IMPRESS
Improving and Integrating Respiratory Services

IMPRESS GUIDE TO INFORMATION ABOUT USE OF MEDICINES IN THE NHS

A SECTION OF THE IMPRESS GUIDE TO INFORMATION

This document is not about best practice prescribing or information about medicines for patients, but about the information available to help clinicians, commissioners and managers to know what is being prescribed by whom, for whom, at what cost, and at what benefit and how this compares to other geographic and disease areas. It draws together the information available across the primary, community and secondary care system. It focuses on respiratory care, but many of the lessons are of wider relevance to the management of long term conditions.

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Introduction

Medicines use forms a crucial element of respiratory care, represents significant expenditure and also reveals substantial variation. Its use also yields considerable amounts of data both to support clinical care, and to monitor health service use. Therefore IMPRESS has decided it warrants the provision of practical guidance. The use of such data is not without problems. For example there remain problems in sharing data between primary and secondary care clinicians that hinders safe and effective care. Secondly there are problems in data analysis. Surprisingly, prescribing data tend to be analysed and monitored separately from other health service activity. An important limitation about the data is that they are not patient-linked. Therefore, if a medicine is used for more than one diagnosis and changes are noticed, it is not possible, from the data, to say what has caused that change. Therefore activity that can be patient-linked is sometimes given priority by analysts, thereby downgrading prescribing data.

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There is a separate section on other information available to support needs assessment and performance management. Clearly there is also a further layer of analysis that examines the role of prescribing on other activity – for example, does increased prescribing for COPD or asthma lead to changes/reductions in admissions? This tends to require local analysis combining several datasets, but can be done. Some SHAs have commissioned services from universities. For example, Keele University School of Pharmacy supports the West Midlands Medicines Management Network providing prescribing services to all the PCTs and SHA in the West Midlands http://www.keele.ac.uk/schools/pharm/pctsla/files/COPD&Asthma(Apr08).pdf and http://www.keele.ac.uk/schools/pharm/pctsla/files/respiratory.pdf

Please note that IMPRESS uses real examples to illustrate what is possible. It makes no specific recommendations of systems.

Joint formulary – the starting point

IMPRESS is an advocate of integrated care across primary, community and secondary care. Therefore we would expect healthcare economies to have agreed, through the active participation of primary and secondary care prescribers and medicines management experts, a joint formulary for the management of asthma, COPD and tobacco dependence.

Ownership across the system

If a community of practice, or network exists locally, it should be central to decision-making and discussion on the formulary. Commissioners should specify that this jointly agreed formulary should also comply with NICE, National Patient Safety Agency and other safety alerts, and be used by all contracted service providers. The normal processes for changing the formulary are via drugs and therapeutic committees in acute trusts and the area prescribing committee across the healthcare community. These need to be working to the same agenda. This should be the standard to ensure good quality care, and to provide a benchmark for assessing clinical prescribing behaviour.

Include co-morbidities

IMPRESS argues that the formulary should extend to include the antibiotics formulary based on Health Protection Agency (HPA) guidelines for respiratory infections as well as asthma and

COPD. It should also be informed by a joint formulary for the major co-morbidities associated with asthma and COPD. This could include cardiovascular disease (heart failure in particular), osteoporosis, anxiety and depression. This would address a current problem where specialists in one disease may initiate outdated therapies for a co-morbidity.

Interface between primary and secondary care – shared

The most likely cause of risk of adverse events or poor quality care is the lack of coordination.[1] There is significant opportunity to improve this at the interface between primary and secondary care at discharge, and following a medication change. Primary care often experiences delays in receiving discharge information, which may then be inaccurate, and secondary care may not have received clear information about how long an admitted patient may have been on treatment or why some medication has been stopped or started. There is also the possibility here of the patient becoming confused about their medication requirements and either over- or under-using.

The 2009 Care Quality Commission report underscored this[2]:

"Sharing personal information effectively is a fundamental part of an integrated healthcare system. The most common concern we found was the need for hospitals to improve the quality and timeliness of information sent to a patient's GP when they are discharged from hospital. Most GPs who responded to a survey conducted by the NHS Alliance believed that this compromised the safety of patients."

Improved sharing of patient-level medicines information

Currently, in many places, there is a lot of waste and delay in the system. The patient is discharged; goes home; books an appointment to see the GP; takes along hand-written information – which may not include the rationale for the change, and leaves the GP to piece together what has happened and decide what to do next. In some cases a patient may attend A&E, be nebulised but not admitted, and A&E data is not adequately communicated to the GP. It is not purely a problem of secondary care to primary care transfer, there may also be under-communication between members of a primary care team about changes to medication.

Primary care perspective

IMPRESS argues that the most helpful solution for primary care would be to have real-time accurate and pharmacy-checked electronic medicines information available as the patient is discharged from hospital or leaves the clinic. This would include an accurate list of medication and information from the specialist team about why it has been changed or adapted.

Secondary care perspective

In high performing systems, primary care routinely supports secondary care by attaching current medication information to referral letters and this works as well out of hours as during usual GP hours. This is endorsed by IMPRESS. However, this is not yet the norm.

For both primary and secondary care, it is useful to have electronic access to formularies.

For emergency admissions, there are some innovative practices to support improved medicines information on admission. For example the Patient's Medicine Bag that also contributes to efficiency savings. Each bag makes an average saving of £6.78 by reducing medicine waste and staff time.[3]

[1] Dr John Ovretveit Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to health service providers. Sept 2009 For Health Foundation

[2] The right information, in the right place, at the right time A study of how health care organizations manage personal data Sept 09 http://www.cqc.org.uk/_db/_documents/Info_governance_FINAL_PDF.pdf

[3] http://www.institute.nhs.uk/resources/nhslive/3871/NHS%20LIVE%20Case%20Studies%20The%20Little%20bag.pdf

Integrated electronic records
A number of healthcare economies are testing ways to share electronic records of key data across primary and secondary care, such as the summary care record, and electronic transfer of discharge information and this should improve the situation. This should include medicines information.

Example
The IMPRESS Award winner for 2009 Guy's and St Thomas' & Kings Charities, Guy's and St Thomas' and Kings College NHS Foundation Trusts, and Lambeth & Southwark Primary Care Trusts set up a pathway project with a web-based patient database available across primary and secondary care that supports a 24/7 helpline service. This links with GPs, practice nurses, community matrons and the ambulance service to share key information about those patients registered on the system with more severe COPD.

Medicines reconciliation
NICE and the National Patient Safety Agency (NPSA) published medicine reconciliation on admission guidelines in Dec 2007[4] emphasising the patient safety issues. In addition, the National Prescribing Centre guidance[5] argues that the risks are not confined to admission and emphasises that checking and reconciliation of medicines should occur on discharge, or on transfer to another hospital as well as on admission to hospital. There is evidence that if patients are provided with information about their medicines on discharge then there are fewer risks associated with errors. This could be simply a copy of the discharge letter – as long as this contains full information. In some acute trusts a patient cannot be discharged without a discharge letter that includes current medicines. However, this is often variable by speciality and by hospital. What is needed is an agreed system across the healthcare community.

Mandatory standards from April 2010
In April 2008 the NHS (England) acute contract introduced a new national standard: acute hospitals must send a discharge summary to a patient's GP within 72 hours of the patient's discharge. In April 2010, this dropped to 24 hours. Failure puts hospitals in breach of their contract and they can be penalised financially. This should incorporate medicines reconciliation for all patients on admission, as guided by NICE and the NPSA alert. However, many places are still not meeting this target.

