DMS WEBINAR – 9 FEBRUARY 2021 – Q&A SUMMARY

These are the questions and answers from the Discharge Medicines Service event ran on the 9 February 2021. There are still elements of the service which are being communicated nationally, so if there is any doubt, please refer to www.psnc.org.uk/dms for the most up to date information.

BACKGROUND AND GENERAL

Q: Why is DMS an essential service and not an enhanced service like MUR's?
It has been commissioned as an essential service to ensure that when hospitals send out the information all pharmacies are able to provide the service – commissioning it as an enhanced service would be too risky.

Q: Is DMS roll out national or England only; what if there is visitor from Scotland does it still apply, and can we claim for it?
The service is only commissioned in England at present - there will not be a referral unless they have been discharged by the hospital in England.

Q: Will TCAM run alongside this or is DMS in place of it?
DMS referrals replace TCAM for discharge referrals. Hospitals where TCAM admissions notices have been setup will continue.

Q: Where can the tool kit be found?
https://www.england.nhs.uk/publication/nhs-discharge-medicines-service-essential-service-toolkit-for-pharmacy-staff-in-community-primary-and-secondary-care/

Q: Will the DMS tracker be available on PSNC website before Monday?
Not on the PSNC website but the LPCs will host it and yes, we will make it available following the meeting.

THE SERVICE

Q: Who in the trusts would make the referral - Ward Pharmacist/Doctor/ Nurse? Who should we engage with in the trusts to resolve issues?
Each referral will include contact details for a clinician at the Trust as part of the minimum data set; these are the people you should contact.

Q: Can we undertake reviews/discussions with a patient representative where appropriate (with patient consent) and still claim for the service?
Yes, the third stage of the service can include a discussion with the patient and/or their carer (with patient consent) to check understanding of medication.

Q: When do we get patient consent?
NHS trusts are required to develop a system of consent to ensure that patients are fully involved in decisions about their care following discharge and have agreed to the whole DMS pathway. Where the referral is for a patient who regularly uses the pharmacy, the receipt of a referral can be accepted as implied consent by the patient agreeing to have the referral made to the pharmacy. Consent for further parts of the service where you need a consultation/conversation with the patient or if you need to access SCR you must get patient consent directly from the patient.

Q: It asks us to check SCR do I need to ask the patient consent first?
Correct, if access to SCR is necessary, consent is still required from the patient.

Q: Do the SCR records get updated automatically by the GP? And in what timeframe will this happen after discharge?
SCR will get updated by the GP as they process new discharges. The clinician at the GP surgery will get a prompt to upload the new SCR where there are changes made within their own clinical system.

Q: What happens if we receive a DMS request but the patient has been discharged to a hub?
If you receive a DMS referral you can provide the service and contact the hub if any issues.

Q: Who orders the patient's first repeat prescription? eg if it's a blister pack patient?
Prescriptions should be ordered in the usual way by the person who usually performs this task. DMS does not affect prescription reordering in any what whatsoever.

Q: What if the first script does not contain any of the new items whatsoever - do we chase GP for the info?
Yes, it is important that you flag to the GP practice if newly started medication included on the discharge letter is missing from the first prescription; it could be that the patient's medication has changed between discharge and the first prescription or that the information has not transferred appropriately to the GP practice. A discussion with the GP practice will ensure everyone is clear what the patient should be taking.

Q: Will we have to chase up repeats if none arrive after an appropriate timeframe?
You follow the process that you usually follow in your pharmacy. DMS does not affect prescription reordering in any way whatsoever.

Q: I have received incomplete data sets on current eTCP referrals when compared to the full GP discharge paper. How to we proceed with the DMS referral and work alongside GPs effectively if the information we are receiving is not the same?
We are aware that there are some issues with discharges for a small number of Trusts. If you are then you should contact your LPC who will be able to escalate with the Trust team and PharmOutcomes to resolve.

Q: If, when we compare the discharge medicines with the last PMR medicines, there are differences do we have to speak to the hospital to confirm the changes every time?
The DMS referral in stage 1 means you have to check for changes. As long as differences are declared within the notice then this is the purpose of the message and you should not need to confirm it unless there are specific clinical queries you want to raise with the prescriber. You do need to check existing prepared prescriptions to ensure they are still relevant with the changes and make arrangements/notes on the PMR to carry out stage 2 on receipt of the first prescription.

