Kent Surrey Sussex Academic Health Science Network

Living Well For Longer

Polypharmacy – a person-centred approach

This document contains the complete feedback provided from each of the stakeholders involved in the polypharmacy pilot project that ran from August 2016 to February 2017. This document complements the summarised evaluation document that outlines the 6 key findings from all the feedback.

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Contents

Background and introduction

Problematic polypharmacy – when an individual's multi-medication regime is not providing the intended benefit – can lead to adverse drug reactions and reduced quality of life. The average older person admitted to hospital is prescribed 13 medicines and adherence is also poor resulting in significant waste of resources. Problematic polypharmacy is both a quality and patient safety issue.

Insight was gathered from across Kent, Surrey and Sussex around what work was being carried out across the region and a number of CCGs had specific projects focussing on reducing levels of polypharmacy with positive results. Issues were shared, which often focussed around funding and resources.

Evidence shows that the gold standard of medication reviews is fully holistic 'level 3' face-to-face review of medicines and the individuals' condition with patient/care input.

It was therefore agreed that the AHSN would support a project to look at the benefits of carrying out level 3 medication reviews specifically, to enable comparisons to be made between the results and outcomes of previously projects, mainly focussing on level 2 medication reviews.

In August 2016, KSS AHSN initiated a 6 month pilot in Brighton and Hove to reduce levels of problematic polypharmacy in patients over 65 years old. Brighton and Hove CCG was selected as there was an already established annual care home medication review service in place for a number of years (delivered by iRx Solutions) with supporting data and a comprehensive evaluation of results to date. There would therefore be the opportunity to compare results and learnings from the projects focussing on different levels of support.

The AHSN funded 2 posts to support this work – a pharmacist and a pharmacy technician. Project Pharmacist Mairead O'Malley, Lead Pharmacist in Elderly Care at BSUH was

seconded to the position of Senior Clinical Pharmacist and Project Pharmacy Technician Syred, Specialist Pharmacy Technician at Sussex Community NHS Foundation Trust was seconded to the position of Senior Pharmacy Technician. Their role was to provide Level 3 medication reviews for patients in care homes and in their own homes, identified and referred by a number of routes:

- New admissions to care homes
- Complex patients at risk of medicine related harm flagged by GP surgeries
- Patients discharged from hospital
- Patients and carers phoning the Age UK Crisis Line with medication-related issues

Aim

By March 2018 evidence cash releasing benefits and improvements in health outcomes from reducing levels of problematic pharmacy by shared decision making in an agreed target population of older people across KSS.

Objectives

1. Identify complex older patients at risk of medicine related harm
2. Carry out holistic patient centred level 3 medications review to optimise medications in order to improve patient outcomes and quality of life
3. Improve communication between and integration of relevant services
4. Demonstrate difference between level 1 or 2 reviews and level 3 reviews
5. Quantify cash releasing savings from reducing problematic polypharmacy
6. Prevent/reduce hospital admissions
7. Support spread and adoption of project across additional localities in KSS

Key expected outcomes:

1. Demonstrate the positive impact on CCG prescribing budgets
2. Reduce readmissions
3. Increase quality of life

Outputs:

- Evaluation and key learnings for pilot locality following phase 1

A project board was set up – made up of the stakeholders listed below – and met monthly. The group discussed all aspects of the project set up, any issues that arose throughout the pilot, agreed appropriate referral routes and comms requirements, and supported Project Pharmacistand Project Pharmacy Technician in their roles as the service providers.

- AHSN project support
- Clinical leads
- Project pharmacist and pharmacy technician
- Brighton and Hove CCG
- BSUH – geriatrician, pharmacist
- Age UK Brighton and Hove
- Community Pharmacy
- Brighton and Sussex Medical School

Metrics were agreed and collated on an ongoing basis and fed into a collection sheet which allowed us to generate a data dashboard showing the results.

Peer-to-peer support sessions were set up, run by Lelly Oboh, Consultant Pharmacist, Care of Older People, NHS Specialist Pharmacy Services. These learning sessions provide additional support around polypharmacy and all pharmacists within B&H (from all service providers) were invited to attend.

We are also linked to the national medicines optimisation agenda via the AHSN Medicines Optimisation network, and will be sharing the results and outcomes of this work within the network.

What's next?
Another project will be implemented within a second locality to support the reduction of problematic polypharmacy. All the learnings from the work carried out in Brighton and Hove CCG will be used to shape the project. At the end of this phase, a toolkit will be developed based on both phases of the polypharmacy work – and findings from other relevant polypharmacy work – for other CCGs/localities to use to implement their own project to reduce problematic polypharmacy in older people in their area.

Results

Please see the dashboard in appendix 1. This should be reviewed alongside the supporting narrative that can be found in appendix 2.

Feedback from project board members

Project board members:

Name	Job title	Project role
Liz Butterfield	Pharmacist Consultant	Strategic Pharmacist Lead
Zoe Schaedel	GP	GP Clinical Lead
Mairead O'Malley	Pharmacist	Project Pharmacist
Sara Syred	Pharmacy Technician	Project Pharmacy Technician
Beatrice Gahagan	Health and Wellbeing Development Manager	Age UK lead
Katy Jackson	Chief Pharmacist	Brighton and Hove CCG lead
Bethany Edge	Consultant in elderly medicine	Geriatrician Lead
Penny Woodgate	Business Support Manager	East Sussex Local Pharmaceutical Committee lead
Nikesh Parekh	Clinical Research Fellow	BSMS lead

Findings from each of the project board members is included below into the sections further findings, lessons learnt, recommendations and added value.

Further findings

Strategic Pharmacist Lead

- Takes time and buy in to change and improve inter-professional working relationships and trust
- Integration of community pharmacy is really beneficial, otherwise they are in the dark and can do a lot to help people with meds
- Investment in real-time electronic comms would really help across the whole system (including community pharmacy) - delays result in readmissions and problems for patients and family.
- Audit of medicines-related readmissions was undertaken to identify learning about potentially avoidable situations for the future. To date this work is still ongoing and will be really valuable to build in to phase 2.