In addition primary care should have guidance in place for transfer of information on admission and prioritising for medication review certain patients post discharge eg COPD/asthma patients following admission or a change in medication.

See Appendix 1 for the NHS Somerset Guidance for the provision of patient information on elective or unplanned admission from primary care and Appendix 2 for NHS Somerset Guidance for the reconciliation of patient information on discharge from health services (March 2010).

Pharmacists' role
The NPC guidance provides a minimum dataset (see Appendix 3) and a mnemonic for medicines reconciliation: the 3 C's:

- **Collecting** (medication history and other relevant medicines information)
- **Checking** (that current drugs and doses are correct)
- **Communicating** (changes documented, dated and communicated).

Example of electronic approach: eDischarge
One example is the system across Cheshire, established by Central and East Cheshire PCT led by a shared information service across the county. This electronic transmission system

[4] "Technical patient safety solution for medicines reconciliation on admission of adults to hospital" http://guidance.nice.org.uk/PSG001
[5] Medicines reconciliation: a guide to implementation (Feb 2008) http://www.npci.org.uk/medicines_management/safety/reconcil/library/library_good_practice_guide1.php

enables any practice, including (and this is what differentiates it from a number of other systems) across PCT boundaries, to receive electronic discharge information, including medicines, within 24 hours from two acute trusts. GPs agreed a template of discharge information that must be completed by the acute trust medical staff. All 54 practices in Central and East Cheshire have Electronic Document Transfer (EDT) that draws down any letters from a web repository. The information team monitor this process. There are a number of sign-offs that need to be completed before a patient can be discharged to ensure full information, including medicines checked by pharmacists, is available to the practices. The next stage of development is for a ward-based pharmacy checking service and to expand to include all clinical correspondence (out patient letters, A&E letters etc) using digital dictation. The biggest challenge is engaging senior clinicians in the discharge process. It could be perceived that most of the benefits are gained by primary care, therefore the engagement task is to demonstrate how secondary care benefits. This is most tangible for specialties that care for patients with long term conditions where ongoing integrated care matters most. Contact: Debi.Lees@cheshireict.nhs.uk Website: www.cheshireict.nhs.uk and Dispensary Manager Karen.burton@echeshire.tr.nwest.nhs.co.uk

Example of a polysystem approach: Outer North East London

This polysystem, an approach in London to integrate primary, secondary and social care, has developed a CHD pathway from discharge to Day 14. The acute hospital faxes discharge summaries to practices within 24 hours of discharge and GP practices are required to contact the patient within 3 days of discharge. Patients have a face to face appointment within 10 days at which time the clinician will use a standardised checklist to review patients. Clinicians have access to data on the patient's treatment, diagnostic results and medication changes via email. After the first two months of operation they were meeting the standard 50% of the time.[6]

Incentives

Medicine management teams in primary care may have incentive schemes to help GPs to follow guidance. The teams are therefore able to monitor prescribing patterns. The PCT prescribing team is the main contact.

The Care Quality Commission recommends that PCTs performance manage and introduce fines for trusts failing to meet their discharge information times and quality. NHS Plymouth has done this.

CQUINs are another opportunity to stretch performance further, but should not be used to repeat standards set in the Operating Framework and standard NHS contracts.

The Outer North East London Polysystem delegates authority to the local primary and secondary care clinicians to design and deliver care pathways and increases the amount of autonomy they have as their performance improves.

" Big dots[7]" - scope for significant improvement

Big dots are important measures that reflect the quality of care delivered and which, collectively, provide an answer to the question, "How good are we?" as a system. So, what are the big dots in medicines management, which would show how well the system was doing at reducing adverse events or increasing efficiency?

Your Medicines Management team can advise on audits and reviews. There are some medicines like oxygen, which needs review in most places. Prescribing variation is also well-known to Medicines Management teams who can produce graphical presentations.

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6 http://www.nuffieldtrust.org.uk/uploadedFiles/Events/Summit2010_Session3_Reform_Lab_Concurrent1_Conor_Burke_Lucy_Moore.pdf

7 Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition).* Cambridge, Massachusetts: Institute for Healthcare Improvement; 2008. (Available on www.ihi.org)

Prescribing trends might be an important "balancing measure" when reviewing the impact of the implementation of new services for COPD.

Oxygen

One area of weakness in many healthcare economies is the prescription of oxygen (in all formats). In many economies there is scope to improve the safety and efficacy. The wrong prescription for oxygen therapy affects patient independence, and the inappropriate use of oxygen for breathlessness rather than hypoxia creates significant safety and waste problems. The whole health system needs to better understand this problem and take responsibility for improving it. There are significant costs incurred for emergency oxygen and many PCTs are charged for patients who have died. Therefore a review system is necessary, and a standard process to ensure the supplier is informed if oxygen is no longer required. The palliative care register is another place to check if information is correctly recorded.

IMPRESS has produced a separate guide to commissioning oxygen services and for more information on how this can contribute to the QIPP agenda, please see our More for Less paper June 2010.

Topics for audit

The amount of variation varies by primary care organisation (PCO). Therefore these should be discussed locally with your medicines management adviser and your formulary committees.

a. There is well-recognised widespread duplication and wastage of inhalers. Patients often have multiple versions of inhalers at home, either in duplicate or more often with variations in dose of inhaled corticosteroid, or different devices. This is the result of repeat and new prescriptions (either planned or inadvertently changed), including prescriptions on admission to hospital (rather than a system where the patient brings in and uses what they are already prescribed and using). Patients and clinicians are generally not aware of the cost of many inhalers and many prescribers do not know how to choose the most clinically and cost-effective prescription from the wide, and at times confusing, range of products available. In the absence of integrated IT systems, IMPRESS would like to see active electronic systems for medicines reconciliation at both admission and discharge (see above). There are also many GP data extraction tools that enable cost-effective arms-length audit to help improve prescribing.

b. There is overuse of high dose inhaled corticosteroids and/or combination products which provides potential to reduce costs and quality.

c. There is an association (in COPD) between the use of high dose inhaled steroids and incidence of pneumonia that can be monitored locally.

d. There are quality concerns if asthma patients are prescribed long acting beta agonists with no inhaled corticosteroid.

e. There is a need to review asthma patients requesting excess short acting beta agonists with no other treatments.

f. Scottish Intercollegiate Guidelines Network (SIGN)[8] recommends audit of the percentage of patients with potential adverse effects of treatment, for example, the percentage of children prescribed or using >800 micrograms/day of inhaled beclametasone who are not under the care of a specialist respiratory physician and also the percentage of patients using >800 micrograms/day of inhaled beclametasone without documented consideration of add-on therapy.

g. There is no evidence to support the use of enteric coated (EC) over uncoated

[8] British Thoracic Society and Scottish Intercollegiate Guidelines Network. British Guideline on the Management of Asthma. May 2008 revised June 2009

prednisolone tablets for patients with COPD or asthma[9]. For COPD/asthma the clinical risk is that EC prednisolone does not give as rapid a steroid dose as soluble or plain oral prednisolone and in some patients EC potentially gives a sub therapeutic dose. So COPD/asthma patients should never be prescribed EC prednisolone tablets on clinical grounds. In addition there was a six-fold price difference on Drug Tariff Jan 2010. In Somerset, (population 500,000) in 2009 primary care prescribed 38,000 items of 5mg EC prednisolone alone. If it had prescribed plain tablets to 50% of these patients they could have freed up more than £130,000.

