with a prescriber, delays occurred due to being unable to contact the prescriber in a timely manner.

The pharmacist validation of the outpatient prescriptions is undertaken predominantly by a junior pharmacist on rotation. The junior pharmacists described frequent situations where they needed senior support, and either were not sure who to go to or were not supported by individuals when they directly asked for help. On a similar note, the assistants reported scenarios where senior staff support was needed and it was unclear who they should go to.

Staff reported that there is no formal late duty rota, and all staff are expected to come into the dispensary at 4pm to assist and stay until the work is finished. Staff felt that some staff were exempt from coming in at 4pm and "always the same people come in" and it was difficult if they had after work commitments.

The weekend dispensary consists of an oncall pharmacist and two staff members on rotation rostered to work extra hours (more than contracted working hours). In the UK staff would not be expected to work routinely more than their contracted hours.

A pharmacy robot supports the dispensary and stores and distribution services assisting with safe and timely supply of medicines to patients. An area to consider is the need for pharmacy

assistants to have an additional check to release stock fridge medicines to clinical areas which could be removed.

The department is responsible for ensuring the correct holding of medicines by procuring them from the pharmaceutical supply chain. The department is part of a collaborative group of hospital trusts in SW England and benefits from their collective purchasing power if follow agreed agreements.

9.3.2 Clinical workload

At the time of review, the clinical pharmacy service had been severely restricted to manage critical medication supply against the current staffing levels. This necessary action taken had significant impact on patient safety as well as staff morale. The benchmarking figures for inpatient beds visited, and the number of pharmacists per 100 beds would suggest that the clinical workload is high/excessive for the pharmacists in the department. The Quality Improvement or QI team at the Hospital had very recently undertaken a multi-faceted review of the clinical pharmacy service (March 2024). This highlighted gaps in service delivery and using the time taken to measure processes identified that pharmacists had insufficient time to safely complete all the necessary steps for each prescribed medicine for patients. There is a risk for this area on the Corporate Risk Register.

The aseptics unit uses less ready prepared adult nutrition bags compared with the UK reported 2023 average (57% vs. 80%). Preparing of the bespoke bags takes 1-2 hours each day of staff in a unit already constrained by staffing and space.

9.3.3. Recommendations

Short term (3-6 months)

- As above point in staffing, appoint 3 x pharmacy receptionists to help manage the telephones and other administrative/reception services to allow pharmacy assistants to undertake dispensing.
- Allow pharmacy assistants to supply stock fridge medicines without a check.
- Implement a Manager of the Day (MOD) rota within the senior team to give more junior pharmacy staff a clear escalation points each day.
- Stop dispensing of all private prescriptions (requires support from Medical Director/communications-see External factors).
- Stop dispensing of all outpatient prescriptions for medicines that can be purchased OTC (requires support from Medical Director/communications-see External factors)
- Expand the use of discharge pre-pack medication across all areas of the hospital where possible (prioritise A and E and surgical wards plus day unit).
- Ensure all prescribing clinicians have contact numbers registered with switchboard (requires support from Medical Director/communications-see External factors)
- Review the need for a late duty rota in the dispensary -organisational change process required after staff investment to ensure a fair and equitable rota and staff can plan

for after work activities/duties at a defined work finish time. Suggest staff are involved on an informal basis to co -produce a proposed solution.

Medium term (6-12 months)

- Implement an Island-wide communication campaign about bringing medicines into hospital if admitted (link with ambulance services, community pharmacies, GP surgeries, nursing homes).
- Review operations within the dispensary- including use of staff to function as a co-ordinator to deal with patients and other hospital staff coming to the hatches or phoning and reprioritise work coming/ in the department as needs change. This role can be rotated amongst staff during a day freeing up other staff to work in teams to dispense prescriptions in a safe and timely manner without interruption.
- Review the need for bespoke adult nutrition feed bags to release capacity within the Unit.
- Develop a business case for Trust porters to regularly deliver prescriptions and stock medicines to clinical areas freeing up pharmacy assistants to support services and assist in the management of medicines at ward level.
- Review the need for an appropriately funded formal weekend rota which would encompass weekend working as part of the core staff contracted hours (options of how to generate rest periods). This could also provide an opportunity to open the outpatient pharmacy service again at weekends to patients which could improve user convenience and satisfaction. Would also require a process of organisational change. Suggest staff are involved on an informal basis to co-produce a proposed solution.

