**SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST**

**EXECUTIVE SUMMARY REPORT**

**B**

**BOARD OF DIRECTORS – 18TH JANUARY 2017**

| | |
|---|---|
| **Subject:** | Carter Review: Hospital Pharmacy Transformation Programme |
| **Supporting Director:** | Dr David Throssell |
| **Author:** | Damian Child, Chief Pharmacist |

**PURPOSE OF THE REPORT:**

To seek approval for the proposed Hospital Pharmacy Transformation Programme developed at STH in response to the 2016 Carter Report

**KEY POINTS:**

- In June 2014, Lord Carter of Coles was appointed as Chair of a new NHS Procurement & Efficiency Board and stated his intent to include a review of hospital pharmacy and medicines optimisation. In February 2016 Lord Carter published his final report to the Secretary of State for Health, identifying unwarranted variation across all of the main resource areas of the NHS.
- Recommendation 3 of the report stated: ***"****Trusts should, through the Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding, in agreement with NHS Improvement and NHS England by April 2020; so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities".*
- A key requirement of Lord Carter's report was that all trusts are required to submit a board-approved hospital pharmacy transformation programme (HPTP) plans to NHS Improvement by April 2017. These plans will inform boards, and NHS Improvement regional and national teams, how trusts will meet their Model Hospital benchmarks and the specific recommendations contained in the Carter final report.
- The attached plan has been developed with the assistance of a multidisciplinary HPTP Board, supported by Dr David Hughes as the designated representative of Dr David Throssell, Executive Medical Director

**RECOMMENDATION(S):**

The Board is asked to:

- Note the significant transformation work already undertaken
- Approve the Hospital Pharmacy Transformation Programme proposed for STH
- Acknowledge those areas detailed within the report where STH does not meet the requirements at the current time against the Carter sub-recommendations
- Note the risks and issues raised and support the mitigation actions to address these

**IMPLICATIONS**[2]

| | AIM OF THE STHFT CORPORATE STRATEGY 2012-2017 | TICK AS APPROPRIATE |
|---|---|---|
| 1 | Deliver the Best Clinical Outcomes | ✓ |
| 2 | Provide Patient Centred Services | ✓ |
| 3 | Employ Caring and Cared for Staff | ✓ |
| 4 | Spend Public Money Wisely | ✓ |
| 5 | Deliver Excellent Research, Education & Innovation | |

**APPROVAL PROCESS**

| Meeting | Date | Approved Y/N |
|---|---|---|
| | | |

**Hospital Pharmacy Transformation Programme (HPTP)**

## 1. Background

In June 2014, Lord Carter of Coles was appointed as Chair of a new NHS Procurement & Efficiency Board and stated his intent to include a review of hospital pharmacy and medicines optimisation. In February 2016 Lord Carter published his final report to the Secretary of State for Health, identifying unwarranted variation across all of the main resource areas of the NHS worth an estimated £5billion in terms of efficiency opportunity. Of this, the report stated that the NHS could save at least £800million through transforming hospital pharmacy services and medicines optimisation. It made a specific recommendation against this with seven sub-recommendations.. All of the recommendations were accepted.

*Recommendation 3: Trusts should, through the Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding, in agreement with NHS Improvement and NHS England by April 2020; so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities.*

a) *developing HPTP plans at a local level with each Trust board nominating a Director to work with their Chief Pharmacist to implement the changes identified, overseen by NHS Improvement and in collaboration with professional colleagues locally, regionally and nationally*

b) *ensuring that more than 80% of Trusts' pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits and reviewing the provision of all local infrastructure services, which could be delivered collaboratively with another Trust or through a third party provider*

c) *each Trust's Chief Clinical Information Officer moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)*

d) *each Trust's Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, is accurately recorded within NHS Reference Costs*

e) *NHS Improvement publishing a list of the top 10 medicines with savings opportunities monthly for Trusts to pursue*

f) *the Commercial Medicines Unit (CMU) in the Department of Health undertaking regular benchmarking to ensure NHS prices continue to be competitive, and updating its processes in line with the Department of Health's NHS Procurement Transformation Programme*

g) *consolidating medicines stock-holding and modernising the supply chain to aggregate and rationalise deliveries to reduce stock-holding days from 20 to 15, deliveries to less than 5 per day and ensuring 90% of orders and invoices are sent and processed electronically*

A key requirement of Lord Carter's report was that all trusts are required to submit a board-approved hospital pharmacy transformation programme (HPTP) to NHS Improvement by April 2017. These will inform boards (and NHS Improvement regional and national teams) how trusts will meet their Model Hospital benchmarks and the specific recommendations contained in the Carter final report. It is important that different Trusts across a region explore and agree opportunities to collaborate and rationalise the supportive and infrastructure elements of hospital pharmacy services.

