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NHS Discharge Medicines Service – Essential Service

Toolkit for pharmacy staff in community, primary and secondary care

15 January 2021

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1. Introduction to the NHS Discharge Medicines Service

Discharge from hospital is associated with increased risk of avoidable medication-related harm.[1] Reducing harm at transitions of care is one of the three main elements of the World Health Organization's (WHO) Global Patient Safety Challenge: Medication Without Harm,[2] which aims to reduce avoidable harm from medicines by 50% over five years. Issues with medications arising at discharge are often the result of poor communication between healthcare providers and studies have been conducted which demonstrate the benefit of effective communication systems when transferring patients from one care setting to another.[3,4]

Discharge from hospital is associated with increased risk of avoidable medication-related harm.[5] NICE guideline NG05[6] included the following recommendations:

a) Medicines-related communication systems should be in place when patients move from one care setting to another.

b) Medicines reconciliation processes should be in place for all persons discharged from a hospital or another care setting back into primary care and the act of reconciling the medicines should happen within a week of the patient being discharged.

Implementation of these recommendations requires pharmacy professionals and their teams across hospitals, primary care networks (PCNs) and community pharmacy to work together much more effectively. Improving medicines safety at transfers of care forms part of our Medicines Safety Improvement Programme.

Academic Health Science Networks (AHSNs) have been supporting NHS trusts to put in place communication systems with the patient's community pharmacy team at home, through their work on Transfers of Care Around Medicines (TCAM).[7] This

[1] https://apps.who.int/iris/bitstream/handle/10665/325453/WHO-UHC-SDS-2019.9-eng.pdf.
[2] World Health Organization (2017) The third WHO Global Patient Safety Challenge: Medication Without Harm (2017). Available at: https://www.who.int/patientsafety/medication-safety/medication-without-harm-brochure/en/
[3] Hamde N et al (2016) 'New transfer of care initiative of electronic referral from hospital to community pharmacy in England: a formative service evaluation'. Available at: https://wessexahsn.org.uk/img/projects/BMJ%20Open-2016-Nazar-.pdf
[4] Sabir FRN et al (2019) 'Evaluating the Connect with Pharmacy web-based intervention to reduce hospital readmission for older people'. Available at: https://wessexahsn.org.uk/img/projects/Sabir2019_Article_EvaluatingTheConnectWithPharma.pdf
[5] Technical report WHO Medication safety in transitions of care https://apps.who.int/iris/bitstream/handle/10665/325453/WHO-UHC-SDS-2019.9-eng.pdf
[6] Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. Available at https://www.nice.org.uk/guidance/ng5
[7] ASHN Network (2019) 'Transfers of Care Around Medicines (TCAM)'. Available at: https://www.ahsnnetwork.com/about-academic-health-science-networks/national-programmes-priorities/transfers-care-around-medicines-tcam

involves patients who have been identified as being at risk from adverse effects or needing support with their medicines on discharge being referred via secure electronic message for advice and support to their usual community pharmacy. As the roll out of TCAM across England continues and more hospitals start to upgrade their IT systems or introduce electronic prescribing and medicines administration systems, it is expected more referrals to community pharmacies will be made.

We are introducing the NHS Discharge Medicines Service into community pharmacy as an essential service under the Community Pharmacy Contractual Framework from 15 February 2021, to set out clearly the expectations of the community pharmacy contractor when receiving a discharge referral, including when they should involve PCN pharmacy teams and NHS trusts.

By referring patients to the community pharmacy with good information about changes made to medicines in hospital, community pharmacy contractors can work effectively with their pharmacy colleagues in general practice to support patients on discharge to improve outcomes, prevent harm and reduce readmissions. Where new medicines have been commenced, the community pharmacist may also be able to provide further support via other commissioned services, such as the New Medicines Service, where this would be clinically appropriate and where the patient meets the eligibility criteria.

2. Purpose of the NHS Discharge Medicines toolkit

This toolkit supports cross-sector implementation of the NHS Discharge Medicines Service as an essential service in all NHS community pharmacies in England. It sets out the shared responsibility and roles of pharmacy teams in community pharmacy, NHS trusts and PCNs in ensuring patient safety, better patient outcomes and medicines reconciliation on discharge.

The NHS Discharge Medicines Service toolkit is intended to support delivery of the NHS Discharge Medicines Service and ensure that:

1. An integrated approach to supporting patients with medicines reconciliation and optimisation following discharge is taken across healthcare sectors, ensuring clear and identifiable links between community pharmacy, NHS trusts and PCN member practices.
2. A consistent approach to handling a referral for post-discharge medicines reconciliation is adopted. This is to reduce harm to patients caused by medication changes, give patients an improved understanding of their

medicines post discharge, ensure medicines are stopped as intended, and reduce hospital readmissions because of medication issues.

3. NHS trusts develop local processes for patients to be referred to community pharmacy post discharge and these referrals are linked to a consistent service in community pharmacy.
4. Community pharmacy contractors and PCNs collaborate to support patients with medicines optimisation following discharge. This includes community pharmacy contractors referring patients to PCN practices (eg PCN pharmacy team for any additional medicines support such as a Structured Medication Review).

