Wessex Academic Health Science Network

NHS

Transfer of Care Around Medicines (TCAM)

Lessons learned from the national rollout

This is the report from the round table discussion

June 2021 Version 1

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The AHSN Network

Contents

What is the TCAM programme?

Work across England has demonstrated that where transfer of care around medicines (TCAM) processes are in place (to transfer information about a patient's medicines from hospital to their community pharmacist) they result in reduced harm from medicines on discharge and reduced rates of readmission at 30, 60 and 90 days. There is early evidence to suggest a reduced length of stay if a patient is readmitted.

The World Health Organisation has highlighted the risk of harm to patients from transitions of care as part of their 3rd Global Patient Safety Challenge 'medication without harm'.

To find out more visit **https://bit.ly/32BgvcK**

In 2018, the Healthcare Safety Investigation Branch (HSIB) highlighted the need for electronic transfer of patient information to improve communication about medicines when patients move between care settings.

To find out more visit **https://bit.ly/3aoyQ0T**

To find out more visit **https://bit.ly/33BCUqN**

The AHSN Network (the national collaborative of Academic Health Science Networks) has been working since 2018 to scale up this intervention and now over 70 trusts are live. Therefore, as this work transitions to the new nationally commissioned Discharge Medicines Service, we wanted to capture the lessons from the pioneers of this important service. In March 2021, we convened a round table discussion to look at three general themes.

- **Why and how to get started**
- **Barriers and issues**
- **Lessons learned**

To watch the recording of this event please see **https://bit.ly/3gZwJTC**

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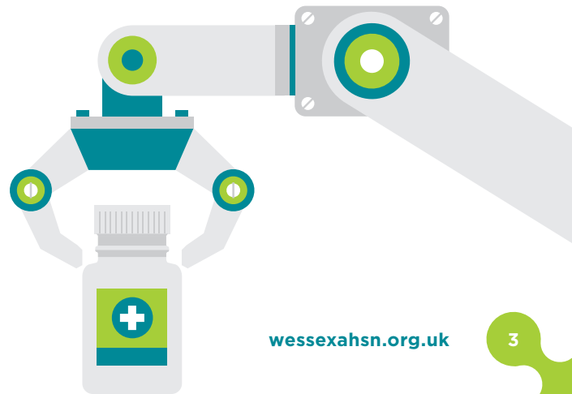

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Summary of key findings

- Using TCAM provides good patient care as it helps reduce problems when patients are discharged from hospital. Once people could see that TCAM worked elsewhere, that the evidence base shows the benefit of reduced readmissions, they were happy to get involved.
- Prior to TCAM, there was frustration about the lack of information provided to community pharmacies when patients were discharged from hospital and that was impacting on their ability to provide good patient care. TCAM offered a solution to this. The value to community pharmacy of TCAM was the ability to do the job in community pharmacy and provide better patient care.
- Building on good local relationships and getting the right people engaged early on is key. Launch events can be formal or informal, with high level executive sponsorship or work starting quietly, both approaches work if the right people are on board. Local Pharmaceutical Committees (LPCs) need to use a variety of approaches with their community pharmacies. Contact with individual pharmacies can be very helpful and linking with big-chain regional or area managers helps too.
- IT can be issue for some trusts but not others. Similarly, information governance (IG). Some trusts seemed to have huge IG concerns, others none at all, and it felt like it came down to the individual view of the trust IG Lead.
- Activity data is important, it helps drive the behaviour changes needed to make the referrals. It is important with the new Discharge Medicines Service (DMS) that trusts retain the access to data that they previously had with TCAM. This is important for policymakers to consider.

And finally...

- **Build local relationships**
- **Speak to trust IG leads early on**
- **Share the evidence regarding readmissions**
- **Share patient stories**

Why we chose TCAM: insights from our pioneers

Q: What were the key motivations for getting involved in this work? There was no contractual obligation to get involved with transfer of care around medicines, so what made it worth your investment?