## 2. STH context

Whilst the Carter report is relatively new, hospital pharmacy transformation certainly isn't and our HPTP builds on the foundations of previous work. Examples from STH:

- Rationalisation of pharmacy stores and aseptic units
- Regional collaboration on pharmaceuticals procurement (circa 12:1 return on investment)
- Delivery of multi-million pound medicines budget savings every year
- Extension of some pharmacy services across evening and weekend periods (delivered within core budget)
- Expansion of ward-based clinical pharmacy services (safer care by reducing medication errors and omissions, freeing up nursing time on medicines management, helping to speed up the discharge process and reducing medicines budget costs)
- Re-engineering of dispensary services with robotic dispensing systems (resulting in a reduction in dispensing errors and prescription turnaround times being more than halved)
- Outsourced OPD dispensing and expansion of Homecare medicines delivery services (reducing patient waiting times, releasing hospital pharmacy staff to focus on inpatient care and delivering further multi-million pound savings)
- Extension of pharmacist prescribing (STH currently has the highest proportion of pharmacist prescribers of all the Shelford Group Trusts)
- A major staff engagement program has improved staff satisfaction and productivity and reduced turnover
- Regional collaboration to develop the Y&H School of Medicines Optimisation, now commissioned by Health Education England Y&H to deliver multidisciplinary co-ordination of training to develop skills within the wider workforce focusing on any staff that prescribe, dispense or administer medicines.

## 3. STH Hospital Pharmacy Transformation Programme (HPTP)

The Trust's HPTP Board was established in June 2016 to oversee a cross-organisational programme of work as part of the organisation's 'Making it Better' transformation programme. The HPTP Board formulates and oversees all actions in place to deliver the pharmacy recommendations in the 2016 Carter Review; performance-manages delivery of the HPTP; reports progress and identifies and escalates issues that require additional assistance or high level decision making; and finally, communicates details of the HPTP across the organisation as required.