Q: How does the new pharmacy know which pharmacy has the original DMS?
It will be at the top of the report received and come from the NHSmail from that pharmacy.

Q: What happens if you action stage 1 after 72 hours?
The essential service is contracted within 72 hours so technically will be a breach of the core contract. If it does get to this point, it is far better to take the actions as soon as possible than not do so however and we believe that PharmOutcomes will still allow the service to proceed. NHSE will have the service report as they are the body commissioning the service.

Q: Is a patient care compromised if Stages 1-3 are not completed in timely manner?
If you are aware that a patient has had changes to medication and the first prescription has not been received within 7-14 days it is worth flagging to the GP practice.

Q: Is there any sort of time limit on completing stage 2 or 3 once stage 1 has been done?
There is not a specific limit applied to stages 2 and 3 as this will depend on when the patient needs their next script. However, if they have new medication you would expect to see a script for this within 7-14 days. If you do not, flag to the GP practice

Q: Are GP's expected to automatically issue a script post discharge?
Patients will usually be discharged on 7 or 14 days of medication. It depends on the processes in the GP practice as to when the prescription is issued, and each practice may be different. They may wait for the patient or carer to order the medication. For blister pack patients it is important that the script is issued quickly so that you have time to prepare the blister pack. In this instance it would be useful to flag the need for a new prescription to the GP practice on receipt of the DMS referral.

Q: Can we reject all (ed: TCAM) referrals before 15th so we get a clear page on our PharmOutcomes?
You will need to review the referrals and action them as appropriate. The DMS service does not apply but they may contain appropriate information which you still need to action.

Q: Usually before you declare on DOC, you normally need to be competent and confident with the services such as complete the CPPE, am I right?
No, it does not have to be CPPE. Pharmacists and pharmacy technicians providing the service need to be trained on how the service will operate and their role in providing it. There is no requirement to undertake a specific training programme but reading the NHS England and NHS Improvement regulations guidance and the DMS Toolkit will provide key information that professionals need to understand. The CPPE DMS training programme will also support professionals to understand the service and their role within it. All pharmacists and pharmacy technicians that will provide all or part of the service need to complete the DMS Declaration of Competence to demonstrate that they have

the necessary knowledge and competence to provide the service. A copy of the completed Declaration of Competence should be given to the pharmacy contractor.

TECHNOLOGY

Q: Is PharmOutcomes being used widely for this service?
Yes, it is commissioned all the way across Cheshire and Merseyside. There are other systems running nationally, such as Refer2Pharmacy or direct NHSMail, however all of our trust sites are utilising PharmOutcomes at present.

Q: Will we be able to export discharge reports from DMS?
We believe so to send via NHSMail; there is an export function for where a patient moves pharmacy mid-service so we would expect there to be something similar. However, we will confirm with PharmOutcomes however to make sure. The backup of printing as a PDF and send securely via NHSMail would remain an option where your system supports it.

Q: Do we know if PMR providers will be updating their systems to provide support for the service?
Pinnacle are in discussions with PMR suppliers and are willing to talk to any about integration, but we currently do not have any timelines as to when this will happen. PMR suppliers will no doubt want to express this as a benefit of their own system as soon as the functionality is available so you will hear this from them directly once more details are known.

Q: Can referrals come through NHSmail and be manually entered on PharmOutcomes like CPCS?
Yes, currently the referrals will come through via PharmOutcomes. If a pharmacy receives a referral and the patient moves to another pharmacy, they will need to transfer the referral via secure NHSmail accounts. The receiving pharmacy will need to record their actions onto PharmOutcomes using a manual data entry template which will be available soon.

Q: Is PharmOutcomes able to provide a downloadable pdf version of the discharge?
No, the discharge is sent to PharmOutcomes; you could save a print of the PharmOutcomes screen of the discharge and save as a .pdf.

Q: Will any management information be available on Pharmoutcomes eg number of referrals rejected/accepted, Stage 1 completed within 72 hours, number of referrals where Stage 2 and 3 not completed? Will this be available at group level?
If you normally get group level management reports from PharmOutcomes, then it will be incorporated into that. Some pharmacies under multiple ownership have commissioned those reports from PharmOutcomes but the LPC has no visibility of them.