Trust 1: I was spending a lot of time dealing with patient complaints around transfer of care around medicines, so anything to improve that felt worth looking at. I saw a presentation on digital products enabling the transfer of information. There was no financial incentive, but I could see the benefits of improvement of data quality and engagement with community pharmacy.

Trust 2: We wanted to work in a more integrated fashion and the impact on readmissions data coming out of the centre was helpful. We saw it as a dual win with the wider professional community.

Trust 3: With electronic discharge summaries there was frustration that community pharmacy colleagues didn't get the same information. It was a no brainer to get involved when the opportunity came along.

Reduced readmission rates sparked our interest and we felt a duty of care to do this. It was good to have AHSNs involved presenting data on the impact rates. Without this, we wouldn't normally have heard of TCAM.

Trust 4: There was a lightbulb moment for us. This was about patient safety medication safety,

Summary

This is good patient care and it was clear that it helped reduce problems when patients were discharged from hospital. There was a clear gap in the system and, once people could see that TCAM worked elsewhere, they were happy to get involved.

Q The response of Local Pharmaceutical Committees (LPCs) was variable. So why did the LPCs represented here get involved and support the work?

LPC 1: We saw the same patients coming out of hospital but we didn't have the right information. Integration and joined up IT was a big thing.

LPC 2: There was frustration from community pharmacy that without the information you can't help and we feel responsible for patients. I had personal experience of a previous project working with an acute trust where they shared information with us and we had very good examples of the difference community pharmacy has made to these patients. Integration made greater relationships. This work makes community pharmacy's job easier and they can make informed decisions to support patients.

LPC 3: We had a paper-based system that failed. It was double entry and there was difficulty transferring information. The local area wanted to support this. We put in a lot of support for contractors, pharmacies really needed the information.

I agree with what others have said regarding integration, pharmacies need the information to provide sound clinical input. We got 100% sign up from contractors as they valued having that information around high-risk patients.

Chair: This reflects what we've seen; once community pharmacies get involved, they value this information; however, this wasn't enough to get engagement from all parts of the country.

Summary

There was frustration about the lack of information provided to community pharmacies when patients were discharged from hospital and that was impacting on their ability to provide good patient care. TCAM offered a solution to this.

Getting started

Q: What first steps did you take? Who were key players?

Trust 1: We had a head start in our area, we already had an integrated community and acute trust, we already had a platform for integrated working, a specific projects group set up to support this, plus technical teams to do the IT side. We decided we would need a good communication plan and it was important to get the IT right. Using the PharmOutcomes web tool seemed too time consuming so we needed to link the software in with the trust's discharge system. A key first step was getting the right people round the table and come up with a sensible project plan.

LPC 1: We had a great partnership with heads of management too. Great leadership to get GPs on board.

Chair: The role of commissioners was really important, pivotal to keeping things moving in some places.

Trust 2: We were fortunate that groundwork had been done by an early project in a nearby trust. It was good that we had discussed how to manage the integration of the IT. Discussions started around information governance, they felt that this was the right thing to be doing. Patients would expect all sectors to know about their medicines. We worked with the LPC and colleagues and with commissioners to do our launch events. We started ahead of others in our patch as we had the integration and interface already.

LPC 2: It felt like an easy launch for trust 2 as it was all there. We had an evening meeting to win community pharmacies' hearts and minds. We wanted to make sure referrals were picked up. We had a great response to the meeting to get everyone to know each other. It was different for another as they were starting from scratch. But we had all the different stakeholders so agreement could be reached that everything could be done and what could be learned from trust 2. The other trust had support from the trust CEO so it all seemed very natural and easy.

Trust 1: We had a simple, basic project team of 3 or 4 people who had connections with or knew the stakeholders. We prioritised it with IT, essentially to get it top of the IT agenda/work plan. We were fortunate in knowing how to talk with IT to get the functionality needed out of the system. The project benefited from being initially off the radar so there was not too much pressure. Covid was a double-edged sword – it helped me to sell TCAM to the secondary care teams. We had good buy-in from the LPC and did the launch with community pharmacists with the help of our local AHSN.

