#AskAboutAsthma webinar: innovations in pharmacy for CYP asthma

NHS England – London
Babies, Children and Young People's Programme

Housekeeping

Attendees are automatically muted with camera switched off during the webinar.

Use the group chat feature to ask questions and please like any questions that you would like answered.

This session is being recorded. A link will be available after the webinar with the slides.

Agenda

#AskAboutAsthma webinar: innovations in pharmacy for CYP asthma

Tuesday 12 September 2023 7:30 – 8:30pm

Click here to join the meeting

Topic	Speaker
Chair: Steve Tomlin Director of the Children's Medicines Centre and Associate Chief Pharmacist at Great Ormond Street Hospital	
PCN pharmacy support: Baby Steps to Asthma Right Care	**Darush Attar-Zadeh** Clinical Fellow Respiratory Pharmacist – NWL Integrated Care Board and London CYP Pharmacy asthma group Co-Chair **Alison Summerfield** Paediatric Nurse and Asthma Senior Delivery Project Manager, NWL ICB
South East London's pharmacy incentive scheme	**Reena Patel** South East London Local Pharmaceutical Committee Support Officer
The effectiveness of the Discharge Medicines Service (DMS)	**Sukeshi Makhecha** Paediatric respiratory Pharmacist, Royal Brompton and Evelina Hospitals and London CYP Pharmacy asthma group Co-Chair
Q & A	**All**

NWL CYP Asthma Network
Helping CYP live better with asthma

PCN pharmacy support
Baby Steps to Asthma Right Care

Darush Attar-Zadeh (d.attar-zadeh@nhs.net)
Alison Summerfield (alison.summerfield@nhs.net)

CYP Pharmacy asthma group Co-Chair (subgroup of LALIG Leadership and Implementation Group**)**

Paediatric Nurse Asthma Senior Delivery Project Manager

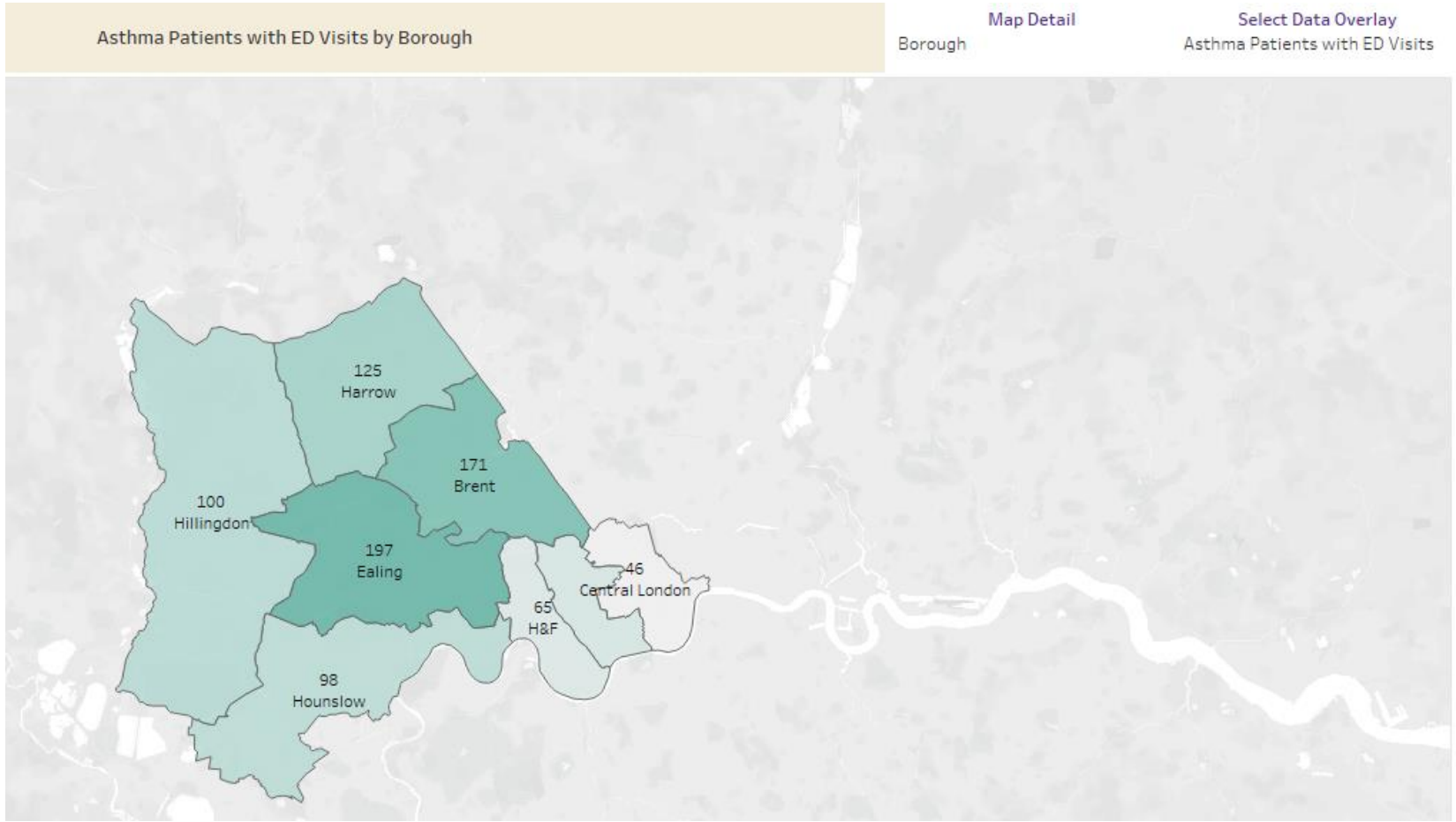
NWL CYP Asthma Network offer of support:

- **MDT sessions** – paediatric consultant, nurse, pharmacist – discuss challenging patient cases
- **Pharmacy support –** baby steps to Asthma Right Care – audits, searches, data (progress reports) safer labelling, acute/variable repeat, starting the conversations
- **Group consultations**
- **Possible mentoring sessions**

Specialist nurse:

alison.summerfield@nhs.net

Population health – every life matters



London Asthma Decision (LADS) Support tool

-

Being proactive rather than reactive

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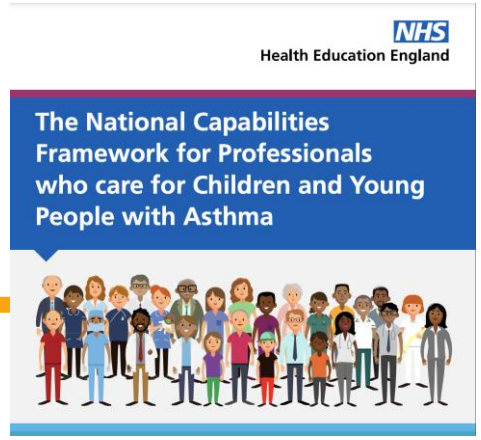
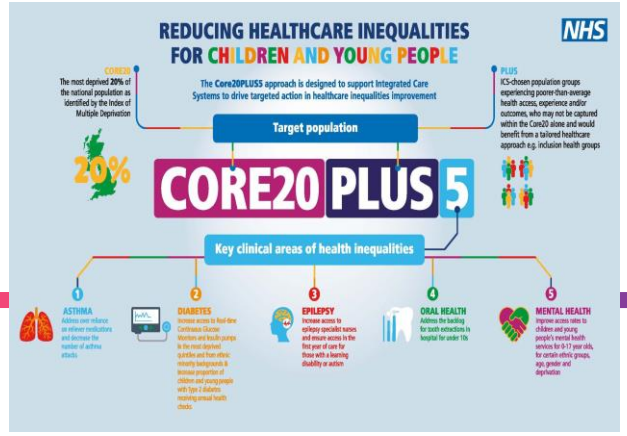
Reducing the **RISK OF** Asthma attacks

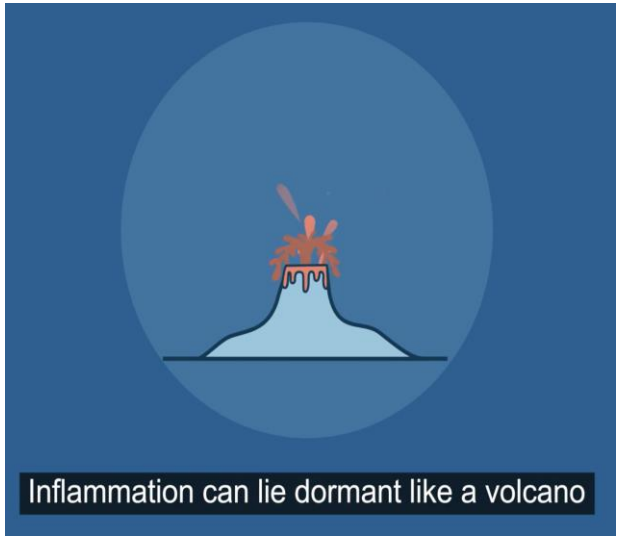
USE CASE

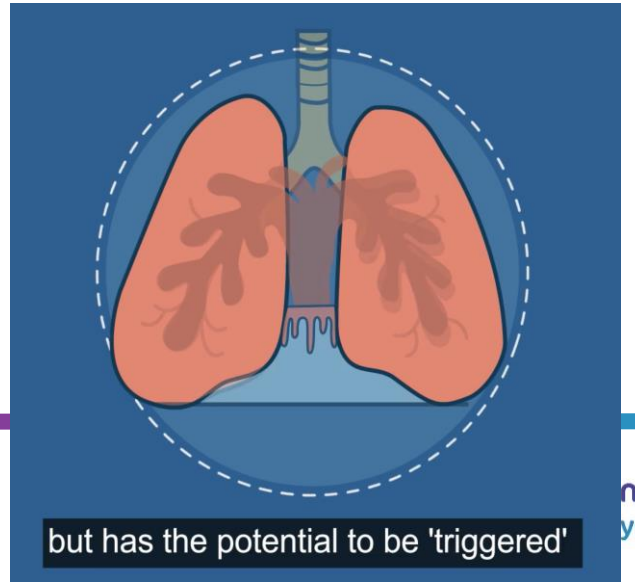
- **R**atio: ICS & SABA, pMDI & DPI (device consistency)
- **I**CS potency sustainability
- **S**moking & exposure
- **K**nowledge – English language, ACT <20, PAAP (co-creation)

