Methodology for the management of outsourced outpatient services within the NHS pharmacy service

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ABSTRACT

Objectives The successful management of outsourced services is a skill which is increasingly required in the UK National Health Service (NHS). However, it is not something that is widely taught and contract managers tend to operate singly and in isolation. A group has been created in SE England to share expertise and knowledge in contract managing outsourced outpatient services in hospital pharmacies. The initial activities of this group may be useful to others and are shared in this article.

Methods A group of contract managers of outsourced outpatient services in London, East of England and Thames Valley and Wessex has been created to share expertise and knowledge. The group members come from trusts in the three regions and either manage an existing service or are in the process of letting a contract. One of the sites manages a subsidiary company (ie, owned by the trust) which runs the outpatient services separately to the trust pharmacy service. The group identified a series of tasks which could usefully be undertaken collectively to compare service provision, costs and contract management techniques (eg, performance indicators).

Results The initial findings of the group are detailed in the report. These are:

- Nature and type of services.
- Performance indicators.
- Costs.
- Staffing and support requirements.
- Additional delivery services.
- Issues and risks log.
- Dealing with payment by results excluded medicines and patient access schemes.
- Collection of prescription charges.
- Preparing a business case.

Conclusions The operation of the group has allowed sharing of information and expertise within the NHS. It has been particularly useful for centres about to start a service. More work needs to be done, particularly on performance indicators but both the NHS and the contractors appreciate a collective approach with the reduction in variation, costs and risk that this entails. Such an approach has been forced on the NHS by the failures in the homecare market and it seems logical to apply the lessons from the management of one outsourced service to another.

INTRODUCTION

If a service is to be outsourced, it is essential that a contract management system is employed to measure and govern the outsourced partner. The National Health Service (NHS) has learnt this lesson to its cost with recent difficulties within the

homecare market which has demonstrated that without coordination, providers can behave as individuals and services are neither consistent nor even appropriate. The NHS has found that performance indicators we thought understood were not defined clearly enough, incidents and complaints were being dealt with differently by different providers and cultures around patient confidentiality and acceptance of risk were different to that within the NHS. The principle should be that NHS patients should receive the same standard of care whether their service is provided by an outsourced partner or the NHS itself and this requires close matching of service cultures and formal agreement on standards which are closely monitored.

While pharmacists are familiar with the quality assurance of products, the skills required to manage a service are very different and are not widespread in the hospital pharmacy service.

In order to share and develop the expertise required a group was created in March 2014 within London and East of England. Imaginatively called the Outsourced Outpatient Contract Managers Group (OOCMG), the group consists of the pharmacy staff responsible for contract management of an outsourced partner delivering outpatient services to trusts in London and East of England. The group has now expanded to include trusts from Thames Valley and Wessex and includes several subsidiary models (where the trust itself creates a company to run the outpatients). The group is undertaking a number of activities and thought it might be useful to the NHS in general to share the various work streams we have started.

GROUP STRUCTURE AND TERMS OF REFERENCE

The group is made up of trust representatives from London, East of England and now Thames Valley and Wessex. Members have some level of responsibility for the governance of the outsourced partner and vary in grade from procurement technician to chief pharmacist. The terms of reference are in online supplementary appendix 1.

NATURE AND TYPE OF SERVICES

The group have surveyed the types of services that are being commissioned by members to ascertain similarities and differences between the various trusts. (NB: some trusts only partially responded to the survey.) See online supplementary appendix 2 for details.

Points of interest were:

- The opening times varied significantly from trust-to-trust but seemed to reflect the existing trust pharmacy opening times.