Smoking cessation

On average, each smoker who manages to stay off tobacco for the rest of their life gains 3.6 life years. Smoking cessation is the single most cost-effective lifesaving intervention provided by the NHS. Half of all quit attempts are 'assisted quits' – they are made by people with support from NHS Stop Smoking Services or primary care, or using over-the-counter medication. However, this means that the other half are 'unassisted (cold turkey) quits', which have the lowest chance of success[10]. The average unit cost of the stop smoking service is estimated at £192 per individual.[11]

ASH calculates that smoking causes £1 billion in hospital admissions annually[12] of which COPD contributed £190 million, lung cancer £120 million and other respiratory diseases £90 million. One third of patients admitted to hospital with COPD in 2008 still smoke so there are major opportunities to offer coordinated smoking cessation.

Incentivising referral for smoking cessation

Not all hospitals prescribe NRT to patients except in specialist units eg ITU. However, all hospitals should have in place systems to ensure smokers are referred, with their consent, to smoking cessation services.

For example, Leicester PCT has set its acute trusts a CQIN for 2010/11 asking for 60% of all smokers admitted to the hospital to be referred (and consent to be referred) for smoking cessation.

There is much work to be done as the British Thoracic Society (BTS) has figures that suggest only 11% of smokers admitted to hospital (all causes) were referred to smoking cessation experts in 2009. BTS surveys conducted by its Tobacco Committee in 2005 and again in 2007, demonstrated that at best just over a half of hospitals had access to a stop smoking counsellor[13].

Co-morbidities

There is much opportunity to improve the care of people with comorbidities, including those with respiratory problems. The link between COPD and heart failure is important and requires correct diagnosis and treatment. There is a Quality and Productivity Challenge working group working on this, and so we will not tackle it here, other than to repeat the point that shared formulary should include treatments for common comorbidities.

Looking ahead

There is the potential to use information technology to review all medication virtually for both asthma and COPD.

Example of review service

Optimum Patient Care Limited provides a clinical review service in primary care for COPD and asthma that helps identify patients most at risk of an exacerbation through software interrogation of GP routinely recorded information and patient-completed questionnaire data. It

[9] http://www.nelm.nhs.uk/en/Download/?file=MDs1MTY3MDA7L3VwbG9hZC9RQSBQcmVkIEVDIGZpbmFsLkRPQw__.DOC

[10] http://www.impressresp.com/ServiceDelivery/SmokingCessation.aspx

[11] Consultation on a Strategy for Services for COPD in England: Consultation Impact Assessment February 2010. DH.

[12] www.ash.org.uk/beyondsmokingkills accessed 19 May 2010

[13] 3. Buttery R. 2008 British Thoracic Society Winter Meeting London.

also enables active patient involvement in disease management with the aid of websites Asthmatrak and COPDtrak that offer patients self-assessment questionnaires and feedback.

Example of decision support for prescribers
ScriptSwitch prescribing decision support tool is embedded within all of the major GP clinical systems and can be used to guide prescribers, and to analyse prescribing patterns. http://www.scriptswitch.com/ It is used in some SHAs.

Issues to consider

Involvement of industry
There will be a guide from the DH England to working in partnership with the pharmaceutical industry. It is broadly supportive of closer partnerships. However, one area with obvious potential conflicts is medicines management. We would advise that the involvement be restricted to

1. Providing the evidence to formulary committees but staying outside the decision-making process
2. Monitoring prescribing: pharmaceutical companies use commercially available data on prescribing bought from IMS. Their data and knowledge is therefore of interest to the NHS. A number of pharmaceutical companies include prescribing as one of the data sources in analysis of performance at PCO level – eg prescribing by drug compared to NICE by practice. This is detailed in our Guide to Information, available from end July 2010 on http://www.impressresp.com.

What information is available and from where

For commissioners and primary care

1. Information about the process of agreeing, monitoring and reviewing a joint formulary across the respiratory network including prescribing and ordering of oxygen can be requested from the Medicines Management lead in the primary care organisation (PCO). This can include cost-effectiveness analyses.
2. Commissioners should be able to ask and receive confirmation that electronic templates/ordering systems exist that default to the formulary and offer guideline-based advice. Commissioners need to check that electronic prescribing is available in local acute trusts. It should be standard on GP clinical systems.
3. The Information Centre publishes prescribing data from primary care, prescriptions dispensed in the community and hospital prescribing derived from IMS Health analysis: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions. This looks at the total spend on NICE approved drugs and compares with the previous year. Hospital prescribing data is available from the pharmacy team.
4. The PCO medicines management department can provide routine data in a number of graphical formats. See Appendix 4 for some national examples from NHS Prescriptions Service on cost and use. Standards can be agreed locally on frequency of reporting and the time-lag between prescribing and reporting.
5. Medicines management departments can also support respiratory networks to understand the root cause of variation, using other statistical analysis. This can be supported by work from the Public Health Observatories.
6. “Red flag” analysis can be useful to flag use of medicines that have a high risk profile. See Appendix 5.
7. See the note above about analyses from pharmaceutical companies.

For Community services (eg community nursing, physiotherapy, access to psychological therapies, stop smoking)

Nurses in the community have their own coloured prescriptions so that they can be audited and monitored and use codes to identify which practice budget they are accessing. However, as a paper based system it is hard to integrate them into other audit systems. It is also important

that nurse prescribing is considered as part of the health economy's approach to medicines management, and is guided by the same joint formulary we advocate at the beginning of this paper.

Secondary care

The Pharmacy department can provide monthly analyses on any dispensed medication. Therefore they can provide information on key indicators such as top ten prescribed items, and trends in prescribing. These should be reviewed by respiratory teams supported by ward pharmacists.

Regular audits can provide insights into adherence to protocols and guidelines such as:

- Adherence to antimicrobial guidelines
- Error reporting and near misses

Service line reporting (clinical budget-holding in secondary care)
This remains undeveloped in many trusts. The budget for prescribing should rest within that service line (eg respiratory) and so should the financial savings for better prescribing. However, in reality, this is often taken out of the budget and managed separately as it is such a large budget and seen as offering significant potential for cost reduction by the trust. It is also sometimes double-counted within budget lines so this remains a very underdeveloped area.

We recommend that in the absence of service line reporting, respiratory teams analyse their top ten prescribed items, action to improve, and the outcomes. IMPRESS will be producing a guide to service line reporting in the autumn 2010. View the website for more information: http://www.impressresp.com

Conclusion
There is considerable scope to improve the coordination of care for people with long term conditions, including COPD if medicines management is integrated across the healthcare economy and real-time accurate information is available to patients and to prescribers. Information about medicines management activity is readily available, and provides some of the most comprehensive data in terms of cost and quantity although it cannot easily be patient-linked More could be done to use this systematically to review provider performance.

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The following pages contain useful links, and real-life examples.