- **O**CS frequency (in the last 12 months)
- **F**orecast (Weather, Pollution, Deprivation Index)





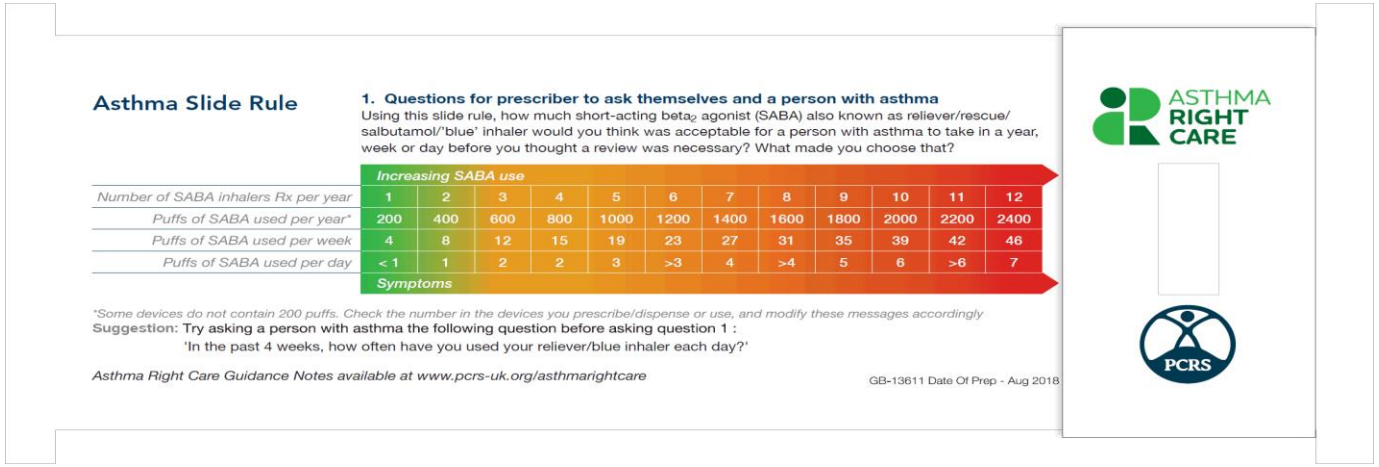




30th Mar 2023

Borough wide pharmacy training events	7
PCNs engaged (out of possible 45)	32
PCN pharmacy initiation sessions delivered	26
Part 2 initiation session deliverd	18
Follow up sessions delivered	13

K&W PCN Pharmacists & Technicians upskilled to L1&2



Asthma Slide Rule

1. Questions for prescriber to ask themselves and a person with asthma

Using this slide rule, how much short-acting beta$_2$ agonist (SABA) also known as reliever/rescue/ salbutamol/'blue' inhaler would you think was acceptable for a person with asthma to take in a year, week or day before you thought a review was necessary? What made you choose that?

Increasing SABA use

Number of SABA inhalers Rx per year	1	2	3	4	5	6	7	8	9	10	11	12
*Puffs of SABA used per year**	200	400	600	800	1000	1200	1400	1600	1800	2000	2200	2400
Puffs of SABA used per week	4	8	12	15	19	23	27	31	35	39	42	46
Puffs of SABA used per day	< 1	1	2	2	3	>3	4	>4	5	6	>6	7

Symptoms

**Some devices do not contain 200 puffs. Check the number in the devices you prescribe/dispense or use, and modify these messages accordingly*

Suggestion: Try asking a person with asthma the following question before asking question 1 :
'In the past 4 weeks, how often have you used your reliever/blue inhaler each day?'

Asthma Right Care Guidance Notes available at www.pcrs-uk.org/asthmarightcare

GB-13611 Date Of Prep - Aug 2018

ASTHMA RIGHT CARE

PCRS

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Initiation Session Part 1 (The need to ⬇SABA, OCS over reliance,⬆ICS)

- **1-hour long sessions** (open to pharmacy teams in GP practices & MDT)
- **Content:** Asthma Right Care, why pharmacy?, Scale of the problem (data snapshot, LADS), NWL incentives/quality indicators, 2 Tier support (1) MECC (2) CYP Asthma Reviews, bolstering CPD Journey (national bundle)
- **No. of participants**: usually PCN wide (5 to 30 participants)
- No. of **PCNs engaged so far**: 32/45

Engage, Educate, Empower to take baby steps

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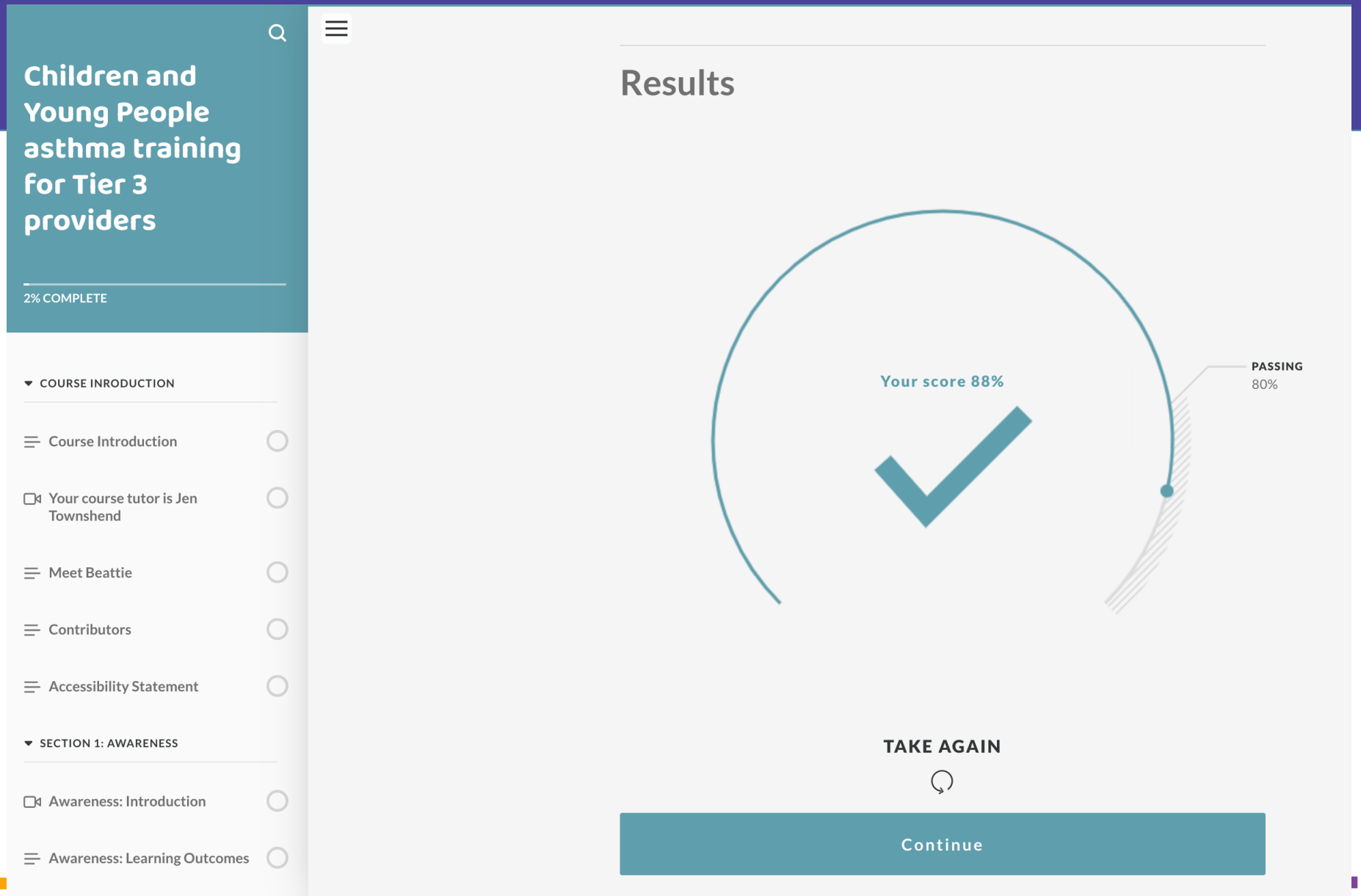