It is important that this toolkit is read by all pharmacy staff involved in medicines referrals and reconciliation across NHS trusts, community pharmacy and PCNs so there is a shared understanding of the service and respective roles and responsibilities.

This toolkit is not intended to replace the NHS Discharge Medicines Service regulations guidance published by NHS England and NHS Improvement, which must be adhered to by all community pharmacy contractors providing the service.

3. Implementing the NHS Discharge Medicines Service

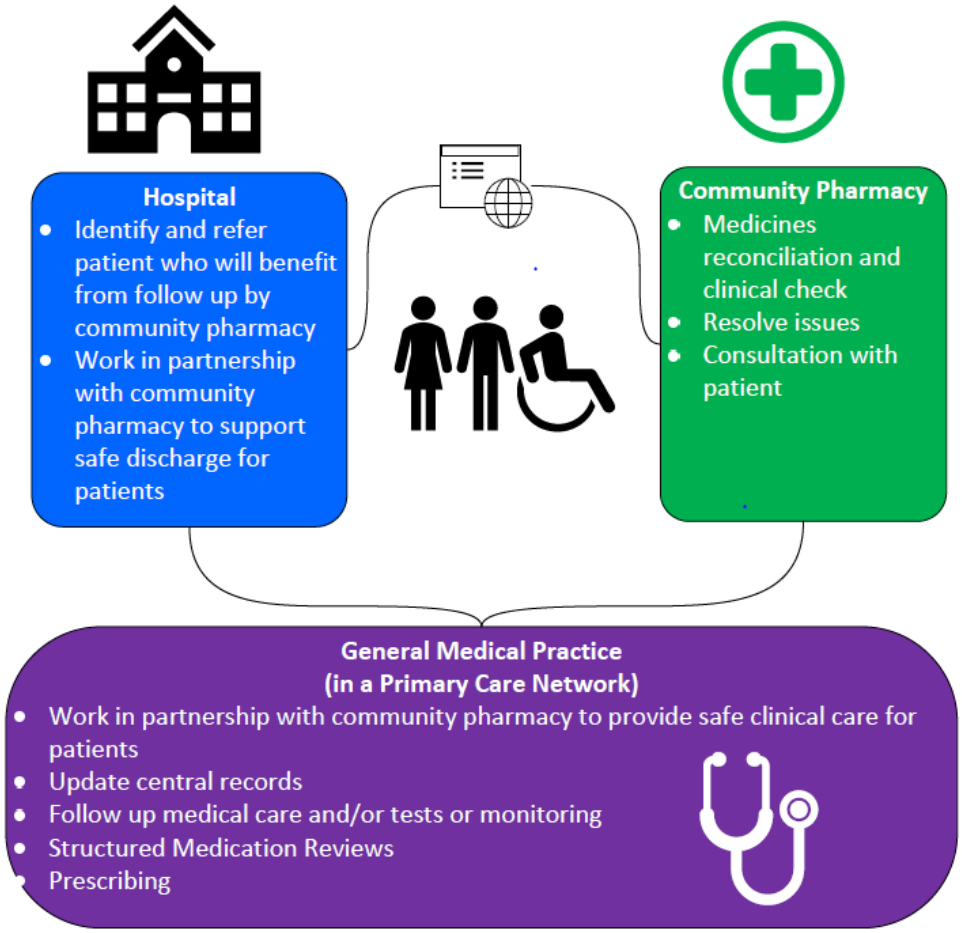
3.1. Overview

Implementation of the NHS Discharge Medicines Service will require cross-system collaboration between key stakeholders such as NHS trusts, community pharmacy contractors and PCNs. Support is also required from medicines optimisation teams in clinical commissioning groups (CCGs) and AHSNs, which are supporting the rollout of the TCAM programme until April 2021. Local system leadership groups (eg the Integrating NHS Pharmacy and Medicines Optimisation programme system leadership for pharmacy) have a role in providing pharmacy leadership to support cross-sector relationships, roll out and sustainability.

While the NHS Discharge Medicines Service is commissioned as a national essential service from community pharmacy contractors, it will need active involvement from NHS trusts and primary care teams to maximise the impact on patient safety and quality of care. Figure 3.1 shows the interdependencies between NHS trusts, community pharmacy and general practices in PCNs.

In this section, key tasks are listed for system leaders, NHS trusts, community pharmacy contractors and PCNs to ensure a successful NHS Discharge Medicines Service.

Figure 3.1: NHS Discharge Medicines Service patient pathway



3.2. Cross-sector stakeholder group

Local systems (eg integrated care system, place or neighbourhood) should nominate a cross-sector stakeholder group to lead on the implementation of the NHS Discharge Medicines Service. Key tasks to consider are shown in Box 3.1.