Useful links

Information Centre prescribing data http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions

NHS Prescription Services, previously known as the Prescription Pricing Authority, calculates the remuneration and reimbursement due to dispensing contractors across England. They also provide the NHS with a range of drug, financial and prescribing information including reports on prescribing for asthma and COPD. The latest report is Prescribing Review May 2010 for the period Jan-Mar 2010 in England. http://www.nhsbsa.nhs.uk/Documents/Jan_-_Mar_10_Asthma_and_COPD.pdf

It published a companion document – the latest edition of the PCO discussion document "May 2010 Asthma and COPD - Prescribing guidance and discussion points too. http://www.nhsbsa.nhs.uk/3106.aspx

National Prescribing Centre: http://www.npc.co.uk/ supports the NHS, and those working for it, to improve quality, safety and value for money, in the use of medicines for the benefit of patients and the public. Its COPD Merec bulletin is still referred to by prescribing teams. In the main it still reflects the NICE COPD guidance of 2004 but may need to be updated in line with forthcoming changes to NICE guidance http://www.npc.co.uk/ebt/merec/resp/copd/resources/merec_briefing_no33.pdf

The National Prescribing Centre National electronic Library for Medicines – also has bulletins called On the Horizon - Future Medicine and On the Horizon - Post Launch Update which are produced in conjunction with Wessex Drug and Medicines Information Centre.

www.medicines.org.uk is where the SPC for all products are found.

UK Medicines Information website (UKMI) http://www.ukmi.nhs.uk/ is an NHS pharmacy based service. This is a very popular and useful site for medicine information. It is provided by a network of pharmacy departments. Find your local medicines information centre here: http://www.ukmi.nhs.uk/ukmi/directory/default.asp

UKMI also produces THINKING AHEAD which is a resource document for specific health events and seasonal conditions that may have a public health impact. This edition is for No Smoking Day March 10th 2010:

The **Pharmaceutical Services Negotiating Committee** PSNC http://www.psnc.org.uk/ represents community pharmacy on NHS matters and is a good source of examples of community pharmacy projects.

Community Pharmacy Wales (CPW) http://www.lpc-online.org.uk/community_pharmacy_wales/

National Institute for Clinical Excellence www.nice.org.uk

NHS Evidence www.library.nhs.uk

Medicines and Healthcare products Regulatory Agency www.mhra.gov.uk

National Patient Safety Agency www.npsa.nhs.uk

NHS SOMERSET GUIDANCE FOR THE PROVISION OF PATIENT INFORMATION ON ELECTIVE OR UNPLANNED ADMISSION FROM PRIMARY CARE

Version No. 4. Final

Sponsor:	**David Slack, Director of Primary Care Development**
Approved by:	**Professional Executive Committee**
Date:	**March 2010**
To be reviewed by:	**March 2012**

STANDARD OPERATING PROCEDURES FOR THE PROVISION OF PATIENT INFORMATION ON ELECTIVE OR UNPLANNED ADMISSION FROM PRIMARY CARE

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3.0	5 March 2010	Following comments received from the admissions/discharge meeting held on 11 Feb 2010
4.0	29 March 2010	Minor amendment following PEC approval

Author:	Shaun Green, Associate Director, Head of Medicines Management
Policy Group :	Admissions and Discharge Working Group
Document Reference:	

Confirmation of Equality Impact Assessment for Primary Care Trust documents / Policies / Strategies and Service Reviews

Main aim of the document:

To promote the safety of patients through the safe transfer of all appropriate information from primary care on admission at all times, acting within the legal frameworks :-

Outcome of the Equality Impact Assessment Process:

This guidance applies equally to all patients irrespective of age / race and gender. No issues were identified in the Equality Impact Assessment.

Actions taken and planned as a result of the equality impact assessment, with details of action plan with timescales / review dates as applicable:

None

Groups / individuals consulted with as part of the impact assessment:

Somerset Prescribing Forum Medicines Management Group Patient Safety Directorate Clinicians – LMC – Wyvern –acute trusts Community and secondary care pharmacists

NHS SOMERSET GUIDANCE FOR THE PROVISION OF PATIENT INFORMATION ON ELECTIVE OR UNPLANNED ADMISSION FROM PRIMARY CARE

1 POLICY STATEMENT

1.1 All relevant information held by a GP Practice about a patient being admitted to a clinical facility should be transferred in a secure and timely manner to the admitting unit in order to facilitate the safe and effective treatment of the patient.

1.2 Where a GP Practice is contacted by the admitting unit because there is missing information or clarification of the information supplied the practice should endeavour to supply the missing information as promptly as possible.

2 STANDARDS

2.1 The information held by a GP practice should comply with agreed record keeping standards as set out in Records Management: NHS Code of Practice.

2.2 Responsibility for maintaining and updating these records is a professional duty for the patient's GP and a contractual responsibility for the patient's practice.

2.3 The practice should have a regular process in place for checking the accuracy of information on the patient's record and for example removing medication no longer required from the patient's repeat record.

2.4 The accuracy of information to be supplied on admission should also be checked if the patient is undergoing a pre operative check.

2.5 Transfer of patient information on elective or unplanned admission from primary care should comply with Records Management: NHS Code of Practice and any other relevant guidance.

2.6 The information should be obtained and transferred in the most efficient way available to the practice at the time and dependent upon whether the referral is elective or non elective, which may include via facsimile, letter or secure email.

2.7 Subject to the qualifying criteria in place (currently excluding paediatrics) non elective referrals should be made via Somerset Primary Link.

2.8 A standard practice admissions template (dependent on the GP practice IT system) which automatically extracts the core data set of information required to facilitate safe patient transfer on admission, should be in operation.

2.9 Standard practice admissions template should be enabled to collect:

- Current active problems
- Past significant problems
- Significant active problems

2.10 Doctors within a GP practice should, if not defined by the GP practice IT system, agree which data set of patient information is allocated to:

- Current Active problems
- Past significant problems
- Significant active problems

2.11 The standard practice admissions template should also allow the facility for the referrer to free type any additional information deemed appropriate.

2.12 Patients preparing for a planned admission should be reminded to take one pack of current medication with them on admission to a clinical unit.

2.13 The minimum data set of information to be supplied should contain if applicable:

- Patient details (including NHS number)
- Presenting complaint
- Medical History (active and significant past)
- Allergies
- Current medication (repeat and acute)
- Red drug medication (Prescribed by Specialist)
- Any existing Care Plan

3 OBJECTIVES

3.1 To ensure consistency across the Somerset healthcare community and compliance with CQC requirements on the information to be provided on admission.

3.2 To reduce the risks to patient safety when a patient has an elective or unplanned admission from primary care, by ensuring the safe, secure and timely transmission of all relevant information.

3.3 To provide clear guidance to all NHS Somerset GP practices on the minimum information to be supplied.

3.4 To improve the history taking processes occurring on admission thereby facilitating speedier and safer admission.

3.5 To improve the medicines reconciliation processes occurring on admission thereby facilitating speedier and safer admission and reducing the need to contact the GP practice for clarification.

3.6 Preventing inappropriate admissions by increasing the earlier identification of patient history or medicines reconciliation issues relating to the presenting complaint or reason for referral.

3.7 To improve quality and consistency of information provided by primary care on admission thereby reducing the need for practices and GP being contacted at a later time for further information.

3.8 Improving the quality and consistency of information provided by NHS Somerset GP practices thereby increasing the speed and safety of any future transfer or discharge.

4 RESPONSIBILITIES

4.1 NHS Somerset has responsibility for agreeing this guidance with representatives of the Somerset Health Care Community and disseminating this guidance to general practitioners.

4.2 Individual NHS Somerset GP practices are responsible for any decision to adopt this guidance for the provision of patient information on elective or unplanned admission from primary care.