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Content Part 1 -

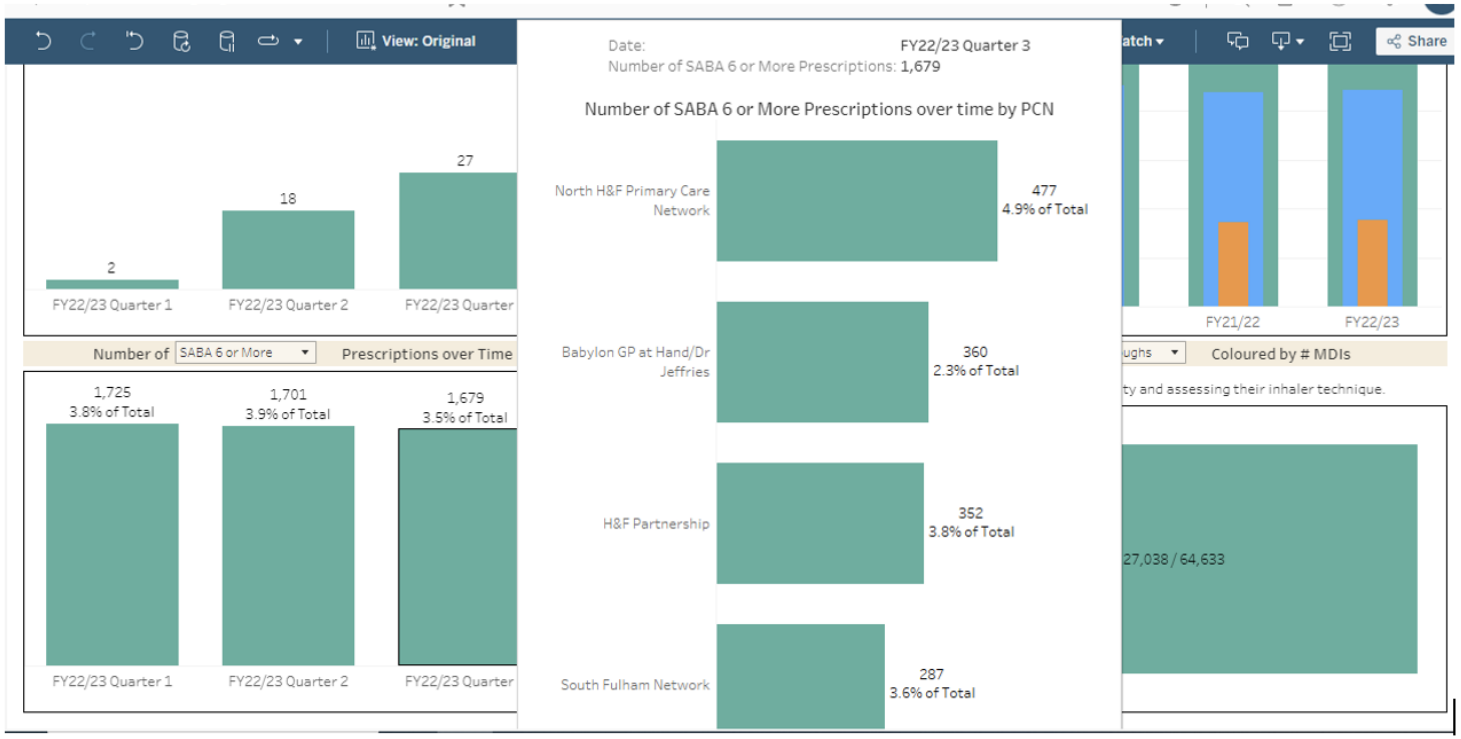
- Introductions
- Background to Asthma Right Care CYP pharmacy role
- What does basic asthma care look like?
- High Risk Factors
- Local Data
- NWL incentives to support quality
- Knowing your numbers? Practical session (1st Asthma Right Care tool)
- CPD – National Bundle of Care, Asthma Right Care (PCRS), CPPE
- Consultations with CYP – further reading
- Next steps & evaluation

Greener Respiratory Prescribing Data Pack (April 2023)

[redacted]d PCN

London Asthma Decision Support Tool (for asthma patients)

- 70% of the total carbon footprint of inhaler devices in the UK is represented by SABAs.[1]
- In asthma 83% of SABAs prescribed go to patients using ≥3 inhalers a year. [2]
- People with asthma who use 3 or more SABA canisters per year have twice the risk of a severe asthma attack.[3] This data below from LADS in Quarter 3 highlights – [redacted]PCN 360 prescriptions over time are for 6 plus SABA over a 12-month period.



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In NWL there were 22,931 patients receiving 6+ SABA over 12 months

Proportion of patients receiving 6+ SABA inhalers

Trend over time for NHS NORTH WEST LONDON ICB - W2U3Z

Display:- Data

Month	Numerator	Denominator	Comparator Value	SICBL in National Average
Oct-21	22,931	118,247	19.39	24.69
Nov-21	22,926	119,819	19.13	24.50
Dec-21	22,768	121,043	18.81	24.38
Jan-22	22,690	121,626	18.66	24.30

Refresh - Print - Export

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2762 fewer patients are exposed to one of the risk factors of a future asthma attack

Proportion of patients receiving 6+ SABA inhalers

Trend over time for NHS NORTH WEST LONDON ICB - W2U3Z

Display:- Data

Month	Numerator	Denominator	Comparator Value	SICBL in National Average
Feb-23	20,862	127,485	16.36	16.36
Mar-23	20,631	128,252	16.09	16.09
Apr-23	20,352	128,637	15.82	15.82
May-23	20,016	128,872	15.53	15.53
Jun-23	19,928	129,883	15.34	15.34

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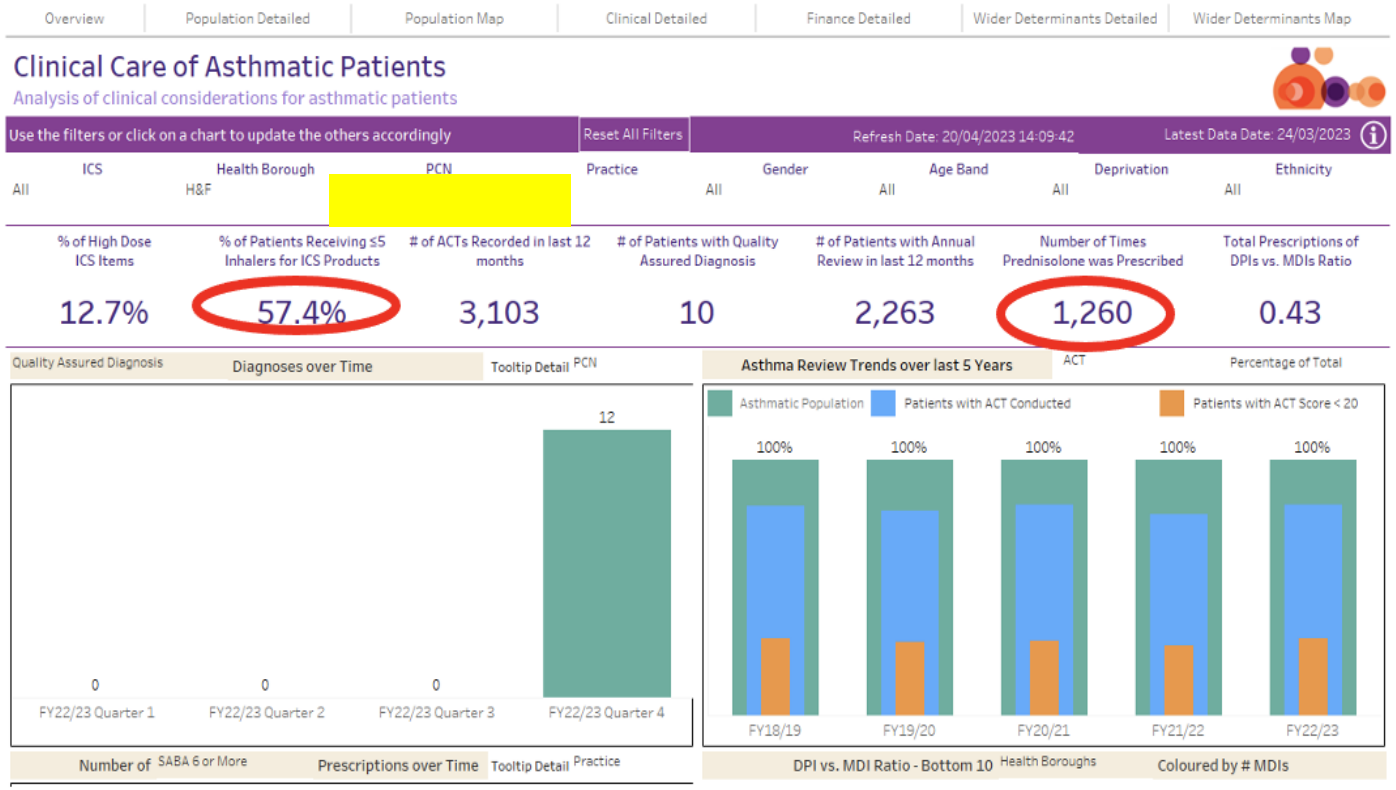
To help keep patients well controlled and out of hospital it's useful to see the LADS data below - % of patients receiving less than 5 ICS a year, number of times prednisolone has been prescribed in the last 12 months and inhaler technique checks that are good in the last 5 years.

This data can be analysed at a practice level if you access LADS.



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When we started there were 62.1% patients receiving 5 or fewer ICS inhalers

Proportion of patients with 5 or fewer ICS products

Trend over time for NHS NORTH WEST LONDON ICB - W2U3Z

Display:- Data

Month	Numerator	Denominator	Comparator Value	SICBL in National Average
Aug-21	79,027	128,198	61.64	51.58
Sep-21	79,634	128,820	61.82	51.63
Oct-21	80,618	129,813	62.10	52.01
Nov-21	81,986	131,370	62.41	52.38

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63.18% patients are exposed to one of the risk factors of a future asthma attack

What lessons can we learn for this metric?
What is the rest of England doing to improve on this?
How can we increase confidence around ICS use in CYP/Parents/Guardians/ Clinicians

Proportion of patients with 5 or fewer ICS products

Trend over time for NHS NORTH WEST LONDON ICB - W2U3Z

Display:- Data

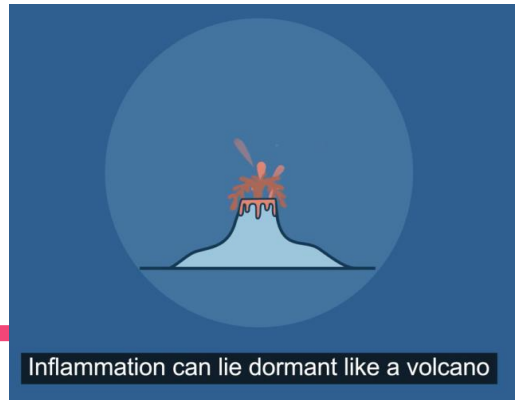
Month	Numerator	Denominator	Comparator Value	SICBL in National Average
Nov-22	85,175	135,931	62.66	52.90
Dec-22	86,073	136,918	62.86	53.18
Jan-23	87,012	137,851	63.12	53.33
Feb-23	87,616	138,675	63.18	53.50

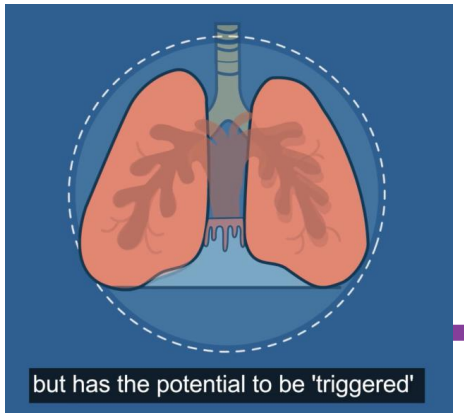
Refresh - Print - Export

Inhaled Corticosteroid containing treatments

What words do you like to use to describe how they work?

