Department of
Health, Social Services and Public Safety
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CONSULTATION QUESTIONNAIRE - THE MEDICINES OPTIMISATION QUALITY FRAMEWORK

CONTENTS

Introduction

This consultation document is to give all citizens in Northern Ireland an opportunity to provide their views on a Medicines Optimisation Quality Framework, which aims to support better health and wellbeing for all people in Northern Ireland through improvements in the appropriate, safe and effective use of medicines.

Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time to enable them to gain the best outcomes.

By focusing on patients and their experiences, the goal is to help patients to:

- improve their outcomes;
- take their medicines correctly;
- avoid taking unnecessary medicines;
- reduce wastage of medicines; and
- improve medicines safety.

Ultimately medicines optimisation can help encourage patients to take ownership of their treatment.

Medicines optimisation also requires multidisciplinary team working. Healthcare professionals working together to ensure patients have individualised care, know how to take their medicines correctly, are supported to improve adherence when needed and have their medicines reviewed at appropriate intervals to optimise outcomes.

The Medicines Optimisation Quality Framework has been developed to meet a number of objectives, these include:-

- Better health outcomes for individuals through the appropriate use of medicines, taken as prescribed.

- Better informed patients, engaged and involved in decisions about their medicines.
- Improved systems for medicines safety at transitions of care.
- An active medicines safety culture within health and social care organisations.
- Reduced variance in medicines use through the consistent delivery of medicines management best practices.
- Improved intra and inter professional collaboration and a HSC workforce who recognise their role in medicines optimisation and deliver it as part of routine practice.
- Better use of resources for the Health and Social Care Service through the consistent, evidence based and cost effective prescribing of medicines.
- A strategic focus for continuous improvement and innovation in the development and implementation of best practice related to medicines use.

The Framework complements existing policies, quality standards, Transforming Your Care principles and is specifically aligned with the Quality 2020 strategic themes of safety, effectiveness and patient/client experience.

The Framework has been compiled in anticipation of the increasing demands of

(i) **A growing and ageing population**.

Northern Ireland has the fastest growing population in the UK, a rising number of older people with increasing multi-morbidities and a health seeking culture in which people use more medicines with higher associated costs per head per annum than other countries. Therefore, there are potentially significant challenges ahead which require a renewed focus on using medicines to gain the right outcomes for patients at the right cost for the Health and Social Care Service.

(ii) **Advances in medicines and technology,**

Advances in medicines and technology continue to drive change in the range of services that can be provided safely in the community. This is to enable more people to be diagnosed, treated and cared for at home or close to where they live. New technologies have for example the potential to make medicine taking more convenient for the patient which

can improve adherence and outcomes. Advances in medicines and approaches based on predict, prevent and treat will become more common and translational genomics will allow for specific targeting of treatments to individuals.

The electronic care record and ongoing ICT development programme will facilitate better sharing of information between healthcare professionals and enable advances such as electronic prescribing.

(iii) **In recognition of a growing evidence base**

Global innovation in medicines development and improved access to medicines with a good evidence base for example NICE Guidance have contributed to an increase in life expectancy helping people to stay healthy for longer and many previously debilitating or fatal conditions are now prevented or managed, often on a long term basis, through regular medicines use.

(iv) **The need for consistent delivery of best practices and cost effective medicines management.**