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- ▶ The expected and delivered work volume varied considerably from between 550 items per month per whole time equivalent (WTE) to 2000 items per WTE per month. It would be interesting to see what effect this has on waiting times and at what stage in implementation these trusts have reached. Is more resource added postimplementation to support contract delivery?
- ▶ In all but one of the sites surveyed all the providers used the trust pharmacy system.
- ▶ None of the trusts surveyed had a working home/store delivery system set up which was fully operational.
- ▶ There is no consistency about which types of prescriptions providers are allowed to screen themselves.
- ▶ No one surveyed had taken the steps to include discharge dispensing for non-day-case patients.
- ▶ A lack of space allocated to the third party supplier seemed to be a common theme.
- ▶ Annual total outpatient spend.
- ▶ Annual outpatient spend on payment by results (PBR) excluded medicines (medicines where commissioners pay the cost of the medicine back to the hospital under the NHS tariff system of payment).
- ▶ Annual outpatient spend on in tariff medicines (medicines where the cost of the medicine is included in the tariff payment to the hospital).
- ▶ Annual number of prescription items to be outsourced.
- ▶ Footprint of facility being made available (m²).
- ▶ Arrangements for payment for stock (when is it paid for).
- ▶ Inclusion/exclusion of a home delivery option.
- ▶ Length of contract (years).
- ▶ Staff arrangements (Transfer of Undertakings (Protection of Employment) Regulations (TUPE), etc. TUPE is whether staff already working in the department are passed to the provider to maintain their employment).
- ▶ Rent charged.
- ▶ Extent of retail component and potential share of retail profits.

Discussions are being initiated with providers to investigate the need for commercial confidentiality within the NHS.

In the meantime some trusts have provided details in confidence of the cost per item they are charged by their provider. From a relatively small sample costs ranged from around £3.00 per item to just over £6.00 with a mean of £4.62p. NB: these fees were set at different times for different trust circumstances (volume and space).

KEY PERFORMANCE INDICATORS

The group compared their local indicators and has developed a draft set of core indicators (see [table 1](#)). These are now being discussed with providers to develop an industry best practice standard. Ideally all trusts would use at least the core set. This would allow direct comparison between services in different trusts. The group plan to develop standards for these indicators and propose standard penalties for continued contravention.

COSTS SURVEY

To date the group has not been able to collect any meaningful benchmarking information due to the confidential nature of the contracts with providers, although this data would benefit the NHS considerably. The factors that might affect a service charge have been identified as follows:

STAFFING AND SUPPORT REQUIREMENTS

A common assumption when outsourcing an outpatient dispensing service is that the host trust can hand over everything to the contractor once the service has been outsourced, but there

Table 1 Proposed core indicator set

Category	Indicator description	Definition	Reporting frequency
Patient experience	Availability of stock	Prescription items not met in full first time as a percentage of total items dispensed.	Monthly
Patient experience	Waiting time for simple prescription	Average time from receiving prescription to prescription being ready to collect. Prescription screened by contractor with no clinical issues.	Monthly
Patient experience	Waiting time for complex prescription	Average time from receiving prescription to prescription being ready to collect. Prescription with clinical or procedural issues (eg, non-formulary drug or wrong dose). No clock stopping for resolution of query.	Monthly
Patient experience	Waiting time for prescription screened in trust	Average time from receiving prescription to prescription being ready to collect. Prescription screened by trust pharmacy staff.	Monthly
Patient experience	Patient satisfaction survey	Results of patient satisfaction survey as defined by trust.	Three monthly
Clinical governance	Dispensing errors	Average number of dispensing errors leaving pharmacy as percentage of total items dispensed.	Monthly
Clinical governance	Dispensing errors (serious)	Average number of dispensing errors causing actual harm to patients as a percentage of total items dispensed.	As they occur. Summary monthly
Clinical governance	Clinical screening errors	Average number of errors detected during clinical screening process by contractor as a percentage of total items dispensed.	Monthly
Near misses	Near misses during dispensing process	Average number of errors detected during the dispensing process (eg, labelling and dispensing) as a percentage of total items dispensed.	Monthly
Clinical governance	Service failure	Number of contraventions of contract monitoring parameters (as defined by performance monitors written into the contract).	Three monthly
Clinical governance	Service complaints	Number of formal patient complaints received through trust reporting system.	Monthly
Finance	Accuracy of invoices	Number of lines incorrectly priced on the invoice for the period in question.	Monthly
	Value of credits	Value of credits raised to correct invoice errors for the period in question.	Monthly
	Value of credits	Percentage value of credits raised to correct invoice errors relative to the total spend on medicines for that period.	Three monthly

remains a considerable amount of support after the service has been outsourced from an operational, clinical, governance or contract management point of view.

