Health Innovation Manchester

GM Medicines Optimisation Community of Practice

17 October 2023

11am-1pm

Welcome

Nela Roncevic Ashton

Senior Clinical Pharmacist - NIPPS Team, Salford

Health Innovation Manchester

Patient Voice

Russ Cowper

Patient Representative

Manchester University
NHS Foundation Trust

Transfer of Care

Leigh Lord, Head of Medicines Optimisation & Governance

17th October 2023

Manchester University
NHS Foundation Trust

Overview

- Implementation of HIVE
- Admission process
- Medicines reconciliation
- Discharge process
- Questions

HIVE implementation

Successes

- Target implementation date achieved
- All records transferred by target date
- “Cutover” achieved from a medicines perspective
- Immediate access to medical records and data
- Bar Code Scanning of Medicines (BCMA)

Challenges

- Prescribing, administration and pharmacy screens all different
- Unable to see each others screens
- Multiple ways to achieve tasks
- Changes to processes
- Terminology

MFT implemented (EPIC) HIVE on 8th September 2022

Solutions

- Production of Standard Operating Procedures (SOPs) to ensure consistency within pharmacy tea,
- Collaboration with other EPIC sites in supporting solutions
- Glossary of terminology
- Ongoing training
- Formation of time limited task and finish groups
- Pharmacy Pathway Council meets fortnightly to review issues identified – medical, nursing, pharmacy & HIVE representation

Celebrated one year since Go Live on 8th September 2023. Number of Medicines Optimisation projects to support ongoing improvement

Admissions

Successes

- Good skill mix to support medicines reconciliation (MR)
- Designated SOPs to support teams identify patients
- SOPs – level 1 and level 2 medicines reconciliation
- Access to SCR/GMCR

Challenges

- HIVE doesn't interface with Primary Care systems
- Additional time and workload for both secondary and primary care needed to check

Medicines Reconciliation

Solutions

- Update existing SOPs to incorporate HIVE
- Update medicines related policies and guidelines to incorporate HIVE
- Ongoing collaboration with GM IT to support interface – long term project
- Collaboration with Primary Care to support accurate medicines reconciliation

MR supported by SOPs and skill mix.
Ongoing work with GM and Primary Care.

Discharge

Successes

- Electronic version of discharge summary
- “After Visit Summary” (AVS) for patient – electronic
- Discharge SOP for Pharmacy team incorporating HIVE

Challenges

- Matching of discharge summary & AVS
- Complex process – prescribing, dispensing and printing AVS
- Complex process relating to supply check for patients own drugs (PODs), named patient supply and dispensed in pharmacy

Review of incidents – theme around discharge/transfer of care
Review of increased calls to MI querying discharge summaries