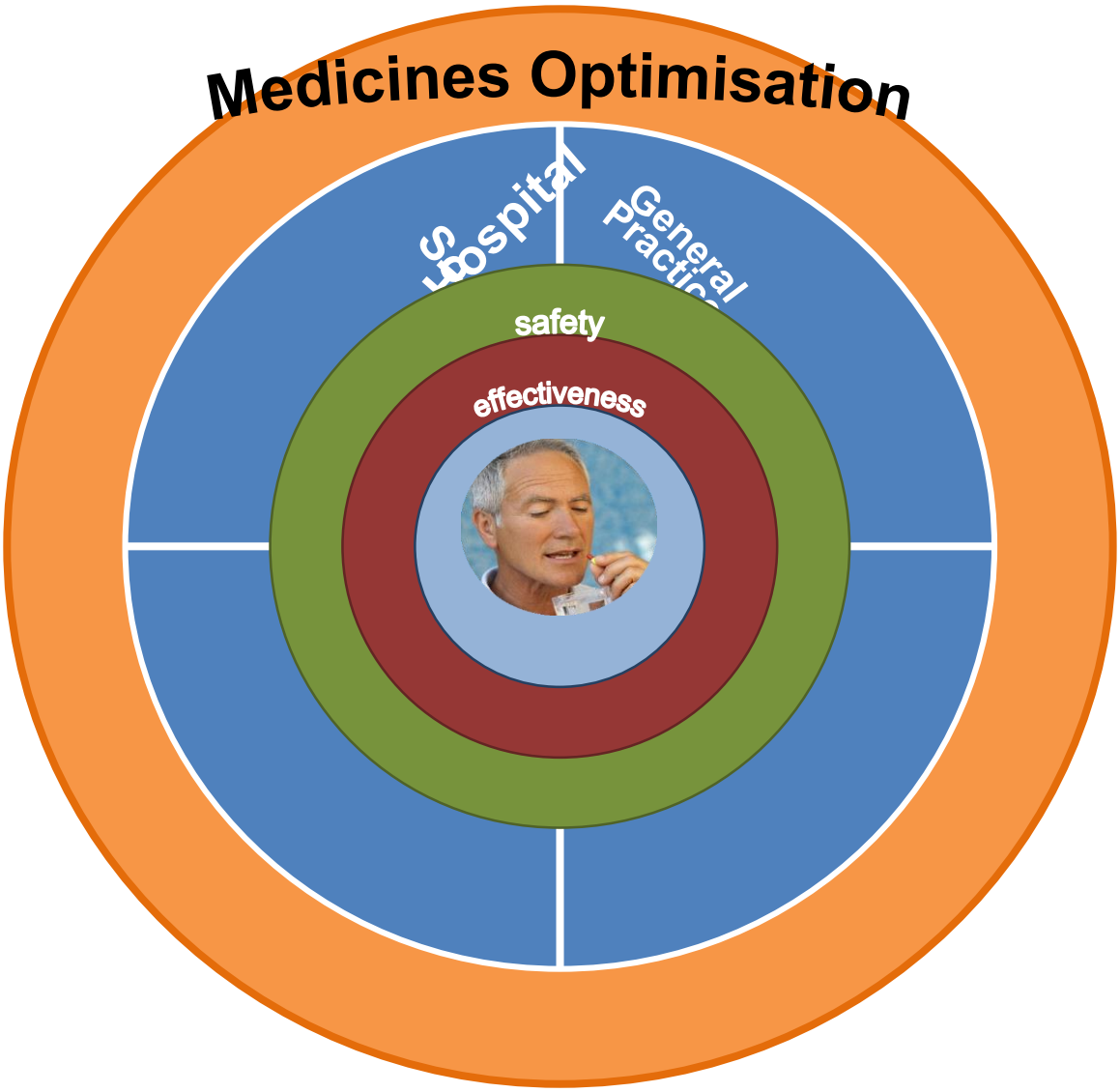
A King's Fund report concluded that there are wide variations in the quality of care in general practice stating that the delivery of high-quality care requires effective team working for which the skill-mix needs to evolve. For example, increasing the utilisation of pharmacists in the community working collaboratively with other health and social care professionals can help optimise patient's medicines use. Their clinical role should be enhanced and embedded in the overall care of the patient contributing to the safe and effective use of medicines and improved health outcomes.

Medicines Optimisation Quality Framework - Components

The Framework has three components.

- A **Regional Medicines Optimisation Model** which outlines what should be done at each stage of the patient journey to help gain the best outcomes from medicines.
- **Quality standards** which describe what patients can expect when medicines are included as part of their treatment. These standards will identify:
    - What best practice should be delivered and any gaps in best practice which need to be addressed.
    - Recommendations for change.
- **A regional medicines innovation plan** to support the sustainable delivery of the quality standards which identifies the priority areas for research and service development required to address the gaps in best practice in medicines optimisation over a five year period 2015-2020.

Regional Medicines Optimisation Model



Supported by:

- **Delivery of best practices** - new Controls Assurance Standards for Medicines Optimisation.
- **Available Quality systems** - including ICT infrastructure supporting connectivity, electronic transmission of prescriptions, access to the Electronic Care Record, prescribing support, NI Formulary, enhanced prescription data analysis.
- **Supporting infrastructure** - including the Regional Medicines Governance Team Regional Medicines Management Pharmacy Team, Education, Learning and Development Providers, Effective commissioning, Funding Streams, A Regional Innovation Programme.
- **Multidisciplinary professionals** working collaboratively, communicating and sharing information to meet the needs of patients.

Medicines optimisation will promote a common understanding for Health and Social Care providers and patients of what is expected when medicines are included in an individual's treatment in Primary and Secondary Care as well as within Community Care and Social Care. Below in tabular form is a summary of what you should expect as routine practice with regards to medicines optimisation in the different settings – Hospital, General Practice, Social Care and Community Pharmacy.