To substantiate this, a number of trusts responded to a request to estimate the number of hours per month of support they provided to their contractor (table 2).

This illustrates the estimated number of hours that the trust provides to the contractor each month (note: the trusts are *not* comparable in size). The variation suggests results should be interpreted cautiously. Nevertheless, it is clear that a variety of existing support functions remain after the service is outsourced. There are also a number of additional support functions such as commercial and legal support, contract management and specific finance input to the contract. This support averages 224 h per month (about 1.5 WTE).

The grade or job banding of support provision varied depending on the type of support being provided. Typically, band 5–7 staff supported routine day-to-day functions such as information technology (IT) and dispensary issues and band 8a upwards supported more ‘high-level’ or complex activities such as contract management.

ADDITIONAL DELIVERY SERVICES

The use of outsourced outpatient services to provide additional delivery services has been considered by many of the member trusts. These are seen as an alternative to basic homecare services, which require only delivery of medication to patients with no additional functions.

Two models of additional delivery services are being used by group members: home delivery of medication is being used by two trusts, and delivery of medication to an alternative location for collection (eg, other branches of the outsourced outpatients partner’s chain) is being used by six trusts. Varying restrictions are put on the delivery services dependant on provider, such as no delivery of chemotherapy, no delivery of liquids and no delivery of refrigerated items.

The majority of logistics are provided by either a courier company or Royal Mail; however, one provider uses its own transport networks to arrange deliveries to its own stores in other locations. The cost of the service varies between providers. Only one trust has a fixed price for the additional delivery service (£27.50) while the majority of trusts are charged dependant on size, weight and delivery location of the package (services starting from £6). Two trusts receive a service including a free of charge option for patients to collect medication from any of the outpatients partners stores.

Only three trusts have actively repatriated homecare patients over to these additional delivery services, but others

have used logistics to augment the outsourced model. The majority of the trusts in the group are interested in establishing one of the above models for some aspects of their outpatient services.

NB, it has recently become apparent to the homecare market that there are issues with both the postal and collection from retail outlet options. These issues need to be addressed if these options are considered.

ISSUES AND RISK LOG

Several members had prepared a risk log detailing the types of risk the project exposed the trusts. These are detailed in table 3.

LESSONS LEARNT AROUND IMPLEMENTING A SERVICE

The group collected together lessons learnt from their experiences of implementing an outsourced service. These can be summarised as follows:

1. General feedback
 - A. Excellent working relationships, ongoing communication and trust between the commercial pharmacy and trust pharmacy staff are essential to form a true partnership. This starts with the planning stage which involves collaborative working with estates, IT, finance, procurement and communications.
 - B. Implementing the arrangements from contract award requires at least 6 months to be effective.
2. General planning/meetings
 - A. Trust staff need to be fully engaged with setting priorities in work streams and in agreeing the timelines for progress.
 - B. Weekly steering group meetings are essential.
3. Training for contractor staff
 - A. Contractor staff training with trust pharmacy staff is vital to give a good grounding in the culture and work practices of the trust.
 - B. Training should concentrate on IT systems (pharmacy system, e-trading).
 - C. Training in the pharmacy system (if it is being used) is vital and should be undertaken by trust pharmacy staff. The training for provider managers needs to include the reporting systems.
 - D. There should be considerable support from trust pharmacy staff over the first few weeks of operation.
 - E. There should be weekly IT conference calls during implementation to keep the work stream on track.
4. IT issues
 - A. Providing the drug file for the pharmacy system locality can be a major issue and can take months to be resolved.

Table 2 Estimated number of hours support provided by the authority to the contractor each month

	Trust A*	Trust B	Trust C	Trust D	Trust E	Trust F	Average
Commercial and legal	2	1	5	2	2	52	11
Finance input	22	6	0	150	15	52	41
Dispensary input	54	12	60	116	100	N/A	57
Operational management	3	3	60	24	10	8	18
Clinical and contract management	1	1	10	8	100	N/A	20
Stores/procurement	362	4	10	Included with dispensary	15	8	67
Pharmacy/trust IT	0	2	5	Included with finance	15	45	11
Total	444	29	150	300	257	165	224

*Trust A is a subsidiary model. The remaining trusts (B–F) are fully outsourced services.

