Central London Community Healthcare NHS
NHS Trust

Your healthcare closer to home

CLCH Medicines Optimisation Projects

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Providing community healthcare
in London and the Home Counties

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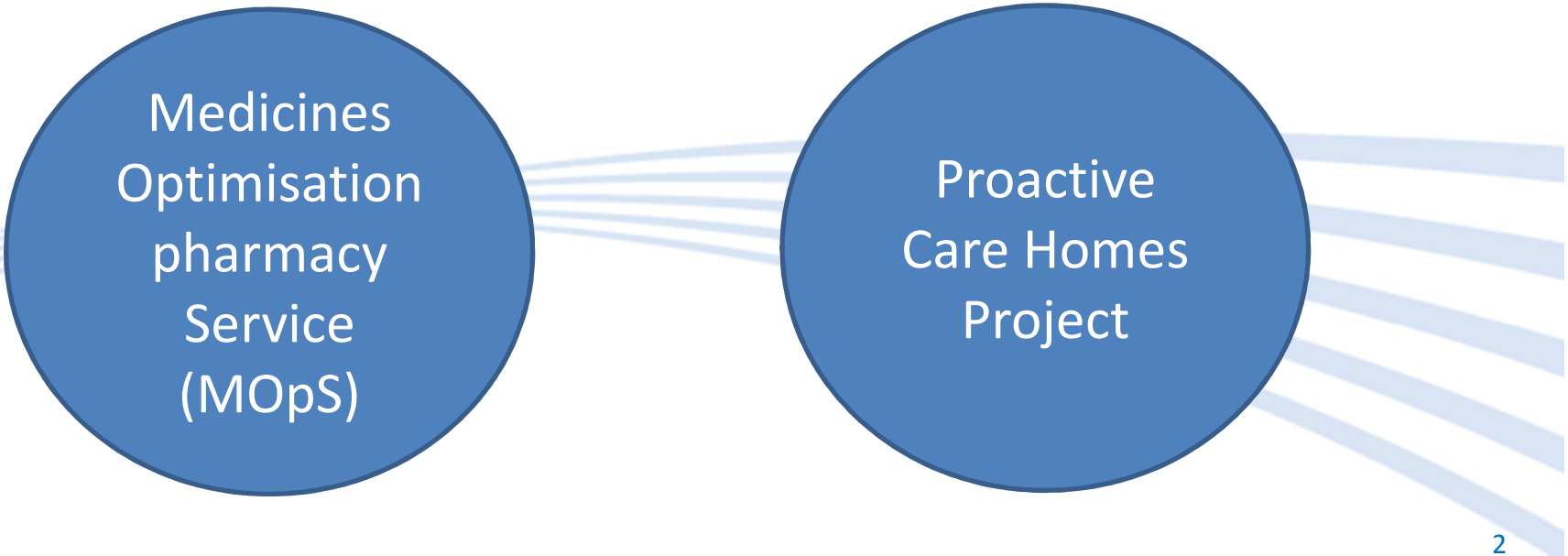
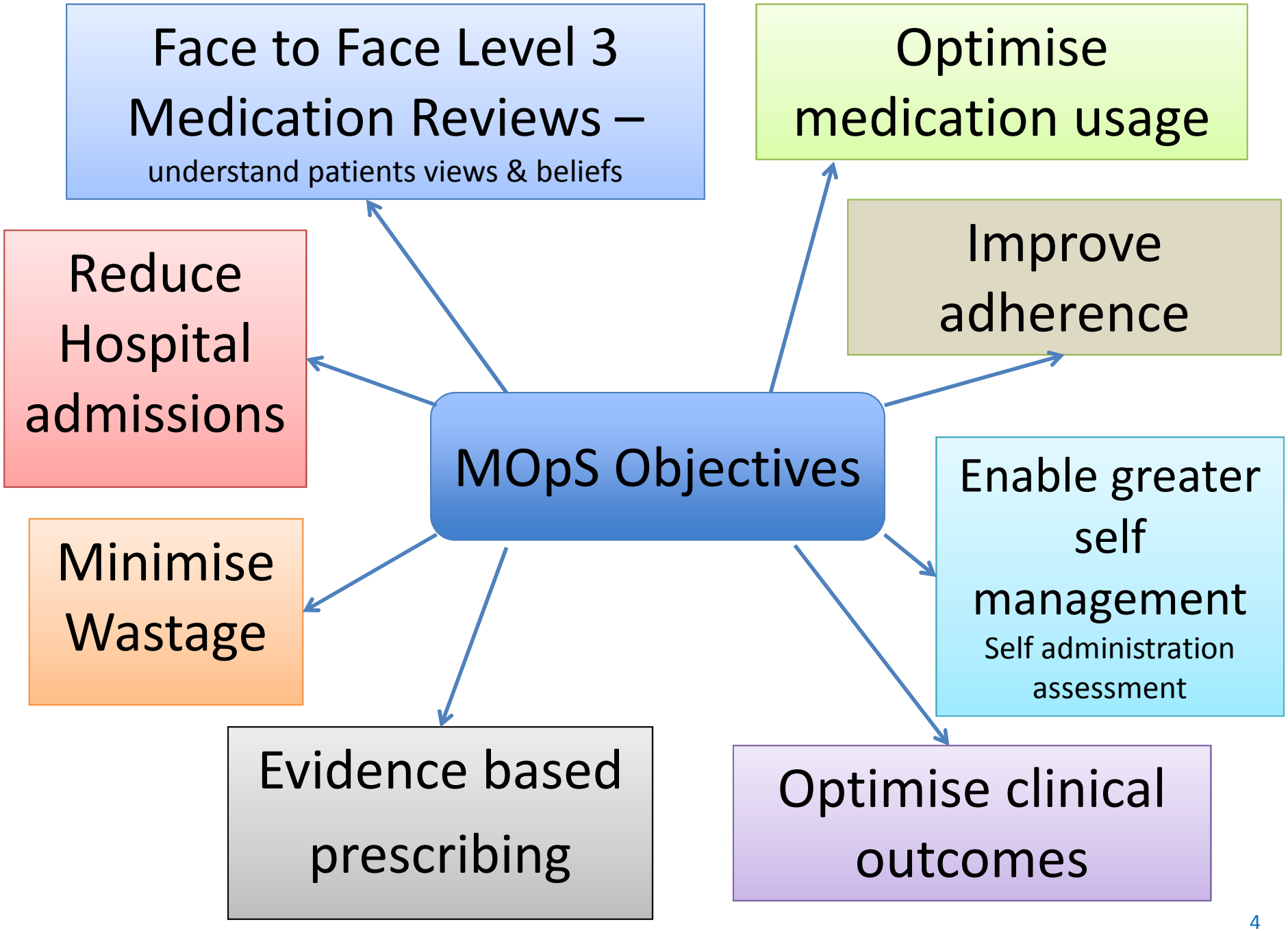