Solutions and progress

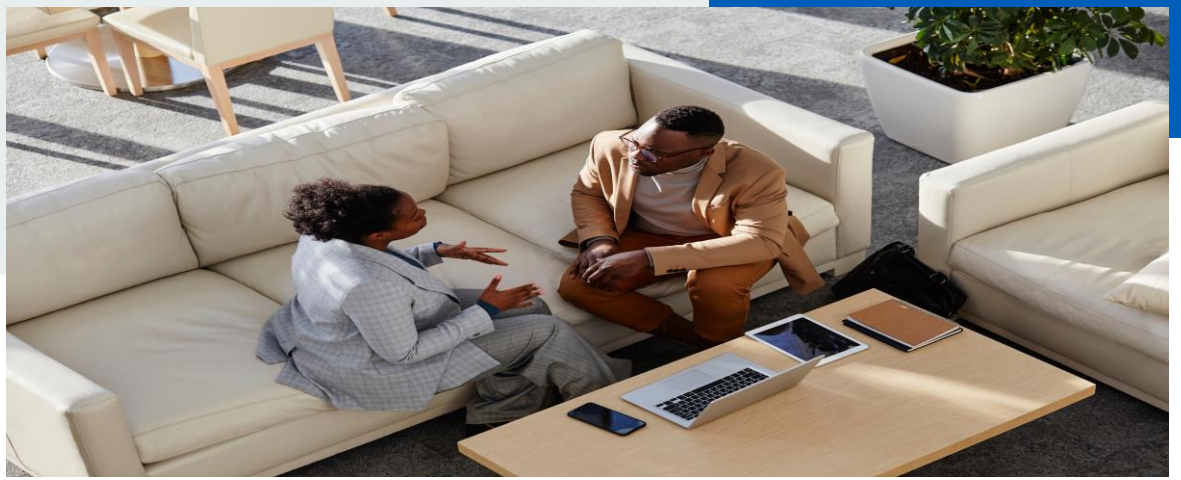
- Triage and report discharge related incidents through safety committee
- Ask to stand back up Discharge task and finish group, led by MFT clinician and membership from primary care
- Continued collaboration with Primary care to ensure support for patients, clinicians and pharmacy teams
- Internal triage and action of calls to Medicines Information (MI) to ensure answered in a timely manner and MI free to concentrate on MI and patient queries
- Review of monthly data from calls to MI – report to discharge task and finish group
- Commence training programme with Primary Care teams around discharge and medicines information

Triage and feedback of discharge related incidents to discharge task and finish group

Summary

- Transfer of care is complex and still causes problems
- Implementation of an electronic system has been positive but challenging to transfer of care, especially discharge
- Recognise the problems, escalate and work on short-, medium- and long-term solutions
- Collaboration with MFT and Primary Care colleagues has been pivotal to ensuring success of any solutions
- Continue to ensure improvement through Medicines Optimisation projects

Complex, but collaboration, openness and clear communication key to success



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Thank You

Transfer Of Care, MFT Pharmacy Team

Discharge to Assess Pathway 3 Primary Care Support

Manchester Integrated Care Partnership

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Jamie Higgins, Senior Medicines Optimisation Advisor, NHS GM (Manchester)

Context

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August 2020 the Government published the *Hospital Discharge Service: Policy and Operating Model* ("the Discharge 2 Assess Model") that replaced the COVID-19 Hospital Discharge Service Requirements in March 2020.

Sets out how health and care systems should support the safe and timely discharge of people who no longer need to stay in hospital.

Commissioning D2A beds became a national requirement.

Enable patients who are medically optimised but need a period of assessment to determine their long-term needs, to have these assessments outside of the hospital setting

Benefits include:

- Improving system flow
- Reduces LOS and NRTR
- Reduces risks associated with extended hospital stay eg deconditioning, delirium, HAI

D2A Beds- Manchester Locality

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- Initially commissioned on a ‘spot purchase’ basis only
- Spot-purchased issues:
- In any care home across the city, dependent upon the needs of the individual, regardless of CQC status.
- Large quantity- approximately 80 beds in use at any one time.
- Not in scope of an additional primary care support service (patients seen as part of EHCH).
- Manchester decided to ‘block book’ D2A beds to provide a more standardised service provided by the Local Care Organisation (MLCO) and Local Authority (MCC).
- Data concluded that the system required 80 blocked booked beds to meet the local demand and minimise the need for spot-purchased placements over time.

D2A Beds- Manchester Locality

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Manchester Citywide P3 Bed Establishment

Current Manchester Citywide P3 commissioned Beds

- 35 Nursing
- 27 Residential
- 0 Complex

62

Ideal Manchester Citywide P3 commissioned Beds

- 42 Nursing
- 32 Residential
- 6 Complex

80

Difference in Manchester Citywide P3 commissioned Beds (below establishment)

- 7 Nursing
- 5 Residential
- 6 Complex

18

Current Spot Purchased Beds (Citywide)
83

Current Establishment Detail

62

NORTH			
Home	Nursing	Resi	Complex
Avrill	12	2	0
Brookdale View	10	0	0
Total	**22**	**2**	**0**