Box 3.1: Checklist for cross-sector stakeholder groups

- ☐ **Leadership:** Establish a cross-system stakeholder group to lead on the implementation of the NHS Discharge Medicines Service.
- ☐ **Referral process:** Agree the referral process and technology and tools which will support the NHS Discharge Medicines Service.
- ☐ **Streamline medicines support:** Understand that all patients will continue to be supported by their general practice on discharge but look to streamline support on medicines.
- ☐ **Cross-sector collaboration:** Ensure system-wide (NHS trusts, community pharmacy, PCNs and CCGs) staff engagement to understand the aims of the NHS Discharge Medicines Service, benefits to patients, and their roles and responsibilities. This includes considering the implications and requirements for information sharing for patients in a PCN.
- ☐ **Review process and data collection:** Develop a system of long-term and regular, cross-system review to develop and maximise benefit to patients from the NHS Discharge Medicines Service. This will need to include agreeing a process to collect relevant data to measure the impact of the service and support future service improvement and development; pharmacy contractors will submit a standard dataset in relation to each referral received, which will provide data to support this.
- ☐ **NHS Discharge Medicines Service training:** Ensure that staff across all sectors are competent to refer patients to the NHS Discharge Medicines Service and understand the full patient pathway. It is advised that NHS trusts and PCNs ensure that staff making and supporting referrals to the NHS Discharge Medicines Service complete the CPPE NHS Discharge Medicines Service training to reinforce their knowledge. Update and training materials are available at https://www.cppe.ac.uk/programmes/l/transfer-e-02

3.3. NHS trusts

This section sets out the processes that NHS trusts (acute, community and mental health trusts) should set up to ensure that they are ready to implement the NHS Discharge Medicines Service in February 2021. Key tasks to consider are shown in Box 3.2. NHS trusts should ensure they take a consistent approach to referrals and queries across the PCNs/community pharmacies they serve.

Box 3.2: Checklist for NHS trust chief pharmacists

- ☐ **Leadership:** NHS trust chief pharmacists need to lead NHS trust processes for supporting the NHS Discharge Medicines Service as a key medicines safety priority, working with senior medical, nursing, management and IT colleagues to deliver a high-quality referral process.
- ☐ **Patient identification:** NHS trusts should ensure there is a robust process for identifying patients who may benefit from a review by community pharmacy. Section 4.1 details where medicines or patients could be considered high risk and therefore a referral may be appropriate. NHS trusts should review volumes and types of referral regularly.
- ☐ **Referral:** The NHS trust is responsible for ensuring that the appropriate patients are referred to community pharmacy within 24-48 hours following discharge (depending on weekends/bank holidays) to receive support with medicines optimisation and reconciliation on discharge. The guidance in Section 4.1 should be followed by NHS trusts when developing the referral process.
- ☐ **Consent:** NHS trusts should develop a system of consent to ensure that patients are fully involved in decisions about care following discharge and have agreed to the whole NHS Discharge Medicines Service pathway. Several consent models have been developed and local AHSNs can support development and implementation of these consent models. Examples include seeking consent: at the point of admission, during the inpatient stay when the reason for referral becomes apparent or at the discharge planning point.
- ☐ **Providing advice:** The referring NHS trust should ensure that the referrers contact details are on the referral and that systems exist to support handling of queries from community pharmacy (eg a single point of access telephone and/or email).
- ☐ **Specialist support:** For more complex patients or where additional support is needed to avoid readmission, NHS trusts (including specialist mental health and community health trusts) should provide specialist pharmacy or multidisciplinary teams (MDT) support in collaboration with community pharmacy teams and PCN pharmacy teams. Specialist pharmacists and/or hospital consultants may also need to be involved.
- ☐ **Data and information sharing:** It is important that NHS trusts share key clinical information with community pharmacy colleagues when patients are referred to the NHS Discharge Medicines Service. As detailed in Appendix A, clinical information needs to be shared across the system for the service to operate. Information governance issues should be considered throughout.

3.4. Community pharmacy contractors

The NHS Discharge Medicines Service regulations guidance outlines the service requirements for community pharmacy contractors. The service will comprise three distinct elements for community pharmacy contractors to complete as detailed below, and contractors should note that stages 1, 2 and 3 of the service may occur in parallel (more detail is provided in Section 4). At each stage of the process, community pharmacy teams must ensure that appropriate notes are recorded in the patient medication record and/or other appropriate record.

- **Stage 1: The community pharmacy receives a discharge referral.** A clinical review is undertaken by a community pharmacist following receipt of a patient referral. The community pharmacy team may contact the referring NHS trust contact or the PCN pharmacy team to discuss any concerns (eg an important medicine the patient usually takes is omitted on the discharge referral) and to seek clarification about the discharge referral.
- **Stage 2: The community pharmacy receives the first prescription following discharge.** The pharmacist or pharmacy technician will ensure medicines prescribed post-discharge take account of the appropriate changes made during the hospital admission. If there are discrepancies, the pharmacy team will try to resolve them with the general practice, utilising existing communication channels. Alternatively, the community pharmacist may refer the patient to the PCN pharmacy team for a Structured Medication Review or other intervention.
- **Stage 3: The community pharmacy checks the patient's understanding of their medicines regimen.** The pharmacist or pharmacy technician will hold a discussion, adopting a shared decision-making approach, with the patient (or the carer if appropriate) to check their understanding of their post-discharge medicines' regimen. The pharmacist or pharmacy technician will identify any adherence, clinical issues, outstanding questions or needs the patient may have regarding their medicines.

Key tasks for community pharmacy contractors to undertake are shown in Box 3.3.