1) The treatment to dampen down inflammation/stop eruptions
2) The treatment to open up the airways
3) Becoming your own plumber
4) The preventer treatment/Every day inhaler
5) All of the above
6) None of the above





Metaphor:

Does this work for explaining when to use relievers and preventers for asthma?

"You have a leak in your house. You can do one of two things: use a bucket or call a plumber."

What metaphors do you use?

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Clinical Care of Asthmatic Patients

Analysis of clinical considerations for asthmatic patients

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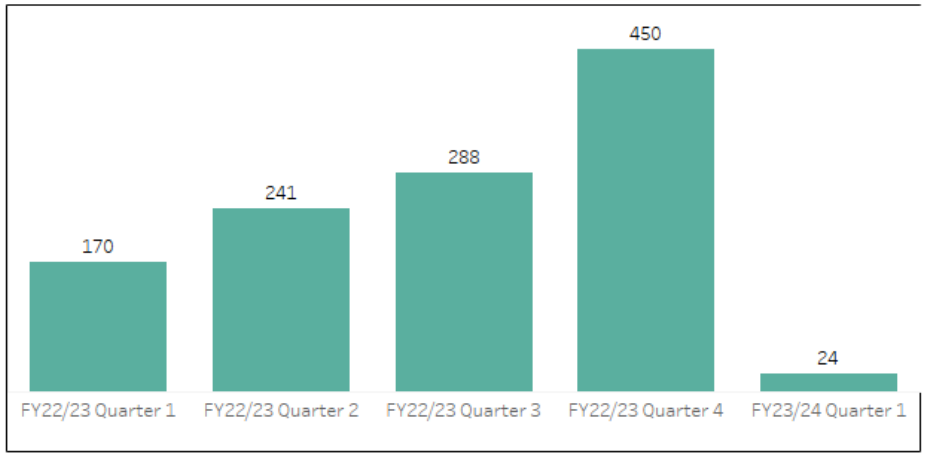
rking together for better health and care

Use the filters or click on a chart to update the others accordingly | Reset All Filters | Refresh Date: 26/04/2023 11:00:27 | Latest Data Date: 18/04/2023

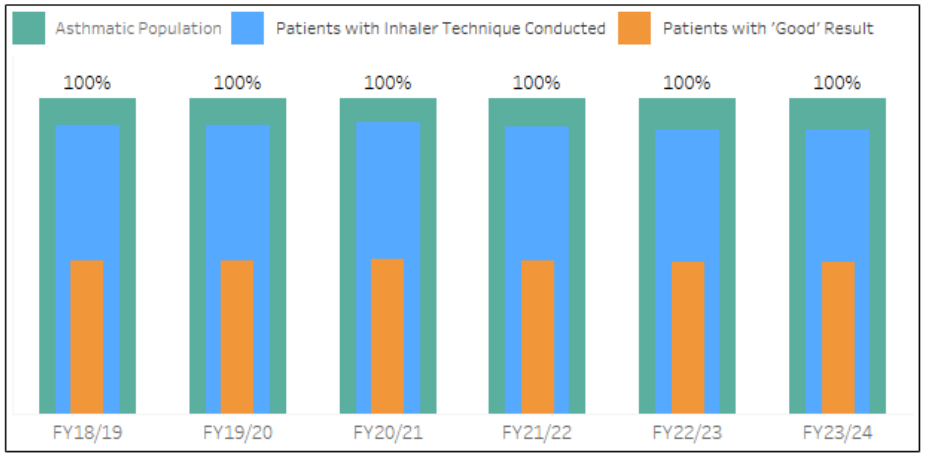
ICS	Health Borough	PCN	Practice	Gender	Age Band	Deprivation	Ethnicity
All	All	All	All	All	All	All	All

% of High Dose ICS Items	% of Patients Receiving ≤5 Inhalers for ICS Products	# of ACTs Recorded in last 12 months	# of Patients with Quality Assured Diagnosis	# of Patients with Annual Review in last 12 months	Number of Times Prednisolone was Prescribed	Total Prescriptions of DPIs vs. MDIs Ratio
13.0%	59.9%	85,315	882	83,357	47,101	0.33

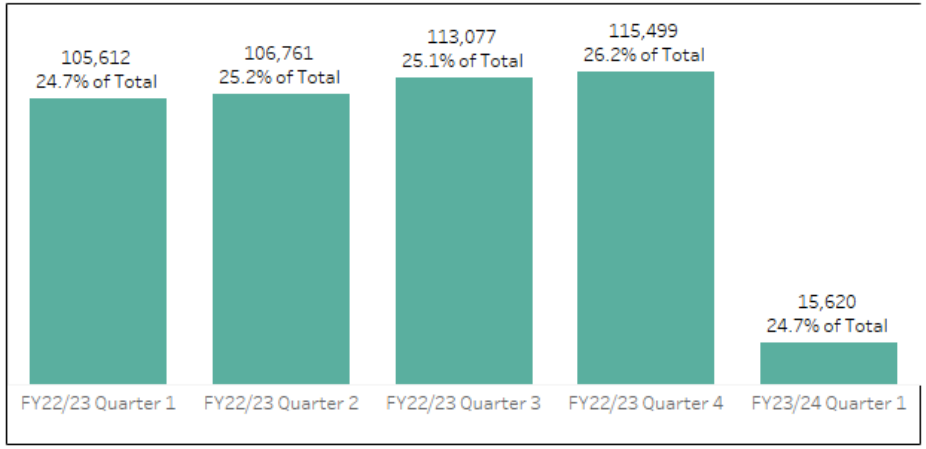
Quality Assured Diagnosis | **Diagnoses over Time** | Tooltip Detail Health Borough



Asthma Review Trends over last 5 Years | Inhaler Technique | Percentage of Total

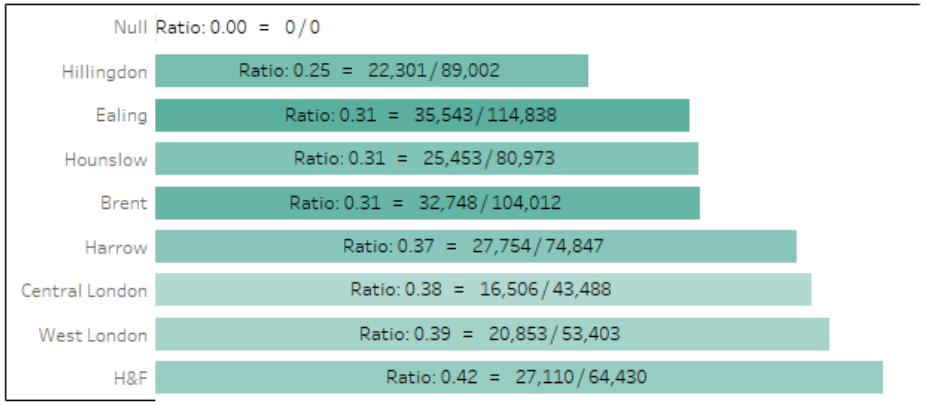


Number of ICS | **Prescriptions over Time** | Tooltip Detail Health Borough



DPI vs. MDI Ratio - Bottom 10 Health Boroughs | Coloured by # MDIs

Do not change inhalers without reviewing patient suitability and assessing their inhaler technique.



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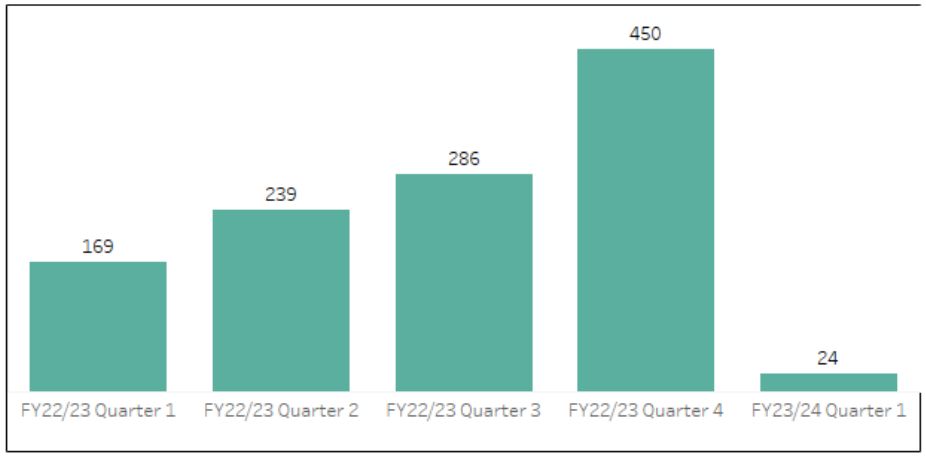
All	All	All	All	All	Multiple values	All	All

% of High Dose ICS Items	% of Patients Receiving ≤5 Inhalers for ICS Products	# of ACTs Recorded in last 12 months	# of Patients with Quality Assured Diagnosis	# of Patients with Annual Review in last 12 months	Number of Times Prednisolone was Prescribed	Total Prescriptions of DPIs vs. MDIs Ratio
14.5%	58.2%	75,346	877	73,113	45,849	0.37

