PACESETTER SCHEMES 2018-19

Health Board	Betsi Cadwaladr University Health Board
Pacesetter Title	An external review of the BCUHB Pharmacy and Medicines Management (P&MM) service. This will review how services are currently delivered; drive service redesign to deliver a Pharmacy and Medicines Management service model for the future.
Context: what is the current evidence and how does this project add value?	Historically the Pharmacy profession has been a technical service with expertise in medicines supply and use. The pharmacy degree has been a scientific and technical degree with limited clinical development. The main roles have included purchasing, dispensing, supervision, clinical advice, patient counselling and within the acute hospital setting, specialist clinical support at ward level. Within the last 10 years with the advent of non medical prescribing and rapidly advancing technology, the opportunity to develop Pharmacists to work as autonomous clinical practitioners has developed and an advanced role has been defined. This has created the opportunity for the extension of the Pharmacy Technician role as the technical lead for pharmacy, taking on the workload historically see as the Pharmacist's role. There is a need to review the historic service and design a service delivery model for the 21st century that is agreed and supported through the organisation. Pharmacy and Medicines Management supports the Health Board to ensure that all aspects of medicines use are safe, clinical efficacious and cost effective. The governance standards for medicines use are set out in the BCUHB Medicines Code, the formulary and monitoring of clinical practice to ensure standards are achieved and maintained. There are 401 Whole Time Equivalent (WTE) pharmacists, pharmacy technicians, pharmacy assistants, clerical staff and 6 medicines management nurses working in the three acute hospitals, General Practices (GP), community hospitals and care homes to support the safe prescribing, dispensing and administration of medicines. In 2017-18: • They are on track to deliver savings of more than £9m for 2017-18 • They will have dispensed more than 1,500,000 items for inpatients and patients going home from our hospitals, who are often complex medication regimes. • More than 40,000 interventions will be made on inpatient prescriptions to ensure that patients get the right medication at the right time, right dose and by the right route. • They have stopped more than 21,000 medicines which are no longer needed by the patient. • We will have prepared almost 100,000 doses of readymade antibiotics, pre-prepared syringes of high risk medicines, cancer treatments and parenteral nutrition for neonates and adults.

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Aims of project	The aim of the project is to develop a service model that ensures medicines governance, expert technical support and a clinical service to deliver optimum patient care. The scope of the review will include: 1. A review of the P&MM structure and accountabilities within the Health Board. 2. A baseline review of our current model of the P&MM service and benchmark performance across n Wales. 3. Which aspects of the P&MM service can be safely centralised to reduce duplication of effort? Such as procurement / specialist production and quality control, medicines governance / centralised store / others. 4. Have we got the P&MM workforce working in the right place undertaking the most appropriate tasks? a. What is the role of the P&MM team within a GP surgery? What is the correct level support needed within a GP surgery? b. What is the role of the P&MM team on an acute or community hospital ward? What is the correct level support for an acute or community hospital ward? c. What opportunities are there to integrate community pharmacy contractors to support service delivery? Such as WP10 dispensing d. How should these staff be funded by BCUHB? 5. How integrated is the P&MM team? a. Is there any duplication in the work undertaken? I.e. does a patient get a medication review by pharmacy staff in primary care – then in ED if admitted and then repeated again on an acute ward? b. Discharge review within community pharmacy 6. What other activity is being undertaken by P and MM staff? i.e. care home support, IP clinics, POAC 7. What is the impact of extended hours in west on activity and should extended hours working roll out across other areas within BCUHB? 8. What is the impact of the on call acute hospital service to support hospital sites? 9. What are the impacts of the local enhanced service for clinical effectiveness within the primary care setting? 10. Up skill Community Pharmacists to advanced practitioner roles for medication reviews, triage of patient, and independently prescribe. 11. Develop Community Pharmacies to be a first 'port of call' especially in rural areas, and where there are shortages of General Practitioners. 12. Explore ways to develop and utilise Community Pharmacies for enhanced services, and to be resource hubs to support GP Practices and community resource teams.
Allocation	£100,000
Start date of project	1st April, 2018.