Box 3.3: Checklist for community pharmacy contractors

- ☐ **Declaration of competence:** Ensure that all pharmacy professionals who will be engaged in delivering the service have completed a Declaration of Competence prior to providing this service.
- ☐ **Awareness of service requirements:** Ensure that all members of the community pharmacy team who will be involved in providing the NHS Discharge Medicines Service understand the aspects of the service and the parts of the service specification relevant to their role.
- ☐ **Develop a standard operating procedure:** Ensure that a standard operating procedure for delivering the NHS Discharge Medicines Service which is read is developed and understood by all staff involved in providing the service.
- ☐ **Understand the referral process:** Understand how referrals will be received from NHS trusts in their local area and ensure relevant members of staff can access them.
- ☐ **Identify key contacts:** Consider and identify key local contacts in the system (eg the local PCN pharmacy team) and build relationships to promote integrated working.
- ☐ **Patient engagement:** Consider how to best explain the service and offer advice on taking medicines effectively to patients, relatives and carers. Reflect how to share this advice where the patient has limited capacity to engage in the conversation or to understand complex medication issues (eg under the Mental Capacity Act 2005).
- ☐ **Medicines understanding discussions:** Where discussions take place on community pharmacy premises, make sure there is a consultation space in the pharmacy suitable to undertake the review with the patient and/or their carer. Where the patient and/or their carer does not wish to attend the community pharmacy for this discussion, consider undertaking the discussion in a manner which meets the patient's/carer's needs, eg by telephone or video consultation.
- ☐ **NHS Discharge Medicines Service training:** Community pharmacy contractors should ensure that staff are competent to provide this service and, where there is any doubt, should seek further training in readiness for service commencement on 15 February 2021. It is strongly recommended that all pharmacists and pharmacy technicians delivering this service complete the CPPE NHS Discharge Medicines Service training to reinforce their knowledge. Update and training materials are available at https://www.cppe.ac.uk/programmes/l/transfer-e-02

3.5. General practices/primary care networks

The NHS Discharge Medicines Service does not replace the role of general practice in managing patients' medicines on discharge (eg reconciling medicines with the general practice clinical IT system). In line with NICE guidance, this should be an opportunity for cross-sector working to support patients with their medicines when discharged from hospital.[8] To ensure that care is joined up, pharmacy teams in PCNs should work in partnership with community pharmacy contractors, providing additional medicines support when a patient is discharged, as detailed below in Box 3.4.

Box 3.4: Checklist for general practices/PCN pharmacy teams

- ☐ **Alignment of medicines discharge work:** The discharge of patients should continue to be managed in line with NICE guidance and usual general practice, including ensuring medicines changes are updated on the patient's clinical record. The general practice or PCN pharmacy teams should work collaboratively with community pharmacy to align the NHS Discharge Medicines Service to their current work and minimise duplication.
- ☐ **Agree responsibility:** Agree who is responsible (at general practice level) for supporting the NHS Discharge Medicines Service. This includes liaising with community pharmacy teams where additional information or clarification is needed. This could be a team working across the PCN.
- ☐ **Awareness of medicines support on discharge:** Ensure that all relevant staff understand the patient pathway for medicines support following patient discharge from hospital, including the role of general practice and PCN pharmacy teams in providing support and additional services as required, such as a Structured Medication Review.
- ☐ **Providing advice:** Once a referral has been received from an NHS trust, the community pharmacy team may require information, support and clinical expertise from the general practice or PCN pharmacy team. General practices should be willing to provide this support to allow community pharmacy teams to safely reconcile medicines and support patients effectively.
- ☐ **Clinical support:** Some scenarios will require community pharmacy teams to work with colleagues in general practices to jointly manage a discharged patient (eg when stopped medicines are to be restarted pending test results). If medication changes are significant or discussion with the patient demonstrates that they do not understand how to use their medicines, the community pharmacist or pharmacy

[8] https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#medicines-related-communication-systems-when-patients-move-from-one-care-setting-to-another

technician can refer the patient to the general practice or PCN pharmacy team for a Structured Medication Review.

- ☐ **Specialist support:** For more complex patients or where additional support is needed to prevent readmission, general practice or PCN pharmacy teams should be prepared to receive referrals or collaborate in MDTs with the community pharmacists and NHS trusts.

4. Operating the NHS Discharge Medicines Service

In this section more detail is given on how to operate the NHS Discharge Medicines Service, including the specific tasks which should be completed and the considerations which should be made.

Note, the community pharmacy's first contact with the patient could happen at any stage in the NHS Discharge Medicines Service process. First contact is when the patient or their carer makes contact with the pharmacy to either:

- discuss the medications they have been prescribed;
- request that a prescription is dispensed or
- collect a prescription that has already been dispensed

Alternatively, the community pharmacist may wish to initiate first contact with a patient when a referral is received.

4.1. Referral into the NHS Discharge Medicines Service

The NHS trust is responsible for ensuring that appropriate patients are referred to community pharmacy within 24-48 hours following discharge (depending on weekends/bank holidays) to receive support with medicines optimisation and reconciliation. Referrals to the NHS Discharge Medicines Service must be made via secure electronic message. Appendix A contains information on the minimum dataset to be transferred by an NHS trust with a referral to community pharmacy.