Trust 4: The initial hook was a national conference. Our local AHSN contacted us and the LPC and we set up a small project group. I thought it could be powerful as, at that time, we were faxing all discharges to community pharmacy which wasn't ideal. We wrote the business case, got IG involved early and had key players around the table. A big positive was the nearby teaching hospital trust had already run with it so we didn't have to do all the communications work with commissioners so could piggyback on that. Our IT is less sophisticated, so we went with the web based version of PharmOutcomes. There was quite a lot of caution, but we focussed on education and raising awareness among patients/service users.

LPC3: We were supported by our AHSN which was a big factor (project management and time). We approached trusts, they had the same considerations around IT as everyone else. There were so many other competing priorities but this was led by the Chief Pharmacist, and it was important to highlight patient safety around this. There was scepticism initially about transferring to other settings. We focused on the value to patients. When we launched with the contractors, we visited them. There had been a previous event that had negative views that "this is just more work". We flipped it on its head by emphasising that it was information sharing, not a service- we focussed on the value to contractors. At the end we said if you want to opt out, we can take you off the referral pathways. Two people called us, out of 136 contractors, but ultimately we had 100% buy-in and no one opted out.

Summary

It was important to be honest about the evidence base, there will possibly be the benefit of reduced readmissions. The value to community pharmacy then was not financial but more about the ability to do the job in community pharmacy and provide better care.

A key theme was building on good local relationships and getting the right people engaged.

The launch events could be formal or informal, they could have high level executive sponsorship or start work quietly under the radar. Both approaches work if the right people are on board.

Overcoming barriers to implementation

Q: What were the big barriers faced in the early days to get running and keep it running?

Trust 1: IT – we seemed to have a discharge system no one else had, this held us up for six months. We were all ready to go but waiting for two IT systems to talk to each other. That was the biggest problem.

Trust 3: We had struggled with electronic systems/IT infrastructure previously, we are a few years behind other trusts, for example we still have paper prescribing. This helped us as the discharge summary was developed in-house and the IT guys could build on this interface. We managed to push this up the IT portfolio quickly with gentle persuasion as this was a small change in their work plan. Keeping it on the radar of IT cannot be underestimated.

There was a bit of scepticism about PharmOutcomes. The idea of referring to community pharmacy was not new but, as we didn't have an integrated system, we had to go to a web interface manually. Making it simple - I counted three clicks and selecting the pharmacy as additional to normal work flow - this won people round.

Trust 2: We had to make decisions on volume versus quality, the interface used was not the final discharge summary. Pharmacists needed to get involved, I echo statements around getting ward pharmacist on board. I kept an eye on the number of people to refer each day. It was challenging to add oversight to this. I still don't think we quite refer all the right people at right time.

Trust 4: A big challenge for us was IG - this was a real stumbling block. It pushed us back by three or four months and was mostly around consent. Oddly there was very little IG concern around faxing discharge notes to community pharmacy but now suddenly there was a concern about a digital transfer. We had an issue around when people were being admitted; if they are really unwell, how do you get consent? Now we have implied consent. When the patient is discharged, we have a conversation. Another issue was around staff engagement - this was seen as an 'extra' role to do but we removed this barrier by showing the evidence. We used the PharmOutcomes tool to do shorter prescriptions. We used those hooks for people to accept/ recognise that the patient is getting a better service.

Information technology, information governance

Q: IT seemed to be a mixed picture. Some trusts made it happen quickly, some not. Were there any IT issues on the community pharmacy side doesn't need capitalising? Community pharmacy were using PharmOutcomes for other services. IG was different in different trusts; some trusts wouldn't set this up without agreement with every community pharmacy but this is a show-stopper and unnecessary.

LPC 3: It was not a big problem for us but there was big variation between trusts. We went live with four trusts, the entire integrated care system (ICS)/county footprint. Real concerns were not mirrored across the system, which was surprising. We had some trusts struggling with IT, but IG was ok – some trusts were able to go live with a fully integrated system, conscious of every map of information across systems. It felt unexplained as to what official rules were being applied. We could only say it was a secure platform. Asking "what are we doing already?" It was important to understand concerns, and in most cases we managed to get around the concerns.

