

**AHSN support for a national template and
core data for electronic transfer of care
around medicines:
The case for clinical handover to
community pharmacy.**

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The strategic case for change – Medicines Optimisation

Medicines are the most frequently made healthcare intervention in England. In 2014, over one billion prescription items were dispensed in primary care alone. However, over recent years, it has become apparent that whilst the number of prescription items is growing, there are some significant failings in medication safety. Added to this, there are a number of improvements that have been shown to support patients to get more from their medicines but that are not being utilised and therefore the improved outcomes promised by these medicines are not always being realised.

We know that between 30 and 50% of medicines are not taken as intended. Evidence shows that 5-8% of unplanned admissions to hospital are due to medication issues and that the risk of people suffering harm from their medicines increases as the number of medicines taken by each patient increases.

Data from England shows us that between 2003 and 2013 the average number of prescriptions per year for any one person has increased from 13 to 19. The King's Fund has recently highlighted the consequences of inappropriate polypharmacy, where patients receive multiple medications and where this may or may not be appropriate. Where problematic or inappropriate polypharmacy occurs, at best the intended benefit of the medicines are not realised and at worse, they cause harm, severe harm or even death.

All of these issues demand a step change in our approach to medicines that has not been delivered under the term medicines management. The concept of Medicines Optimisation has been evolving in the NHS in England over the last four years. It provides a much greater focus on the patient and begins the transition from thinking of the cost and prescribing of a medicine towards a broader approach that tries to harness the value of a medicine whilst minimising harm for the patient.

NICE has defined medicines optimisation as “a person centred approach to safe and effective medicines use to ensure that people obtain the best possible outcomes from their medicines.”

Many patients leave hospital having had new medicines initiated, doses of existing medicines changed, and medicines stopped. Unintended discrepancies in patients' medicines after discharge from hospital frequently occur, affecting up to 87% of patients. Patients' understanding of the nature of and reasons for changes made to their medicines in hospital is often incomplete; hence it is unsurprising that their medicines taking may be different from that intended by the hospital.

There is a clear need to have a patient centred approach to transfer of care around medicines

Strategic level

Need to have a patient - centred approach to transfer of care around medicines



Pharmacy level

All sectors need to take a more co-ordinating role so that the pathway works for the patient and their medicines and those with need related to their medicines are referred into the right and appropriate levels of support



Standards of care

RPS guidance gives health and social care professionals a common framework and clear expectations concerning good practice around the transfer of information about medicines.

<http://www.rpharms.com/current-campaigns-pdfs/1303---rps---transfer-of-care-10pp-professional-guidance---final-final.pdf>



**Tools
E referral -
Standard
template for
referral and
data recorded *.**

**Tools
SCR**

**Tools
<http://www.rpharms.com/unsecure-support-resources/referral-toolkit.asp>**

*** Note this paper concentrates on the template for referral and core data recorded**

Evaluation Phase: AHSNs will work together to explore common themes for evaluation of schemes.

2. Background. Transfer of care around medicines.

Many patients leave hospital having had new medicines initiated, doses of existing medicines changed, and medicines stopped. Unintended discrepancies in patients' medicines after discharge from hospital frequently occur, affecting up to 87% of patients. Patients' understanding of the nature of and reasons for changes made to their medicines in hospital is often incomplete; hence it is unsurprising that their medicines taking may be different from that intended by the hospital. Furthermore, during an admission, problems with a patient's medicines may be identified, which are more appropriately managed by the primary care team, including the community pharmacist.

Medicines-related problems after hospital discharge are associated with potential and actual adverse health consequences, many of which are preventable. Groups of patients at particular risk include those taking warfarin, those with heart failure and following a hospital admission for acute coronary syndrome (ACS).

The literature shows clear potential to reduce medicines-related problems after discharge and thus a role for Discharge Medicines Use Reviews (DMURs). There is some evidence from other countries (notably the Netherlands, Australia and Wales) that post-discharge medicines reviews are effective in resolving discrepancies and problems in medicines use.