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Alignment with Emerging Model	Within primary care the P&MM team are working to release capacity within GP Practices for planned care appointments, support the sustainability of the Primary Care service in North Wales, particularly in reducing avoidable emergency admissions to hospital due to adverse effects of medication / harm due to polypharmacy, improve the outcome for patients from the medication they take (medicines optimisation) and achieve better patient satisfaction. The extended role of the pharmacy team within primary care supports the strategy for transforming the way services and healthcare is delivered in Primary Care and adds to the model of developing the multidisciplinary team that surrounds the GP. The P&MM service is aligned to the Care Closer to Home strategy and forms part of the 2018-2019 Primary Care IMTP. It is essential that P&MM is an integrated service that supports patients to get the best possible outcome from their medication regimen. This enables patients self care and to manage their own conditions and to maintain their health.
Potential to demonstrate financial redesign / resource shift	This scheme is designed to identify how best to utilise the skills of the P&MM team across BCUHB and to cost how the team is funded. In primary care and secondary care, P&MM team will do the work previously done by GPs/Clinicians and nurses. • Cost avoidance - right person, right skills, right location and right time. • Cost avoidance – GP time is focussed on planned care appointments in the GP Practice. • Cost avoidance – unnecessary Unscheduled Care hospital admissions due to medicines related harm • Cost avoidance – Polypharmacy review to ensure patients get the maximum from their medication regimen and medication is stopped were no longer appropriate. • Cost avoidance – adds to the MDT within a clinical team in any setting and as a result supports the sustainability of that GP practices and clinical teams.
Dates for submission of Business Plan and Delivery agreements	28th February, 2018.
Status within: **HB strategy** **IMTP process** **Cluster Action Plans**	• The Scheme has a common theme to the existing Pacesetter and Delivery agreements within the Health Board and meets the 3 aims of Primary Care funding; Service sustainability; improved access; More services now available in the community. • The Scheme is an action for the IMTP being developed by Primary Care with implementation in Quarter 1 for 2018-2019, • The Scheme is currently not included in Cluster Action Plans, but will be included in all the 2018-2019 plans. This provides an opportunity to evaluate how services can be delivered in a different way. There is opportunity for creativity; innovation and to lead the change in the NHS. This strategy aims to help combat the present and future recruitment and retention issues facing the General Practitioner workforce and to contribute to a sustainable Primary Care workforce of the future.

Timescales for each stage of project, with rationale	Quarter one: Recruit external consultant to deliver project and agree final project plans with stakeholders, objectives, timescales and outcomes. Quarter two: Commence baseline review and commence data gathering from across three areas around activity with P&MM. Undertake semi-structured interviews with key stakeholders on current service delivered. Quarter three: Review data collected and identify further data collection requirements and complete. Quarter four: Develop a draft P&MM service model for consultation. Complete project March 2019.
Evaluation methodology and measures to be used	The methodology will be agreed when the external consultant is appointed. It will include: • Quantitative analysis of activity data and finance data • Qualitative analysis of semi structured interviews with stakeholders • Patient stories • Patient questionnaires • Review of concerns, complaints and compliments • Identify opportunities for further research and sharing current development by publishing the outcomes/impacts of our work.
Project support available	1. Access to Programme Management office and Service Improvement Team for support. 2. Access to Primary Care Workforce Project Manager for support. 3. Dedicated named Project Manager to oversee the development and implementation of the scheme.
Describe anticipated impact on health inequalities	1. **Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.** Within the P&MM team we work with all patients to optimise their medication regimen and to educate patients around the benefits/risks of their medication focusing on co-production. Embedding the P&MM staff within the GP / Clinical teams provides a focus around prescribing and safe administration that promotes best practice prescribing, medication review and de-prescribing where there is no longer any benefit to the patient. 2. **Care for those with the greatest health need first, making the most effective use of all skills and resources.** Within primary care , the P&MM team work within GP practices answering queries from patients and healthcare professionals; ensure that drug monitoring of complex drugs are undertaken; audit prescribing to ensure safe practice and undertake medication reviews. There role is variable in each practice but they prioritise safe effective clinical care. Community Pharmacy services are triaging patients with unmet clinical need. We have developed a prioritisation process for patients when newly admitted to hospital. We have skilled mixed with pharmacy technicians and pharmacists working within teams to ensure that we review the deteriorating patients first.

	3. **Do only what is needed, no more, no less; and do no harm.** We monitor prescribing and drug spend to identify variation and divergence from best clinical practice. We will work with clinicians to ensure that gold standard clinical practice is delivered. 4. **Reduce inappropriate variation using evidence based practices consistently and transparently** We benchmark our services within BCUHB and UK to identify variation and use key performance indicators to monitor our performance.
Potential for rollout at scale, with indication of costs and workforce implications	We will develop an integrated model for primary, community and acute care for the whole of BCUHB.

NATIONALLY AGREED CRITERIA FOR PACESETTER PROGRAMME – 2018/19

1. The schemes should be aligned to the work of the Implementing the Emerging Model Group in terms of building on:

    - Outcomes of previous Pacesetter projects
    - The whole system emerging model for primary care
    - Outcomes of the Pacesetter Critical Appraisal
    - Outcomes of the Parliamentary Review into Health and Social Care

2. Projects should actively explore the potential for whole system financial redesign and resource shift between sectors

3. Each project to be underpinned by a clear business plan and delivery agreement that has been agreed by the Health Board executive team, PC Directorate, cluster leads, the relevant cluster and the professionals responsible for delivering project outcomes.

4. A clear and realistic approach to timescales for project outcomes that takes account of bedding in, transforming care and reporting arrangements.

5. Robust measures for evaluation to be defined at the outset and using an appropriate range of methodologies to give a clear understanding of outcomes and benefits, including costing

6. The programme of work to be an integral part of the relevant cluster action plan, the health board strategy and the IMTP process

7. Evidence that the project team will be supported through appropriate backfill arrangements; dedicated project management; access to expertise in research analysis, IT systems usage and data analysis.

8. Consideration should be made of the specific challenges faced by professionals working with deprived communities in relation to innovation and redesign. Primary care teams in these areas often need more support and/or resource to initiate new ways of working and a proactive approach is required to promote innovation.