Hospital	**General Practice**
On Admission • Patients bring their medicines to hospital so that they can be checked and used where possible. • Within 24 hours of admission patients have a medicines reconciliation check by a pharmacist. It involves collecting information about current medicines, checking for omissions, duplications and other discrepancies and then recording and communicating any changes. Patients, family members or carers may be involved in this process. • If patients move from one ward to another within a hospital, medicines reconciliation occurs again. **Following Medical Assessment/Diagnosis** • Patients are involved in decisions making about their medicines and receive information about new medicines and the expected health outcomes. • Patients have the opportunity to speak to a healthcare professional and ask questions about their medicines. • During the inpatient stay prescription charts are monitored and reviewed in conjunction with medical notes and relevant medical laboratory results. • Patient responses to medication therapy are monitored and best practices relating to 'high risk medicines' are followed **Administration of medicines** • On some wards patients may be able to administer their own medicines however if this is not possible medicines are administered on time following a check that the direction to administer is appropriate and other related factors are taken into consideration **On discharge** • Prior to discharge the medicines reconciliation process is repeated. • Patients receive a supply of their prescribed medicines and are provided with accurate, up-to date information about their ongoing treatment where necessary. • Patients know who to contact if they have a query about their medicines after discharge. • Accurate and up-to date information about medicines is communicated to the patient's GP, Community Pharmacy and social care worker where relevant.	**When you visit your general practice** • Patients registering with the practice for the first time have a medicines reconciliation check. • During consultations patients are involved in decisions making about their medicines, receive information about new medicines and the expected health outcomes. • Patients taking multiple medicines or taking 'high risk medicines' are identified and where appropriate receive additional information and advice to help take their medicines safely and effectively. • All patients on repeat medication have an annual face to face clinical medication review. (This may be more frequent depending on the individual's care plan or type of medication). • Patient responses to medication therapy are monitored. Medicines that are not beneficial and not evidence based are not continued. • Patients with problems taking their medicines as prescribed (non-adherent) are referred for an adherence assessment. • Patients are involved in decisions about their medicines and are encouraged to ask questions about their treatment and to be open about stopping medication. • Patients discharged from hospital have their medicines reviewed. • Prescribers have up to date information to support clinically appropriate and safe prescribing. • Prescribers have access to information and advice about polypharmacy and patients taking multiple medicines. • Practices provide information about prescribed medicines to hospitals and other appropriately authorised health and social care professionals to assist medicines safety during transitions of care.

Social Care

Nursing, Residential homes and Childrens homes

- When individuals first move into the home and at each transition of care thereafter their medicines are checked with their GP Practice and Community Pharmacy.
- Adequate supplies of medicines are always available and prescription ordering systems in homes are carefully managed and monitored to avoid waste.
- Individuals with specific medication needs such as Parkinson's disease or Diabetes or those taking multiple medicines and 'high risk medicines' are identified and receive the appropriate care in line with best practice.
- Individuals who take their own medicines are monitored to ensure they are taking them as prescribed.
- Medicines are administered on time following a check that the direction to administer is appropriate.
- Individuals taking repeat medication have an annual clinical medication review, the frequency of the review may vary depending on the care plan
- Care home staff have contact with pharmacists in the community to assist with queries about medication.

Domiciliary care

- Domiciliary care staff have a defined role in helping with medicines taking.
- They have appropriate information about the individual's current medication and are aware of any changes following a transition of care, such as discharge from hospital.
- They receive training on 'High Risk Medicines' and have easy access to information about all medicines.
- They have contact with pharmacists in the community to assist with queries about medication.

Community Pharmacy

- On presentation of a prescription the pharmacist will carry out a check of the prescription before it is dispensed. This will inform the level of information and advice that is needed for the patient to take their medicines safely and effectively.
- High quality medicines are dispensed safely.
- Patients receive appropriate information and advice with the supply of medicines, particularly if a new medicine or a 'high risk medicine' is supplied.
- If the presentation of a repeat medicine changes, the patient is advised of this change and reassured of continued efficacy.
- Patients are offered a medicines review after a significant change in their medication. For example following discharge from hospital or after starting new treatment regimen.
- Patients having problems taking their medicines as prescribed have their adherence needs assessed and appropriate support provided.
- Patients are asked if they need all their repeat medicines before they are supplied to reduce the risk of waste.
- Pharmacists work closely with other health and social care professionals to ensure patients are on the most appropriate medication and have contact with pharmacists working in local GP practices and hospitals.
- To support safe transitions pharmacies provide information about medicines supplies to the pharmacist conducting a medicines reconciliation check after admission to hospital or to appropriately authorised health and social care professionals in a nursing or residential home.
- On discharge from hospital the community pharmacy receives up to date, timely information regarding the patient's medication.
- Pharmacies may provide other services such as clinical medication reviews and monitor health outcomes from medicines to support medicines optimisation.

Quality standards

In order to support the Regional Medicines Optimisation Model, ten new minimum quality standards have been developed to drive consistency and bring about a common understanding about what service providers are expected to provide and what patients can expect to receive when medicines are included as part of their treatment in any Health and Social Care setting.

The standards address issues relevant to all patients within the three overarching quality domains of safety, effectiveness and patient/client focus as outlined in the following table.