Table 3 Suggested items and assessments for a risk log

	Work stream	Description of risk	Suggested rating	Suggested impact	Probability
1	Finance and procurement	Arrangement for gain share is in place and working	H	H	L
2	Finance and procurement	Are the figures in the business case accurate	L	H	L
5	Communications	External stakeholders delay the proposed change	M	M	L
6	Commercial and legal	VAT rules change	H	H	L
7	Estates	Difficulty in finding appropriate location on site	M	M	M
8	Pharmacy	IT issues in accommodating provider onto existing pharmacy system	H	M	M
9	Communications	Overview and scrutiny committee request for information	L	L	L
10	Communications	Ensure all communication approved	H	H	H
11	Operational	Who will dispense clinical trial materials?	L	L	L
12	Operational	Project will require V.10 of ascribe for shared businesses	M	H	M
13	Estates	Indecision on location and associated building/enabling works could delay opening	H	H	M
13	Operational	Building works may be disruptive	H	H	H
14	Finance	Loss of income if do not bill PAS and PBR medicines to appropriate commissioner	H	H	M
15	Finance	Access and availability of baseline information	H	H	M
16	Finance	Review pricing matrix	H	H	H
17	IT	Lack of link between pharmacy system and PAS may cause problems in reconciliation of patient data/summary care records (patients' notes)	M	M	M
18	Finance	Change in savings from those approved in business case	H	H	H
19	Finance	Change to national commissioning for high cost drugs	H	H	M
20	Estates	Delays to building work will put at risk opening of new pharmacy	H	H	L
21	Recruitment	Delays to recruitment will delay training of staff and could increase risk to patients	M	M	M

PAS, patient access schemes, PBR, payment by results; VAT, value added tax.

- B. Staff entering any data relating to medicines should be local and hence familiar with the process and drug names. Do not outsource this task!
- C. Trust IT department may be not familiar with contractor IT systems hence may be unable to help with training and support.
- D. Information is needed to understand server requirements, connectivity, capacity and cost implications.
- E. These issues must be resolved before going live.
5. Operational issues
 - A. Procurement
 - I. Medicine suppliers need to be contacted to confirm that trust contract prices will be made available to the contractor. The Commercial Medicines Unit (CMU) who arrange contracts for hospitals in England have devised a standard letter for this. This process should be completed well before the start of the service.
 - II. Trust pharmacy procurement staff need to assist the contractor in ensuring the correct mix of products in suitable quantities are stocked prior to the start of the service. Equally trust stocking levels need to be reduced to take account of the reduction in demand.
 - III. Suitable arrangements need to be put in place for sharing out of stock items between the trust and the contractor, especially during the first few weeks of service.
 - IV. Arrangements need to be put in place to ensure changes to trust medicine contracts are communicated to the contractor in good time.
 - B. Operational issues
 - I. Signage is often an issue and should be addressed early.

- II. A phased transfer of outpatients might be considered over the first few months of opening.
- III. A 2-day or 3-day preopening 'dry run' might be useful to test if stock was available and systems operational. It is worth undertaking a dummy run with 'practice' prescriptions of different types to unearth teething difficulties.
- IV. There needs to be a clear processes for managing and invoicing so-called pass through medicines (PBR excluded drugs, innovative pricing schemes (patient access schemes (PAS) see below) and the other complex pricing systems unique to the NHS!

DEALING WITH PAS AND PBR EXCLUDED MEDICINES

Issues of PBR medicines need to be logged at patient level so the appropriate commissioner can be invoiced.

Trusts need to ensure that providers are aware of the PAS schemes the trust has signed up to, understand and respect the confidentiality of the arrangements and can access the correct price (or free stock) as appropriate. Providers need to be able to administer these schemes appropriately. This may involve keeping patient logs. Providers need to understand the confidentiality of these patient records. Finally, appropriate charges need to be identified so that the trust can invoice the commissioner appropriately. (Most of these medicines are PBR excluded.)

COLLECTION OF PRESCRIPTION CHARGES

Although the survey size is small (five trusts) they represented the three main service providers (Lloyds Boots and Sainsbury's).