CENTRAL			
Home	Nursing	Resi	Complex
The Dell	0	10	0
Abbottsford	0	15	0
Total	**0**	**25**	**0**

SOUTH			
Home	Nursing	Resi	Complex
Anson	6	0	0
Wellington	7	0	0
Total	**13**	**0**	**0**

‘Blocked-booked’ D2A Beds

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- Launched December 2020
- Series of issues identified:
- Poor communication to clinical teams upon admission to beds
- Lack of local offer- assumption local GP aligned to care home would take on care
- Further exacerbated where individual was placed at distance from usual registered GP
- High turnover- created additional pressures on primary care services
- Lack of medicines supply, clarity of DC Summaries or requests for follow up post-discharge (e.g., blood tests)
- Identified clear need for a bespoke clinical service to support residents.

Service Objectives

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- Deliver a service that provides a safe, responsive, and timely health provisions for patients placed in a ‘block-booked’ D2A care home bed.

- Work closely with the Enhanced Health in Care Homes (EHCH) service (if not delivered by the same provider), primary care, MLCO and wider services to deliver D2A additionality on top of the EHCH service to ensure full wrap around care in and out of hours.

- Safety net D2A discharges so that issues are identified and resolved early.

- Support the flow of patients through the healthcare system.

- Work with partners to improve patient outcomes.

Service Aims

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To provide a consistent and equitable clinical offer for all patients placed in a block booked bed:

- Clear and robust process for identifying, assessing and supporting new D2A admissions.
- Agreed process for registration of new patients to a GP practice within the care homes' PCN
- Access to local clinical systems (GP EMIS) for staff providing the service to enable clear record keeping.
- Improve referral and signposting to appropriate services and to coordinate care to ensure that patients have access to diagnostics and specialist services from the right person at the right time where required post discharge from hospital.
- Clear lines of communication/collaboration between stakeholders including D2A primary care, secondary care (MFT),care home providers, existing EHCH teams, commissioners, and the MLCO.
- Robust handover process on discharge out of the D2A bed to the clinical teams taking over care.
- To support care home management and staff

Primary Care Service Model

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ACP or GP lead service, Monday to Friday

In addition to EHCH service & routine primary care by aligned GP practice

- Mixture of service provider: GP practice and 3rd party provider (*gtd Healthcare ltd*)
- Full registration with aligned GP within 24 hours of admission
- Initial assessment/clinical review within 48 working hours
- Allocated time to follow up after initial assessment and answer ad-hoc queries
- Attendance at weekly patient flow MDT
- Pre discharge review and discharge summary
- Close collaboration with MLCO D2A Teams

Manchester Local Care Organisation (MLCO) D2A Assessment and Enhanced Support Teams

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D2A Assessment Team	D2A Beds Coordinator
	Occupational Therapist
	Physio
	Rehab asst
	Nurse
	Nurse
	Nurse
	Home finder
	Home finder
	Admin Support x 3
Enhanced Support in Care Homes	Process Support Manager
	Pharmacist
	Pharmacist
	Pharmacy Technicians x 2
	Data analyst

Medicines Optimisation Support

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ICB Manchester Locality MOT historically provided medicines reconciliation support. Now focus more on strategic leadership/commissioning.

Now operationally lead by MLCO Community Medicines Optimisation Service

- Weekly attendance to D2A home
- Medicines reconciliation
- Review resident medication
- Support medication queries from care home providers/clinical teams
- Attend the weekly flow MDTs

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Thank You

Fireside Chat

Hosted and facilitated by Wendy Stobbs

Head of Programmes, PSL Patient Safety Collaborative, HInM

Health Innovation Manchester

Have your say

and help shape future activity.

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Closing Comments

Nela Roncevic Ashton

Senior Clinical Pharmacist - NIPPS Team, Salford