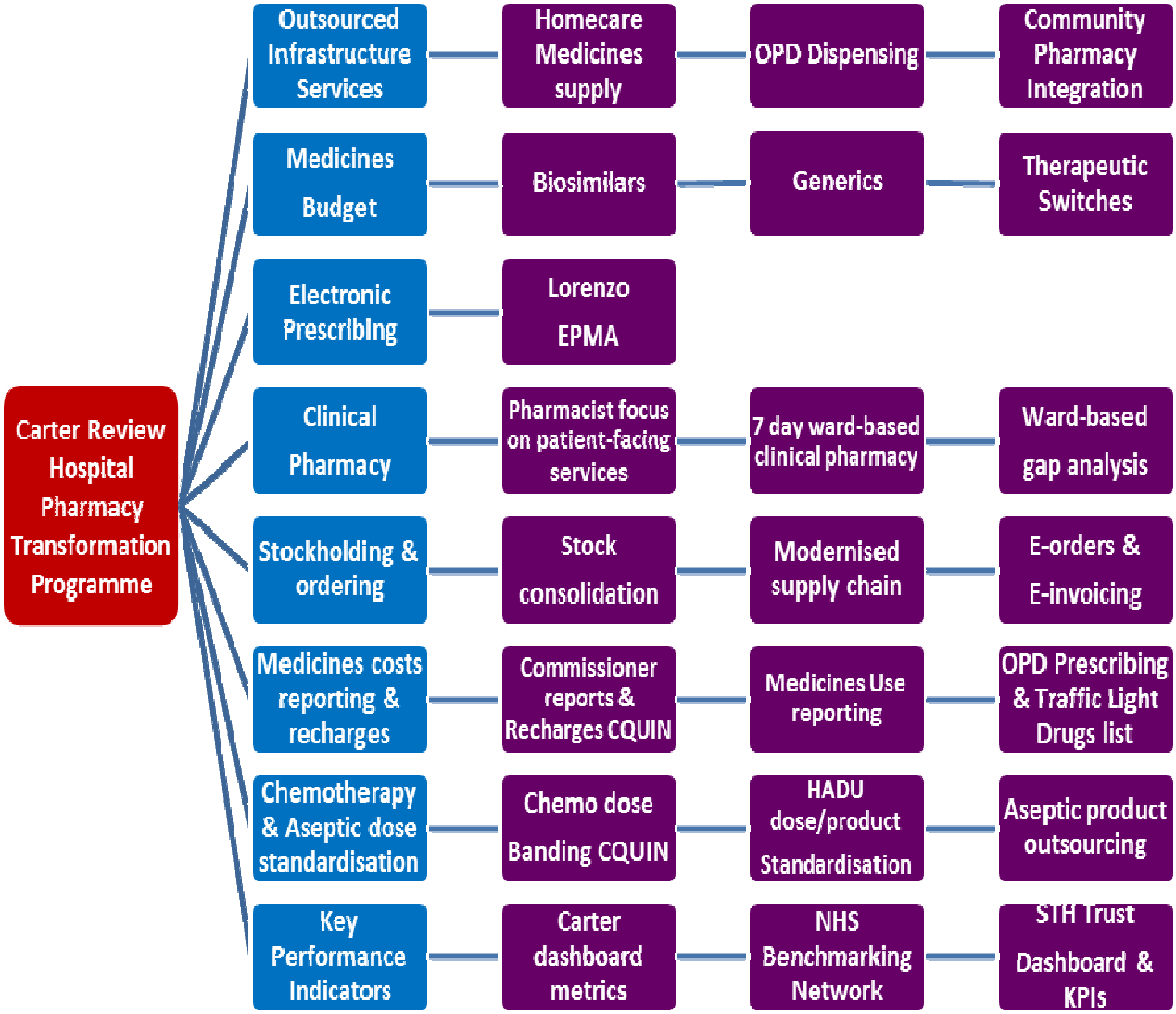
Yorkshire and Humber acute Trust chief pharmacists have collated all our HPTPs and we are reviewing these to share best practice and ensure that proposals are co-ordinated. The South Yorkshire Trusts received collective feedback from NHS Improvement stating that all our draft HPTP documents were "good or very good", though we weren't told how individual Trusts had fared. However, we were encouraged to "*share and copy the good stuff*" and have agreed the topics below as possible areas for consideration of closer working arrangements:

- Aseptic dispensing/preparation
- Quality Assurance/Quality Control
- Medicines Information
- Medicines procurement
- Stock distribution
- Education and training
- Emergency OOH on-call
- Outsourced outpatient dispensing (subject to the timescales of existing contracts)

NHS Sheffield have also produced a draft 'Plan on a Page' for pharmacy community services within the STP and we have incorporated this into our HPTP under the Community Pharmacy Integration workstream, though it also feeds into our electronic prescribing project and management of "Traffic Light" drugs suitable for shared care arrangements with GPs.

We have proposed a new model for STH community pharmacy services, aiming to deliver pharmaceutical care based on patient pathways and not restricted by organisational boundaries across the primary / secondary interface. This includes admissions avoidance in addition to the current post-discharge step-down services that support Intermediate Care and Active Recovery, and bridge the gap between hospital and community to provide a citywide rapid response service for at-risk patients and those in crisis, linking into neighbourhood medicines management services such as community pharmacy and clinical pharmacists in GP practices.

A comprehensive programme has been agreed by the STH HPTP Board, with a framework of 22 projects across 8 major workstreams (summarised in the figure below) each with a designated lead and supported by the Trust's Service Improvement PMO. Detailed projects with timescales and milestones have been formulated and are updated on an ongoing basis. Details of the HPTP has been fully incorporated into the pharmacy staff engagement programme and the directorate business plan for 2017/18, presented to the Trust's Clinical Management Board (Oct 2016) and catalogued on a dedicated Sharepoint site accessible to all staff.