Quality Theme	**Medicines Optimisation Standards**
Safety - **Preventing and minimising harm related to medicines use.** • **Safe and secure use of medicines** • **Avoid adverse drug events** • **Avoid adverse drug reactions**	1. Safer Transitions of Care 2. Risk Stratification of medicines 3. Safety/Reporting and Learning culture
Effectiveness - **Right patient, right medicine, right time, right outcome, right cost.** • **Evidence based-practice** • **Decisions transparent and robust** • **Discontinuation of medicines no longer required or deemed not cost-effective**	4. Access to medicines you need 5. Clinical and Cost Effective Use of Medicines and Reduced Waste 6. Clinical Medication Review 7. Administration
Patient/Client Focus - **Patients involved in decisions about their treatment with medicines.** • **Shared decision-making between the patient and health professional** • **Supporting patients** • **Adherence to medicines**	8. Safer Prescribing with Patient Involvement 9. Better information about medicines 10. Supporting Adherence and Independence

The ten standards within the Medicines Optimisation Quality Framework are listed as follows:

Standard 1 – Safer Transitions of Care
Checks occur at each transition of care to ensure that the transfer of medicines and medicines information between patients, carers and health and social care workers is safe, accurate and timely.

Standard 2 – Risk Stratification of Medicines
Patients who may be at risk because of the medicines that they use receive the appropriate help to take their medicines safely.

Standard 3 – Safety/Reporting and Learning Culture
Organisations promote an open and transparent culture with evidence of processes for the reporting, prevention, detection, communication and cascade of learning from medication incidents and adverse drug reactions.

Standard 4 – Access to medicines you need
Patients have appropriate, equitable and timely access to quality assured, evidence-based and cost-effective medicines.

Standard 5 - Clinical and Cost Effective Use of Medicines and Reduced Waste
Within organisations a culture exists promoting a shared responsibility for the appropriate, clinical and cost effective use of medicines supported by systems for avoiding unnecessary waste.

Standard 6 – Clinical Medication Review
Patients have face to face clinical medication reviews on a regular basis.

Standard 7 – Administration
Following an initial check that the direction to administer a medicine is appropriate, patients who have their medicines administered receive them on time and as prescribed.

Standard 8 - Safer prescribing with patient involvement
Prescribing is carried out in a manner which promotes safety and optimal health outcomes, with patients involved in decisions about their treatment.

Standard 9 – Better information about medicines
Patients/carers receive the information they need to take their medicines safely and effectively.

Standard 10 – Supporting adherence and independence
People are helped to remain independent and self manage their medicines where possible but receive support with adherence when needed.

A regional medicines innovation plan

A new strategic approach to pharmaceutical innovation is proposed to support and drive continuous improvement through the development and implementation of best practice in medicines optimisation in Northern Ireland using existing funding streams and resources where possible.

This will involve a high level alliance of stakeholders involving commissioners working to provide the necessary leadership and focus for the development and implementation of evidence based best practice associated with each medicines quality standard.

The approach has three components

- **A regional medicines innovation plan**
- **A regional centre for medicines innovation, research and service development**
- **A medicines optimisation network**

The regional medicines innovation plan will be agreed by the high level group of stakeholders. The plan would prioritise projects in a programme of translation, research and service development with clear outputs and timelines for developing, testing and implementing solutions.

As the programme will draw on the activities of a range of different organisations accessing different funding streams and with varied outputs it is proposed that this work is undertaken under the governance of a new **Northern Ireland Medicines Optimisation and Innovation Centre (NIMOIC).**

The medicines optimisation network would link to other health and life science networks and provide an opportunity for building and sharing knowledge and developing collaborative working partnerships.

How to Respond to this Consultation

This consultation invites views on the Medicines Optimisation Quality Framework. A Consultation Response Questionnaire follows in the next section.

A response can be submitted by letter, fax or e-mail.

Details are:

Post:
Department of Health, Social Services and Public Safety
Medicines Policy Branch
Room D3.22
Castle Buildings
Belfast
BT4 3SQ

Fax: (028) 90522335
E-mail: medicinesoptimisation@dhsspsni.gov.uk

Completed consultation response questionnaires must be received by the Department by **5.00pm Friday 14th August 2015.** Responses received after this date will only be considered with prior agreement from the Department.

If you have any queries regarding the consultation please email your query to: medicinesoptimisation@dhsspsni.gov.uk

Medicines Optimisation Quality Framework - Questionnaire

The Department of Health, Social Services and Public Safety welcomes your views on the Medicines Optimisation Quality Framework

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

(Please tick a box)

I am responding: as an individual ☐ on behalf of an organisation ☑

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Views are invited on the following questions by 5.00 pm Friday 14th August 2015

The aim of the Medicines Optimisation Quality Framework is to support better health and wellbeing for all people in Northern Ireland through improvements in the appropriate, safe and effective use of medicines. Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time.