Quality Assured Diagnosis | Diagnoses over Time | Tooltip Detail Health Borough



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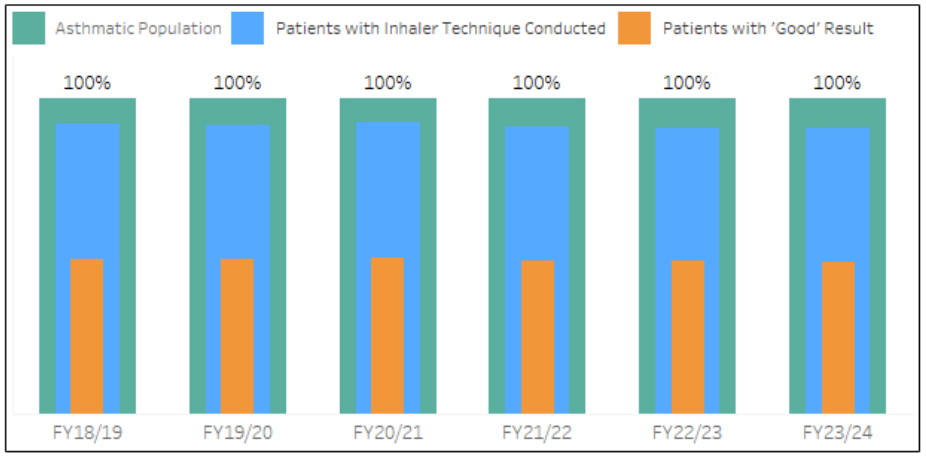
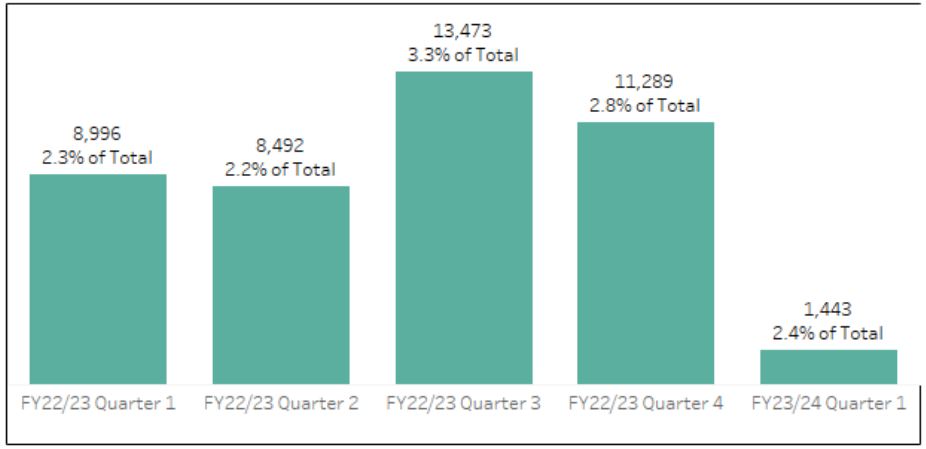


Number of Prednisolone Prescriptions over Time | Tooltip Detail Health Borough



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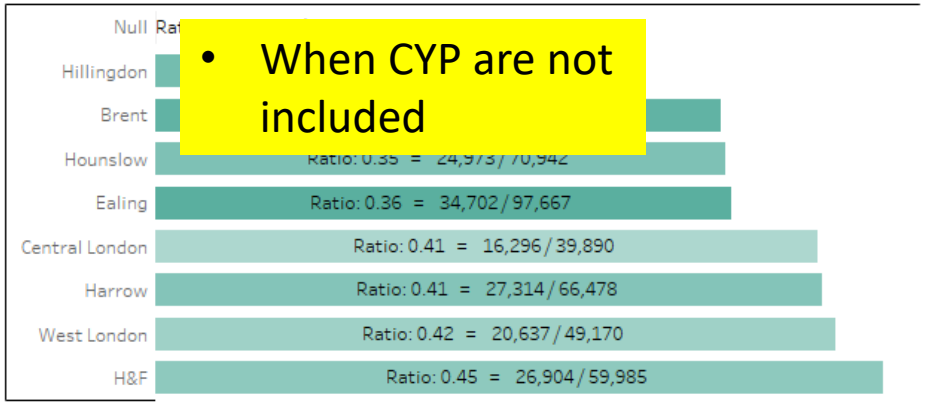

- When CYP are not included

Clinical Care of Asthmatic Patients

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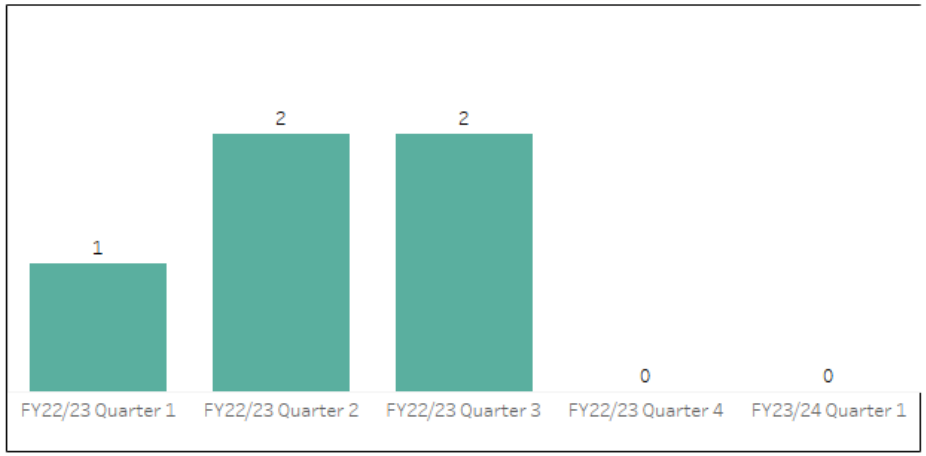
2.8%	72.0%	9,969	5	10,244	1,252	0.05

Quality Assured Diagnosis — Diagnoses over Time — Tooltip Detail: Health Borough



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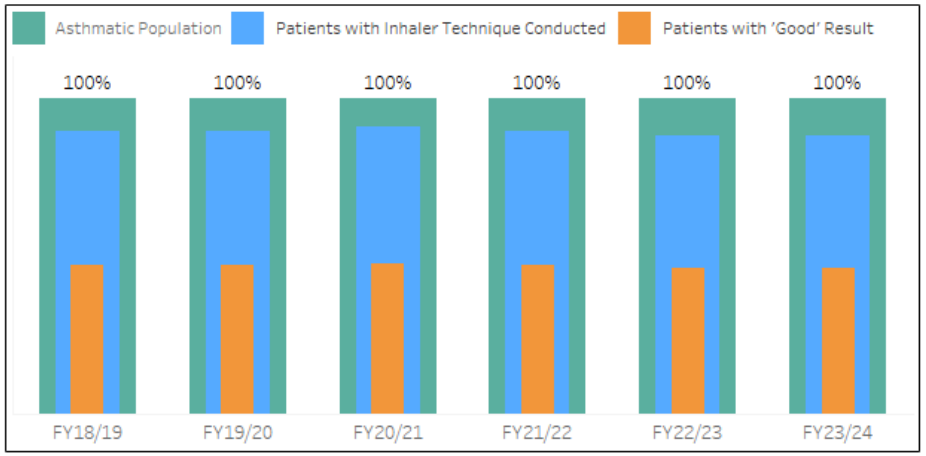
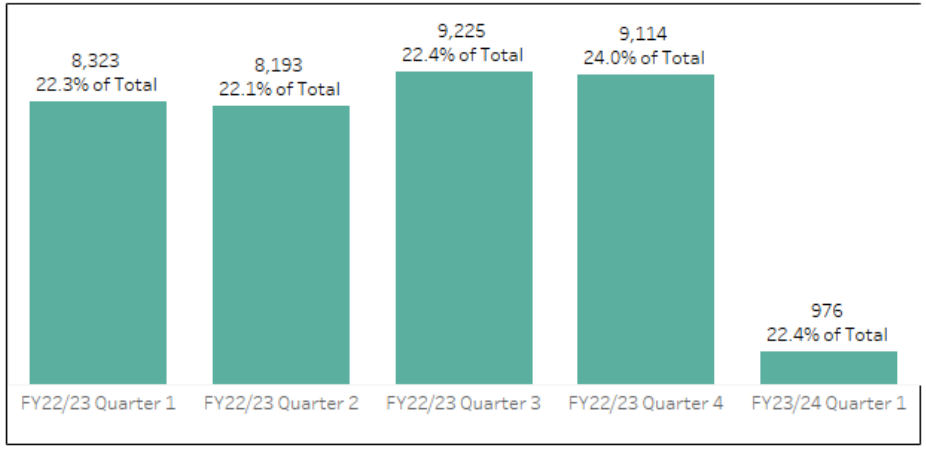
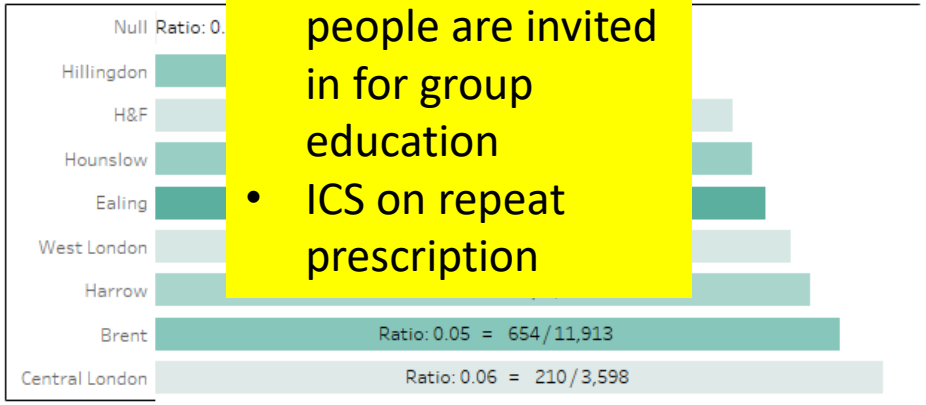


Number of ICS — Prescriptions over Time — Tooltip Detail: Health Borough



DPI vs. MD … by # MDIs

Do not change inhalers wi… nhaler technique.