MOpS – The Beginning …….

- Tea room chat – May 2012
- North West London Integrated Care Pathway
- Out of hospital (OOH) fund
- Business Case Approved
- MOpS Pilot STARTED July 2012!!
- Proactive Care Homes Project – Dec 2013


Face to Face Level 3 Medication Reviews –
understand patients views & beliefs
Optimise medication usage
Improve adherence
Reduce Hospital admissions
MOpS Objectives
Enable greater self management
Self administration assessment
Minimise Wastage
Evidence based prescribing
Optimise clinical outcomes

Patient Selection Criteria

1. ICP consented patients
2. Housebound Patients over 75 years old
3. 4+ Medicines and/or
4. On a ‘high risk’ medicine

Outline Process

prep

- Preparation for 1st visit – Visit GP surgery

1st Visit

- Medicines reconciliation
- Medication review & optimisation
- Adherence assessment
- Medication counselling and compliance support

Care Plan

- Care plan agreed with patient & recommendations made to the GP

Follow up

- Onward referrals
- Telephone or visit

Results from the Pilot – 387 patients

- 1799 Interventions
  - 480 (27%) - advice on stopping a medicine £42K
  - 224 (13%) - advice on starting a medicine £9.8K
- Excess medication removed in 85 patients ~ £6k
- 64 Grade IV (Reversible harm or admission to hospital)[1]
- 1 Grade V (Averted death or major permanent harm)[1]
- Drop in number of non-elective hospital admissions in 6 months post visit - 19 less visits in 6 months

