SCHEDULE 2 – THE SERVICES
A. Service Specifications (B1)

Service Specification No.	02/GMS/0024
Service	Medicines Management Service
Commissioner Lead	CCP for General Medical & Surgical
Provider Lead	Natasha King
Period	2013/14
Date of Review	To be Agreed

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	*
Domain 2	Enhancing quality of life for people with long-term conditions	*
Domain 3	Helping people to recover from episodes of ill-health or following injury	*
Domain 4	Ensuring people have a positive experience of care	*
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	*

1. Purpose

1.1 Aims

Promotion of medication self management by patients supported where appropriate by carers in the community utilising the wider health and social care resources. The aim of the service is to support patients who have very complex and multiple needs. This will include patients who are visually impaired, have neurological conditions or who have multiple admissions for issues relating to medicines management.

1.2 Evidence Base

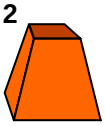
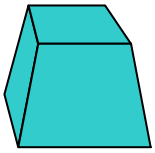
Within NHS Bournemouth and Poole Localities there are potentially over 13,000 patients who are over 75 and are taking four or more medicines. As many as 50% of this group of people may not be taking their medicines as intended, equating to potentially 6,500 patients in Bournemouth and Poole. However the majority of these patients will not require input from specialist services.

Based on the pyramid of care it is estimated that 5% of patients will have multiple, complex and co-morbidity problems, with a requirement for specialist support. For Bournemouth and Poole this would give an estimate of around 650 patients who are over 75 and require specialist support.

In addition there will be some patients who are under 75, have multiple, complex and co-morbidity problems and who require specialist advice/help with the management of their medicines.

The specialist medicines management service is aimed at patients in the aforementioned 2 groups i.e. at the

top of the pyramid of care model (level 3), those with multiple, complex and co-morbidity problems.

Patients with multiple, complex and co-morbid problems - 5% of patients (Target group for the service)	**Level 3** 
Maintenance – Disease Management – 25%	**Level 2** 
Diagnosis and initial management	**Level 1** 

1.3 General Overview

The Specialist Medicines Management Service is open to patients aged 18 years and over who are registered with a Bournemouth and Poole GP. The service is provided in the community and works closely with other health and social care staff involved in the care of the patient.

This service currently sits outside the essential services delivered through the Community Pharmacy Contractual Framework and essential services provided within primary care.

1.4 Objectives

This service is for patients who are having, or have been assessed as likely to have, difficulty managing their medicines:

- To equip patients and carers to self medicate and better manage their medication safely with support from integrated medicines management service in primary care.
- To ensure that patients receive appropriate support to enable them to;
  - Gain the maximum benefit from their medication
  - Maintain or increase their quality and duration of life
  - Not suffer unnecessarily from illness caused by excessive, inappropriate, or inadequate consumption of medicines
- To prevent avoidable admissions to hospital and support patients in the community
- To facilitate a patients discharge from hospital and support them in the community
- To reduce expenditure on drugs by reducing waste

1.5 Expected Outcomes including improving prevention

The Specialist Medicines Management Service will provide enhanced support for the intermediate care teams and long term conditions services.

2. Scope

2.1 Service Description

- Undertake community based assessments on eligible patients to understand the patient's ability to manage their medication.
- Consider the patient's health issues and social support in relation to the prescribed medication and liaise with prescriber/referrer to adjust medication or support accordingly.
- Use a standard screening tool, to assess whether the patient / carer can medicate from original packets or identify what other support is required for example, reminder charts, administration record charts, large print labels, easy open bottle tops, individualised colour/symbol coding of medicines to make it easier for patients/carers to identify medicines and the times that they are to be taken; *multi-compartment compliance aids will be available as a last resort and only where this is to the benefit of the patient* and enables them to manage all of their medication without any other support.
- If appropriate, and to avoid confusion, obtain the patient's consent, remove surplus medication from the home and take this to registered pharmacy premises for destruction.
- In exceptional circumstances a multi compartment compliance aid (MCA) may be required. If an MCA is required the service will liaise with the patient's community pharmacy to arrange for the pharmacist to carry out a DDA assessment of the patient. It is anticipated that, in the majority of cases where a MCA is required the patient will be eligible under the DDA to receive a MCA as part of the community pharmacy contract arrangements.
- Work interactively with the patient for up to 4 to 6 weeks depending upon the patient's individual needs, until the most appropriate method and dosage has been established to enable compliance and concordance.
- Liaise with the patient's community pharmacist and GP on an ongoing basis, when the patient is stable the team will discharge the patient back to their GP and community pharmacist. Where necessary a referral will also be made to other community based services.
- Attend multi-disciplinary case conferences.
- Provide support, information and training for carers when appropriate (only if PCT cannot provide training).
- Enable a further step change towards self care.