Q1	**Is the aim of the Medicines Optimisation Quality Framework clear throughout the document?**

(Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
While the overall aim of the framework is clear, I think it would benefit from reiterating the meaning of medicines optimisation at an appropriate point in the body of the document, rather than just in the joint introduction (beginning of Section 1 and end of Section 2 would seem appropriate places for consideration). For example, a reference could be made to the NICE (2014) medicines optimisation definition "*evidence-informed decision making about medicines, involving effective patient engagement and professional collaboration to provide an individualised person-centred approach to medicines use, within available resources*." This definition is further endorsed by the Kings Fund paper (2013) on medicines optimisation. Similarly the Royal Pharmaceutical Society's paper on medicines optimisation (2013) suggests the following four guiding principles: • Aim to understand the patient's experience • Evidence based choice of medicines • Ensure medicine use is as safe as possible • Make medicines optimisation part of routine practice. While the consultation document does address each of these elements, I think it would be helpful to set this out so it is clear how medicines optimisation differs from existing approaches. It is important that the patient focus remains central during the implementation phase and this framework translates into a change in accessible services, support and improved outcomes. The recently published RQIA Review of Medicines Optimisation in Primary Care (July 2015) also notes the principles of medicines optimisation include the need for patients to be involved in decisions regarding their medicines use. The review team concludes that further work in Northern Ireland is required in this area. As a general point, given the RQIA Review post-dates the Medicines Optimisation Quality Framework consultation document, it would seem sensible for this to be referenced where appropriate within the over-arching framework.

Section 1 of the Medicines Optimisation Quality Framework details the history of medicines management in Northern Ireland 2000-2014.

Q2 Does Section 1 provide a comprehensive review of medicines management? (Please tick a box)

Yes ☐ No ☑ Don't know/ no views ☐

Additional Comments
While it is a very comprehensive review of medicines management in terms of PCE and secondary care developments it lacks detail on the community pharmacy side. It would be useful to add two or three paragraphs expanding on some community pharmacy medicines management developments, such as those listed under supply and adherence, the 2004 Making it Better Strategy could be also be referenced.

Section 2 of the Medicines Optimisation Quality Framework details the key challenges to address in moving to medicines optimisation.

Q3 Are the key challenges in moving to medicines optimisation comprehensive and clear within the Framework? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
I note this section has changed considerably from the last version shared with the Steering Group and while this has resulted in a rather lengthy section, I believe it adds useful context. I have only one suggested change to the new paragraph 31 which mentions the Donaldson Review, TYC and Living with Long Term Conditions. As each of these references explicitly recognise the increased role that *community* pharmacists could have in improving patient care, to ensure this is accurately reflected in the current document, I suggest that the term "*community pharmacists*", rather than "*pharmacists*" is used i.e."… *all recognise the role that community pharmacists have to play in raising a patient's quality of care*…" The RQIA Review of Medicines Optimisation in Primary Care, also refers to TYC, stating "*TYC outlines that community pharmacists have a greater role to play in managing patients with long-term conditions, who are taking multiple medicines.*" The RQIA review also states "*An effective medicines optimisation process in primary care requires a multidisciplinary approach, involving both medical practitioners and community pharmacists.*" A general observation is that this new Section 2 is written very much from an organisational perspective and the needs articulated relate as much to medicines management as they do to medicines optimisation. I think it would be useful if, at the beginning of this section, a new paragraph 1 is inserted (as discussed in my response to Q1) which makes it clear how medicines optimisation differs from medicines management in terms of a more patient-focused approach which properly considers the patient's experience while using evidence based approaches to ensure patients gain optimal outcomes from the medicines they take.

Similarly, once all the needs are articulated I think it would be useful if the summary paragraphs 49 and 50, could bring the focus back to exactly why a medicines optimisation approach is called for, this is well stated in the first four new bullet points under Objectives given on page 7 of the Introduction.

Section 3 of the Medicines Optimisation Quality Framework details the Medicines Optimisation model