Challenges

- Engaging GPs & MDT
- Gathering information
- Communication
- Prioritisation
- Obtaining hospital admission data
- Commissioning and payment based on number of visits completed
- Securing ongoing funding

How the MOPs service has evolved

- CL CCG Village Project: March 14 - April 16
- WL CCG – From April 15
- Attendance at monthly MDT meetings
- Referral Pathway developed:
  - MDT meetings
  - Referral form on Systm 1
- Access to GP clinical systems (Systm 1)
- Improved communication though MDT working

Latest Results – WL MOPs

- 316 visits completed April 15- Sept 16
- 1765 interventions (6 per patient)
  - 23% advice on stopping a medicine, resulting in potential cost savings of £47K.
- Excess medication removed in 79 patients, amounting ~ £7.8K
- 2% (36) Grade IV (Reversible harm or admission to hospital)[1]

Costings for April 15 – Sept 16

- 1.79 wte 8a clinical Pharmacists = £218,700

Indicator	Cost (£)
Total Cost of medicines stopped per patient	£162 (Total: £47,140)
Total Cost of medicines started per patient	£44 (Total: £12,811)
NET SAVING per patient	**£118 (Total: £34,329)**
Cost of preventing 36 hospital admissions	**£128,556**
Total (including MDT interventions)	**£237,876**

- Cost Neutral
- Hidden benefits

Patient feedback

- 58 out of 61 patients (95%) that responded are likely or extremely likely to recommend the service to friends and family if they needed similar care or treatment.

"Everything was thoroughly done and explained in a professional and friendly manner"

"Excellent two way communication. The follow up was well detailed and informative and has been very useful"

MOpS Patient

- Suitcase full of loose medicines
- Parkinson's – not following recommended regimen

"I'm taking too many tablets, I'm scared of the side effects so stopped them"