- AHSN project management and evaluation support really valuable and enabling. Funding and leadership also helped integration and collaboration.
- Emergency department need for real time comms around follow up for patients who have had meds changed or added but no admission and no discharge summary.

GP Clinical Lead

- The important relationship between the pharmacist and front line clinicians. The need for the project leaders to be championing the aims of the project and creating momentum amongst clinical teams. Change and buy in was dependant on these relationships
- The need to create a sustained movement and culture around prescribing and polypharmacy. It is a huge challenge to shift behaviour and this will take years to fully embed, this project is a catalyst for further change in relation to the community approach t problematic polypharmacy.
- The need to create case studies and narratives around those patients served by the project. These led to connection and increased understanding and buy in for clinicians.
- The project demonstrated the successful relationship and engagement of different community providers, connecting voluntary sector, primary care, pharmacy, patients to AHSN.
- Opportunity to develop cross sector working and relationships with a diverse project team enabled a perspective on the project from different parts of the system.
- Exploration and testing of pathways and learning about the relative successes of these.

Project Pharmacist

- The power of this project and its outcomes lies in the relationships it has developed and breaking down barriers in a highly complex system. Prior to working on this project, I worked at the acute trust, BSUH, for eight years. In this time I had a very limited knowledge of the primary care services and little to no understanding of their hugely important roles. This project has facilitated an independent resource to transcend individual services, to mediate the demands and to understand how this complex system might work better together. We have been able to create meaningful relationships with our third sector charity colleagues in Age UK, often isolated from service discussions, to understand the challenges and appreciate the circumstances in which care and support are required. We have been able to open lines of communication, on which further developments can be built once the pilot is complete.
- In the very short six month timeframe we have been able to meet with the six clusters which make up Brighton and Hove GP services. We have had quite a positive response with practices in four clusters engaging our services to complete reviews for their patients. We have been available for GP's to contact us directly to complete a review in a very short timeframe, enabling the GP to understand medication issues which have arisen through transfer from the patient's home, to acute care, rehab and home again. The feedback we received was very positive and the actions on our recommendations were highest in these "prompted" reviews.
- Our partnership with Age UK was very successful, allowing the carers to contact us directly via their crisis team manager to prompt a review. The reviews completed on these patients were varied, some requiring multiple visits and follow up in order to prevent a hospital admission to those who simply required a discussion about their medicines to increase understanding and compliance. In all cases, however, we were able to alleviate the burden from the Age UK carers to find a solution for their individual needs.
- We also developed very good relationships with the existing primary care pharmacy services. There was good dialogue between our services and Community Rapid Response Service (CRRS), often telephoning one another to ensure there was no overlap on services, referring patients to the other service if they had been involved

previously etc. We have also taken referrals from iRx care home review service and the Better Care pharmacists for those patients who required a review more urgently.

Project Pharmacy Technician

- The project has provided an invaluable source of Pharmaceutical expertise to Age UK personnel. This pathway needs to be continued; provisional plans suggest that Better Care Pharmacists' may have capacity to support this
- Integration between existing services CRRS and Better Care particularly is essential.
- Communication with community pharmacy providers must be improved

Age UK lead

- Crisis is a small, non-medical team who provide an emergency response to our clients. As some of our clients have not had any formal assessments when we accept the referral (some clients self-refer) we find a lot of medication issues can surface during our initial contact with them. We also support a lot of clients who have been discharged from hospital with new medications and whose GPs are yet to learn they have been in hospital. There is often a lot of confusion about what medications the person should be taking as clients often have a stock pile of old meds and these can get muddled in this process.
- The polypharmacy pilot has provided some very beneficial support to our Crisis Service. It has potentially avoided some hospital admissions and provided some safe and practical steps for clients to use to ensure they take their medications effectively. The pharmacy professionals have also provided some training for our carers to help give them confidence in some areas of medication where they felt concerns.
- Having this point of contact to pharmacists who are skilled and knowledgeable has been a real asset to us and we are extremely sorry that the pilot coms to an end. Crisis receives referrals from the council and from health services. Initially we were referring clients from both parts of our service to the polypharmacy pilot, and for the clients using CRRS hours this was replicating what the CRRS pharmacists could have (or were doing) This was quickly identified and we believe the outcome was positive as the two teams liaised with each other and worked out a solution to this. For our clients using BHCC hours and thus not under the CRRS umbrella we were able to create swift access to polypharmacy which they would not necessarily have had without the project.
- The pilot has helped us clear up some of the 'grey areas' that have plagued us at times in the past when we have not been clear what the best course of action to take was.
- The polypharmacy team have been brilliant to work with, easy to refer to and they have been fast to respond. Project Pharmacist and Project Pharmacy Technician are very pro-active and client centred and it has been a pleasure to be involved in the project with them. If there were a way we could continue using this service it would be wonderful. So many clients could benefit from this joint working and we feel that if the pilot was extended it would pay for itself (less hospital admissions, less GP involvement etc.). We look forward to learning about future developments arising from the pilot.

Brighton and Hove CCG lead

- The power of partnership working
- Identified gaps in current provision
- Gave ideas for Creating a sustainable pathway opportunity

Geriatrician Lead

- From a hospital perspective, we regularly encounter patients in whom we worry about whether they are taking their medications appropriately and in whom we would like to be able to rely upon a constant presence of an experienced community pharmacist. Knowing that Project Pharmacist was available to provide this service gave us confidence in discharging these complicated patients.

East Sussex Local Pharmaceutical Committee lead

- East Sussex Local Pharmaceutical Committee (LPC) organised and facilitated a community pharmacy induction session at a local community pharmacy for the Project Pharmacist and Technician. This consolidated good working relationships in the project group by enhancing the understanding of the challenges and legal frameworks across the primary and secondary care interface. The cost of LPC Officers' time was borne by East Sussex LPC and hence Community Pharmacy contractors in East Sussex and Brighton.