2.2 Accessibility/acceptability

The Specialist Medicines Management Service is open to all patients aged 18 years and over with multiple, complex and co-morbidity problems registered with a Bournemouth and Poole GP. The SMMS team work closely the service provider and other health and social care staff involved in the care of the patient.

2.3 Whole System Relationships

- NHS Bournemouth and Poole
- Prescribing Sub-Committee,
- Community Pharmacists and staff
- GPs and GP prescribing leads
- Non-medical prescribing leads
- Long Term Conditions Services
- Acute Care Closer to Home Services
- Acute hospitals
- RPSGB Inspector
- Local Pharmaceutical Committee (LPC)
- Medicines Management Committee
- Prescribing Support Technicians
- Patients and carers

2.4 Interdependencies

- Bournemouth and Poole Community Pharmacies

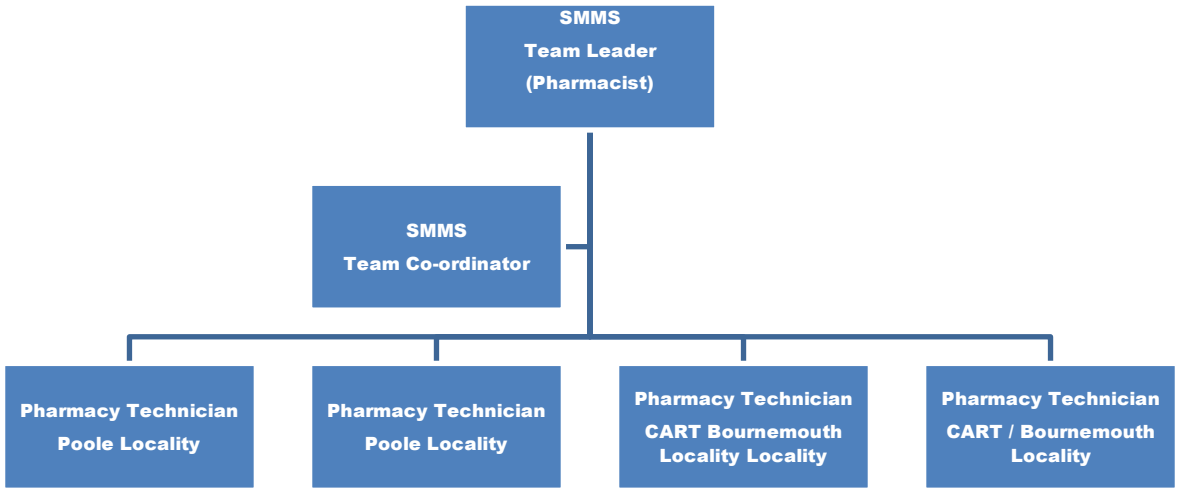
- NHS Bournemouth and Poole GPs and Nurses
- Poole Hospital Foundation Trust and Royal Bournemouth and Christchurch Hospitals Foundation Trust
- Long Term Conditions Services
- Acute Care Closer to Home Services

2.5 Relevant networks and screening programmes

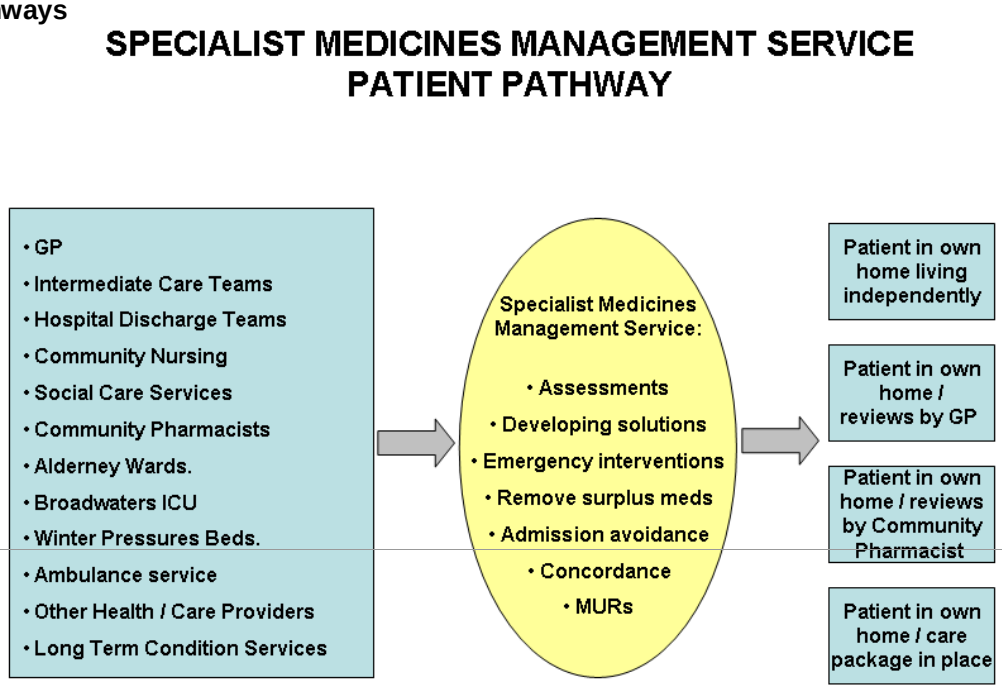
- Medicines Management Committee
- National Institute for Clinical Excellence