4.3 NHS Somerset is responsible for facilitating the widespread adoption of this guidance for the provision of patient information on elective or unplanned admission from primary care.

4.4 GP practices which do not adopt this guidance for the provision of patient information on elective or unplanned admission from primary care are still responsible for ensuring the safety and quality of the provision of patient information on elective or unplanned admission from primary care.

4.5 NHS Somerset and GP Practices have shared responsibility to continue working to improve the provision of patient information on elective or emergency admission from primary care.

4.6 NHS Somerset has responsibility for recording, investigating and sharing learning from any incidents which arise relating to the provision of patient information on elective or unplanned admission from primary care.

4.7 NHS Somerset has responsibility for developing mechanisms with admitting units to assess the quality and timeliness of the provision of patient information on elective or unplanned admission from primary care.

5 PROCESS

5.1 NHS Somerset will ask GP Practices to adopt this guidance and provide confirmation that the guidance has been implemented.

5.2 It is recommended that whenever possible and clinically appropriate Somerset Primary Link are used as the portal for unplanned admissions in Somerset.

5.3 The electronic, facsimile or written transfer of information which complies with the Records Management: NHS Code of Practice is all acceptable and the most appropriate method agreed with Somerset Primary Care should be used.

5.4 NHS Somerset encourages the use of agreed standard electronic, facsimile or written templates for the provision of patient information on elective or unplanned admission from primary care.

5.5 Where standard templates are not used, every attempt should be made by the general practitioner to ensure the minimum information requirements for elective or unplanned admission from primary care listed above are supplied.

6 SAFETY

6.1 Nothing in this guidance should jeopardise patient safety. In exceptional circumstances it is acceptable not to provide patient information on elective or unplanned admission from primary care where to do so would jeopardise patient safety.

7 AUDIT & RECONCILIATION

7.1 NHS Somerset should seek to assess and audit the provision of patient information on elective or unplanned admission from primary care and seek continuing improvement.

7.2 It is expected that GP practices will wish to self audit their compliance with the guidance.

7.3 It is expected that Somerset Primary Link and acute trusts will provide feedback on compliance with the guidance.

Appendix 1 Suggested Template Contents

The patient's name The patient's address The patient's phone number The patient's NHS Number The patient's Gender The patient's Date of Birth The Patient's GP The patient's GP Practice address The patient's past medical history The patient's known allergies The patient's biological values List of recent medication on repeat and acute use List of any specialist medication (Red Drugs) prescribed by clinicians other than the GP eg clozapine / transplant drugs Presenting complaint / reason for referral Relevant recent consultations Known previous side effects to medication Smoking status BMI	**Suggested Template Contents of the Current Active Patient Summary**
The patient's past significant Issues (Eg surgical / mental health history) Co-existing relevant risk factors (alcohol use/ drug use) The patient's HIV status The patient's HEP B or C status The patient's MRSA and C Diff status	**Suggested Template Contents of Past Significant health status fields of Patient Summary**

The patient's next of Kin (preferred contact) Any clinically important issues from the patient's Pre–op check Details of the Patient's Care Plan The patient's relevant social history The patient's relevant family history The patient's concerns, expectations and wishes The patient's advanced decisions / directions (living will) Known medication compliance or concordance issues Whether the patient has been informed to take all current medication with them on admission Clarification of indication for each medicine if considered clinically important (eg where medicine has multiple indications for use) List of medication/supplements the patient is known to self medicate (if available)	**Suggested Template Contents of Significant Active field of Patient Summary** **These aspects may need to be free-typed**

Appendix 2

NHS Somerset

NHS SOMERSET GUIDANCE FOR THE RECONCILIATION OF PATIENT INFORMATION ON DISCHARGE FROM HEALTH SERVICES

Version No. 2. Final

Sponsor:	**David Slack, Director of Primary Care Development**
Approved by:	**Professional Executive Committee**
Date:	**March 2010**
To be reviewed by:	**March 2012**

NHS SOMERSET GUIDANCE
FOR THE RECONCILIATION OF PATIENT INFORMATION ON DISCHARGE FROM ANY NON PRIMARY CARE SERVICE

Document Status:	Final.
Version:	2.0

DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1.0	18 September 2009	First draft for comments
2.0	March 2010	Following comments received from the admissions/discharge meeting held on 11 February 2010

Author:	Shaun Green, Associate Director, Head of Medicines Management
Policy Group :	Admissions and Discharge Working Group
Document Reference:	

Confirmation of Equality Impact assessment for Primary Care Trust documents / policies / strategies and service reviews

Main aim of the document:

To promote the safety of patients through the safe transfer of all appropriate information on discharge from secondary to primary care at all times, acting within the legal frameworks :-

Outcome of the Equality Impact Assessment Process:

This guidance applies equally to all patients irrespective of age / race and gender. No issues were identified in the Equality Impact Assessment

Actions taken and planned as a result of the equality impact assessment, with details of action plan with timescales / review dates as applicable:

None

Groups / individuals consulted with as part of the impact assessment:

Somerset Prescribing Forum Medicines Management Group Patient Safety Directorate Clinicians – LMC – Wyvern –acute trusts Community and secondary care pharmacists

2 POLICY STATEMENT

1.1 All relevant information received as a result of the discharge of a patient is dealt with in a secure and timely manner and that the detail of the information is reviewed, recorded and actioned appropriately to ensure that the patient's primary care medical record is up to date.

3 STANDARDS

2.1 The information held by GP practices should comply with agreed record keeping standards as set out in Records Management: NHS Code of Practice.

2.2 Responsibility for maintaining and updating medical records is the professional responsibility of the patient's GP and a contractual responsibility for the general practice.

2.3 Transfer of patient information on discharge should comply with Records Management: NHS Code of Practice and any other relevant guidance such as those from CQC and NPSA.

2.4 Transfer of patient information on discharge should comply with the contractual obligations covering timeliness and quality of the provider organisation discharging the patient.

2.5 A copy of discharge information should also be given to the patient on discharge by the responsible healthcare provider.

2.6 The information should be directed to a single contact point at the patient's general practice in order that it can be reviewed, actioned and disseminated in the most timely and appropriate way by the receiving general practice.

2.7 Dissemination of discharge information should take place using the format (written, electronic or facsimile) agreed with individual practices or across the healthcare community.

3 OBJECTIVES

3.1 To reduce the risks to patient safety when a patient is discharged from health services, by ensuring the safe, secure and timely management of all relevant discharge information received by the general practice.

3.2 To provide clear guidance to all NHS Somerset GP practices on best practice for safe management of patient discharge information.

3.3 To provide clear guidance for the medication review processes on discharge thereby facilitating timely, safer update of primary care medical records and improved patient concordance.

3.4 To improve the medicines reconciliation on discharge thereby ensuring continuity of care and safe prescribing and taking of medicines.

3.5 To prevent inappropriate readmissions by prioritising the review of recently discharged patients who are deemed high risk patients for readmission and/or are taking high risk medications.

3.6 To improve the quality and consistency of information provided by secondary care on discharge, thereby reducing the need for practices to follow up missing or erroneous patient information requiring clarification.

3.7 To encourage the reporting of incidents related to discharge information and to share learning and help improve the quality and timeliness of discharge data in the future.

4 RESPONSIBILITIES

4.1 NHS Somerset has responsibility for disseminating this guidance to general practitioners.

4.2 Individual NHS Somerset GP general practices are responsible for the decision to adopt this guidance for the effective use of patient information in the discharge process from secondary care.