BSMS lead

- This was a multidisciplinary project group that brought many different skills to promote the success of the project. The good working relationships were further nurtured over the time course of the project and have culminated in the organisation of a collaborative event between BSMS, AHSN and Age-UK which is quite unique.
- In the future, the organisations represented know that they can trust one another to support mutual interests and consider further project to collaborate on.

Lessons learnt

Strategic Pharmacist Lead

What went well

- Linking pharmacists together across the whole system really helps with patient care and support – less fragmentation and addressed gaps and comms.
- Supporting Age UK crisis line callers and also realising that we need systems that prevent crises for people and families at vulnerable times in their lives.

What didn't go so well

- Not sure we picked up on some of the people where we could have had more preventative impact – but that is the nature of a pilot, we are trying something new to improve care and learn some lessons. So I think we would have improved our referral rate and quality (in terms of need) if we had been running for longer as we only had 3-4 months in reality.
- Focus on avoiding readmissions but think we will have more information on this by the time of report.

What issues did you come across

- Recognition that there is a bit of 'no man's land' between Care settings where reviews done in a timely way would be really beneficial. There is an assumption that GPs are taking responsibility when in reality they may not even have up to date information on previous care. AHSN supporting links between pharmacists in different sectors with real time info would really help support GPs and their patients (and sometimes other GPs patients that have been transferred).

What could be done differently

- I would like more community Pharmacy involvement in follow up
- Also more geriatrician care in community settings working closely with pharmacists and GPs.

GP Clinical Lead

What went well

- Holistic and patient centred assessment gave real attention to what mattered most to the patient, maximising the impact of the medication reviews.
- The care offered by the pharmacist and technician was flexible and wrapped around the patient, their needs and priorities.

- The project enabled an alternative perspective of the system, and shone a light on some challenging areas of provision and gaps,

What issues did you come across

- It was challenging to penetrate the hospital discharge process. The existing system was not flexible for reasons including staff shift and turnover, pressures of work, competing systems and initiatives relating to discharges. The pilot status of the project may have contributed. There was early recognition of the need to review any restrictive referral criteria and open the service up to those in need.
- The IG processes around sharing clinical information between multiple practices and partners should not be underestimated.
- The need to avoid information overload must be balanced with the need to keep clinicians informed and able to share and publicise the project.

What could be done differently

- It would have been interesting to explore the idea of patients as their own referrers earlier in the project

<u>Project Pharmacist</u>

What went well

- Having existing relationships with the Acute and Community Trust was absolutely vital in this pilot. My background from the hospital allowed me to engage with GP's on the basis that I understood the issues they faced. I was able to use my contacts at the hospital to garner support, join ward rounds and give multiple presentations to showcase the pilot project. Having Project Pharmacy Technician as a resource who understood the CRRS team and rehab workflow was hugely valuable to join the dots.
- Having a highly experienced and capable technician on the pilot was also invaluable. Project Pharmacy Technician was able to visit patients and complete reviews on her own, continue the service during pharmacist annual leave and provide a hugely valuable skillset to the reviews. The Technician role is often overlooked however, in this instance, it highlighted the importance of having an appropriate skillset to increase efficiency.
- The ability to create our own template documents was fantastic – it allowed us to consider the most important aspects of the reviews we would be completing.
- Being part of this AHSN pilot opened up valuable lines of communication across the region via the B&H Primary care pharmacy meetings and the peer to peer sessions with Lelly Oboh.
- The response to our reviews was generally positive – those reviews which were "prompted" were very well received.
- Having a dedicated phone number is hugely important for both patients and other healthcare professionals to contact the service directly. The issuing of business cards was also helpful to circulate to key stakeholders.

What didn't go so well

- The referral rates from BSUH NHS Trust were disappointing. There may be a number of reasons for this, time pressures being the most likely. However, it does raise the question of engagement and how you can create meaningful relationships for onward referral of patients in busy NHS environments, particularly if the process adds time to the individual referring. The most likely solution would be the introduction of an electronic system like PharmOutcomes to create an almost "automatic" referral pathway.
- For those patient who were not "prompted" referrals by a GP, i.e. for Age UK referrals or those patients who were given to us in a list as they met criteria, it was particularly difficult to have our recommendations actioned by the GP's. We were given a list of ~30 patients to review by one GP practise and of those reviews we completed, the % of recommendations actioned upon were significantly lower than those where the GP had prompted us to review. These patients were also the most likely to refuse our service. The reasons behind both of these issues were most likely due in part to those patients not perceiving themselves as being in "crisis" and therefore not requiring urgent GP

appointments for review of specific issues. The follow up letter we sent therefore would only be viewed once a patient has been into the surgery for an “acute” issue, after our two week follow up timescale.

- We tried to engage with a specific surgery who has a very large volume of care homes in B&H, we offered help with review on registration for new patients etc. but the uptake was nil. This was rather disappointing.
- We also tried to engage with British Red Cross and their facilitated discharge programme from BSUH NHS Trust – this too did not garner any referrals which was disappointing as it is likely that patients would have encountered issues with medication on discharge.
- Not having an official office space was often difficult as we worked from my home. Whilst it was OK, it was not ideal and would have been nice to have an official base to separate work and home.

What issues did you come across

- The most frustrating issue we faced at the beginning was IT and Governance. There were some key issues regarding consent and data holding which were not anticipated prior to starting the project. There was a lot of time spent trying to understand how we could get patient’s consent to be involved in the pilot, particularly in those with some cognitive impairment. We had discussed requiring next of kin which was not possible. The issues were finally sorted when it was agreed that we would need to work under our substantive organisation’s governance structures using their IT.