Q: During the DMS stage 1 if spotted new medicines came through, it can be also claimed under NMS simultaneously so no restriction only able to claim for DMS?
When you get to stage 3 and have a chat with the patient about the medication you can sign up to NMS if the medication is included in the NMS service. Consent for the NMS is required separately.

DMS provides funding for the pharmacist or pharmacy technician to undertake a discussion (taking a shared decision-making approach) with the patient to ensure they understand their medicines regimen, including any changes made while being treated by the NHS trust; that is stage three of the

service. Normally this would occur when the first post-discharge prescription is received. Where appropriate, other services which form part of the Community Pharmacy Contractual Framework can also be provided.

The New Medicine Service (NMS) could be offered if clinically appropriate, if the patient would get additional benefit from provision of the service, provided the medication is one listed as included in the NMS and the patient condition or therapy area the medication is prescribed for is one on the scheduled list.

Q: When there is a discrepancy between the PharmOutcomes data and MYS, will we be able to amend the MYS data manually?
Yes, you will.

Q: Is there any method of getting an area manager log in for PharmOutcomes without having to get each individual site to request it to make sure these are being processed in a timely fashion?
If you currently have access to all sites you should be able to see all sites, if not you can email the Pharmoutcomes helpdesk helpdesk@phpartnership.com

Q: Is the PharmAlarm still available?
Yes, the LPC's will be sending details on how to purchase. Information can be found at https://pharmalarm.app/

Q: How can we clear all the existing eTCP referral that are not eligible for DMS on PharmOutcomes?
They will still be there and will not be feed into the DMS toolkit however, only messages sent on or after 15 February will feed into the DMS service.

COMMUNICATION

Q: Have the GPs been briefed about the new service, are they prepared that they might be getting more queries from the pharmacy teams regarding discharges?
There is a GP briefing available on the PSNC website and the MALPS LPC's have sent this to CCGs to send out. The BMA are sighted on this service nationally also. Pharmacies can also send copies to their local practices and use this as a way to identify the correct person to resolve any issues

Q: Is there a risk of GPs complaining that we'll be unnecessarily messaging them ie if we contact GP to say XYZ has changed and they say 'yes we already know we're issuing a new prescription etc'?
The pharmacy would usually only contact the GP if there were discrepancies or other issues, the pharmacy team will try to resolve them with the GP practice, utilising existing communication channels. Complex issues may need to be resolved by the general practice undertaking a Structured Medication Review; make appropriate notes on the PMR and/or other appropriate record.

Q: I am concerned that if there is an issue and we need to get clarification from the GP's, they will not necessarily respond. Is there anything in this that means they have to respond in the same way we have to provide the service?

Before any referrals are sent you could work with your GP pharmacists or PCN clinical pharmacist who would be the best contact to discuss issues. We believe the relationship contractors and their teams have with their local PCN pharmacists will be critical to this part of the service.

Where a referral is received for a patient who is new or unknown to the pharmacy, the pharmacist or pharmacy technician may need to contact the NHS trust and/or the patient for more information; and to check that the patient does wish to use this pharmacy for the DMS. In this scenario consent can be confirmed verbally and could then be recorded in the pharmacy clinical service record.

Patients, like in any other service, are free to withdraw their consent to receive the service at any point in the service.

Q: Are the hospital teams going to be frustrated that we are confirming every single change with them for every patient?
We would not expect every single change to be confirmed – if the information received declares an item as changed then it is explicit within that communications. Its only for DMS patients that the hospital want to send a referral eg on high risk medicines where there are ambiguities where you would need to have a clinical conversation with the hospital pharmacy team.

Q: Who will be the key contact in each region, is it LPC for overall/general queries?
Please contact your LPC and they will support or escalate.

Q: Do you have a list of PCN pharmacists that you can let us have, it would be easier for relief pharmacists?
No, we do not hold such lists. Each practice and PCN should have details of the clinical PCN pharmacist(s) who are working locally, and the pharmacies will need to make contact directly with their local practices to find out ideal contact routes.