- Is it time to ensure people are invited in for group education
- ICS on repeat prescription

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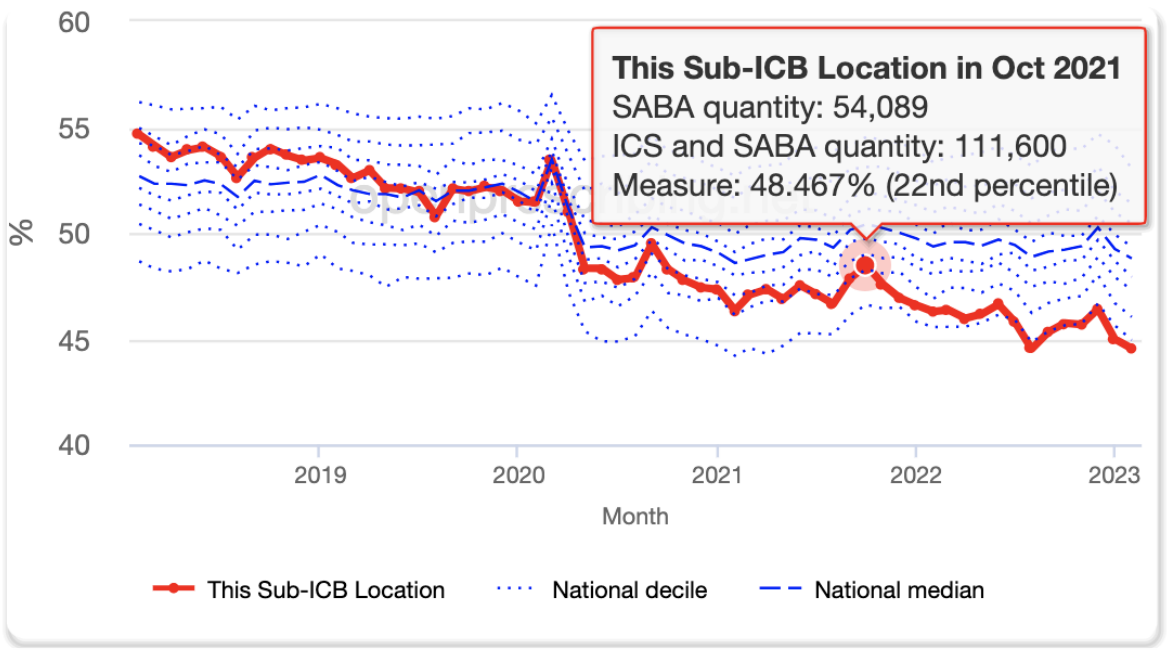
8962 less SABA prescribed since Oct 21
943 more ICS prescribed since Oct 21

Short acting beta agonist inhalers

Prescribing of short acting beta agonist (SABA) inhalers - salbutamol and terbutaline compared with prescribing of inhaled corticosteroid inhalers and SABA inhalers



Download data

Short acting beta agonist inhalers

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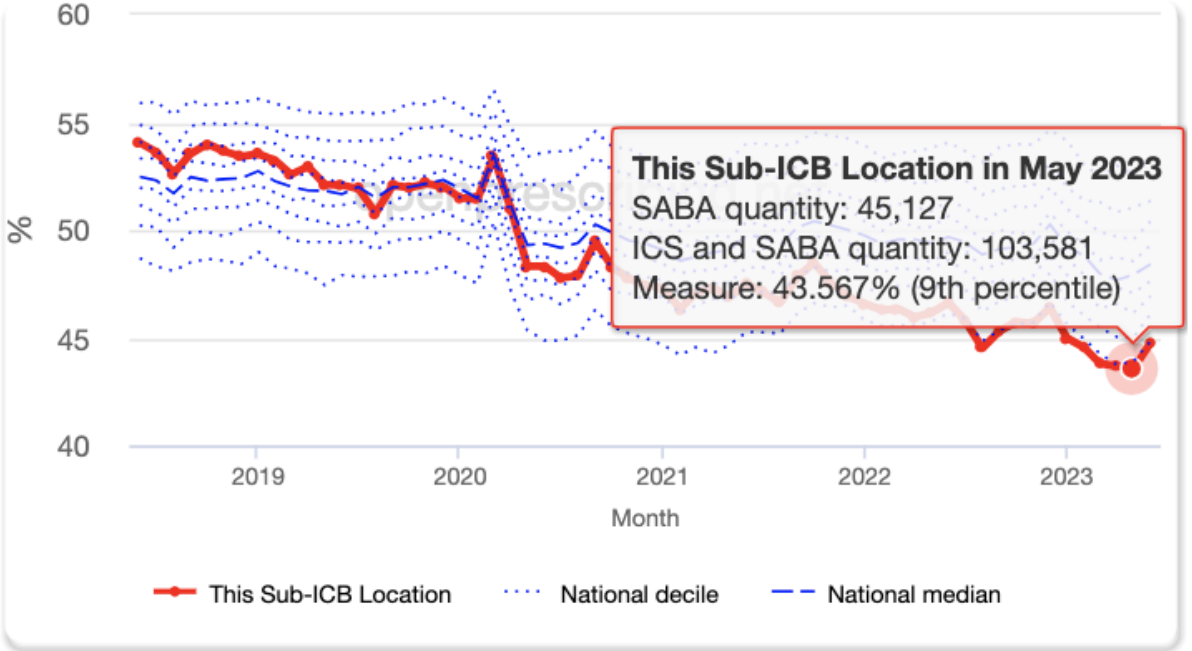


Download data

Initiation Session Part 2 (SABA audits, searches and labelling)

- **1-hour long sessions** (open to pharmacist teams & MDT)

- **Content:** System searches (WSIC, EPACT2, System 1, EMIS), Audits, Prescriptions and pharmacy labels, using thought provoking tools in discussion, national bundle (EPM), case study, common statements exercise

How often is a follow up appointment planned when a SABA is prescribed/dispensed?

Is follow up more likely to be clinician-directed or patient-directed?

Instruction on the label:
Inhale ONE or TWO puffs for cough, wheeze or shortness of breath, and get medical help if this doesn't help or if the relief lasts less than 4 hours.

Instruction on the "Pharmacy Info" section: If you need to use your blue inhaler THREE OR MORE TIMES A WEEK, or have any night time symptoms, please book an appointment with your practice nurse/pharmacist as these are signs of your asthma worsening.

Next steps

- Implementation of **behaviour changes** to more colleagues (new starters)
- **Progress data report** - A plateau in CYP asthma data in the last 6 months – renewed focus.
- **Peer support** network, Community of Practice, attendance to **PCRS conference** (group discount)
- **National competency framework** Tier 3 training
- **Senior nurse support/mentorship** with highest activity practice
- **More group sessions planned**

NWL CYP Asthma Network
Helping CYP live better with asthma

PCN pharmacy support
Baby Steps to Asthma Right Care

Darush Attar-Zadeh (d.attar-zadeh@nhs.net)

CYP Pharmacy asthma group Co-Chair (subgroup of LALIG Leadership and Implementation Group**)**

Bexley, Bromley & Greenwich
Local Pharmaceutical Committee

bbglpc

Lambeth, Southwark and Lewisham
Local Pharmaceutical Committee

CYP Asthma Service

September – November 2022

By Reena Patel

Background Information

- 30,000 CYP in SEL prescribed inhalers.
- Poor management increases risk of adverse events and loss of control.
- Evidence shows planned care can reduce exacerbations and improve quality of life.
- Collaborative working between CCG and LPC to develop the service.
  - Formulation of service specification
  - Contract
  - DPIA
  - SOP

Key Information

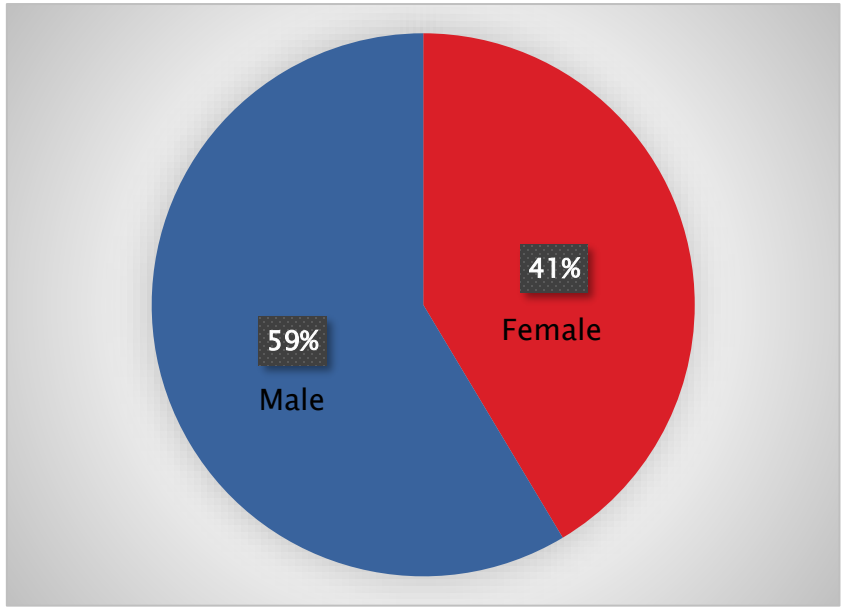
- Cohort: CYP 5-18 years old.
- 36 community pharmacies participated resulting in 681interventions being made.
- Contractors to undertake training on:
  - Inhaler technique
  - Basics of Asthma care
  - Medicines optimisation principles for Asthma
- Proactively contact and arrange an appointment and complete a structured intervention which was recorded in PharmOutcomes.
- Pharmacies were paid for the completion of 15 interventions with an additional payment of every further 15 interventions made.