NHS trusts should develop a system of consent to ensure that patients are fully involved in decisions about care following discharge and have agreed to the whole NHS Discharge Medicines Service pathway. Several consent models have been developed and local AHSNs can help support development and implementation of these consent models. Examples include seeking consent: at the point of admission, during the inpatient stay when the reason for referral becomes apparent or at the discharge planning point.

Many NHS trusts, supported by their AHSN, have a TCAM service with clear guidelines and procedures in place for meeting this responsibility. NHS trusts that have not yet implemented a TCAM service should consider working with key stakeholders to implement this medicines safety intervention and enable equitable access to the NHS Discharge Medicines Service for their patients.

When developing eligibility criteria, NHS trusts should take into consideration local population needs, such as care homes and areas of deprivation. Box 4.1[9] and Box 4.2[10] below list situations where medicines or patients could be considered high risk.[11] These lists are not exhaustive and actual referral criteria should consider local population needs and the NHS trust's capability to refer patients.

Box 4.1: High risk medicines

- Multiple resources cite a list of 'high risk medicines'. They include but are not limited to: anticoagulants (eg warfarin, dabigatran), antiepileptics, digoxin, opioids, methotrexate, antipsychotics, cardiovascular drugs (eg beta-blockers, diuretics), controlled drugs, valproate, amiodarone, lithium, insulin, methotrexate, non-steroidal anti-inflammatory drugs (NSAIDs) and aspirin among others.
- Newly started respiratory medication, including inhalers.
- Medication requiring follow-up, eg blood monitoring, dose titration.
- Patients prescribed medicines that have potential to cause dependence (eg opioids).
- Those for which doses vary/change, either increasing or decreasing over time.

[9] Sugget E, Marriott J (2016). Risk factors associated with the requirement for pharmaceutical intervention in the hospital setting: a systematic review of the literature.
[10] Howard R et al (2006) Which drugs cause preventable admissions to hospital? A systematic review. *Br J Clin Pharmacol* 63:2;136-147.
[11] https://wessexahsn.org.uk/img/projects/Who%20might%20benefit%20the%20most%20from%20a%20TCAM%20referral%20FINAL%20Oct%202019.pdf

Box 4.2: High risk patients

- People taking more than five medications, where the risk of harmful effects and drug interactions is increased.
- Those who have had new medicines prescribed while in hospital.
- Those who have had medication change(s) while in hospital.
- Those who have experienced myocardial infarction or a stroke due to likelihood of new medicines being prescribed.
- Those who appear confused about their medicines on admission/when getting ready for discharge, and have already needed additional support from a healthcare professional.
- Those who have help at home to take their medications.
- Those patients who have a learning disability.

Case study 4.1 gives an example of important information and action taken by the community pharmacy contractor.

Case study 4.1: Providing relevant clinical information

Mrs Ballantyne was admitted to hospital after falling at home. While in hospital, her medicines were discontinued. Prior to discharge, all her usual medicines were restarted except for furosemide (prescribed for heart failure) as her sodium levels were still low. She was referred to the NHS Discharge Medicines Service with a request to restart furosemide when her blood tests were normal. The community pharmacy contacted Mrs Ballantyne and she agreed to get a blood test the following week at her surgery. The blood test results were normal. The pharmacist already had a prescription for furosemide and this was then dispensed.

4.2. Stage 1: What to do when a discharge referral is received by community pharmacy

On receipt of a patient referral to the NHS Discharge Medicines Service, the following steps should be taken by the community pharmacy team:

- Undertake a pharmacist clinical check within 72 hours of receipt of a referral (excluding hours of days on which the pharmacy premises are not open for business). Box 4.3 sets out a checklist for reviewing medicines information for patients referred to community pharmacy from an NHS trust.
- The pharmacist or pharmacy technician then compares what has previously been recorded as prescribed in the patient's patient medication record and summary care record with what has been communicated on the discharge note,

including any amendments to the medicines being taken. All medicines should be compared, not just those taken orally. Attention should be paid to the patient's demographic details (name, date of birth, address, etc) to ensure the pharmacy team are reviewing the correct patient.

- If any clarifications are needed, then the pharmacist or pharmacy technician should use the details on the referral to contact the NHS trust or the patient's general practice. Any changes must be recorded on the patient medication record (or other appropriate record) and the patient and patient's general practice should be notified if appropriate.
- The community pharmacy team must also check any previously ordered prescriptions for the patient that are in the dispensing process or awaiting collection to see if they are still appropriate. Particular attention should be paid to electronic repeatable prescriptions as these could be pulled down from the system sometime after the patient has been discharged from hospital.

Case study 4.2 below gives an example of undertaking stage 1 of the NHS Discharge Medicines Service and reviewing discharge information.

It should be noted that as an essential service, community pharmacy contractors cannot choose whether they provide the service. However, where a referral is received for a patient who has not accessed services at the pharmacy before, the pharmacist or pharmacy technician may wish to contact the patient directly to ensure they intended for the referral to be sent to that pharmacy. In a case where the patient or NHS trust confirms the referral has been sent to the pharmacy in error, the community pharmacy contractor should contact the hospital and ask that the referral is amended and sent to the correct community pharmacy.