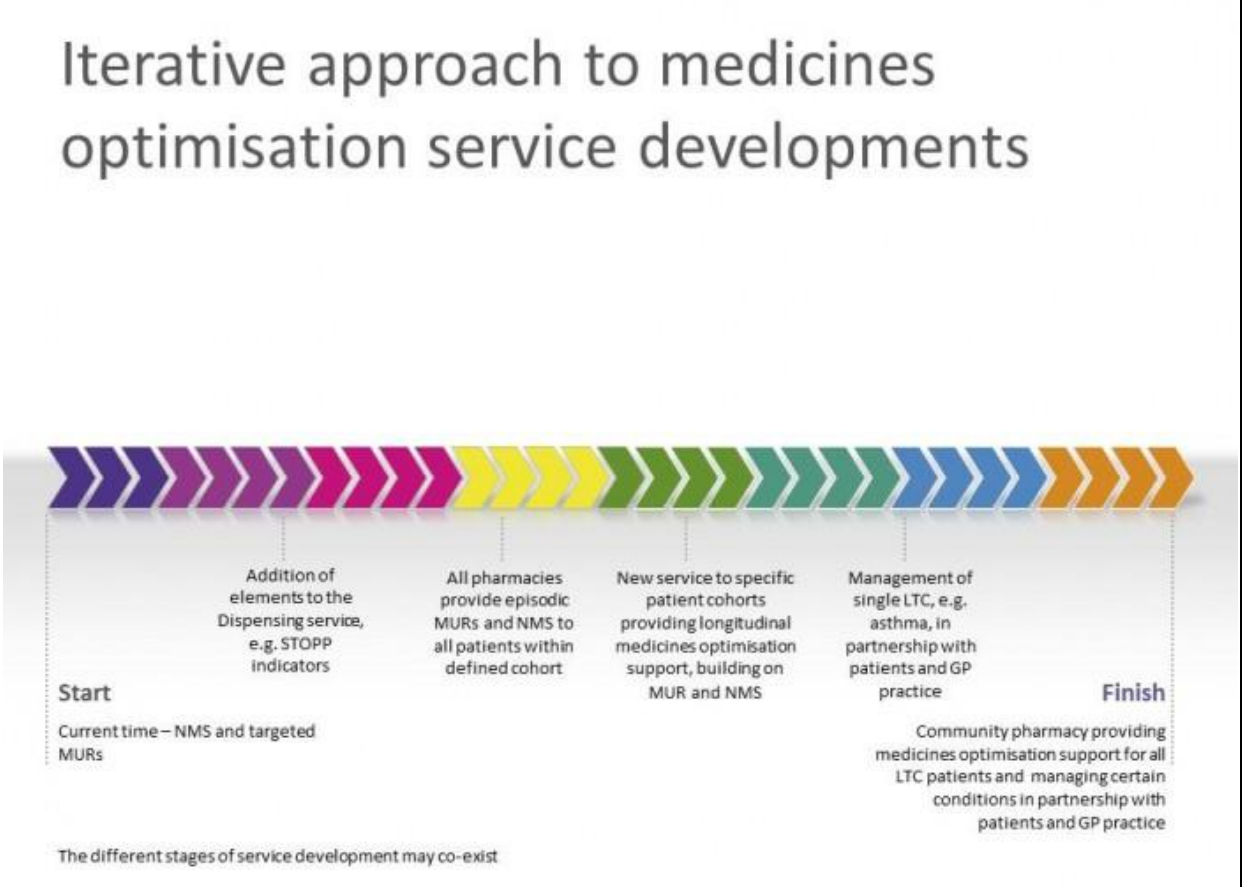
Q4 Do you think the Medicines Optimisation model visually demonstrates the key aim and objectives of medicines optimisation? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments

The illustration, of the Medicines Optimisation model given on page 38 of the document successfully describes the essence of medicines optimisation with the patient at the centre and the full range of care providers represented around the key features of safety and effectiveness. It is a considerable improvement on the last version shared with the Steering Group.

A further illustration often used in England which further describes the patient journey within the model, with particular reference to the community pharmacy dimension, is given below.



Medicines optimisation will promote a common understanding for Health and Social care providers and patients of what is expected when medicines are included in an individual's treatment in primary and secondary care as well as within Community Care and Social Care. Section 3 provides a number of tables of what a patient should expect as routine practice with regards to medicines optimisation in the different settings – Hospital, Community Pharmacy, General Practice and Social Care

Q5	**Is it clear from the list of activities provided in the tables in Section 3 of the Framework of what a patient should expect as routine practice with regards to medicines optimisation in the different Health and Social Care settings? (Please tick a box)**

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
This Section differs significantly from the last version shared with the Steering Group and while in the main it is an improvement, I firmly believe the role of the community pharmacist could be expanded within the model to fully utilise the cost-effective range of skills within this sector. This is also endorsed in the recent RQIA Review which states "*An effective medicines optimisation process in primary care requires a multidisciplinary approach, involving both medical practitioners and community pharmacists*." This Review recommends improved communication between secondary care, GPs and community pharmacies, together with access to the ECR for community pharmacists and limited registration with community pharmacies for those patients who require multiple medicines. The Review suggests that such steps "*may improve future medicines adherence post discharge."* Community pharmacy teams are the most accessible healthcare professionals and often the ones who are seen most regularly by patients. They have shown how they can help patients and it is vital that we build on this potential, with pharmacists in other settings collaborating closely with them to ensure patients are receiving joined up and consistent care. I hope that any investment gives community and other pharmacists a chance to explore new ways of working, ideally with collaborative training opportunities to offer the best possible care to patients. Community pharmacists in Northern Ireland are currently constrained, not by apathy but by the limited range of services they have been commissioned to provide. Currently the only related services commissioned uniformly across the community pharmacy network are a repeat dispensing service (in need of updating), a very limited minor ailments service and a Medicines Use Review Service (MUR) for patients with asthma and diabetes. This differs considerably from all other UK where a wider range of services are available. CPNI firmly believes that the development of medicines optimisation services by the HSCB should expand the range of the MUR service to include other patient groups by initially introducing those started on new medicines and those recently discharged from hospital. Community pharmacies are currently capped at providing 120 MURs per year, this limit should also be reviewed.

This approach to medicines optimisation could be extended, as endorsed by the RQIA Review, via a patient registration model which would see community pharmacies taking responsibility for provision of specific support to an appropriate cohort of patients, which would allow the community pharmacy support to be embedded within local patient care pathways. Within such an approach patients and other healthcare professionals involved in the care of the patient would have certainty about what support community pharmacies would provide to patients, thus supporting team working across primary care. With a registered patient population, it would be possible to implement patient outcome measures for the pharmacy services against which community pharmacies would be held to account and also rewarded where appropriate outcomes are achieved.