LPC 2: We had one trust who had major issues around the IG element. We said everyone else is doing it. There were barriers for community pharmacy – we decided to call it a process not a service. Reminding pharmacies to close the loop (mark the referral as complete) once the referral message had been picked up. My experience was of constant reminders for everyone to keep doing it with teams, as people move around, get new staff, so there needs to be checks in place that the process is being adhered to. Because there are not many referrals per individual pharmacy, it takes quite a while to become business as usual. It was difficult at the start to get people on board and continue to be on board. You need dedicated champions. Once launched, the job is not done, you need to keep it going.

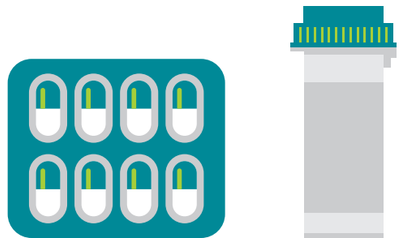
LPC 1: I agree, IT was a common issue for everyone. Everyone had a role to play (project team). After the engagement event, the AHSN support came in. There were no IG issues for us. We did live webinars with community pharmacists. The role has changed over two years, it's more about engaging, this took a lot of monitoring. Two trusts still struggling. How do we continue the success?

Summary

IT was a massive issue for some trusts but not others.

As national leads, we were repeatedly asked for templates about which patients should be referred.

IG was incredibly variable. Some trusts seemed to have huge IG concerns, others none at all and it felt like it came down to the individual view of the trust IG Lead.



The important role of data

Q: Data was quite important to show us what was happening in real time, such as how many referrals were being made. How has data been used in reports? How has data been used to keep the service running well?

LPC 3: We worked with trusts to set up PharmOutcome reports. We had a support officer to check the reports. They logged which pharmacies they had spoken to. We produced a standard email to action within the time frame. Next time the report came through, if the action had not happened we followed that up with the community pharmacists – "you have not actioned this, is there a particular issue?" This was time and labour intensive. We hope now it is a core service people are more used to looking for the referrals, especially with the Discharge Medicines Service (DMS) having a time limit of 72 hours. We are having to reset our consciousness around this as we were previously relaxed about this. Data is now as important, if not more so, and not as easy to access because of the national service. We are not getting the same information as previously and this is a big concern for us at the LPC.

Q: What impact did data have on running the service?

Trust 4: We weren't referring big numbers but we used to produce a quarterly report which was beneficial because we were able to compare discharge numbers versus referral numbers. We look at the data and see where the gaps are. Some staff are well engaged and some not. Data can help tap into areas of challenge, eg find out what are the barriers to using this process. Data is a concern now it has moved to a nationally commissioned service. How do we get data and in what form? In year one, I was asked to do a business case to show how it had worked. I did a report with data / case studies which supported the benefits of the service. I feel nervous about what we can get out now as data was previously invaluable.

Trust 2: Data helps to remind people of the value of TCAM. I have been pulling together data on the impact on patients, simple monetary value on what it is costing the NHS but also looking at those patients seen / not seen. It has been valuable as it's a big number, everyone can see what value they're adding (by saving time and money in the system).

Trust 3: I agree about the importance of data. Reviewing PharmOutcomes data was essential to championing this. IT helped with producing data internally – for example, how many pharmacists doing how many referrals? We broke it down by ward and speciality. We named people which helped, creating a league table (no one wants to be at the bottom!). We wouldn't have been so successful without this.

Trust 2: We cajoled people to ensure they were not bottom of the table. We made sure new staff were inducted properly and not missed. We started with 'you're not doing these, why?' etc then followed up after they'd been shown not to improve, explaining what we are getting out of it and why it was important. However, this rarely happened once they realised we could watch them (the fact that they weren't doing it).