Longer term (12-24 months +)

- Review and increase the medicines available on the GP prescribing list (longer term action).
- Develop Shared-care arrangements for key medications (longer term action in parallel with review of GP prescribing list).

9.4 EDUCATION AND TRAINING

There is no education and training of staff strategy within the department. There has been limited training of pharmacy technicians and pharmacists (also lack of training staff as support). Students within a service can offer a pipeline of further candidates for future recruitment with effective training.

There has been a lack of clinical supervision within the department at all levels; this would include being responsible for a specified trainee's clinical work and to provide constructive feedback during training placements/rotations.

Some pharmacists have been trained as Independent Prescribers (with the ability to support acute and elective activity). The training numbers, and associated support, have been limited and there is no clear strategy setting out an ambition for the short and longer term.

Students or staff in training reported that limited time for training was provided within working hours as service pressures required staff to be operational on many occasions.

Staff across the department commented on resilience training sessions that have been recently introduced and deemed to require compulsory attendance (some comments of further sessions to be scheduled). It is understood that these sessions were well intentioned to assist staff in coping with the demands described including dealing with members of the public and other service users. Most staff that we spoke with, or submitted survey comments, were not positive about the sessions in terms of time out of the busy day attending and found very limited value from the tools and techniques provided with the sessions.

Arrangements exist for the induction of staff -including requirement for logs to be successfully treated before staff can independently dispense or check prescriptions (if meet training criteria). No evidence was found of screening logs for pharmacists in advance of independently screening prescriptions.

There has been a lack of management development, and resilience, within the department. It is possible that this is a result of significant challenge put on managers by successive senior managers, leading to breakdown, resignation, or refusal to apply for managerial roles.

Staff cited their feeling of a prior lack of compassionate leadership role modelling being demonstrated. There were reports of some staff undergoing the Modern manager training although this was not widely utilised.

9.4.1 Recommendations

Short term (3-6 months)

- Identify areas/medicines that junior pharmacists cannot screen (e.g. cancer drugs list) to support juniors. This will require senior staff support.
- Set up screening logs process for new starters (and consider whether updates/refresher logs required).

Medium term (6-12 months)

- Develop an education and training strategy for all staff groups.
- Develop strategy for use of Independent Prescribing Pharmacist (training numbers over a period and where to deploy).
- Introduce peer support for managers-such as buddy up mentoring from management point of view with managers across the Trust and/or provide access to coaches.
- Review the need for any further resilience training (after evaluation of prior sessions).

9.5 EXTERNAL FACTORS

The high outpatient pharmacy workload levels have been described and contributed to the decision to close the weekend outpatient pharmacy service. The reviewers witnessed queues at various parts of the day. This was contributed by the current arrangements of some medicines not on the primary care "white list", some supply chain issues with ADHD medicines and the agreement reached for the medicines to be dispensed at the hospital, lack of pre-packs used during the working day and some inappropriate prescribing of medicines (for hospital dispensing) following private patient consultations.

Improvements could be made to how the queues are managed, including waiting times displayed that are visible wherever patients are waiting in the queue.

Staff also reported cases of "inappropriate" prescribing as NICE guidance has not been fully adhered to. Examples include tirzepatide, fremanezumab and Botox cases. The process of registering compliance will need further development locally and across the Island using a system such as Blueteq (planned for implementation). This would involve a regular review of patients to provide assurance that patients still meet the agreed treatment criteria.

9.5.1 Recommendations

Short term (3-6 months)

- Consultants to cease prescribing for private patients- prescriptions to be taken to community pharmacies.
- Ensure all prescribing clinicians have contact numbers registered with switchboard (requires support from Medical Director/communications-see clinical workload
- Improve the visibility of waiting times for the length of the queue.

Longer term (12-24 months +)

- Implementation of Blueteq (process of registering, and reviewing, high-cost medicines to demonstrate patients meet NICE or other locally guidance).
- In time further development/expansion of the "white list" through legislation amendments to support prescribing and dispensing of some further medicines closer to patient homes.

9.6 GENERAL

There was no demonstration of a pharmacy or medicines strategy approved at hospital /Island level that set out priorities, KPIs and milestones in the short, medium, and long term. The strategy should ideally be co-produced through staff engagement and involve regular monitoring of progress. This is a priority.

The new pharmacy structure at hospital and Island level is an opportunity to provide a framework for delivery of the clinical, regulatory, and operational aspects of the strategy.