## 4. Current performance against the Carter Model Hospital Metrics and Benchmarks

The latest iteration of the Pharmacy and Medicines Model Hospital dashboard is shown in Appendix 1, compared to our peer group of the Shelford Group teaching Trusts. Notable points for comment:

- Pharmacy staff and medicines cost per "Weighted Activity Unit" shows STH as 3.75% higher than peer group median, although the NHS Benchmarking Network report shows pharmacy costs excluding medicines as 4.9% below the UK mean / 0.1% above the median.
- Use of generic immunosuppressants (as % of total) shown as not available, but we know from the NHS benchmarking network data that STH was 73% in 2015/16 cf mean 55%
- Total antibiotic consumption DDD/1,000 admissions. 4,626 figure shown is lower than peer median but trendline shows increase from 2014/15 to 2015/16. However, data for the first half of 2016/17 (not yet on the Carter Dashboard) shows a significant reduction down to 4,325
- % e-prescribing for outpatients shown as 0% but does not take into account the chemotherapy prescribing done on Chemocare or the renal directorate prescribing on Proton.
- % pharmacists actively prescribing – STH best in peer group
- Use of Summary Care Records – STH highest in peer group
- % infliximab uptake – STH best in peer group
- % biosimilar etanercept – STH shown as just 3.5% for August, but latest data for November shows a 17-fold increase in usage since August
- % medication incidents causing death or harm – lowest in peer group
- Sunday on ward clinical pharmacy hours of service – zero. STH is one of only 2 Shelford Trusts (the other being Addenbrookes) to provide no weekend clinical pharmacy service to admissions units other than limited "winter pressures" non-recurrent funded service Nov-March
- % sickness absence rate – reduced from 3.6% 2015/16 to 3.2 % for 2016/17 YTD

## 5. HPTP Summary

Key activities to achieve the Carter recommendations and Model Hospital benchmarks:

### 5.1 Outsourced infrastructure services

- Homecare: >90% patients now managed by pharmacy (circa 5,000 patients), project timetable in place to address remainder, almost completely established as business as usual
- OPD dispensing: completely established as business as usual, over 150,000 prescriptions pa.
- Community Pharmacy Integration:
    - short-term priority is progressive rollout of formal referral/handover mechanism to community pharmacy on discharge (via Pharmoutcomes) – starting year 1 (2017/18)
    - medium term priority is implementation of pharmacy staff into STH community services neighbourhood teams (within local STP) – year 2 (2018/19)
    - long-term priority is seamless integration of medicines optimisation across Trust, community pharmacy and primary care boundaries – year 3 (2019/20)

### 5.2 Medicines budget

- Implementation of NHSE medicines optimisation CQUIN action plan 2017/19. "Invest to save" business case in development following review at Trust Business Planning Team Nov 2016.
- Biosimilars – highest priority, multi-million pound savings potential. Etanercept switch already underway, local actions agreed for rituximab (starting April 2017), trastuzumab (2017/18) and adalimumab (2018/19) scoping underway.
- Generics: already business as usual, supported by collaboration with regional pharmacy procurement team. Key priorities are pregabalin (switch program now completed) and imatinib (switch starting January 2017), analgesics (especially nefopam and lidocaine patches)
- Therapeutic Switches: business as usual. Comprehensive local medicines savings schemes in place supported by Trust Service Improvement PMO.

### 5.3 EPMA (Electronic Prescribing and Medicines Administration)

- Already in place for chemotherapy (Chemocare) and critical care (Metavision), plus limited OPD functionality in renal medicine (Proton) and Ophthalmology (Medisoft). The Chemocare system needs a major upgrade (business case in development) and the renal directorate is preparing for the replacement of Proton (both 2017/18)
- Comprehensive project in place for inpatient EPMA (Lorenzo), on target to undertake pilot January 2017 and full Trust rollout starting April 2017
- EPMA for OPD and homecare patients anticipated 2018/19

### 5.4 Clinical pharmacy

- Target to achieve 80% pharmacist time on wards by 2020: Proposals to increase from current 64% in development; multi-layered approach to be delivered via a combination of internal pharmacy efficiencies, skill-mix review and invest to save initiatives agreed with admitting directorates (increased use of ward-based medicines management technicians and assistants), supported by the Trust's "Transformation Through Technology" project (primarily impact of e-prescribing and e-whiteboards on pharmacy operational service delivery)
- 7 day services: Investment or reallocation of existing resources will be required to deliver a year-round 7 day service to NGH acute admissions units (AMU 1 & 2, Frailty Unit, Huntsman 5 ward and Surgical Admissions Unit). Trust Business Planning Team has already reviewed existing service configuration and could not agree on disinvestment in established pharmacy Monday-Friday services to reconfigure staff rotas to provide additional weekend service cover. Cost estimated at £256K pa and identified in the pharmacy directorate business plan for last 2 years but funding not available to implement. Currently provided November to March only using non-recurrent winter pressures funding. Trust has since identified the need for additional input to support the new Medical Ambulatory Care unit, Theatre Admissions Unit and Chesterman 2 ward (all 7 days). Progress entirely dependent on funding.
- Ward-based service gaps: annual gap analysis undertaken and presented to Trust Business Planning team, detailed in the annual pharmacy business plan with prioritised incremental progress made via combination of internal pharmacy efficiencies, skill-mix review, invest to save initiatives agreed with admitting directorates.