4.3 NHS Somerset is responsible for facilitating the widespread adoption of guidance for the effective use of patient information in the discharge process from secondary care.

4.4 NHS Somerset is responsible for improving the safety and quality of the effective use of patient discharge information in those practices which do not adopt this guidance.

4.5 NHS Somerset and GP Practices have shared responsibility to continue working to improve the effective use of patient discharge information received from health services.

4.6 NHS Somerset has responsibility for recording, investigating and sharing learning from any incidents which arise relating to the effective use of patient discharge information from health services.

4.7 NHS Somerset has responsibility for developing mechanisms with health services to assess the quality and timeliness of the provision of patient discharge information.

5 PROCESS

5.1 It is recommended that each practice adopts a robust standard operating procedure for dealing with discharge information, and that there is an accountable person and deputy for the process.

5.2 Received discharge information should be date stamped and put for the attention of the named GP or clinical person responsible for care.

5.3 Robust arrangements should be set out in the standard operating procedure for receiving discharge information when the named GP is absent, for example ensuring a named deputy is agreed.

5.4 Discharge information should be clinically reviewed, processed into the patient's medical record as soon as possible after receipt.

5.5 Discharge information should ideally be clinically reviewed within 24 hours of receipt.

5.6 The named GP should reconcile discharge medicines with those on medical records (acute and repeat) and code any new diagnosis and/or medicines related issues.

5.7 If discharge information is insufficient, illegible, outside of normal guidance, or in any way deemed inappropriate for that patient, refer to consultant/ward for clarification.

5.8 The practice should also consider submitting an incident report to NHS Somerset.

5.9 Once clarification has been received and agreed the reconciliation process should be completed, it is suggested any documentation is marked "medication list updated".

5.10 The reconciliation process should also include making arrangements for any suggested GP follow up action or monitoring of the patient such as the taking of blood for tests.

5.11 Patient is read coded under Medication Review of Medical Notes and recall date amended if necessary.

5.12 Discharge information and any letters of clarification should be scanned or added to patient's record.

5.13 Any changes in medication should trigger a priority medication review (face to face or telephone), during which the patient's understanding of the changes to medication should be confirmed and the patient should be advised to return any discontinued / unwanted medication to their regular pharmacy/dispensary for destruction.

5.14 The general practice should consider (subject to confidentiality rules) communicating any changes in the patient's medication following discharge to the patient's regular community pharmacy (if known). Currently, no discharge information is communicated to community Pharmacies.

5.15 The general practice should prioritise (subject to confidentiality rules) communicating medication changes to the patient's normal community Pharmacy, for those patients discharged on high risk medication.

5.16 The general practice should prioritise (subject to confidentiality rules) communicating medication changes to the patient's normal community Pharmacy, for those patients deemed at high risk of re-admission or with considerable increases / changes to their pre admission medication.

5.17 The general practice should prioritise (subject to confidentiality rules) communicating medication changes to the patient's normal community Pharmacy, for those patients who are in a care home or receiving a community monitored dosing device.

5.18 Patients should be recalled for any appropriate or requested tests. Patients on high risk medications or in high risk groups should be prioritised for a GP, nurse or pharmacist medication review.

5.19 The general practitioner should make appropriate follow up arrangements deemed necessary for all patients discharged from a health service.

5.20 The general practitioner should make appropriate follow up arrangements as commissioned for any post op patients discharged from a health service.

5.21 Appropriate changes to the patient's medical record should be read coded.

5.22 It is recommended that the general practice consider a Significant Event Audit of any patient readmitted within 30 days of discharge.

5.23 For patients discharged on high risk medication, deemed at high risk of re-admission or with considerable increases / changes to their pre admission medication, consideration (subject to confidentiality rules) should be given to communicating changes to the patient's community matron (any other care provider).

5.24 Following discharge the patients Care Plan may need review and updating.

6 SAFETY

6.1 This guidance has been written to promote patient safety. The prompt analysis and reconciliation of patient information will

minimise risk to patients of unexpected outcomes, inappropriate or unsafe treatment.

7 AUDIT & RECONCILIATION

7.1 NHS Somerset should seek to assess and audit the effective use and reconciliation of patient discharge information and demonstrate continuing improvement.

7.2 It is expected that GP practices adopting this guidance will also self audit their compliance with the guidance.

7.3 It is expected that Somerset Primary Care Trust will provide feedback on compliance with the guidance and any learning from incidents relating to the reconciliation of discharge information.

National Prescribing Centre
http://www.npci.org.uk/medicines_management/safety/reconcil/library/library_good_practice_guide1.php Feb 2008. Page 14

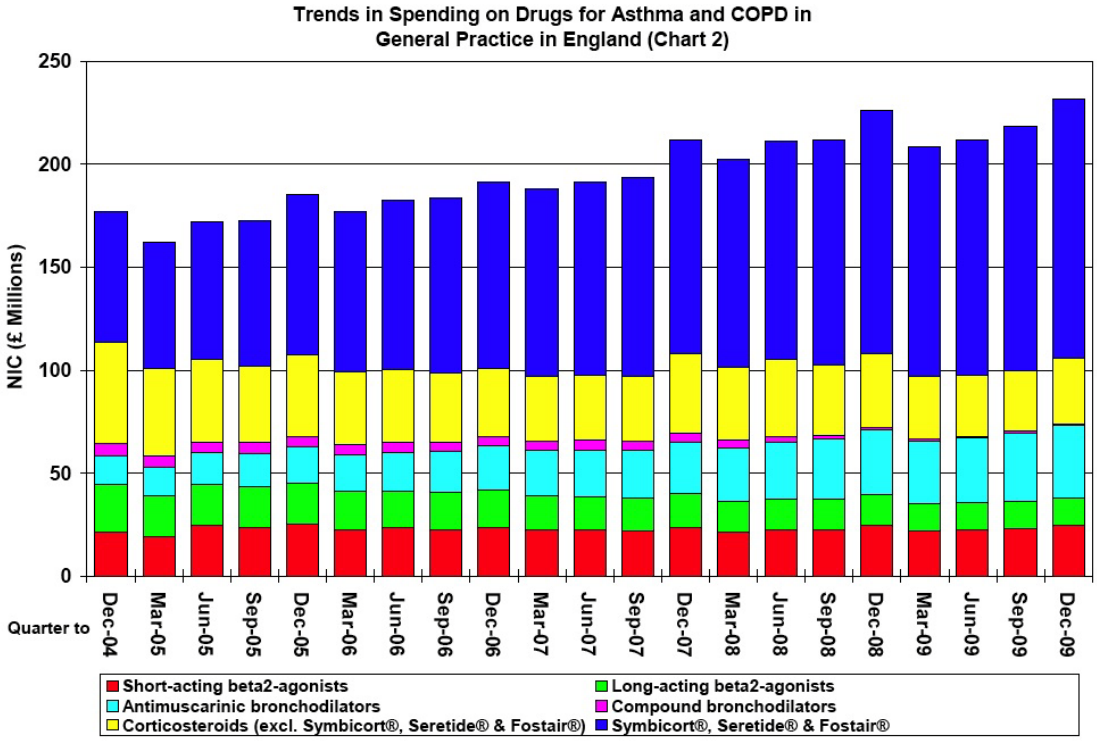
Suggested minimum dataset required in primary care:
To be able to reconcile medicines in a primary care setting, for example, following patient discharge from hospital (or transfer into a care home, return from respite care etc.), it is suggested that the minimum dataset of information available to GPs should include:

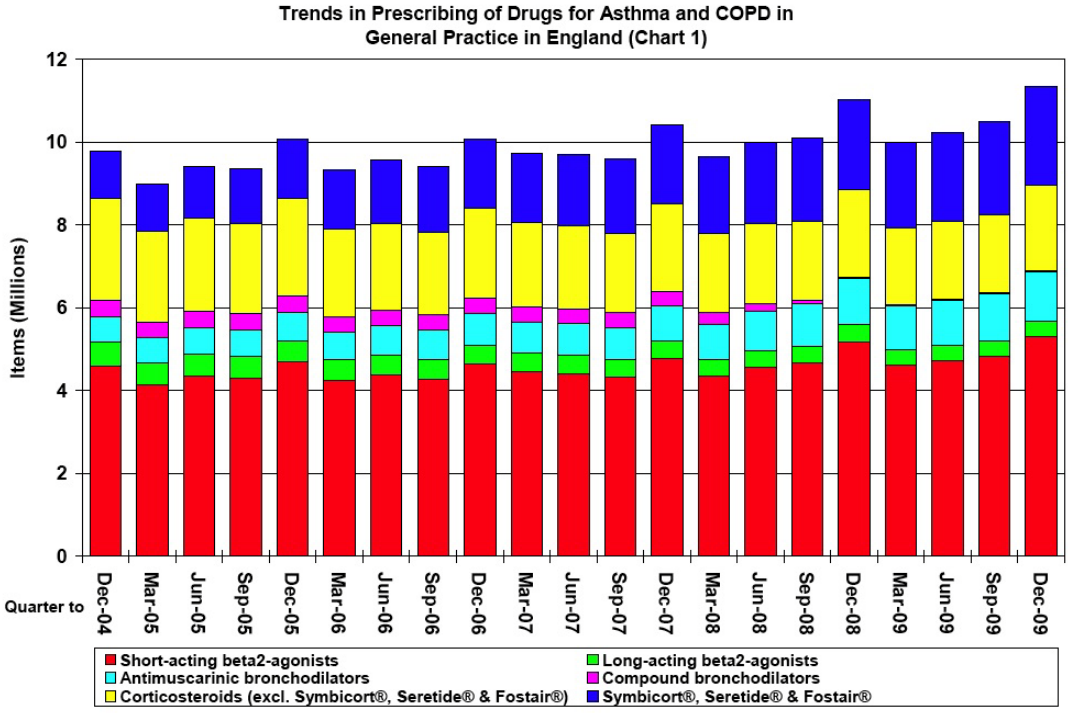
- Complete and accurate patient details i.e. full name, date of birth, weight if under 16 years, NHS/unit number, consultant, ward, date of admission, date of discharge
- The diagnosis of the presenting condition plus co-morbidities
- Procedures carried out
- A list of all the medicines prescribed for the patient on discharge from hospital (and not just those dispensed at the time of discharge)
- Dose, frequency, formulation and route of all the medicines listed
- Medicines stopped and started, with reasons
- Length of courses where appropriate (e.g. antibiotics)
- Details of variable dosage regimens (e.g. oral corticosteroids, warfarin, etc.)
- Known allergies, hypersensitivities and previous drug interactions
- Any additional patient information provided such as corticosteroid record cards, anticoagulant books, etc.
- This information should be clear, unambiguous and legible and should be available to the GP (or other primary care prescriber) as soon as possible. Ideally, this should be within 2 working days of the patient's discharge from hospital.

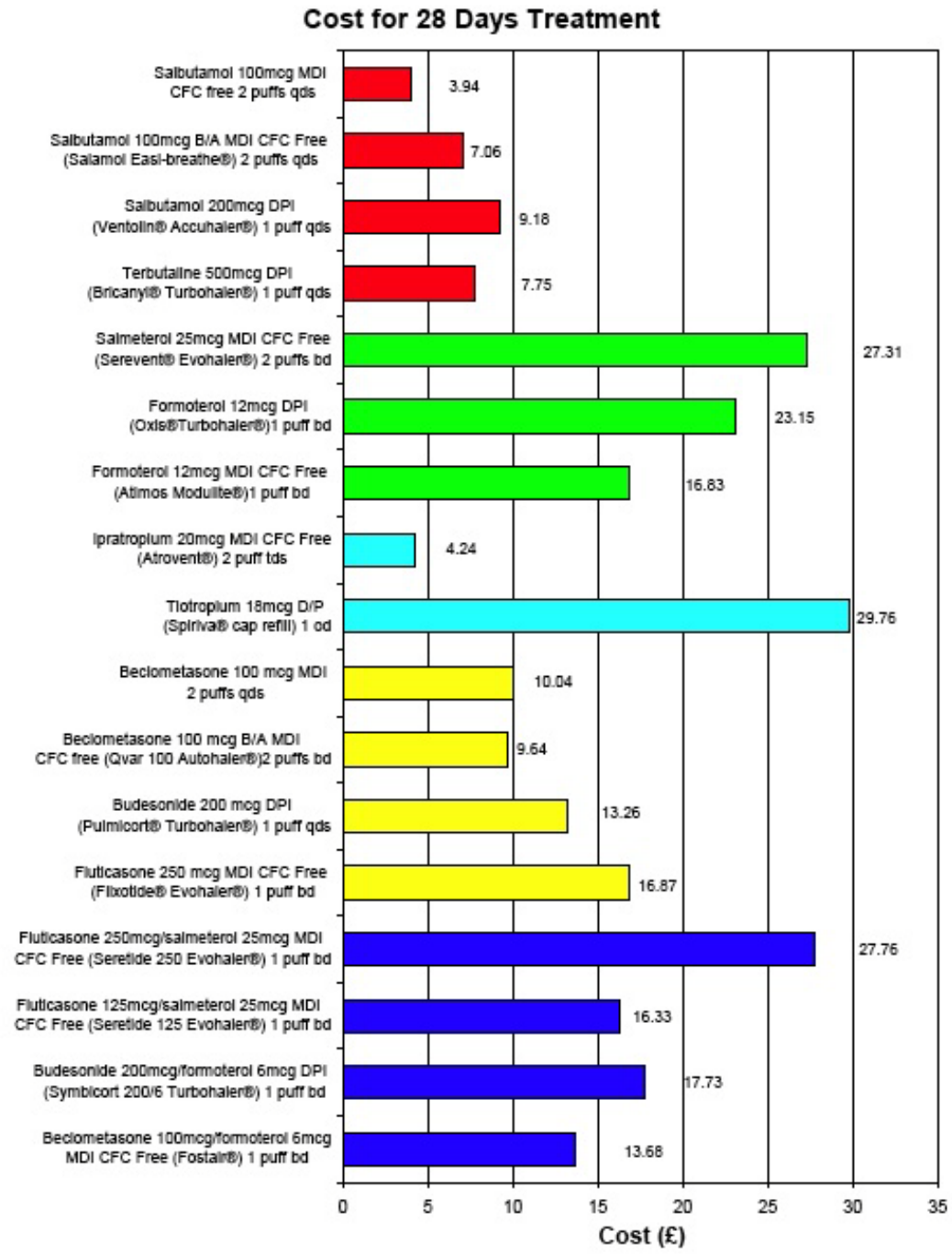
Suggested minimum dataset required in secondary care:
When patients are admitted to hospital they are often at their most vulnerable, and are not always able to contribute accurately to a medication history-taking discussion. It is suggested that the minimum dataset of information available on admission to hospital should include:

- Complete patient details i.e. full name, date of birth, weight if under
- 16 years, NHS/unit number, GP, date of admission
- The presenting condition plus co-morbidities
- A list of all the medicines currently prescribed for the patient, including those bought over-the-counter (where this is known)
- Dose, frequency, formulation and route of all the medicines listed
- An indication of any medicines that are not intended to be continued
- Known allergies and previous drug interactions
- This information should be clear and legible and should be available to the hospital when the patient is admitted for planned admissions, and within 24 hours of admission for unplanned admissions.
- In addition to the suggestions made here, local agreements or policies may require further information to be provided.