Medication Returned for Destruction

Proactive Care Homes Service Level Agreement

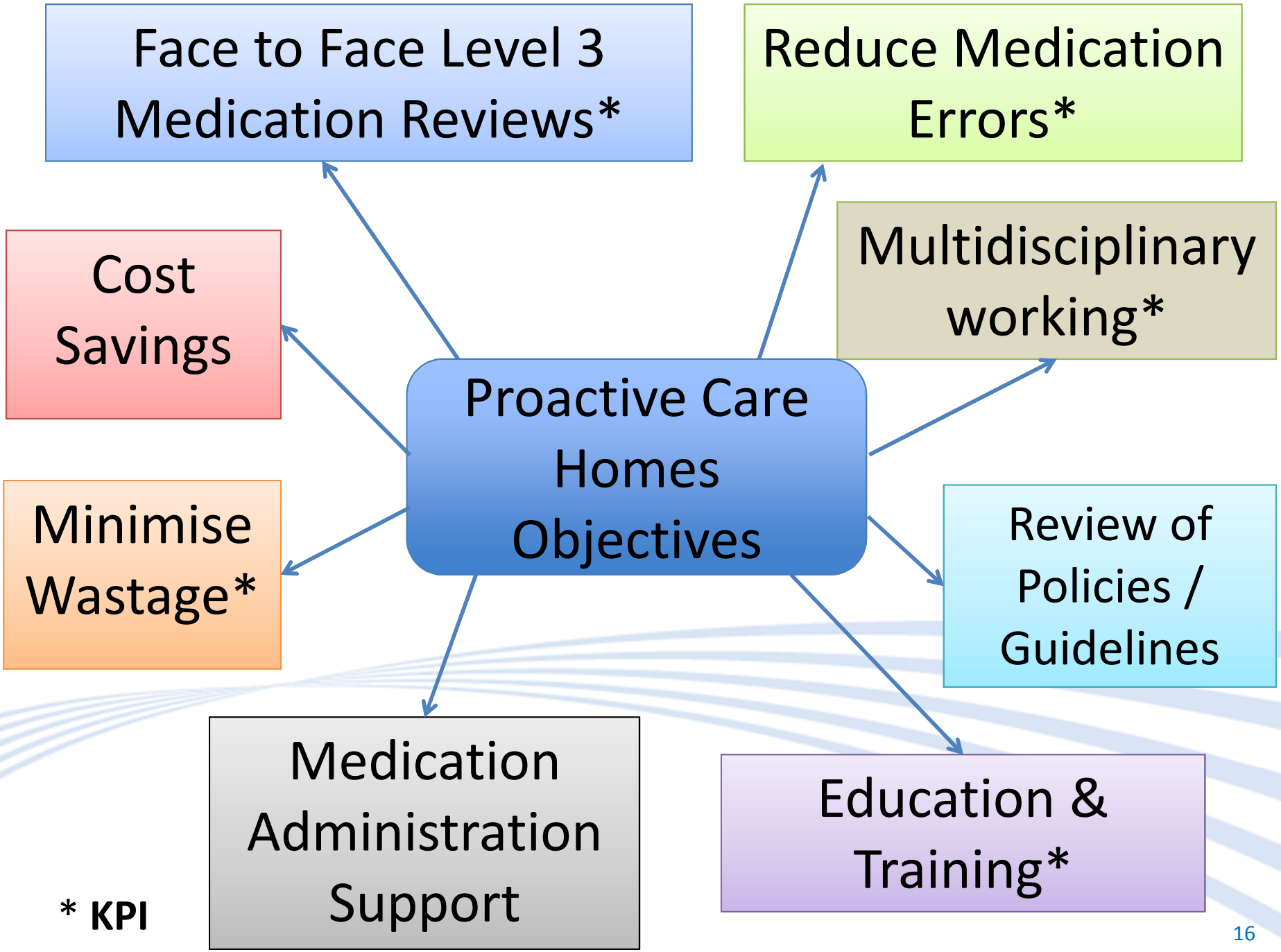
Standardise

Equity

Preventable

Skills

Proactive


Face to Face Level 3 Medication Reviews*
Reduce Medication Errors*
Cost Savings
Multidisciplinary working*
Proactive Care Homes Objectives
Minimise Wastage*
Review of Policies / Guidelines
Medication Administration Support
Education & Training*

* **KPI**

Challenges

Where to start?

Communication

Prioritisation

Engaging

Gathering information

Slow down

Frequency of visits

Fund

Challenges

	Nursing Homes	Extra-care
Clinical	Yes	No
Monitoring	Yes	No
Knowledge on Medicines	Yes	Minimal
Crushing / Covert	Yes	No
Medication administration (non-oral)	Yes (with exceptions)	No

Learning from it

- Awareness of how each care homes are set up
- Communication
- Access to relevant medical records
- Access to specialist community services

Where are we now?

Dec 2013 to July 2016

- 9922 interventions
  - 27% - discontinuation
  - 17% - initiation
- 83% actioned by GP
- 213 x Grade IV (Reversible harm or admission to hospital)[1]
- 2 x Grade V (Averted death or major permanent damage)[1]
- Total net savings £160 K

Where are we now?

- CLAHRC Evaluation comparing 2014 to 2013. Net decreased in:
  - Falls of 35%
  - LAS call outs of 10%
  - LAS call outs from falls of 26%
  - A&E attendance of 16%
  - Hospital admissions of 4%
- West London – WTE pharmacist and physiotherapist
- H&F – Project commissioned until March 2017

Pulse 40, I don’t want to go to hospital…

- Extra-care care home
- 66 years old male PM
- Interaction between Digoxin and Itraconazole
- Pulse 40
- Resident did not want to attend A&E
- Have capacity

Successes

- Appropriately trained clinical pharmacists
- Build relationships with the GPs and MDT
- Improved patient safety
- ‘Cost Neutral’
- Positive impact on non-elective hospital admissions and falls
- Hidden benefits from increased patient understanding and tighter MM processes
- Up-skilling staff
- Excellent feedback from patients and GPs

Reference

1. Specialist Pharmacy Service. SPS: Capturing and Using Pharmacy Contribution Data. Kings College NHSFT Contribution recording form. https://www.sps.nhs.uk/articles/capturing-and-using-pharmacy-contribution-data/ (accessed 18th November 2016)

Questions?

"There are no stupid questions, so let's also agree there are no stupid answers."