What could be done differently

- For phase two, it is imperative that IT and governance is considered for the respective organisations prior to starting.
- An official office space will help improve efficiency particularly if there are more than two on the second phase. Working from individual bases will prove difficult as I feel the impromptu discussions regarding reviews/workflow and process are often the most valuable.
- Engaging community pharmacies from the outset, advising them of the pilot and ensuring they are aware of the work will be hugely important.
- Engaging GP practices to ensure that follow up letters are acknowledged and/or actioned.
- Promoting the pilot before the start date to ensure that referrals start once the pilot does.

<u>Project Pharmacy Technician</u>

What went well

- Fast, effective professional relationship developed between key staff quickly
- Template documents were designed to support accurate and complete records as we processed each patient referral- these worked well.
- Having pre-existing connections to RSCH and SCfT colleagues was a definite advantage - (established trust/relationships)
- Business cards were a positive addition to the project
- Where GPs recruited our services (prompted referral) the conversion of recommendations to actions was very high
- Exposure to peer-peer meetings was enlightening- a great pool of experience & knowledge to learn from

What didn’t go so well

- Where a patient review was conducted for a patient ’under the GP radar’ (un-prompted) the conversion rate from recommendation to action was very low.
- The ability to know whether the GP we made recommendations to had, NOT seen the letter of suggested action on their system, seen it and didn’t want to act on the recommendations, seen and intending to consider at next patient consultation- was very difficult to evaluate. This hindered the time frames of getting patient feedback, particularly when clinically appropriate decisions were agreed in principle with patients and yet no changes were implemented. On several occasions the patients couldn’t recall

our visit and what was discussed, or scored our intervention with a low mark as actually 'nothing had changed'
- This prompted the design of a further 'bullet point' style letter to the patient to include/remind them of the suggested actions recommended to their GP (Would require GP agreement to use this document)
- The hospital teams' referral rate was low- despite obvious connections & advertisement. The 'pick-up' of our service was disappointing.
- GP practice management 'buy in' at some surgeries was also disappointing- particularly in relation to practices that handle a large volume of care homes where we received no referrals for patients newly admitted, even though they had agreed extra support would be beneficial in this area.
- Having a designated work base would be desirable.
- Availability to council parking permit would have saved considerable expense.

What issues did you come across
- As above
- Incorrect Blister packs had been delivered to patients from their usual medicine suppliers who have not had timely updates relating to medication changes. On visiting, found stopped medication in new supplies of Blisters- then ensued the challenge to ascertain whether 'drug x' has been actively restarted by GP or whether it was indeed a timing, communication error?

What could be done differently
- Improve communications to community pharmacies when patients are discharged from Acute setting/Bedded units.
- GPs to acknowledge medication review on systems and record decision.

<u>Age UK lead</u>

Issues
- Crisis receives referrals from the council and from health services. Initially we were referring clients from both parts of our service to the polypharmacy pilot, and for the clients using CRRS hours this was replicating what the CRRS pharmacists could have (or were doing) This was quickly identified and we believe the outcome was positive as the two teams liaised with each other and worked out a solution to this. For our clients using BHCC hours and thus not under the CRRS umbrella we were able to create swift access to polypharmacy which they would not necessarily have had without the project.

<u>Brighton and Hove CCG lead</u>

What went well
- Integration with other pharmacists in the city, identification of gaps in service

What didn't go so well
- Volume of patients referred/reviewed- wish there had been more

<u>Geriatrician Lead</u>

What went well
- Project Pharmacistis so experienced that I am sure her reviews were helpful.

What issues did you come across
- Knowing that Project Pharmacistwas only to be in post for 6 months meant that people were unwilling to become dependent on her presence so I don't feel that enough referrals were made from the hospital perspective.

What could be done differently
- More forewarning about his service and more involvement of the hospital from an earlier stage may have helped this.

<u>East Sussex Local Pharmaceutical Committee lead</u>

What went well

- Communications between the Project Pharmacist or Technician and the patients' community pharmacy were established and implemented. This enabled the attainment of data to determine whether the community pharmacy had been contacted to follow up and whether the community pharmacy was aware that changes to the patient's medication had been made at discharge.

What issues did you come across

- The tendency to a number of patients to go back to the Project Pharmacist and Technician for follow up queries presented a capacity issue for managing these patients long term. However, at that point the service did highlight the existing lines of communication available between a patient and their community pharmacy or GP. Also, the ongoing support community pharmacists can and do provide regarding medicines.

What could be done differently

- At the start of the project, proactively ensure that community pharmacy is integrated into the patient care pathway across the primary and secondary care interface at both admission and discharge; by working to initiate the commissioning a secure integrated data transfer platform for the communication of admission, discharge and medicines optimisation information. This would need to be implemented at no cost to the community pharmacy sector.
- Include patient representation on the Project Board, who should be at the centre of everything that we do.

<u>BSMS lead</u>

What went well

- Identifying issue around referral numbers. We jointly considered how we could improve the awareness of this service and momentum gathered, the success of the project materialised and provided significant benefit for vulnerable patients.

What didn't go so well

- There was a slow start to getting referrals for the medicines review and we had anticipated a larger number of referrals from BSUH trust.

What could be done differently

- Perhaps a greater engagement with GP surgeries prior to the start of the project would have enabled the medicines review service to have run more seamlessly with the practices under which patients were registered.

Recommendations

<u>Strategic Pharmacist Lead</u>

- Definitely real time two-way transfer of information between Care settings - PharmOutcomes or similar but also shared access to patient records across the system would be really beneficial.
- Empower patients and make sure that face to face regular medication reviews and shared decision making is a reality.
- pharmacists in ED would be a great improvement to reviews and communications across the system

What issues did you come across

- There is an assumption that someone else is doing holistic patient centred medication reviews and often this is not the case. This is not a criticism of anyone in the healthcare system but the pilot highlights the need for this to be addressed and communicated widely.
- Community pharmacy - they are issuing and helping people with their medicines but often working in the dark. My understanding is that in the main they are keen to be more involved and have much to contribute.