### 5.5 Stockholding

- Stock consolidation: Trust has already reduced proportion of total cost via own dispensaries to 54% of total medicines budget turnover. Local review of remaining stock underway
- Modernised supply chain: regional collaboration on scoping exercise underway to increase inter-Trust stock management.
- E-orders and e-invoicing – already part-way through implementation project.

### 5.6 Medicines reporting

- Directorate reporting is currently delivered via pharmacy JAC computer system reports and Crystal report writer (combination of Excel spreadsheets and PDF reports) but time-consuming to produce and difficult to interpret. Proposals to implement the use of a SQL server database and increase the use of Refine and Define reports (commercial medicines usage reporting tool from RxInfo) – are in development, aiming to implement both 2017/18
- Upgrade of the pharmacy JAC system is scheduled for April 2017 (in anticipation of commissioner deadline June 2017) to implement dm+d ("Dictionary of Medicines and Devices") as the standard coding system to improve the quality of the NHS England medicines minimum data set (MDS) data, support more accurate and efficient reporting and improved benchmarking and provide further opportunities to identify cost savings
- Commissioner reporting is incorporated into NHSE medicines optimisation CQUIN action plan. Invest to save business case in development following review at Trust Business Planning Team Nov 2016. Aiming to deliver 2017/18
- In the longer term there is a requirement to implement 2D matrix data barcode scanning at the point of dispensing to implement the EU Falsified Medicines Directive to combat the ever increasing risk that falsified medicines reach patients (Deadline February 2019)

### 5.7 Chemotherapy and aseptic services

- Chemotherapy dose standardisation: delivery of NHS England CQUIN a high priority, detailed project in place to implement across 2017/18 and 2018/19
- Chemotherapy capacity planning and demand-management: review underway
- Chemocare system upgrade: see section 5.3, business case in development
- Other aseptic product and dose standardisation and outsourcing: medium priority, primarily focused on demand management cf local production capacity, supported by regional pharmacy procurement team

### 5.8 Key Performance Indicators

- Carter dashboard and Model Hospital metrics: high priority, see section 4 above. Actions in development to improve, cleanse and validate data to ensure it is robust and reliable enough for meaningful benchmarking as well as responding to the metrics
- NHS benchmarking network: 2016 data submitted, review of draft reports underway, collaboration with the Shelford Group underway (as a more meaningful peer group than all teaching Trusts), further proposals to be implemented once final reports published (National summary report anticipated 16th January 2017, bespoke Trust dashboard reports anticipated 18th January 2017)
- Trust dashboard: focused on corporate themes but complementary to above KPIs. Actions incorporated into the pharmacy directorate business plan.

## 6. Risks and mitigations

| Risk | Mitigation |
|---|---|
| Electronic prescribing for inpatients – possible slippage of start date if commercial provider fails to deliver scheduled system updates | Collaboration with NHS Digital team to maintain pressures on CSC<br>Re-profiling of local service delivery team timetable |
| Historical gaps in clinical pharmacy services - potential for failure to acquire the required "Invest to save" support to deliver planned changes. Increasing risk that pharmacy budget savings have to be banked as P&E savings rather than re-invested in clinically facing services | Repeated revisiting of business plans. Incremental improvements delivered year on year |
| Recruitment and retention of the hospital pharmacy workforce, in particular middle grade prescribing pharmacists and in some areas senior pharmacy technicians. Potential threats from other sectors. Challenges in maintaining expertise and pipeline in specialist areas. | STH successfully pursuing a deliberate policy of over-recruiting to key foundation pharmacy posts in anticipation of future vacancies. |
| NHS England Medicines Optimisation CQUIN – potential for a huge bureaucratic burden associated with reporting requirements | Internal Trust business case to fund staff to deliver CQUIN and seek clarity reporting requirements to minimise risk to Trust income for non-payment |
| OPD prescribing and local Traffic Light Drugs ("RAG") list: significant pressures resulting from increasing refusal of local GPs to accept transfer of long-term prescribing responsibility in accordance with commissioned service and agreed shared care protocols. | Medical Director in negotiation with CCG counterpart. To be explored further with South Yorks "Working Together" partnership Trusts. CCG plans to develop pharmacists in GP surgeries may help. |
| Limited project management capacity to deliver huge portfolio of major changes whilst maintaining appropriate response to current demand-led services | Assistance from Trust PMO and planned development of business cases to include necessary staffing |