3. Service Delivery

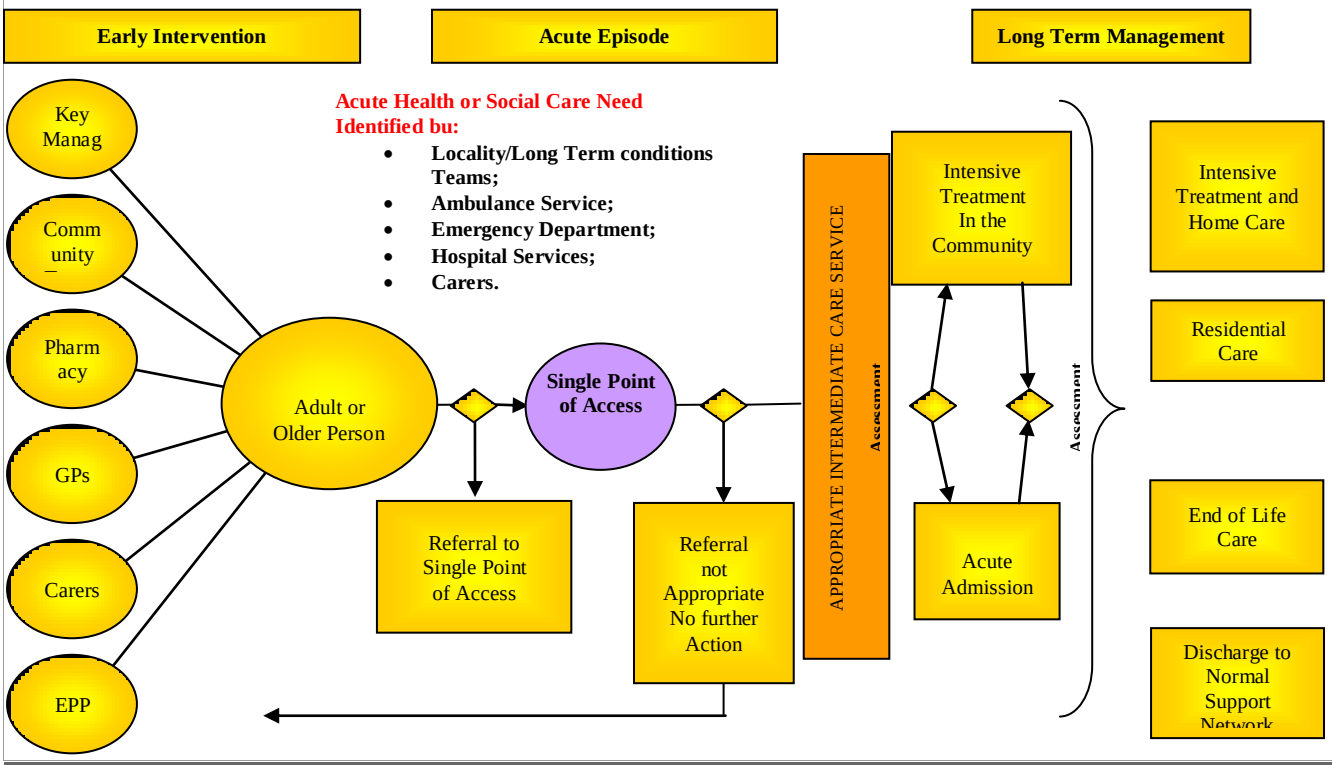
3.1 Service Model



3.2 Pathways



Acute Care Closer to Home Care Pathway



4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

All patients aged over 18 years registered with an NHS Bournemouth and Poole GP.