- ▶ In all cases the provider credits the trust with the payments on a monthly basis.
- ▶ If patients are unable to pay immediately most sites supply the medications and make arrangements to collect the money

at a later date. One supplies one day only (three at a weekend) and asks the patient to return.

- ▶ If a patient cannot provide evidence of exemption most trusts get the patient to sign a form stating exemption and then supply the medicines. One site requires patients to pay and reclaim the payment on provision of the evidence.
- ▶ In most cases trusts saw a rise in revenue from prescription charges after outsourcing. That is, it would appear the providers are more rigorous in collecting prescription charges. One saw no change.

BUSINESS CASES

The group have considered a number of examples of business cases that members have used. From these the group has drawn up a template that we feel contains the most relevant information (see online supplementary appendix 3).

FUTURE AGENDA ITEMS

The group has identified a series of additional subject areas to be explored in the future. These include:

- ▶ Meeting collectively with the providers to discuss issues of mutual interest and develop some industry standards if possible.
- ▶ Confidentiality issues in working with a contractor.
- ▶ Procurement models including
 - dealing with supply issues
 - access to contract prices
 - change of contracts
 - purchasing non-contract lines
 - invoice matching
 - complying with contracts to deliver trust commitment on volumes.
- ▶ Standardised specification and contract documentation.
- ▶ Standardising tender documents with common headings.

Access to contract prices

It is essential for the business case that the providers can access CMU contract prices. However, if they purchase direct (as most do) they do not automatically qualify under the terms of the CMU contract. CMU has produced a checklist of criteria for access to contracts by third party pharmacy outpatient dispensing service providers.

1. Third parties cannot be party to CMU framework agreements and the NHS cannot, therefore, mandate or direct access.
2. Only NHS trusts can request access to the prices from manufacturers and suppliers. In order for a third party provider to access contract prices, the NHS trust must get written permission from the contracted supplier. (A standard letter has been produced.)
3. In the relationships between the manufacturers and suppliers and third parties, NHS terms and conditions do not apply.
4. In awarding contracts to third parties, NHS trusts must make sure that the third party is financially robust.
5. NHS trusts should ensure the ability of service providers to separate and manage stock under third party arrangements.
6. Any third party using the CMU framework should provide purchase data to CMU in the specified format on a monthly basis. A lack of data presented to CMU undermines the credibility of the current NHS sourcing model by compromising manufacturer forecasts. Where this occurs, it introduces risk and when supply problems arise, it makes management of supply harder to deal with.

7. Separate IT systems and associated data flows should be maintained and fully auditable and used exclusively for the purpose as set out in the contract between the NHS trust and third party pharmacy service provider, so as to ensure that framework prices are accessed and medicines supplied to patients only against hospital orders relating to the contracted service. This should be auditable.

IMPORTANCE OF CONTRIBUTING USAGE DATA TO PHARMEX AND DEFINE

For CMU contracts to function correctly, it is essential that contractors have an accurate understanding of the demand for the product (from the PhARMEX system). If there are holes in that data (from homecare or outsourced outpatient usage) then demand may be underestimated and shortages may occur. Not all providers are making this data available to CMU. Similarly, more and more trusts are using Define (or similar systems) to compare clinical usage of medicines across trusts. Loss of data makes these comparisons more difficult.

Discussions are ongoing between CMU, OOCMG and providers. Ideally, the requirement to provide this data should be written into the contract at initiation.

Members of the group are listed in the online supplementary appendix 4.

OOCMG December 2015.

Key messages

What is already known on this subject?

- ▶ The management of outsourced services can be problematic as the homecare market has shown.
- ▶ To date contract management of outsourced outpatients has been undertaken at a trust level and in isolation.
- ▶ The contract management methods have been similar but there is considerable variation in detail and a lot of this is driven by the contractors rather than the National Health Service.

What this study adds?

- ▶ This study details some of the early steps in drawing together the lessons learnt by contract managers of outsourced outpatient services in SE England.
- ▶ The study gives a crude comparison of services, their costs and the support required of the existing trust pharmacy to support the outsourced service.
- ▶ The study points at a potential core set of indicators which could be used to measure the effectiveness of the service.
- ▶ The study shares some useful resources. The study draws together lessons learnt from implementation of contracts in member trusts.

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