## 7. Issues and mitigations

| Issues | Mitigation |
|---|---|
| Major investment needed to improve and update current IT systems, both within the Trust and across partner organisations. Current portfolio of mixed, often outdated, legacy systems is a barrier to collaboration. Interoperability needed for collaboration to function efficiently | Projects already underway and in development to upgrade, replace and/or interface/integrate IT systems. |
| Homecare – ongoing problems with commercial provider performance | Increasing scrutiny of performance against KPIs<br>Ensure all patients receive Trust information pack highlighting key contacts for problem escalation<br>Moving patients to alternative service providers |
| Stockholding – Not currently possible to delivering Carter recommendations regarding stock holding days and number of deliveries, given the current infrastructure eg. running out of essential stock when manufacturers cannot supply | Stocks will not be reduced below safe operational levels unless pharmaceutical suppliers can maintain required delivery schedules<br>Working with regional hospital pharmacy colleagues on scoping project for increased collaboration |
| Cancer Drug Fund data requirements – unclear exactly what is required | Currently a query with NHS England and a response is awaited |
| Provision of 7 day service | Additional funding or disinvestment in other pharmacy services would be required to progress this service. |
| Impact of Commissioning intentions 1:NHS England confirmed proposals to disinvest in the “non-embedded” pharmacy posts currently funded separately to support primary pulmonary hypertension (0.31 WTE 8C pharmacist and 1.0 WTE band 5 technician), cystic fibrosis (0.5 WTE band 7 pharmacist and oncology chemotherapy (0.5 WTE band 8a pharmacist) | Paper to BPT in progress, as recommended by Assistant Director of Finance, describing the potential impact of dis-establishing these posts and proposing the maintenance of internal funding to support the ongoing operational Trust benefits. |
| Impact of Commissioning intentions 2: NHS England proposed a move away from existing medicines savings gain share agreements which has the unintended potential to be a disincentive to or even undermine the financial viability of services that actually deliver the savings | Agree negotiation stances for 2017/18 contract negotiations for both NHS England and CCG commissioners. |

Damian Child
Chief Pharmacist
On behalf of the STH HPTP Board

January 2017

**Appendix: Carter Model Hospital Dashboard for STH (as at 19Dec16)**

# Pharmacy & Medicines, Trust Level

(●) My Peers ( ) NHSI Regional Peers ( ) Sustainability & Transformation Plan Peers ( ) Trust Type Peers (ERIC) ( ) Trust Size Peers (OPEX) ( ) Trust Size Peers (WAUs)

| Money & Resources | Period | Trust Actual | Peer Median | National Median | Info | Variation | Trend |
|---|---|---|---|---|---|---|---|
| Pharmacy Staff & Medicines Cost per WAU | 2015/16 | £525 | £506 | £350 | | | No trendline available |
| Medicines Cost per WAU | 2015/16 | £478 | £466 | £312 | | | No trendline available |
| High Cost Medicines per WAU | 2015/16 | £137 | £173 | £112 | | | No trendline available |
| Non High Cost Medicines per WAU | 2015/16 | £341 | £335 | £196 | | | No trendline available |
| Choice of Paracetamol Formulations [% IV Paracetamol vs Total Spend] *NEW* | 2015/16 | 58% | 53% | 56% | | | No trendline available |
| Use of Generic Immunosuppressants [% Generic vs Total Spend (Selected Drugs)] *NEW* | - | NOT AVAILABLE | - | - | | | |
| Use of Inhalation Anaesthetics - % Spend on Sevoflurane *NEW* | 2015/16 | 65% | 64% | 66% | | | No trendline available |