4.2 Location(s) of Service Delivery

The current locations are:

- Woodlands Intermediate Care Unit, Community Hospital, Ringwood Road, Alderney,Poole BH8 9HW
- Community Assessment and Rehabilitation Team Office, South Team G3 Christchurch Hospital and North Team Wallisdown Heights
- Poole Intermediate Care Office, Poole Hospital NHS Foundation Trust, Longfleet Road, Poole, BH15 2JB

4.3 Days/Hours of operation

Service Hours: 9.00am – 4.00pm Monday to Friday

4.4 Referral criteria & sources

- Patients will only be accepted if they have multiple, complex and co-morbid problems.
- GPs within the NHS Bournemouth and Poole area
- The Intermediate Care Teams including consultants

- The acute hospital discharge teams to support the ongoing management in the community of complex cases.
- Local authority managed and commissioned social care teams / services via the patient's GP.
- Community pharmacists
- Alderney Wards
- Broadwaters Intermediate Care Unit
- South West Ambulance Trust

4.5 Referral route

- The service accepts referrals of patients with very complex needs, mental health issues* and where healthcare professionals working within the community (GPs, community pharmacists, community matrons, District Nurses) have already attempted to work with the patient to resolve their medicines management difficulties.
- Referrers will be expected to identify solutions already attempted.

The GP and other community based staff will remain the first port of call for any medicines management problems identified

4.6 Exclusion criteria

- Patients whose medication services can be met under the existing Local Pharmacy Agreement or within the existing GP service contracts.
- Incomplete referral forms or inappropriate referrals.
- Referrals for patients who have not had aid alternatives prior to referral.
- Referrals from patients who are not registered with an NHS Bournemouth and Poole GP
- Patients aged less than 18 years.

4.7 Response time & detail and prioritisation

- The SMMS team will analyse the referrals within 24h of its arrival (excluding non working days);
- A referrals triage will be proceeded according to patient condition(s) severity;
- The acute/urgent cases will have first contact with an SMMS staff member within 24h of referral acceptance (excluding non working days); and others will be seen no more then 10 working days, depending on patient condition and SMMS workload.

5. Discharge Criteria and Planning

- After a referral has been accepted by the SMMS team, the patient will receive a first contact to assess their condition and identify what aid system(s) will suit the patient; and to provide education to patient in the attempt to get their concordance.
- The SMMS will work interactively with the patient for up to 4 to 6 weeks depending upon the patient's individual needs, until the most appropriate method and dosage has been established to enable compliance and concordance.
- Liaise with the patient's community pharmacist and GP on an ongoing basis, when the patient is stable the team will discharge the patient back to their GP and community pharmacist. Where necessary a referral

will also be made to other community based services.

6. Prevention, Self-Care and Patient and Carer Information

The SMMS will:

- Facilitate patients understanding of their current medicines, or changes in their medication;
- Facilitate patient self administration schemes;
- Facilitate continuity of patient care and empowerment;
- Avoid unnecessary medicines waste, when possible;
- Minimise medication administration errors;
- Provide education for carers regarding the abovementioned when appropriate (e.g. when the PCT cannot provide training for Care Agencies).

7. Continual Service Improvement/Innovation Plan

Description of Scheme	*Milestones*	*Expected Benefit*	*Timescales*	*Frequency of Monitoring*

8. Baseline Performance Targets – Quality, Performance & Productivity

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
Quality				
Service Response Times – 92% percentage of urgent referrals seen within 24 hours (of working day)	-	92%	Monthly Score Card	Monthly
Service Response Times – 98% percentage of follow up visits within 42 days	-	98%	Monthly Score Card	Monthly
Additional Measures for Block Contracts:-				
Staff turnover rates				
Sickness levels				
Agency and bank spend				
Contacts per FTE				

9. Activity

9.1 Activity

Activity Performance Indicators	*Method of measurement*	*Baseline Target*	*Threshold*	*Frequency of Monitoring*
Medicines Management (Number of New Patients)	**Activity Report**	**1,488**	**TBC**	**Monthly**

9.2 Activity Plan / Activity Management Plan

Monthly activity reports as a minimum defines as total and new contacts.

The following will be reported on a monthly basis for the Specialist Medicines Management Service:

- 92% of urgent referrals seen within 24 hours (of the working day)
- 98% of follow up visits within 42 days
- Annual target of 633 new patient contacts per year (number of referrals)

9.3 Capacity Review

10. Currency and Prices

10.1 Currency and Price

Basis of Contract	Currency	Price	Thresholds	Expected Annual Contract Value
Block/cost &volume/cost per case/Other_____*		**£**		**£**
Total		**£**		**£**

**delete as appropriate*

10.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Total	Associate Total	Associate Total	Total Annual Expected Cost
£	**£**	**£**	**£**	**£**	**£**