Sustainability

- Need to consider pharmacist prescribing in the future as this would increase the implementation rate of recommendations - longer term aim that could not be achievable in pilot.
- Reducing waste medicines and avoiding medication related admission and readmissions to release funds for improved care and joined up inter-professional working – funds to support start up.
- There is a shared incentive across primary and secondary care to reduce the human and financial cost of things not going well with medicines - plenty of evidence of problematic Polypharmacy causing increased harm and admissions and this pilot has demonstrated benefits of working together to improve this.
- Lots of scope and opportunity to improve medication reviews and support. Grateful to AHSN for supporting the new peer to peer Pharmacy support network across KSS and look forward to this developing further and involving other HCPs
- Need hospital to be more involved in community care to help with preventing preventable admissions and ED attendances.

<u>GP Clinical Lead</u>

- To focus efforts on referrals from the community setting, and to incorporate community pharmacy as a referral mechanism
- To continue to create interest and momentum within the local community to challenge problematic polypharmacy – with the ambition for this to become a self-sustaining movement
- Work should be done to bring the different strands of Primary Care pharmacy under one roof, and integrate with community pharmacy
- Work on bringing strands of pharmacy activity under one roof and bringing together with community pharmacy

<u>Project Pharmacist</u>

- The introduction of PharmOutcomes at BSUH NHS Trust could and would provide hugely valuable information to community partners i.e. community pharmacies, GP surgeries etc. The possibility of automatically informing surgeries and pharmacies of admission and discharge would reduce waste, both time and money. It would also ensure that information is correct and up to date.
- Going one step further and ensuring that primary care pharmacists i.e. practice based pharmacists, iRx, CRRS and the Better Care pharmacists have access to the system would cut down the time spent seeking the most up to date information for patients prior to review.
- CRRS should have access to the BSUH discharge system and GP systems to reduce time spent collecting information, having GP surgeries fax information to them and allow for automatic inputting of information onto GP systems instead of needing a call to the GP.
- Age UK undoubtedly require support in the reviews they identify – this could be via the patients community pharmacy, the CRRS pharmacy team OR via the Better Care pharmacist team. Discussions need to talk place as to who is best placed to pick up these patients identified as requiring a review. Community pharmacists are capable of performing Medicines Use reviews but would require some training in how to report back findings and recommendations appropriately. At this stage, I am unaware if they will provide domiciliary visits which a large percentage of these patients require.
- BSUH NHS Trust need to engage with CRRS, Better Care Pharmacy and NHSE practice pharmacists to ensure there is fluid transition of care particularly for those requiring follow up. This should involve a round table discussions as to the parameters of the roles and how, when and why patients can and should be referred. It is recognised that each individual organisation is working to capacity; therefore it may require some thought as to

how measures can be taken to create a business case to show value in continuing care in order to prevent admissions and reduce readmissions.

- I did try to arrange a peer review of the RiO scoring tool with everyone who currently uses it in B&H, however, this proved incredibly difficult to arrange. I suggest the CRRS team, IRx team and Better Care Team, a GP representative and an acute physician meet to review cases scored with a monetary value i.e. 2 and above.
- Continuing support of the peer to peer support groups by KSS AHSN. These are invaluable in providing everyone with the holistic approach needed in elderly medicines reviews.

Project Pharmacy Technician

- PharmOutcomes would be a positive development; it would be advantages if rehabilitation units could be included in the commissioning of this, to add their information when a patient goes from Acute –rehab bed- care home/ home setting, as that section of care and potential medication changes can get missed.
- Knowledge of commissioning parameters for SCfT is needed for bedded units relating to involvement at discharge and improved transfer of information back out (not just to GP practice). This is an issue currently as we may only be at a unit one or two days each week and a strategy needs to be implemented where we can have increased involvement at discharge, even when not there.
- Service gaps highlighted for me during this phase of the project are Age UK and New Patients to care homes. At this time it is being discussed whether the Better Care Pharmacists are best positioned to plug this gap
- The hospital discharge teams to recruit support of NHS England pharmacists/pharmacy technicians (where they are connected to GPs) to handover the patients that require a level of 'follow-up' back in the community. E.g. Titrated dosing or adherence concerns

Age UK lead

- Our Crisis Service has been reassured with the polypharmacy involvement.
- All clients should automatically receive a medication review on discharge.

What issues did you come across

- Poor support within the wider health and social care system especially care agencies, where there is a large workforce of carers responsible for administering medications and trying to keep very vulnerable older people with complex needs safe and well in less than ideal conditions and with high turnover of staff

Sustainability

- Better access for carers to technical and clinical support around medications would create great savings in hospital avoidance and more job satisfaction for care workers

Brighton and Hove CCG lead

- Discharge to pharmacy
- Opportunities exist for other services to be linked or workforce groups to be supported e.g. care home med review pharmacy team, Better Care pharmacist, NHS England pharmacists, improved use of pharmacy technicians etc.

Geriatrician Lead

- From an elderly care perspective I feel this is an extremely valuable service. If it were set up in the long term with meetings with geriatricians and key nurses involved prior to the commencement of the service being set up I feel it would increase engagement from the hospital.

East Sussex Local Pharmaceutical Committee lead

- To enable efficient community pharmacy integration into the patient care pathway across the primary and secondary care interface at both admission and discharge, a fully integrated secure data transfer platform must be initiated.
- This would facilitate timely encrypted communication of information direct to the patient's community pharmacy pertaining to patient admission, discharge and medicines optimisation. Benefits would be improved patient safety and reduced medicines waste. I would recommend that the system of choice for community pharmacy would be PharmOutcomes.
- The accessible clinical expertise of community pharmacists combined with their local knowledge of patients in their community, offers opportunities for community pharmacies to provide the continuity of care essential to patient follow up after a one- off consultation in the patient's home. For this to happen, community pharmacists need to be fully supported with the access to discharge information, patient records and be fully integrated into the patient care pathway across the primary and secondary care interface.
- Community pharmacists are ideally placed to conduct follow up medicines optimisation reviews for vulnerable frail patients in their own homes. For this to happen a robust, appropriately funded commissioned service needs to be implemented to include support for community pharmacists to link outcomes into other workforce groups within the patient pathway.