| Safe | Period | Trust Actual | Peer Median | National Median | Info | Variation | Trend |
|---|---|---|---|---|---|---|---|
| Total Antibiotic Consumption in DDD*/1,000 Admissions | 2015/16 | 4,626 | 5,091 | 4,549 | | | |
| % Diclofenac vs Ibuprofen & Naproxen (Monthly) | Jun 2016 | 6.93% | 8.05% | 8.85% | | | |
| % ePrescribing Chemotherapy | 2014/15 | 100% | 100% | 50% | | | No trendline available |
| % ePrescribing IP | 2015/16 | 20% | 100% | 50% | | | No trendline available |
| % ePrescribing OP | 2014/15 | 0% | 40% | 50% | | | No trendline available |
| % ePrescribing Discharge | 2014/15 | 100% | 100% | 60% | | | No trendline available |

| Effective | Period | Trust Actual | Peer Median | National Median | Info | Variation | Trend |
|---|---|---|---|---|---|---|---|
| Clinical Pharmacy Activity [Pharmacist Time Spent on Clinical Pharmacy Activities] *NEW* | 2015/16 | 64% | 70% | 66% | | | No trendline available |
| % Pharmacists Actively Prescribing | 2015/16 | 35% | 22% | 20% | | | No trendline available |
| % Medicines Reconciliation Within 24 Hours of Admission | 2015/16 | 65% | 70% | 73% | | | |
| % Use of Summary Care Record (or Local System) per Month | Aug 2016 | 157.1% | 48.9% | 52.1% | | | |
| % Soluble Prednisolone of Total Prednisolone Uptake | Sep 2016 | 1.6% | 3.5% | 3.4% | | | |
| % Biosimilar Infliximab Uptake (Monthly) | Sep 2016 | 96.7% | 75.8% | 68.3% | | | |
| % Biosimilar Etanercept Uptake (Monthly) | Aug 2016 | 3.5% | 9.9% | 17.0% | | | |
| Total Spend on Etanercept in 201516 | 2015/16 | £3.7m | £2.3m | £1.1m | | | No trendline available |
| Dose-Banded Chemotherapy [Doses Delivered as Standardised Bands] *NEW* | 2015/16 | 45% | 8% | 42% | | | No trendline available |
| Number of Medication Incidents Reported to NRLS per 100,000 FCEs of Hospital Care *NEW* | Mar 2016 | 297.4 | 384.8 | 285.6 | | | |
| % Medication Incidents Reported as Causing Harm or Death/All Medication Errors *NEW* | Mar 2016 | 7.3% | 11.8% | 9.7% | | | No trendline available |
| Number of Days Stockholding | 2015/16 | 28.0 | 19.7 | 18.8 | | | No trendline available |
| Pharmacy Deliveries per Day [Average Number of Deliveries] | 2015/16 | 13 | 15 | 15 | | | No trendline available |
| e-Commerce - Ordering (Alliance) *NEW* | 2015/16 | 85.1% | 89.0% | 90.4% | | | No trendline available |
| e-Commerce - Ordering (AAH) *NEW* | 2015/16 | 67.9% | 84.0% | 82.0% | | | No trendline available |

| Effective | Period | Trust Actual | Peer Median | National Median | Info | Variation | Trend |
|---|---|---|---|---|---|---|---|
| Data Quality of NHS England Monthly Data Set Submissions From Providers *NEW* | Sep 2016 | 19 | 19 | 20 | | | No trendline available |

| Caring | Period | Trust Actual | Peer Median | National Median | Info | Variation | Trend |
|---|---|---|---|---|---|---|---|
| National Inpatients Survey - Medicines Related Questions | 2015/16 | 74.4% | 76.3% | 73.1% | | | |

| Responsive | Period | Trust Actual | Peer Median | National Median | Info | Variation | Trend |
|---|---|---|---|---|---|---|---|
| Sunday ON WARD Clinical Pharmacy Hours of Service (MAU/Equivalent) | 2015/16 | 0.0 | 7.5 | 7.0 | | | |

| People, Management & Culture: Well-led | Period | Trust Actual | Peer Median | National Median | Info | Variation | Trend |
|---|---|---|---|---|---|---|---|
| % Sickness Absence Rate | 2015/16 | 3.6% | 3.2% | 3.1% | | | |
| % Staff with Appraisals Completed | 2015/16 | 100% | 94% | 85% | | | |
| % Staff with Statutory and Mandatory Training | 2015/16 | 98% | 90% | 91% | | | |
| % Staff Turnover Rate | 2015/16 | 8% | 12% | 14% | | | |
| % Staff Vacancy Rate *NEW* | 2015/16 | 0% | 3% | 6% | | | No trendline available |