Box 4.3: Checklist for reviewing the discharge information

The community pharmacist should check all medication for:

- changes to quantity
- changes to dosage
- changes in formulations
- changes to the frequency at which the medicine should be administered
- changes to the frequency at which the medicine will be prescribed
- interactions and contraindications relating to the changed medications
- appropriateness.

In addition, attention should also be given to:

- newly prescribed medication, including considering whether medicines are intended to given long-term or have been initiated for short-term use
- discontinued medication (including removing medicines no longer needed)
- planned changes to medicine (eg antibiotics stopped after course is completed)
- changes to medicine administration route
- concerns highlighted by the NHS trust, eg intentional non-adherence
- bloods or other tests needed to ensure safety or check for efficacy.

Case study 4.2: Reviewing discharge information

Mrs Singh was admitted to hospital with shortness of breath, and she was stabilised in hospital. She takes medicines for hypertension, mild heart failure and diabetes. On discharge from hospital, Mrs Singh was referred to the NHS Discharge Medicines Service. On reconciling her medicines, her community pharmacist noted that during her stay in hospital, Mrs Singh was started on candesartan. However, her PMR showed that she had been taking perindopril and this was also on her repeat medication list. In conversation with the patient, the community pharmacist established that the ACE inhibitor (perindopril) had been changed to the ARB (candesartan) and therefore the prescription for perindopril was no longer needed. The community pharmacist confirmed these findings with the referring NHS trust. A consultation with Mrs Singh found she was happy with the change and there were no side effects or problems. Mrs Singh returned the perindopril remaining from her previous prescription to the pharmacy for destruction; and the perindopril was removed from Mrs Singh's active repeat list.

4.3. Stage 2: What to do when the first prescription is received

There is no defined time it takes for the first prescription for a patient post discharge from hospital to be received. However, for most patients who have a condition that requires regular or long-term medication, a prescription is likely to be received within the first few weeks following discharge from hospital,.

Usually, by the time a first prescription is received post discharge, the patient's general practice will have had chance to amend prescribed medications in line with the information provided to them by the NHS trust on discharge of the patient. However, it is important that the community pharmacist or pharmacy technician closely checks any prescription(s) received against the information enclosed in the discharge referral information and the information on the patient medication record (or other appropriate record) to ensure that any changes that were identified are reflected in the prescription received.

At this point the community pharmacist or pharmacy technician should decide which of the pathways in Table 4.1 to follow, based on the information available.

Table 4.1: NHS Discharge Medicines Service patient pathways

Situation	Examples
Fully actioned by community pharmacy Either no issues are identified post discharge or the community pharmacy is able to resolve any issues identified. Therefore, the patient's care can be fully actioned by the community pharmacy.	• Medicines reconciliation with all information. • Further clarification needed by the community pharmacy team from the NHS trust (eg medicine on the community pharmacy patient medication record but missing on the discharge information).
Collaboration between community pharmacy and general practice in a PCN An issue with the discharge referral information or the first prescription is identified which cannot be fully actioned by the community pharmacy team. The community pharmacy team will therefore need to collaborate with the general practice/PCN pharmacy team to rectify these issues before the first prescription enters the dispensing process.	• Withheld medicine to be restarted when bloods normal. • Bloods, BP or other tests requested by hospital. • New medicine(s) has potential to interact or duplicate effect of existing medicine. • Minor side effects. • Patient has concerns about medicines. • New medicines will need monitoring or follow-up (eg blood pressure medicine that may need BP and bloods). • Complex changes to medicines (eg multiple medicines stopped and/or started). • Major side effects from medicines (eg dizziness, falls after taking new antihypertensive medicines).
Referral to general practice/PCN Complex discharges and complex problems following discharge should be discussed with the general practice team (eg PCN pharmacy team) and patient referred to them for further review (eg Structured Medication Review).	• Patient may benefit from a Structured Medication Review with the general practice or PCN pharmacist. • Adverse event, eg bleeding with anticoagulant, hypoglycaemias with insulin. • Onset of new symptoms or re-emergence of symptoms since discharge. • Intentional or unintentional non-adherence. • Hospital only medicines or medicines with a shared care protocol in place (eg Clozapine and Roaccutane/ Isotretinoin).

Where issues are identified or changes made to the prescribed items following this check in the pharmacy, details must be recorded on the patient medication record (or other appropriate record), and the patient should be advised about these changes.

4.4. Stage 3: Involving the patient

The NHS Discharge Medicines Service should also be used as an opportunity to engage with patients about their medicines on a shared decision-making basis. Whether the patient or their carer makes contact themselves for advice, a referral is received from an NHS trust on discharge or a prescription is received following prescribing changes, the pharmacist or pharmacy technician should take the opportunity to establish the patient's understanding of their condition(s), their associated medications and how each medicine can be best administered to get optimum benefit and reduce unwanted side effects.

It may be appropriate to ask whether the patient would like another person to be present, such as an advocate or carer, particularly where the patient has limited capacity to engage in the conversation or to understand complex medication issues (eg under the Mental Capacity Act 2005).