BSMS lead

- Having a referral lead (possibly a pharmacy technician) in the hospital that can monitor discharges of vulnerable patients might be valuable to increase appropriate referrals to the service. The ED is a service gap, as is the acute medicine ward.
- There is an opportunity to link in community-based pharmacists, and this expertise should be harnessed in some way.

Added value

Strategic Pharmacist Lead

- The AHSN have offered the opportunity to support a system with established pharmacy teams and am personally very grateful to Brighton and Hove CCG for being willing to look at improving things even further by using additional resource to look for some of the gaps. This included looking at medicine related risks and causes for admission/readmissions.

GP Clinical Lead

- The project raised the profile of problematic polypharmacy in Brighton and Hove.
- The skill set and potential contribution that pharmacists can make in Primary Care was advertised.
- Pharmacists were connected to each other to support their patient focused prescribing, in learning groups.
- New models of MDT working were tested, working on pharmacy provision at scale.
- This project supported collaboration around polypharmacy by primary and secondary care, AHSN, academia and the voluntary sector

Project Pharmacist

- The biggest motivator for me throughout this project was the time spent with patients. We were fortunate that we were not time limited and had the opportunity to spend valued time with these patients and their relatives to really listen to their issues.

- The reaction I have received from both patients and their relatives was overwhelmingly positive and really it was the time spent listening which was valued. For the majority of the patients we visited, a ten minutes GP slot was just not adequate. We spent on average 60 minutes with patients to understand what their biggest issues were and how we might solve them.
- I have had several follow up calls from patient's relatives frustrated that they have not been able to follow up the issues discussed and several calls for entirely unrelated issues because we had given them the time in the first instance. In all cases we were able to put their mind at ease and follow up to ensure that there was some action. It leaves me with a degree of sadness that once this project ends they will once again not have someone to call when things are going wrong.
- In implementing this service, there have been a number of frustrating times in being disappointed in the lack of referrals to not being able to access systems and general governance woes. However, I must say that overall it has been a positive experience; we worked very hard to make it as successful as it could be in such a short timeframe. We were persistent in our approach, trying at every given opportunity to engage with and maintain relationships with our primary care, acute trust and GP colleagues.
- The AHSN have provided hugely valuable project management, comms and information governance support with this project. They have been there as advisories and sounding board for issues. Strategic Pharmacist Lead Butterfield has been hugely supportive of our work in B&H and has been instrumental in setting up this project.
- B&H CCG took a risk in allowing us to run this project in B&H and it was incredible to feed back our preliminary results and have such an open and honest discussion regarding these findings. The possibility of creating sustainable pathways of care as demonstrated by this pilot in the future is incredibly exciting and we must thank Brighton and Hove CCG lead Katy Jackson for not just taking a chance on allowing us to run this project but also for understanding the implications of our results.

<u>Project Pharmacy Technician</u>

- I believe the Red Cross Assisted Discharge support team would also benefit from medication support in the same way as Age UK. They seemed reluctant to 'buy in' for a short term project and decided to opt for the 'Patients to self-refer in': we had no referral from this route.
- 6months is a short time frame to demonstrate value and quality and earn the trust of stakeholders. Our involvement, whilst short, was largely received with positivity
- Improved GP systems to show clearer when medication is stopped- e.g. moved from current template to past meds.with action date.
- The patients we have visited and supported have given us a great sense of achievement and have valued very highly our contribution to their health and wellbeing outcomes, where we were able to influence a change.
- Improved comms with community pharmacists have been welcomed

<u>Age UK lead</u>

- There are still issues regarding medication problems following hospital discharge – e.g. we have recently been made aware of a person (not our client) who was issued with the wrong blister pack (another patients') and consequently became very unwell as a result of taking the wrong medication. This was eventually picked up by a district nurse who checked the name on the blister pack which the client could not read.
- This pilot demonstrates the essential value of a clinical 'support' system to agencies and organisations like ourselves who support at risk clients in Crisis who have not yet had a formal assessment. This early stage rapid response intervention is best supported by good links to clinical and technical support of the kind this pilot has provided.

Brighton and Hove CCG lead

- Useful as a commissioner to have a separate team come in and look at current service provision and identify any gaps and make recommendations for improvement
- Would be useful to see the interventions and data outcomes recorded in the same way as the other projects eg care home med review team and also the better care pharmacists

Geriatrician Lead

- It has been so helpful to read Project Pharmacist's reports and hear about how things work from the community pharmacy perspective.

East Sussex Local Pharmaceutical Committee lead

- The engagement with East Sussex LPC and involvement of community pharmacy was beneficial in identifying the gaps around communication and how this can be improved going forward. The funding model of the AHSN introduces many barriers for the full involvement of community pharmacy for the benefit of patients and society.

Key enablers

- Project pharmacist having established links with the acute trust
- Project technician having established links with a community provider
- Having a strategic pharmacist lead with good knowledge of current medication review services
- The inclusion of a skilled technician in the service
- Working with the AHSN – opened lines of communication and provided leadership
- Having a productive, open and honest group of people on the project board

Stakeholder and patient feedback

Patients' feedback:

"Who else would help us with this if not for you?"
"I feel confident when I have someone to call for advice"
"Very comforting going through and having a detailed consultation as Doctors just don't have the time"
"You're wonderful"
"You have taken a weight off my mind"
"It made me concentrate on my medicines and things that matter"
"You were so helpful last time, I knew you would be able to help and advice this time"
"You have been a rock though a very difficult time"
"Thank you for caring the way you have"

GP feedback:

"The best pharmacist review I have had – incredibly useful, Thank you"
"Thank you so much for your help. Could you possibly send me a brief description of what you do, contact details, etc. so that I can put it in our folder of Useful Info for GP's?"