Intervention Details

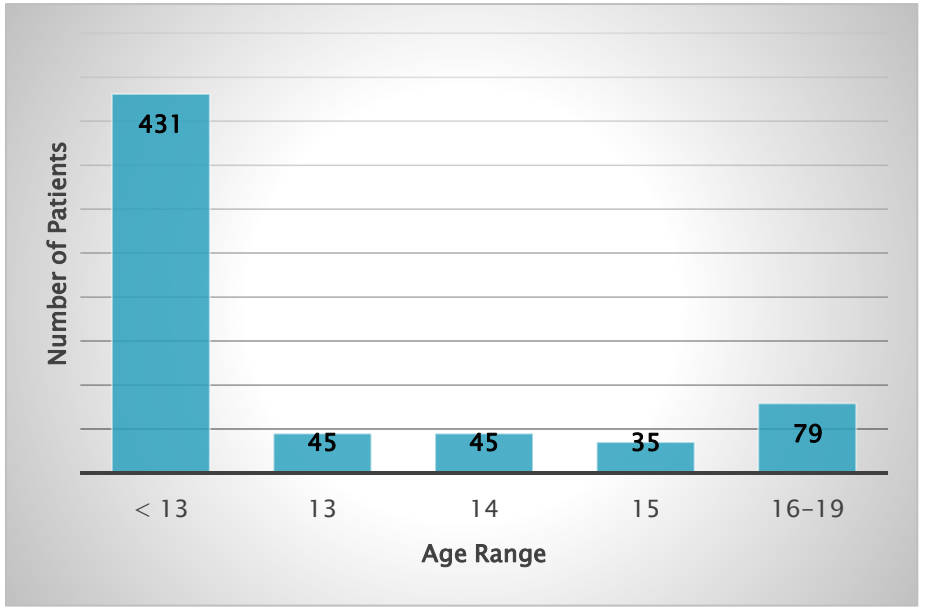
- Inhaler technique was checked at every contact.
- Spacers were given to those that required them and did not have one (funded through the scheme).
- Smoking cessation advice to be given to the CYP and/or the carer (household) where appropriate.
- Excessive and under use of SABAs, ICS and oral steroids identified – environmental impact highlighted.
- Signposting for further information and support.

Key Demographics

- Gender

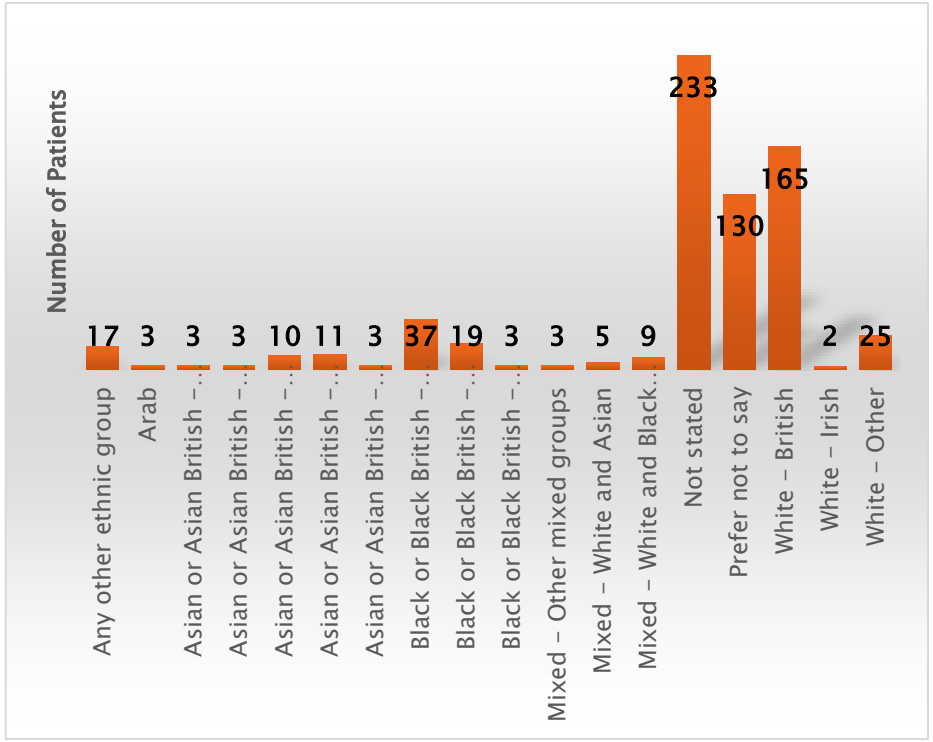


- Age Range

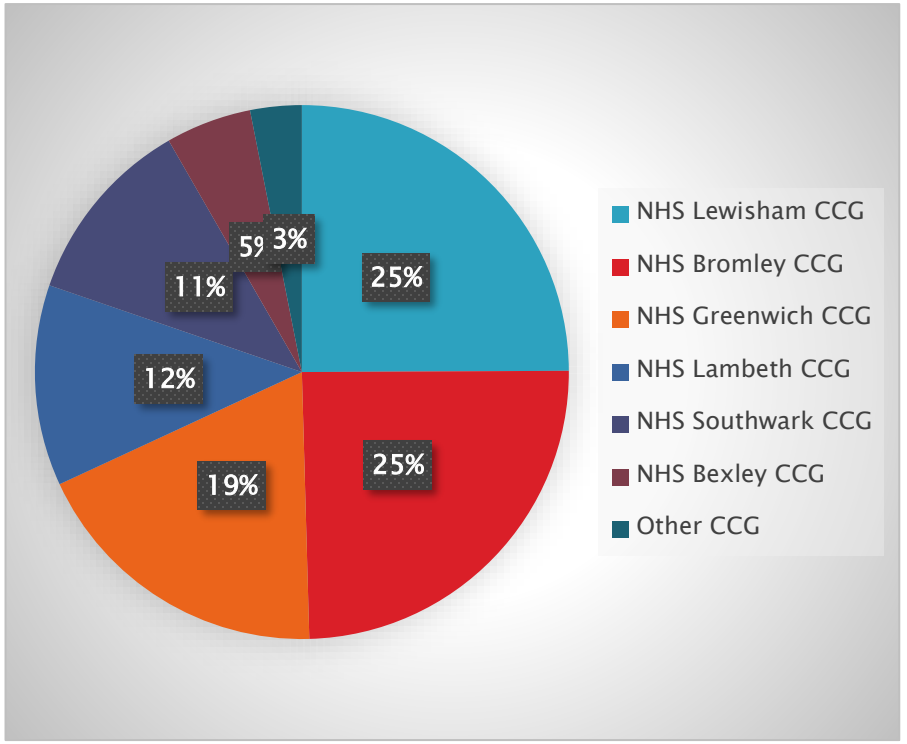


Key Demographics Continued

- Ethnicity

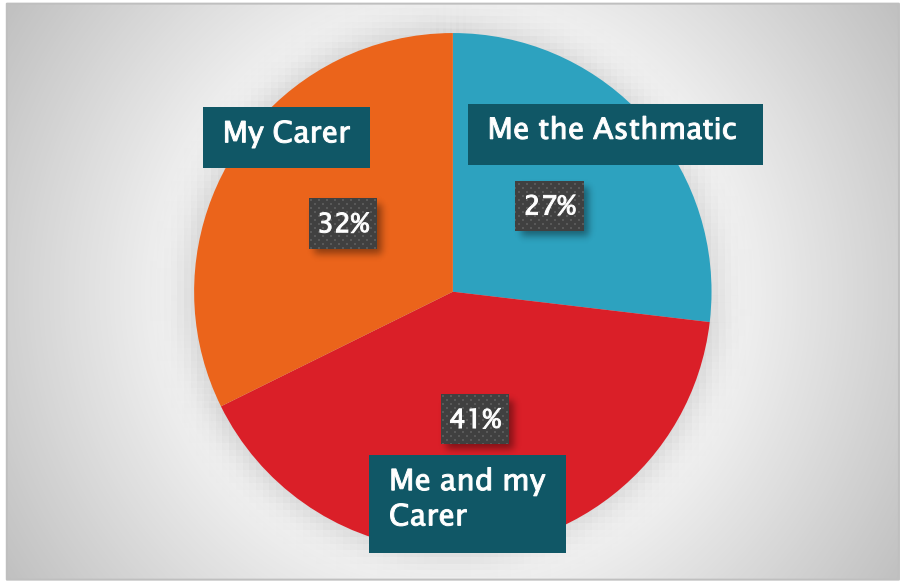


- Breakdown by CCG

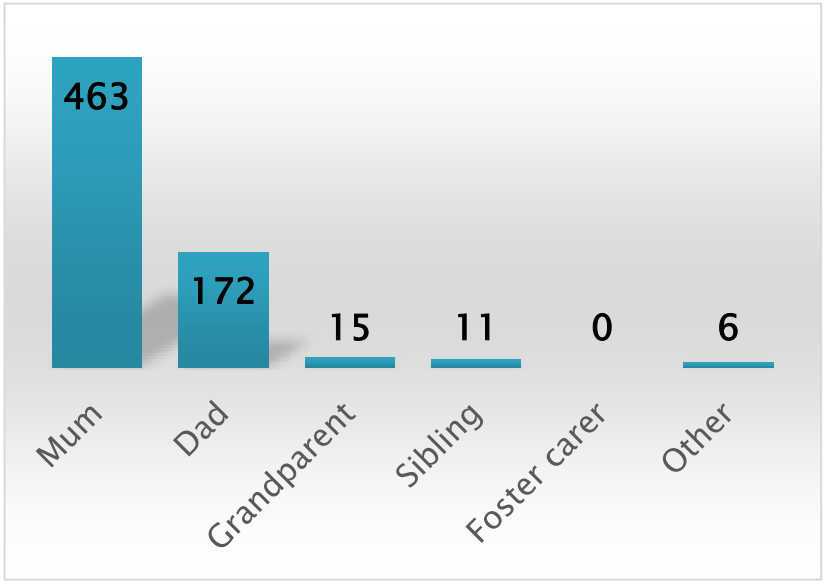


Responsibility and Supportive Person

- Who is Responsible for your Asthma?