The conversation with the patient and/or their carer should be confidential and should take place where it cannot be overheard. If it takes place in the pharmacy, the consultation room should be used where appropriate. Where the patient and/or their carer cannot, or prefers not to, attend the pharmacy for this discussion (eg if the patient is housebound or convalescing following surgery), this support and advice should be provided in a manner which meets the patient's/carer's needs (eg by telephone or video consultation). Box 4.4 sets out key areas the pharmacist or pharmacy technician may want to discuss with the patient.

Following the conversation with the patient about their medicines, a record must be made on the patient medication record and/or other appropriate record. If it is clinically appropriate to share these details with the patient's general practice/PCN pharmacy team as the information would support the ongoing care of the patient, patient consent should be obtained and this information should be sent (including confirmation of patient consent) using a secure method.

Box 4.4: Medicines discussion with the patient and/or carer

- **New medicines:** Does the patient understand what the medicines are for? Do they know what the medicines look like? Explain how and when they should be taken to get best effect and to reduce any side effects. It is also important for the patient to understand any risks of taking the medicines and who they should contact if they are unsure about any symptoms they may experience. The pharmacy or pharmacy technician should also consider whether the patient should be provided with any other Community Pharmacy Contractual Framework services, such as the New Medicine Service, where this would be clinically appropriate and where the patient meets the eligibility criteria.
- **Medicines optimisation:** Does the patient understand how to get optimum benefits from their medicines? Eg understanding when best to take their medicines.
- **Medicines interactions:** Are there likely to be any side effects from taking a number of medicines together? Are there any foods they should avoid while taking the medicines? Although most medicines information leaflets will contain these details, patients may find leaflets overwhelming, so a personalised conversation may help.
- **Medicines disposal:** For those patients in a private household or residential care home, the pharmacist or pharmacy technician should offer to dispose of any medicines the patient is no longer using. This is important to prevent accidental overdosing. It is also important where the dosage has changed, to prevent accidental under/overdose.
- **Supporting the patient with adherence:** Does the patient need any help in taking their medicines, or are there any adjustments the pharmacy can make to improve adherence? This is important for patients who have difficulties with memory and/or cognitive function, but also applies to patients who find taking a number of medicines inconvenient or difficult to manage.
- **Additional resources:** Are there any written or online resources that can be shared with the patient to help them with their medicines? Where these are provided, it is important they are from a reliable source such as the NHS website, so that patients are not given conflicting information about their medicines or their condition.

Case study 4.3 below gives three overall examples of how the NHS Discharge Medicines Service may work. Note that while all community pharmacy contractors must follow the service specification requirements, each patient's experience may vary according to their needs.

Case study 4.3: Examples of the NHS Discharge Medicines Service process

Example 1

Mrs Patel was referred to her community pharmacy on discharge. The community pharmacist reconciled the medicines with the pharmacy patient medication record and noted that Adcal D3 and GTN spray were missing. The community pharmacist then contacted Mrs Patel and discovered that she had forgotten to take these items into hospital and therefore was not given these medicines. The community pharmacist checked that these medicines were still indicated and did not interact with the new medicines prescribed, and then advised Mrs Patel to continue with the Adcal D3 and to use her GTN spray as needed.

Example 2

Mr Barrett, 90 years old, lives alone has also been referred to the community pharmacy on discharge. On reconciling his medication, the community pharmacist noticed that metformin was missing from his discharge information. The community pharmacist contacted the NHS trust and discovered that it had been withheld due to acute kidney disease. However, recent blood results were normal and therefore Mr Barrett should restart the medicine. The community pharmacist worked with the PCN clinical pharmacist to arrange a new prescription. Mr Barrett was contacted and the community pharmacist arranged a discussion with Mr Barrett to coincide with the collection of his dispensed medicines and ensure he understood his medicines regimen.

Example 3

Mr Fisher was referred following a long stay in hospital. He had several changes to his medicines which were clearly documented on the discharge information. The community pharmacy technician updated Mr Fisher's patient medication record. They noted that there was a prescription for Mr Fisher on the NHS Spine which accurately reflected his post-discharge medicines regimen. This was dispensed and delivered to the patient. A telephone discussion was also arranged by the community pharmacy technician to check Mr Fisher's understanding of his changed medication and for any adverse events.

4.5. Where all stages of the NHS Discharge Medicines Service cannot be provided

The process described in Sections 4.2 to 4.4 above represent the normal flow of patients through the service. However, on occasions this will not be the case and the pharmacist/pharmacy technician will need to use their professional judgement to determine the appropriate actions to take. Box 4.5 details some of these examples.

