Services and Commissioning

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The NHS Discharge Medicines Service: an introduction for general practice and PCN clinical pharmacy teams

This document provides an introduction to the **NHS Discharge Medicines Service (DMS)** for general practitioners, Primary Care Network (PCN) clinical pharmacy teams and others working in primary care settings.

General information

- The DMS is a new Essential service which all pharmacies in England will have to provide from **15th February 2021**.
- NHS Trusts will be able to refer patients who would benefit from extra support related to their medicines regimen after they are discharged by the Trust, to a community pharmacy.
- This service builds on the work that the Academic Health Science Networks (AHSN) have undertaken with Trusts and community pharmacies over recent years, as part of the **Transfer of Care Around Medicines (TCAM) programme**.
- Within this programme, the AHSNs have worked with Trusts to put in place processes and IT infrastructure to allow hospital clinicians to identify patients admitted to hospital that might benefit from being referred to their community pharmacy at discharge.

The need for the service

Discharge from hospital is associated with an increased risk of avoidable medication related harm and **NICE Guideline NG05** recommends medicines-related communication systems should be in place when patients move from one care setting to another; and medicines reconciliation processes should be in place for all persons discharged from a hospital or another care setting back into primary care.

- It is estimated that 60% of patients have three or more changes made to their medicines during a hospital stay. Transfer of care is associated with an increased risk of adverse effects[1];
- 30-70% of patients experience unintentional changes to their treatment, or an error is made because of a lack of communication or miscommunication on discharge;
- Only 10% of elderly patients will be discharged on the same medication that they were admitted to hospital on[2]; and
- 20% of patients have been reported to experience adverse events within three weeks of discharge, 60% of which could have been ameliorated or avoided[3].

[1] Himmel, W et al (2004) Drug changes at the interface between primary and secondary care.
[2] Mansur, N et al (2008) Relationship of in hospital medication modifications of elderly patients to post discharge medication, adherence and mortality.
[3] Hesselink, G et al (2012) Improving patient handovers from hospital to primary care - A systematic review.

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Studies have been conducted which demonstrate the benefit of effective communication systems when transferring patients from one care setting to another. A study published in 2016[4] demonstrated that 'inpatients can be effectively referred to their nominated community pharmacist and receive a follow-up consultation tailored to their needs after discharge from the hospital' and that 'early indications are such that the patients referred from hospital, who receive a follow-up consultation from their community pharmacist, may have lower rates of readmission and shorter hospital stays'. A further study[5] published in 2019 supports these findings.

How the service works

- NHS Trusts will identify patients who will benefit from the DMS and, subject to the patient consenting to a referral, they will send a referral to the pharmacy via a secure electronic system. The referral will include details of the patient's medicines regimen at discharge.
- When a referral is received, a community pharmacist will undertake an initial review of the information, comparing the revised regimen to that pre-admission. At this stage, where any clinical issues are identified, these will be queried with the Trust or alternatively, it may require a conversation with the patient's general practice or the clinical pharmacy team within the PCN.
- When the first prescription for the patient is received by the pharmacy following discharge, a further review will be undertaken to ensure medicines prescribed post-discharge take account of the appropriate changes made during the hospital admission. If there are discrepancies or other issues, the pharmacy team will try to resolve them with the general practice or PCN clinical pharmacy team. Complex issues may need to be resolved by the general practice/PCN clinical pharmacy team undertaking a Structured Medication Review.
- The community pharmacist or pharmacy technician will then have a consultation with the patient and/or their carer to check their understanding of what medicines they should now be taking, when they should be taken and any other relevant advice to support medicines use.
- Where the patient and/or their carer cannot attend the pharmacy for this discussion, for example if they are housebound or convalescing following surgery, this can be provided by telephone or video consultation.
- Information that would be of value to the patient's general practice or PCN clinical pharmacy team, to support the ongoing care of the patient, will be communicated as appropriate.
- Where appropriate, there should also be an offer to the patient to dispose of any medicines that are no longer required, to avoid potential confusion and prevent an adverse event.

Implications for general practices and PCNs

The service augments but does not replace the important work general practices undertake to manage patients' medicines on discharge (e.g. reconciling medicines with the general practice clinical 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.

Community pharmacists or pharmacy technicians may contact general practices or PCN clinical pharmacy teams regarding any issues identified with a patient's medicines regimen or where additional information or clarification is required.

Further information

Further information on the service can be found on the **PSNC website**.

Guidance for general practices and PCNs is also available in the NHS England and NHS Improvement DMS Toolkit.

[4] Nazar, H et al (2016) New transfer of care initiative of electronic referral from hospital to community pharmacy in England: a formative service evaluation.
[5] Sabir, F et al (2019) Evaluating the Connect with Pharmacy web-based intervention to reduce hospital readmission for older people.