Trust 4: We did similar and it made a difference. Targeting the training, initially we had champions but, as people leave, this drops off. Quality over quantity. We included training in the staff induction and targeted individuals. Numbers went up massively during the first lockdown as we had to get people less acutely unwell discharged. Staff really engaged with it – this was a blessing as use of PharmOutcomes increased massively.

Impact of Covid-19

Chair: I was so worried that referrals would disappear during Covid and all our hard work would be undone – but actually figures have bounced back after a small dip when hospitals were full and discharges were lower anyway because of Covid. This is really reassuring that the service is valuable.

Trust 1: I was expecting fall off in referrals due to staff sickness during Covid but the numbers bounced back and are not too different from pre-Covid. There is more enthusiasm at one site more than another, and Covid hasn't changed this so we may begin to target individuals like others.

Summary

Data is important, it helps drive the behaviour changes needed to make the referrals.

There are worries about what will happen with the new national DMS as trusts lose the access to some of the data that they previously had with TCAM. This is important for policymakers to consider.

Engaging the disengaged

As national leads, we were repeatedly asked for templates about which patients should be referred up. How did you cajole those community pharmacies not completing referrals?

LPC 1: It was about engagement, independent contractors having an SOP. At the start we engaged with the large chain Community Pharmacy's Head Offices. Once they were engaged in one part of the country it gave us a good start. How do we engage the regional pharmacy managers – "you've got this many referrals still not actioned", gentle nudge. Going to them directly helped, and when the AHSN came on board and developed a brochure we were able to post this to all pharmacies across the patch and it explained it all. We had to change the approach depending on what barrier they had, we found different ways to overcome.

LPC 3: We had a lot of 'mental health' conversations with support officers when we went live, as they had frustrations over having the same conversations with pharmacies. We kept trying different approaches – eg a set of standard emails for use with the pharmacist, directly contact each pharmacy with particular issues, email for first contact, email for contact after that, second contact (how can we support? etc).

Finally, we said that PharmOutcomes doesn't have to be opened only by a pharmacist, it can be anyone who is likely to access it on a regular basis and then they highlight referrals to the relevant people to action. We worked with regional teams where we could send information about the relevant pharmacy where referrals were not being actioned. We targeted specific pharmacies to unlock what their problem was in particular. The good thing was at the end this showed in the figures, with 80% of referrals being completed. LPCs around the country are all set up differently, so not all are able to provide this. This approach was very labour intensive. You have to be alert to a constant drop off, all of a sudden, a pharmacy that had been doing well began to show up on the highlight report. It was a constant process, anxieties around what happens next but it's now contractual so now there is a different tone.

LPC 2: It's not one size fits all, as an LPC you have the overall picture, we know where pressure points are – who is best to use/effect a result in that pharmacy, is it the area manager? Not all LPCs are set up in the same way or have the same resource. We got people to go in and talk to the pharmacies. There is a concern that if we don't have a picture of what's happening how can we maintain success? I tried to discuss this with another LPC, to talk it through with their chief officer, who saw it as shared care, which it's not. I had no success with this, there is a barrier in interpretation. Now it's an essential service, the big guns are coming out if it's not happening. I do have concerns, LPCs have big role to play.

Summary

LPCs need to use a variety of approaches with their community pharmacies. Contact with individual pharmacies can be helpful and linking with big chain regional or area managers helps too.

Lessons learned and tips for new starters

Q: What would you do better? What are your key lessons learned?

Trust 1: Building partnerships at the beginning. Also, if I could I'd pick a different discharge system for our trust - don't underestimate the technical side of interfacing and length of time to resolve.

Trust 2: Try not to be overly descriptive at the start. DMS will help to an extent. This doesn't need to be too complicated and all staff have a different role to play.

Trust 3: Selling it more in the first instance. We went live in December 2019 and then Covid arrived. The key thing is painting a picture of what's in it for referrers and for community pharmacists. Good news messages from the patients are important. It is so powerful to know you have made a difference to someone, having regular feedback, what it means to an individual on a ward.

Chair: Capturing patient stories is very important.