2. Discharge MUR in England

The Discharge MUR has been part of the community pharmacy contract in England since 2011. It covers patients recently discharged from hospital who had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge.

Guidance was published in January 2012 showing how the New Medicine Service (NMS) and post discharge Medicines Use Reviews (MURs) can be used to provide a seamless care pathway for patients who transfer from hospital to the community setting. It was developed and published by NHS Employers and PSNC working with a hospital and community pharmacy reference group and endorsed by the Royal Pharmaceutical Society. In order to increase the uptake of DMURs, a number of areas of the country have developed "refer to pharmacy" schemes to help hospitals directly refer patients to their community pharmacist in order to receive support around their medicines on discharge from hospital.

3. The role of AHSNs

A number of AHSNs were working on this area and it was suggested that agreement could be reached for a common data set for both referral to the community pharmacist and also data collected by community pharmacists. A number of AHSNs are already supporting universities to evaluate these schemes and so a core common data set could lead to a national data set, which could create a greater evidence base of the benefits.

Therefore, it was agreed that Wessex AHSN would lead discussions to gauge support for this approach and agree a common data set, but that the work would be broadly based on the considerable experience that Newcastle upon Tyne Hospitals NHS Foundation Trust has with their eReferral scheme that has been in operation for over a year. (See http://www.pharmaceutical-journal.com/your-rps/hospital-e-referral-initiative-boosts-post-discharge-murs-in-community-pharmacies/20068940.article?utm_medium=twitter&utm_source=twitterfeed&adfsuccess=1) with input also from East Lancashire Hospitals NHS Trust (www.elht.nhs.uk/refer).

Following a TC in March, a number of actions were agreed in relation to refer to pharmacy and discharge MUR schemes. The full list of actions can be found in Annex 1. However, it was agreed that a core data set for referral and follow up would be developed, based on the work of Newcastle, Dorset and East Lancashire and that this would be formally agreed at the AHSN Network.

5. National template

There are currently two known electronic solutions to facilitate the referral and transfer of information from hospital to community pharmacies: PharmOutcomes and Refer-to-Pharmacy. Both systems allow Community Pharmacies to capture the same outcome data once an MUR/NMS has been completed.

PharmOutcomes utilises the web-based application that many Community Pharmacies use to record their dispensing and advanced service activity. PharmOutcomes is now used in 6,675 Pharmacies across England and therefore is the main provider of data that captures the evidence of community pharmacy's benefit for patients and supports record keeping, service management and financial tracking for services provided by community pharmacies. Currently it uses a web form, which requires hospital pharmacists to manually populate a referral with patient demographic information, the reason for referral and to copy and paste elements of the patient's discharge prescription and summary into the referral. It is anticipated that the system will link with hospital systems to replace the manual e-form filling. Referrals are made at the end of the patient's hospital journey.

Refer-to-Pharmacy is an e-referral solution, which is fully integrated into hospital systems. This means referrals can be made at any point from admission to discharge, patient demographic detail is auto-populated and a full copy of the patient's discharge summary and prescription is attached to the referral. Referrals are automatically sent to the patient's pharmacy upon discharge, and for certain patients (care home residents, blister pack users) their community pharmacy is informed at the point of admission that their patient is in hospital and to pause dispensing until they are discharged. The system also facilitates referral to domiciliary pharmacy teams. Refer-to-Pharmacy is deployed at East Lancashire Hospitals NHS Trust (www.elht.nhs.uk/refer) and has been designed by the Trust in collaboration with Webstar Health in a manner that allows it to be deployed to other health economies.

For more information contact: alistair.gray@elht.nhs.uk

Wessex AHSN has, on behalf of the group, worked with PharmOutcomes to develop a template that all AHSNs can use. East Lancashire Hospitals NHS Trust and has shared their work and valuable experience with the group.