Care Home manager feedback:

"The NHS brings out these wonderful pilots and then they disappear"

Age UK Brighton and Hove feedback:
When we were initially asked to take part in the polypharmacy pilot we were a bit anxious that it would be another task for us that would take up our time and not be very productive. How wrong we were!

The Pilot has been extremely beneficial to both our team and our clients. It has given us a support network to help us with the many 'grey areas' that present themselves when dealing with medication and the risks involved when supporting people with medicine when we are providing emergency care.

The project pharmacist and her team are very proactive and have been very quick to respond and to provide feedback when we have identified concerns and high risk medicine related situations. The team are easy to refer to and are practical and down to earth.

Not only have we relied on the pilot to assist with medication problems the project pharmacist has also participated in one of our Crisis meetings to provide training on administering eye drops. This has given some members of our team who were concerned about this new confidence in this area and they are no longer worried about providing this support to clients.

As a result of the help from the Polypharmacy team we have not had to contact G.P's as regularly and we are very confident that we have the support that is so often crucial to enable us to provide safe care to our clients.

Set up *(What needs to be considered when setting up similar projects)*

Project Pharmacist

- IT/IG will need to be figured out with the local acute trust and surrounding organisations – I believe that the CCG governance is sufficient so if they supplied laptops it will work. But be aware that having access to the discharge system, if electronic, is hugely important. I had access to the BSUH discharge system and it really helped to fill in the blanks!
- The team will be required to get set up with the GP practice systems. This took quite a long time for us and until such time you can't really do anything. The only way to view patient records is on the system or get a fax from the surgery…we didn't have a fax machine so would need them to print and collect (time consuming). We decided to email follow up letters as getting access to computers at GP surgeries was difficult and often we would ask and not get a response or be told we could access in two weeks' time, which is not ideal.

Project Pharmacy Technician

- It is essential for the project that IT systems are set up and support provided. We handle patient sensitive data as part of our professional roles and need to be able to use the project laptops to access systems. The early issues around 'Consent' impacted at the start. My SCfT laptop did not connect with the router device whilst working from Project Pharmacists home. I would need to visit each surgery to use my smartcard- which is time consuming and On occasion there are delays in getting the practices to allocate computer availability.
- I felt my limited exposure to GP systems did not equip me with the confidence to task the GPs with our suggestions.
- Perhaps if we had sanction to amend patient records and stop 'an agreed list' of medications similar to the iRx process - that may have supported conversion of some of our recommendations.

Appendix 1

Polypharmacy dashboard

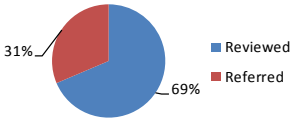
Living Well For Longer
Promoting independence and wellbeing for older people

Polypharmacy Dashboard*
August 2016 - February 2017

Kent Surrey Sussex Academic Health Science Network

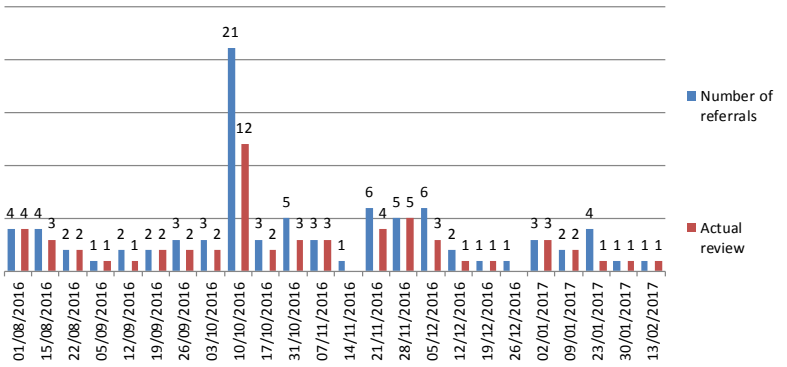
*to be reviewed with supporting narrative (tab 3)

Total number of people reviewed 59
Number of patients referred 86

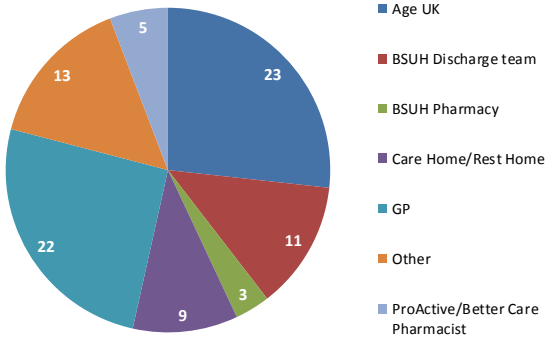


Patient refused 13

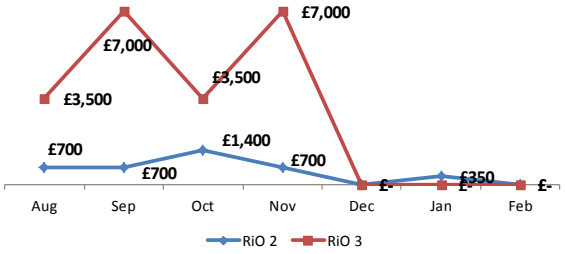
Total number of patients seen (w/c)