Medicines governance needs to be developed to support the anticipated future standards requiring demonstration from the Jersey Care Commission (such as safe storage of medicines). The use of consultant pharmacist roles needs to be set out to demonstrate the clinical and operational elements of role in and out of the hospital setting.

There was a visible lack of space in the department. Staff felt that other departments had been given priority previously at the expense of pharmacy. The lack of space is anticipated to worsen as further posts are recruited to support service delivery. Examples include the dispensary, aseptics, intravenous fluid store (that is inefficiently spread over two on and off-site locations), clinical, training and management office spaces. The space available for the Pharmacy Technical services team should be considered as a priority (space has been removed over the years for other services and the team are working in a very confined space which brings some patient safety risks).

The level of digital maturity is good within the department and on wards. As described the Electronic Prescribing and Medicines Administration System (EPMA) is a good patient safety development but has had an impact on pharmacy staff, as in other hospitals, for time taken to carry out clinical and operational processes as well as supporting medical and nursing staff with prescribing and medicines training/troubleshooting regularly. This is in addition to the development of the Pyxis ward storage system deployed on most of the wards. This system also has safety and security benefits although will need regular pharmacy support to ensure they operate to an optimum level.

The department has been waiting (now coming) for some time to deploy PowerGate to support the procurement of medicines (electronic trading system which acts as a gateway between the hospital pharmacy system and national/UK systems). This system can increase data accuracy, improve supply chain management, save time and decrease paperwork. This would be available in most/all UK hospitals and has been delayed locally to strain on the IT project support available on the Island.

A key role of pharmacy departments is to ensure that medicines are used in a cost-efficient manner. The biggest opportunity to impact this is the optimisation of the use of biosimilar medicines. This entails timely action to consent patients, introduce the biosimilar, and enact switching programs from the expensive originator brands to the biosimilar. Although some of the opportunity appears to have been exploited, it was identified that there was considerably more financial savings which could be made by optimising this area. Due to the size of the savings, some of this money could be used to help fund the additional posts required that were previously described.

The use of Homecare companies (medicines dispensed and administered in patient homes and thereby reducing hospital visits) should be explored to identify if some of the high-cost medicines, such as biologics/biosimilars could be delivered via this route. Clinical and operational pharmacy staffing would be required to support the use of Homecare services.

Collaboration with other hospitals across the Channel Islands may offer some efficiencies in aspects of the pharmacy services provided. Similarly, developing these relationships could

also help with resilience of the services that pharmacy offer. Work to develop this collaboration has started but is at an early stage.

Multiple staff referenced the new hospital as being a “long time coming”, but recognised the opportunity that could bring. There were limited views that pharmacy would “do well” out of the move. The new hospital would provide an opportunity to reset space in and close to the department. We suggest staff engagement in the demonstration of intended department models/patient flows and involvement in the 1:200 and 1:50 design process as much as possible.

It is important that any future service or staffing changes follow the local HR policies. These would include organisational change being discussed at an informal level in advance of formal staff consultation to improve the level of staff engagement and trust. The outcomes are anticipated to be improved for staff and service users.

Issues with the culture in the department have been described in detail. Several staff described a wish to “stop talking about the past” and “move forwards”. Some other staff still demonstrated strong feelings and a scepticism that this review will effect change as “nothing changed from the others”.

9.6.1 Recommendations

Short term (3-6 months)

- Involve all staff, (to some level) in the design phases for the new hospital (**ongoing**).
- Train line managers in the use of relevant HR policies and make sure staff are aware of Policies and kept up to date with any changes. This is anticipated to support the informal and formal ways of working with staff and likely to reduce the level of union activity (**ongoing**).
- Optimise the use of biosimilars and their timely introduction.

Medium term (6-12 months)

- Development of pharmacy/medicines strategy at Trust/Island level for the next three-five years and use as an opportunity to gain staff involvement through co-production.
- Use the strategy an opportunity to agree a way of resetting the culture for the department.
- Ensure pharmacy is adequately resourced in terms of space e.g. in accordance with the relevant Health Building Note and considering likely changes such as introduction of gene therapies.
- Develop medicines governance/assurance arrangements to assist in demonstrating compliance with relevant standards/legislation.

Longer term (12-24 months +)

- Complete roll out of Pyxis electronic storage to all wards in the Hospital

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The reviewers want to thank the staff encountered during the review for their candour and open approach throughout the process.