The Royal Pharmaceutical Society has been consulted and is supportive of the approach the AHSN are taking.

6. Recommendations

The AHSN Network is requested to support this template, and encourage individual AHSNs to use it.

It can be modified if a particular AHSN wish to add to it (in collaboration with PharmOutcomes or Refer to Pharmacy). However the data here should be considered as the “core” data set.

The RPS is aware of this work and will support the AHSNs in ensuring that RCGP is supportive of this approach.

Clearly, any scheme will engage with Local Pharmaceutical Committees and Local Professional Networks as part of their stakeholder engagement.

Patient representatives who are engaged with AHSNs should also be included as key stakeholders in local work to roll out new schemes.

Areas with experience of setting up these schemes have highlighted the benefits of engaging the wider clinical team within the hospital to ensure that all patients benefit from an improved discharge process.

7. Next steps

AHSN Medicines Optimisation leads will continue to collaborate on this work and will next address the key elements of evaluation of such schemes. In particular, they will focus on agreeing core outcomes, working in collaboration to pool data to support common findings and exploring patient benefits, waste reduction and medication safety.

8. National templates



TOC Followup -
PharmOutcomes NATI



TOC Referral -
PharmOutcomes NATI

Further information

<http://psnc.org.uk/services-commissioning/advanced-services/murs/national-target-groups-for-murs/>

<http://www.rpharms.com/unsecure-support-resources/referral-toolkit.asp>

<http://www.rpharms.com/health-campaigns/getting-your-medicines-right.asp>

http://www.pharmaceutical-journal.com/your-rps/hospital-e-referral-initiative-boosts-post-discharge-murs-in-community-pharmacies/20068940.article?utm_medium=twitter&utm_source=twitterfeed&adfsuccess=1

<http://www.elht.nhs.uk/refer>

Annex 1

- There was broad agreement that a core data set for both referral and follow up forms would be useful and beneficial.
- There is much learning that can be gained from the experience to date in Newcastle and their experience has led to a simplified referral and data collection form, which is reflected in this national template.
- Engagement with community pharmacy is key. It shouldn't be assumed that all referrals made will result in the patient receiving the intervention from community pharmacy and so working with the LPC is critical.
- All agreed that the referral form and follow up form should not contain anything that won't be used as it takes time to complete and this adds burden in hospital and community pharmacy. Newcastle has greatly simplified what they require over the 12 months of the project.
- There was a suggestion to take out the recommendation section of the referral form as Community Pharmacists are better placed to determine what is required, and hospital staff may not know much about MUR's NMS etc.
- Based on the IoW experience there should be a space for either NHS number or hospital identifier so that evaluation can link to HES data and demonstrate outcomes (reduced admissions etc.)
- There was a reminder that the original purpose of the referral scheme was to open up communication channels between hospital and community pharmacy departments and thereby increase medicines reconciliation on discharge.
- There was a very strong message not to have totally automated referral for all discharges. This would overwhelm community pharmacy capacity, there was a strong feeling that referral to community pharmacy should be for those who would benefit from intervention by a Community Pharmacist to help patients with their medicines for their long-term condition. Not all discharged patients need a community pharmacy intervention.
- PharmOutcomes confirmed that in the next few months, there will be development in terms of Trust computer systems being able to auto populate the referral form, provided the reasons for medication changes had been recorded.
- It was suggested that Newcastle share their learning so far as this would be very helpful to those starting out.
- There was a strong suggestion that GPs are engaged. There are still issues around not informing GPs when the community pharmacy intervention has taken place. It was agreed that on the back of this work, there could be engagement of RCGP to develop standardization of information sent to GPs on discharge.
- It was also suggested that any AHSN areas that had developed patient -facing communication materials about the discharge MUR should share them with the group.
- It was suggested that if possible, it would be sensible to include a patient self-evaluation of adherence before and after the intervention as part of the follow up.