Referrer breakdown



Potentially prevented Hospital Admissions and associated savings

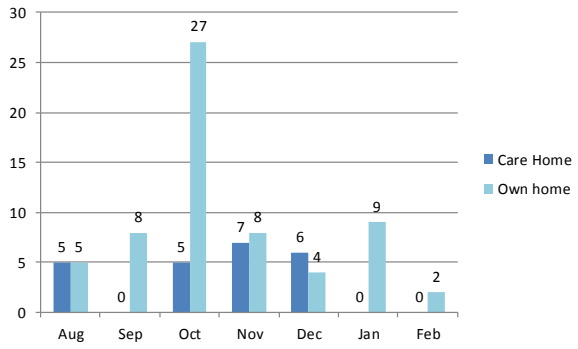


Total saving
£24,850

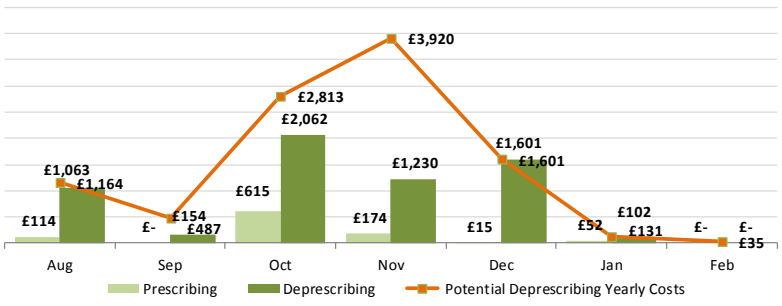
Total savings on potential hospital admission prevention
£421 **per review**

RiO 2=£350 RiO 3=£3500

Place of residence

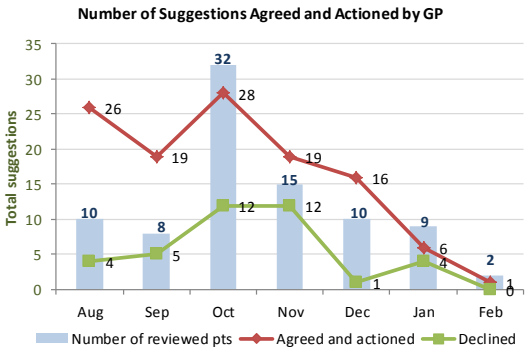


Sum of Prescribing, deprescribing and potential deprescribing



Potential deprescribing costs (orange line) (if all recommended drugs had been stopped)
£172.06 per review

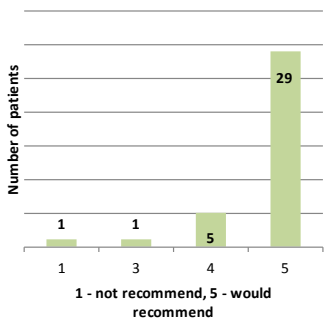
Actual changes made vs suggested medication changes to GP



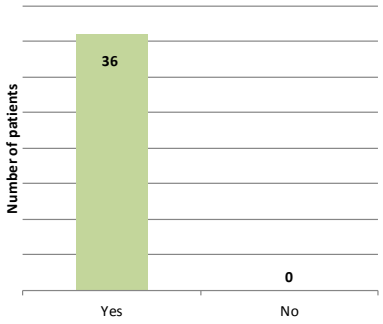
Average costs saved for each recommendation
(115 total recommendations, 38 declined)
£ 66.17

FEEDBACK

Was the review helpful? Answers scale 1-5



Would you recommend us?



SAVINGS

Total savings
£ 6,639.98

Waste removed

COST SAVINGS PER REVIEW	
Savings Includes actual savings made per review	£112.54
Potential savings Includes actual savings made per review PLUS the additional potential savings that could have been made if all recommendations were actioned (i.e. an additional £66.78 per review)	£172.06
Costs associated with potential hospital admissions avoided Using RiO scores (and taken the average to calculate figure per review)	£421.19
Total savings per review Actual savings per review PLUS costs associated with potential hospital admissions avoided	**£533.73**
Potential total savings per review Potential savings (actual savings PLUS additional potential savings) PLUS costs associated with potential hospital admissions avoided	**£593.25**
Waste identified Waste medicine removed from patients' homes (not included in total savings)	£21.77

Appendix 2

Polypharmacy dashboard supporting narrative

- **Referral numbers**: Out of a total of 86 patients referred, 59 had reviews carried out and 13 patients refused. There were an additional 14 people referred but were not seen due to a number of reasons including: patient seen by CRRS (Community Rapid Response) or iRx Pharmacy review service, patient admitted to hospital before review able to take place or the person was out of area.
- **Referrer breakdown – 'other'**: Those captured as 'other' include referrals made to the service by NHSE GP Practice pharmacists, IRx Pharmacy care home review service, CRRS and patients/carers making a direct referral for a polypharmacy review.
- **Place of residence**: 2 patients were referred from the BSUH discharge team with place of residence data missing.
- **Sum of Prescribing, deprescribing and potential deprescribing section – Prescribing**: This indicates a medication which has been started as a result of recommendations made during the polypharmacy review with the patient.
- **Sum of Prescribing, deprescribing and potential deprescribing section – Deprescribing**: This indicates a medication that the patient has been taking regularly or on an as required basis (PRN), which has been stopped as a result of the polypharmacy review.
- **Sum of Prescribing, deprescribing and potential deprescribing section – potential deprescribing**: This indicates medications that the patient has been taken regularly or on an as required basis (PRN), which was suggested to stop as a result of the polypharmacy review, but was not actioned by the GP.
- **Total savings**: Total savings have been added up with actual prescribing, Ddeprescribing and PRN medication changes following the pharmacist review.
- **Waste management**: This figure is calculated from the total cost of medicines that were removed from patients' home as they were no longer using them. Removal of waste medicines was accompanied by the recommendation to the GP to STOP the medicines and therefore avoiding future waste. These figures are not included in the overall savings.
- **Feedback section – missing data**: Only 36 out of a total of 59 patients are included in the feedback section. Data is incomplete in this section due to patients being unwilling or unable to provide responses. This may be due to a patient's physical or cognitive impairment post review, a result of recommendations not being actioned by the prescriber at the time of publishing this data or that the patient is now unable to be contacted via telephone.