- Supportive Person



Classification	Description
Me the Asthmatic	I do not need prompting to use my preventer inhaler, attend GP appointments on my own and collect my own medications from the pharmacy independently.
Me and my Carer	I rarely need prompting to use my preventer inhaler, my carer arranges my prescriptions and appointments
My Carer	I need daily support to use my preventer inhaler, my carer still needs to arrange my prescriptions and appointments

Inhaler Technique and Spacer Use/Supply

- 92.8% of all the patients seen had their inhaler technique assessed.
- 63.6% of all the patients seen already had a spacer and used it correctly.
- 92 spacer devices were provided during the scheme

Use of SABAs and ICS

- The use of SABA's and ICS (where appropriate) were discussed with all the patients in the interventions.
- In 94.6% of interventions, advice and adherence to ICS was discussed.
- 40.3% of interventions required referral to the GP to discuss ICS adherence and SABA overuse.
- ¾ of all interventions, highlighted less than 6 collections of ICS per year showing underusage.
- 73.3% of interventions asked if CYP had a personal asthma plan and if not, they were referred to GP for review.

Smoking

- 20 CYP were highlighted as being smokers and 77 had someone in their household who smoked.
- Stop smoking advice or signposting to a smoking cessation service was given to all of those within this category.

Conclusions

- Engagement from the pharmacies was brilliant during this time period, especially due to winter health pressures.
- Over 40% of interventions required referral back to the GP to discuss ICS usage showing the how important the intervention was.
- The freedom to be able to provide spacer devices through the service allowed the intervention to be of more value.

Inhaler Recycling Scheme (coming soon)

- New pilot project with SEL ICB and NHS England
- Aim to recycle the HFA gases into fridge and coolant systems.
- The metal and plastic from the canister will be recycled as well.
- Process:
  - Patients will return their used/unwanted inhalers to the pharmacy or hospital site.
  - These will be transported for processing
- Still working out the logistics

Thank You
Questions?

The effectiveness of the Discharge Medicines Service (DMS)

Sukeshi Makhecha

Paediatric respiratory Pharmacist, Royal Brompton and Evelina Hospitals

Co-chair Pan-London CYP pharmacy asthma group

NHS
Discharge Medicines Service

NHS Discharge Medicines Service (DMS)

Discharge from hospital is associated with increased risk of avoidable medication-related harm.

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, which aims to reduce avoidable harm from medicines by 50% over five years.

Issues with medication 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.

NICE guideline NG056 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 medicines reconciliation occur within a week of discharge

NHS Discharge Medicines Service (DMS)

NHS Discharge Medicines Service is an essential service for community pharmacy contractors. It commenced on the 15 February 2021. As an essential service, it must be provided by all community pharmacy contractors.

Established to ensure better communication of changes to a patient's medication when they leave hospital and to reduce incidences of avoidable harm caused by medicines. By referring patients to community pharmacy on discharge with information about medication changes made in hospital, community pharmacy can support patients to improve outcomes, prevent harm and reduce readmissions.

NHS Pharmacy Regulations Guidance 2020

NHS England and NHS Improvement has published guidance on the amendments to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, which introduced nationally agreed changes to the Community Pharmacy Contractual Framework for pharmacy and dispensing appliance contractors

NHS Discharge Medicines Service (DMS)

Discharge Medicines Service Toolkit: To ensure that a cross-sector approach is taken to implementation, and to support clinical teams across hospitals, PCNs and community pharmacy to provide the service, a cross-sector toolkit has been published.

Clinical teams in the respective organisations should ensure that they: a) have read the cross-sector toolkit and understand the NHS Discharge Medicines Service; and b)fully understand their role and responsibilities in delivering the NHS Discharge Medicines Service.

Centre for Pharmacy Postgraduate Education (CPPE) Training Materials: Clinical teams engaged in providing the NHS Discharge Medicines Service across all sectors (community pharmacy, hospitals, and PCNs) need to ensure that they understand the full patient pathway and complete the CPPE NHS Discharge Medicines Service training (adults only)

DMS also includes Paeds and is not restricted to Adults only.

First introduced in NWL as the TCAM (Transfer of Care around Medicines) project using Pharmaoutcomes.

NHS Discharge Medicines Service (DMS)

Figure 3.1: NHS Discharge Medicines Service patient pathway

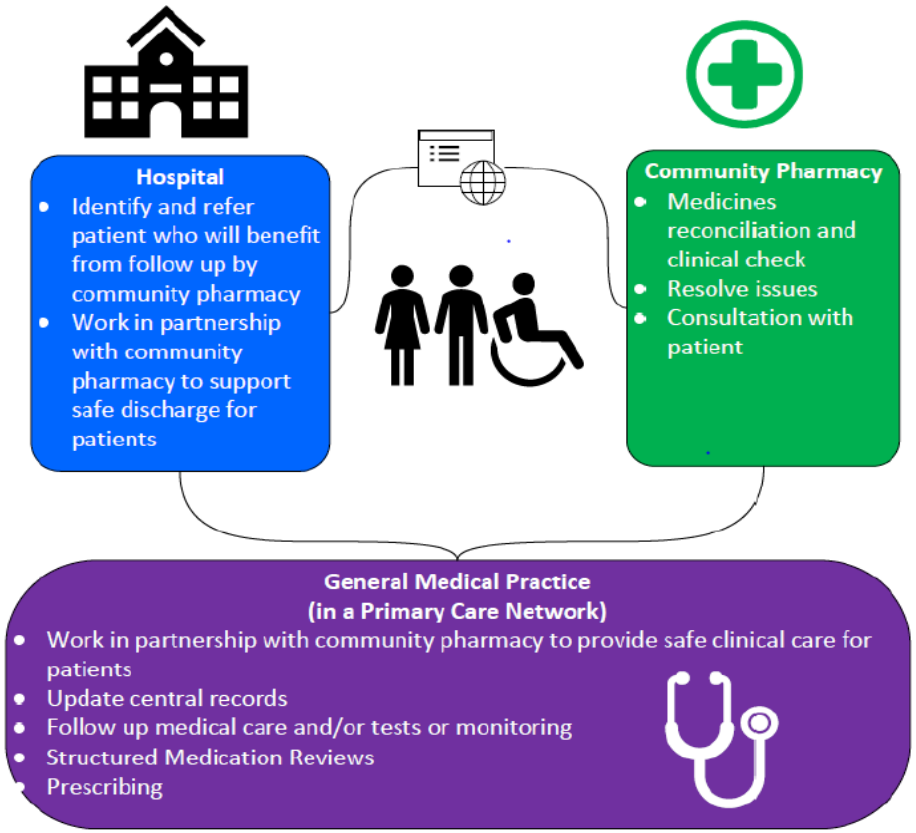


Table 4.1: NHS Discharge Medicines Service patient pathways

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).

Role of pharmacist in respective organisations

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.

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

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 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.

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

Hospital process: Identify, Consent, Refer – Via NHS mail or pharmaoutcomes

Medication discussion with the patient and/or carer

New medicines	• Check patient's understanding of medication use, provide education, conduct NMS, discuss side effects
Medicines Optimisation	• Check patient's understanding of benefits of medication, how and when to take them
Medicines interactions	• Check for any interactions, including food, vitamins and herbal medication
Medicines disposal	• Discuss disposal of medication especially MDI, needles, syringes
Adherence support	• Discuss adherence and if any issues with medication taking. This could be intentional or unintentional. Are there issue with memory, cognitive function or just trying to fit in the times at school etc…
Additional resources/ education	• Online resources, videos, websites, apps

Case of DA

Age: 12 years, weight: 35kg, height: 146.4cm

Diagnosis:

- Severe eosinophilic asthma
- Severe eczema
- Previous recurrent lower respiratory tract infections (Azithromycin prophylaxis)
- Adrenal suppression (sick day hydrocortisone supplement)
- Gastro-oesophageal reflux
- Multiple food allergies (eggs, milk, strawberry)

Presenting Complaint:

- Exacerbations of asthma
- Non adherence to Seretide MDI, High SABA use, High OCS use

Case of DA

Current DHX:

- Seretide MDI 125/25 – 2p bd via spacer
- Salbutamol – 2-3 puffs prn
- Omalizumab Every 4 weeks
- Lansoprazole 15mg od
- Azithromycin 250mg M,W,F
- Hydrocortisone supplements for sick days (10mg am, 5 mg lunchtime, 5mg pm)

Medication changed Sept 22 OP appointment: Stop Seretide. Start Symbicort MART 200/6 – 2 puffs bd & additional doses prn as an MDI, not turbohaler as cannot co-ordinate this – has ASD. In hospital, Changed to 100/3 (3p bd) mdi as did not have any. Education provided. No NMS made at the time.

Case of DA

Spirometry on discharge: FEV1 2.36 L (87% predicted), FVC 2.65L (97% predicted). FeNO <5 PPB

Oct 22 Symbicort T/H 200/6 prescribed in primary care

Nov 22 – Video appointment with home spirometry. Unwell home FEV1 53%, SpO2 – 89-94% - sent to A&E – Nebulised Salbutamol, O2, IV Mg. Started OCS. No other changes to medication

Came to us & discharge referral made (spoke to an excellent community pharmacist & explained re Symbicort MDI 200/6, who followed this up).

Main issues

Symbicort MDI 200/6 –not licensed for use in asthma only COPD & not licensed for use in children & not licensed MART

Letter sent to GP stated Symbicort MDI 200/6, hospital gave 100/3. NMS not made at the time

Non Adherence, ASD, safe guarding, high SABA user, high OCS use

Summary

Simple change of one inhaler – yet so many issues

Community pharmacist – organised and corrected the prescription every time incorrect, followed up on education to mum & GP and DA now continues to have the correct inhaler on repeat & community pharmacist endorses education every time.

DA doing much better, but still has exacerbations, but not requiring hospital admissions. We have now Omalizumab changed to Dupilumab every 2 weeks– helping asthma & eczema. Homecare via video call

Demonstrates the effectiveness of the DMS/NMS service

Questions