Trust 4: IG - anyone starting, check the system out with IG – if you are ready to go and IG put a halt to it, this can be demoralising. Mental health has a lack of parity, so it is a no brainer for mental health trusts to get involved and raise awareness. Use evidence/lived experience.

LPC 2: Think of it as a process rather than a service. Look at what motivates people - mastery, autonomy and purpose. Make sure everyone is properly trained, allow autonomy through not being so prescriptive, stress the purpose (hearts and minds) - why are we doing this? People need to know what's in it for the patient, provide more promotion to public/patients – if they're expecting this service then they will be driving this – it will happen more that way.

LPC 3: Local evaluation of local pharmacies being involved in the pathway – I wish we had looked more at evaluating it. There is the selling point of the Newcastle figures [Nazar H, Brice S, Akhter N, Kasim A, Gunning A, Slight SP, Watson NW (2016) A new Transfer of Care initiative of electronic referral from hospital to community pharmacy in England: A formative service evaluation. BMJ Open but their experience didn't feel real to our system. We didn't have the local evidence so it was difficult to make the case for pharmacy to be involved in the pathway.

To find out more visit **https://bit.ly/3fMFJvV**

LPC 1: I agree about evidence. We looked at early readmission data to get engagement from senior leadership. It's a shame we have to do it again and again but it's a good enabler, shows value of what if we hadn't done it? This is a good time to start if you haven't already – there are fewer barriers now than a few years back.

Summary

- Build relationships
- Don't underestimate the time it might take to sort IT and IG
- Speak to IG leads early on
- Share the evidence regarding readmissions
- Share patient stories

Patient stories

Q: What would you do better? What are your key lessons learned?

LPC3: Very early on, we worked with our local AHSN and could see from data collected about the interventions that there were issues that had been picked up. We had some serious interventions around drug doses not being changed or hadn't been transferred, things not being updated when there was a change of medicines. Case studies around professional value to the pharmacy, how it helped with interactions, were invaluable. Benefit to patient and professionalism of the pharmacy.

Trust 4: From a mental health hospital point of view simple things like, when someone had an acute episode and had been discharged, everyone knowing what medicines they then should be on. We had a number of examples where service users were given a smaller quantity of medicines (if at risk) and this can be communicated to the GP. Useful for sharing information about hospital-only drugs that community pharmacies don't know their patients are taking. Use it as an information sharing exercise tool.

LPC1: Very beneficial during Covid-19. Because good relationships already existed, it was much easier for transition. Lots of conversations around patients being discharged. Change of doses, lots of awareness of meds optimisation and patient safety.

Trust 2: We could do more on patient stories. Having the process embedded in organisations. Doctors/clinicians understanding that the process is beneficial. We would not have been able to provide flu vaccines, etc, as easily if we hadn't had PharmOutcomes. It has taken forward that discussion that wouldn't have happened in the past.

Q: Any other issues we haven't covered?

Trust 3: Looking to the future, we don't have patient anecdotes but community pharmacy has brought a lot to the table - linking to GPs, showcasing their skills and working alongside GP practice pharmacists. How do we take advantage of this situation making it national?

Researcher 1: We are really excited that work has been put together that all system leaders will look at. There are so many answers within this discussion. What does DMS mean for the wider healthcare system? This is a really exciting journey and we don't know what's going to happen.

Researcher 2: Thank you for letting us sit in on such a rich discussion. I'm interested in how this becomes embedded in practice and how DMS is implemented and how we demonstrate impact for patients. It's really clear that everyone is motivated and engaged in this area. We need to speak to people that don't want to engage and why – we know what your reasons are but what are theirs? Thanks for letting us sit in, it's been very useful.

Chair: Thank you everyone for attending and for your willingness to share.

Wessex AHSN and the AHSN Network would like to thank all those involved in setting up TCAM over the last few years. You have helped create a new service and improve patient care.

We would like to add a huge thank you to all of the round table guests for so generously and openly sharing their experiences. We hope that this report and the corresponding film of the event help other hospitals and community pharmacies to establish this valuable service to support the patients they care for.

Actions:

Actions:

Actions:

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