Information available from NHS Prescriptions May 2010







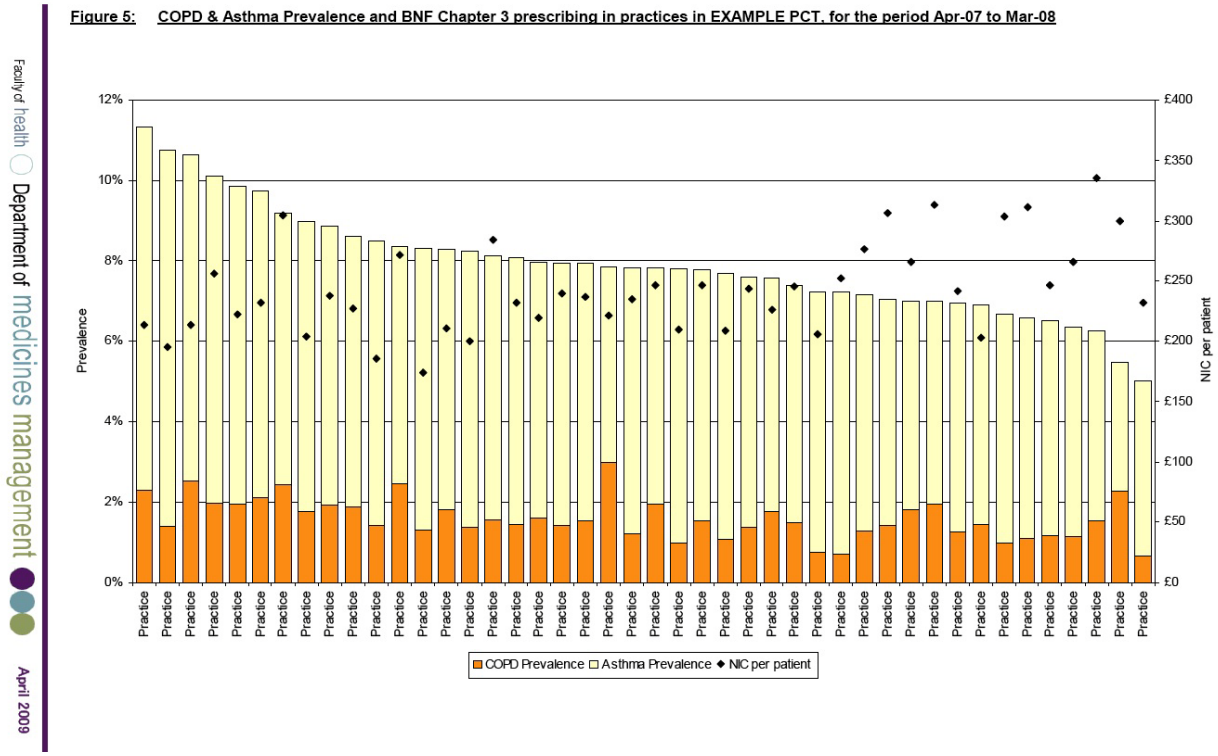
Prices based on Drug Tariff May 2010 and the NHS dictionary of medicines and devices. Dose based on WHO DDDs where possible, otherwise BNF stated dose. The WHO DDD is a unit of measurement based on the assumed average maintenance dose in adults. It may not necessarily reflect the actual dose used.

For examples of how to integrate prescribing information into other sources such as QOF, see these two reports from the Medicines Management Department at Keele University.

http://www.keele.ac.uk/schools/pharm/pctsla/files/COPD&Asthma(Apr08).pdf and
http://www.keele.ac.uk/schools/pharm/pctsla/files/respiratory.pdf

Here is one example showing COPD and asthma prevalence from QOF by practice, and net ingredient costs for British National Formulary Chapter 3 April 2007 to March 2008.

Figure 5: COPD & Asthma Prevalence and BNF Chapter 3 prescribing in practices in EXAMPLE PCT, for the period Apr-07 to Mar-08



Appendix 5

Example of “red flag” prescriptions monitored by NHS Somerset July – September 2009 by practice – just give few examples?

Cabergoline and pergolide	Use of ergotamine dopamine agonists is associated with cardiovalvulopathy particularly pergolide		Ensure cabergoline and treatments in Parkinson to first line alternatives. requires increased echo
Tibolone	Increased risk of stroke in older women should be taken into account	In younger women, the risk profile of tibolone is broadly similar to that for conventional HRT. For women>60 the risks associated with tibolone start to outweigh the benefits because of the increased risk of stroke	Every woman's overall and, in those with an in cancer should be asses
Desmopressin spray	Licence of nasal use in PNE has been removed		Ensure spray is not use start on lowest and incr control symptoms
Ketoprofen	Ketoprofen has been associated with a higher gastrointestinal risk than most other NSAIDs in the class; prescribing advice should be followed carefully, particularly recommended upper dose limits.		
Piroxicam	Piroxicam has been associated with a higher gastrointestinal risk than most other NSAIDs in the class; prescribing advice should be followed carefully, particularly recommended upper dose limits.		Systemic piroxicam sho specialists as a second Patients who currently reassessed at a routine
Sodium ranelate	Hypersensitivity in post menopausal women		Discontinue permanent
Glitazones (thiazolidiediones)	Concerns arisen due to increased risk of heart failure		R and P should not be failure or history. Incide combined with insulin. signs of fluid retention, oedema. Rosi may be a risk of cardiac ischaem with insulin.
Dosulepin	Measures to reduce the risk of fatal overdose	Narrow margin of safety between (maximum) therapeutic doses and potentially fatal doses	Maximum pack sizes e of 25mg/day or 75mg/d
Atorvastatin 80mg	Increased risk of haemorrhagic stroke stroke at 80mg dose		Screen patients with re lacunar stroke (without reduce dose to 40mg a
Varenicline	Depression has been reported in patients taking	A number of ADRs reported- see DRU Dec 2007	Patients experiencing s their medication immed

	varenicline which might include suicidal thoughts and behaviours		doctor
Ketoconazole	Risk of hepatotoxicity identified leading to removal of several therapeutic indications	Other antifungals more effective anyway	Treat only candidosis th topically or patients into antifungals
Moxifloxacin	Safety concerns over increased risk of adverse hepatic reactions with moxifloxacin		Use only when other ar bacterial sinusitis, exac bronchitis, community a
Norfloxacin	Problem- benefits do not outweigh risks in the indication of acute or chronic pyelonephritis		Action- avoid in favour quinolone