One of the failings of the current MUR service is that it generally can only be provided once a year (with brief follow-up) to each patient up to a maximum of 120 patients per year. This episodic approach prevents the provision of longitudinal care within the community pharmacy, to the patient over the course of the year, which is probably needed in order to have the maximum positive impact on optimising the patient's use of their medicines. A second stage of development of medicines optimisation services may therefore be to encompass the support provided by MURs within a new service focused on a specific patient cohort, which allows more frequent interventions in the community pharmacy setting, possibly aligned to dispensing intervals, over the course of the patient's year of care.

The use of innovative technologies, for example smartphone apps, could be incorporated into this service offering, for appropriate patients. This could include provision of reminders to take medicines and support messages about other aspects of the patient's condition.

Over time and assuming that this approach delivered positive patient outcomes, the range of conditions covered could be extended, alongside access to the patient record.

The development of the medicines optimisation services described above could take place alongside a move to support more active management of long term conditions. Currently many long term conditions are managed in general practice by practice nurses. Diseases such as asthma, hypertension and diabetes are managed in line with the structured guidelines provided by NICE and other institutions. Even with the potential appointment of additional GP practice-based pharmacists there will be a need to release capacity in general practice to take on the management of more complex diseases, currently managed in secondary care, or to allow more active case management of high risk patients. This would therefore create the opportunity for community pharmacies, in collaboration with general practices, to manage specific patient groups, or at least to undertake specific elements of disease management detailed in care pathways and quality standards. . For that reason, I, like many others, believe that a co-investment in the community pharmacy sector would offer a real advance, bringing clinical benefits to many patients. I note that the RQIA Review while acknowledging the role of clinical pharmacists in GP practices, states that community pharmacists offer an "*immediate, readily available resource.*"

Disease areas which would seem amenable to community pharmacy management include asthma and COPD, Parkinson's disease, hypothyroidism, hypertension, type 2 diabetes and poorly managed pain.

This approach has been summarised in the illustration given on page 17 of this response.

Section 4 of the Medicines Optimisation Quality Framework details the quality standards for medicines optimisation. The next set of questions are to seek your views on each of the quality standards and proposed recommendations.

Standard 1 – Safer transitions of care

Q6 (a) Do you agree that when a patient moves from one health and social care setting to another, for example from Hospital to General Practice, checks are to occur on each occasion to ensure the safe, accurate and timely transfer of medicines information between patients, carers and health and social care professionals. (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
This is a key area for immediate development. Information flow and communication in general within the HSC system are poor, particularly during transitions of care. A fully integrated IT system, with appropriate access to the patient care record is the gold standard. However, depending on the level of investment and infrastructure needed this may not be deliverable immediately and in the meantime, while this is being developed it is important to bridge this information gap and reduce risk. Successful models funded through modest IT investments have been implemented elsewhere in the UK to, improve patient safety on transitions of care, such models include the "Refer- to- Pharmacy" scheme in East Lancashire and the "Transfer of care" scheme in North-East England and Cumbria which have been found to reduce patient readmission rates. These models are based on a hospital referral for a tailored post-discharge follow-up in the patient's regular community pharmacy. The community pharmacy is often a patients' last port of call before they return to their own home, usually with new or modified medication regimes, so it seems sensible to have a post-discharge service in place from community pharmacy to support patients in their transition back home. Such services are available from community pharmacies across other UK regions, with access to the Summary Care Record also granted to community pharmacists in England and Wales. Addressing these linkages between hospital, General Practice and the community pharmacy must be an early objective which is also endorsed by the recent RQIA Review

Q6 (b) Do you agree with the recommendations within the Framework in relation to safer transitions of care? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
While I believe the nine points are fine, they could be simplified into 3 key actions: i) Development of an integrated IT system for the HSC including community pharmacy ii) Access to the ECR for community pharmacists and other appropriate HSC workers iii) Development of a regional protocol for medicines optimisation on transitions of care

I have some concern around how the existing 9 points will translate into practice, I believe if implementation prioritised the 3 key actions given, this would make the greatest difference in services to patients on the ground in the short-term.

Standard 2 – Risk Stratification of Medicines

Q7 (a) All medicines carry a level of risk, but some are known to carry a greater risk of side effects, adverse reactions and/or admission to hospital than others. Do you agree that when patients who may be at risk because of the medicines that they use receive the appropriate help to take their medicines safely? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments

It is important that patients receive an appropriate level of support to take their medicines safely. On a routine basis, for the majority of patients, the community pharmacist is likely to be the most appropriate health professional to provide this support as they operate closest to patients in their home environment. In addition, while this document focuses specifically on medicine-related risk, the community pharmacist will also usually be aware of social and/or behavioural factors which may add to the level of risk for patients.