Box 4.5: Examples where normal flow of patients through the service may not be appropriate

1. **A referral is received for a new patient:** Where a referral is received for a patient who is new or unknown to the pharmacy, the pharmacy contractor may then need to contact the NHS trust and/or the patient for more information; and to check that the patient wishes to continue using this pharmacy for the DMS.
2. **Patient uncontactable or withdraws consent following completion of stage 1:** Where stage 1 of the service has been delivered but the patient withdraws consent to receive the service, or the first prescription post-discharge is not received by the pharmacy contractor to complete stage 2 of the service and no contact is made by the patient, reasonable attempts must be made by the pharmacy contractor to contact the patient using the contact details set out in the referral. In this scenario, it is possible that the patient has been readmitted to hospital, admitted to a care home or has died. Where the pharmacy contractor is unable to reach the patient (or the patient has been readmitted to hospital or admitted to a care home), the pharmacy contractor should share any findings of concern from stage 1 of the service with the patient's general practice.
3. **Patient uncontactable or withdraws consent following completion of stage 1 and stage 2:** Where stages 1 and 2 of the service are provided by the pharmacy contractor but the pharmacy contractor is unable to contact the patient to complete stage 3 of the service, reasonable attempts must be made by the pharmacy contractor to contact the patient using the contact details set out in the referral. In this scenario, it is possible that the prescription may have been collected by the patient or a representative and either: the patient was unable to discuss their medicines at the point of collection; or the patient/carer does not attend an agreed consultation; or the patient/carer refuses to take calls from the pharmacy contractor; or that the patient/carer states that they do not wish to engage with a consultation about their medicines. Where the community pharmacy is unable reach the patient or the patient withdraws consent to receive the service at this point, the pharmacy contractor should share any findings of concern from stages 1 and 2 of the service with the patient's general practice.
4. **Patient moves community pharmacy after stage 1 of the service has been provided:** The situation may occur where stage 1 of the service has been delivered by a pharmacy contractor and that pharmacy contractor subsequently finds out that the patient wishes to use a different pharmacy contractor for the provision of the service. The first pharmacy contractor should contact the second pharmacy contractor and offer to send them, via a secure electronic message (eg to the pharmacy contractor's premises specific NHSmail account) and with the patient's consent, the referral information received from the NHS trust and any relevant information and/or findings identified during stage 1 of the service. The same approach could be taken if another pharmacy

contractor contacts the first pharmacy contractor to inform them that the patient has asked them to dispense the first prescription post discharge.

5. **Temporary community pharmacy closure means that the complete service cannot be provided:** Where a temporary community pharmacy closure of one week or more means that a pharmacy contractor cannot provide the service, reasonable attempts must be made by the pharmacy contractor to contact the patient using the contact details set out in the referral. The pharmacy contractor should inform the patient of the situation and identify another pharmacy contractor to refer the patient for completion of the service. In these circumstances, the pharmacy contractor should contact the identified pharmacy contractor and offer to share, via secure electronic message (eg to the pharmacy contractor's premises specific NHSmail account) and with the patient's consent, the referral information received from the NHS trust and any relevant information and/or findings identified during stages 1 or 2 of the service if already provided.

5. Recording Data

As part of this service, all relevant information must be recorded as a clinical record on the patient medication record or other appropriate record, in a retrievable manner so colleagues can see it where appropriate to support ongoing provision of care.

Best practice also suggests that where a review of any medications has been undertaken but no action is required, that this is also recorded. So, for example, a note needs to be made of medications that have been changed. However, if the medicines have been checked and it is confirmed that there are no changes, this should be recorded on the patient medication record or other appropriate record so that no one thinks this has been missed and checks it again. It will also provide a full record of what was reviewed and when, should there be future changes or queries from prescribers or the patient.

Information that would be of value to the general practice or PCN pharmacy team to support the ongoing care of the patient (eg any findings of concern) should be communicated appropriately. Local agreements should be in place on how and when this information is shared.

For each service provision, the pharmacy team must also capture the dataset for reporting, as set out in the NHS Discharge Medicines Service data specification. Pharmacies are required to submit this data as part of their payment claim at the end of each month.

Appendix A: Information sharing when an NHS trust makes a referral

Information that should be transferred to community pharmacy at discharge, which is informed by NICE guidance is set out below.[12]

Essential minimum dataset:

- Demographic and contact details of the person and their registered general practice (including their NHS number and their hospital medical record number).
- The medicines being used by the patient at discharge (including prescribed, over-the-counter and specialist medicines, as there may be medicines interactions), including the name, strength, form, dose, timing, frequency and planned duration of treatment for all and the reason for prescribing.
- How the medicines are taken and what they are being taken for.
- Changes to medicines, including medicines started or stopped, or dosage changes, and reason for the change.
- Contact details for the referring clinician or hospital department, to use where the pharmacy has a query.
- Ideally, the referral should also contain the hospital's Organisation Data Service (ODS) code.

Additional recommended dataset:

- Details of other relevant contacts identified by the person, and their family members or carers where appropriate.
- Known drug allergies and reactions to medicines or their excipients, and the type of reaction experienced (see the NICE guideline on drug allergy).
- Medicines that are hospital only so that community pharmacy (and primary care) are aware and can consider any medicines interactions.
- Date and time of the last dose, for weekly or monthly medicines, including injections.
- What information has been given to the person, and their family members or carers where appropriate.
- Any other information needed – for example, when the medicines should be reviewed, ongoing monitoring (including blood tests) needs and any support the person needs to carry on taking the medicines. Additional information may be needed for specific groups of people, such as children and the elderly.

[12] https://www.nice.org.uk/guidance/ng5/chapter/Key-priorities-for-implementation

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