Q7 (b) Do you agree with the recommendations within the Framework in relation to risk stratification of medicines? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments

A regional risk stratification tool should be developed as a matter of priority. Work with GP and community pharmacy IT system suppliers should then be taken forward to ensure systems, including community pharmacy PMRs are capable of identifying patients who are receiving high risk medicines and are reminded that additional support or intervention may be needed.

Standard 3 –Safety/Reporting and Learning culture

Q8 (a) Do you agree that organisations across health and social care should promote an open and transparent culture with evidence of processes for the reporting, prevention, detection, communication and cascade of learning from medication incidents and adverse drug reactions?
(Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
This is an important area for development, however it should be taken forward in such a way that it can be incorporated into normal practice, rather than becoming an overly bureaucratic process adding to workload, which may be to the detriment of patient care.

Q8 (b) Do you agree with the recommendations within the Framework in relation to safety/reporting and learning culture? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
I note most of these recommendations differ considerably from those given in the last draft shared with the Steering Group. However, providing these are taken forward in a sensitive and positive manner and translate into practice with due regard to the impact on existing workloads, the recommendations seem reasonable.

Standard 4 –Access to Medicines you need

Q9 (a) Do you agree that patients should have appropriate, equitable and timely access to quality assured, evidence based and cost-effective medicines? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
It is important that patients in Northern Ireland have a similar level of access to medicines to patients living in other parts of the UK and that all HSC processes are open and transparent both to patients and service providers.

Q9 (b) Do you agree with the recommendations within the Framework in relation to access to medicines you need? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
I agree in principle with Regional guidance to improve awareness and understanding of managed entry processes but note the uncertainty of the process itself given the recent public consultation. While I can support the development of regional guidelines on handling medicines shortages in primary care, it is important to note that these are generally supply chain issues which are outside the control of community pharmacy and as such community pharmacy cannot be held to account. Transparency in medicines costs must be upheld by all stakeholders, to ensure that both cost savings and patient care benefits are clearly demonstrable. The margins survey process in community pharmacy provides transparency within this sector, I suggest that a similar level of transparency should form an integral part of current and future PCE processes.

Standard 5 –Clinical and cost effective use of medicines and reduced waste

Q10 (a) Do you agree that we all, whether patients, carers or health and social care professionals have a shared responsibility for the appropriate, clinical and cost effective use of medicines and to avoid unnecessary waste? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
Waste remains a key issue for the HSC system which must be prioritised. Medicines optimisation initiatives led by community pharmacy would provide the HSC with the opportunity to reduce both waste and the sub-optimal use of medicines.

Q10 (b) Do you agree with the recommendations within the Framework in relation to clinical and cost effective use of medicines and reduced waste? (Please tick a box)

Yes (subject to comment below) ☑ No ☐ Don't know/ no views ☐

Additional Comments
The recommendations could go further in terms of also endorsing a standardised 28 day prescribing policy across both primary and secondary care. Evidence has shown that a 28 day prescribing policy reduces waste, this together with an electronic repeat dispensing service would offer key waste-reducing measures in the short-term. Integrated IT and an expanded range of evidence based community pharmacy-based services such as the Four or More Medicines Service in England, using STOPP indicators would also go a considerable way to reducing medicine-related waste.

Standard 6 –Clinical medication review

The patient is central to medicines optimisation and regular discussions or medicine reviews should take place between the patient and health and social care practitioner.

Medication reviews are carried out in people of all ages. The NICE guideline defines a medication review as 'a structured, critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste' Medication reviews are conducted face to face with the patient and with full access to patient medication records.

Q11 (a) Do you agree that a clinical medication review for each patient should take place on a regular basis? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
A clinical medication review should be a routine part of patient care. This should be carried out by a suitably qualified health professional with access to the appropriate level of patient information in a setting and time convenient to the patient.

Q11 (b) Do you agree with the recommendations within the Framework in relation to clinical medication review?(Please tick a box)

Yes (subject to comment below) ☑ No ☐ Don't know/ no views ☐

Additional Comments
The recommendations are acceptable, particularly in terms of developing a common understanding of what a clinical medication review entails, agreeing frequency, broadening ECR access and developing a regional model for use in all settings. However, I note that in bullet point 6, the wording has been changed since the last version shared with the Steering Group which read "*The role of pharmacists working GP practices/care homes/community pharmacies should be expanded to include detail clinical medication reviews with access to patient medical records*." In order to ensure this intention is translated appropriately during the implementation phase, I would recommend that the wording is changed back to that agreed by the Steering Group. This is consistent with the recent RQIA Review which, in terms of the opportunity for increased involvement of pharmacists in medication use review, refers to community pharmacists as "*an immediate, readily available resource*.", also noting that "*increased use of pharmacy staff will support medicines adherence, improve outcomes for patients and decrease wastage of medicines.*"

Standard 7 – Administration

Some patients will require their medicines to be administered. This will occur in hospital, various health and social care settings, such as nursing homes and possibly in the patient's own home where a carer will be tasked to administer the patient's medicine.

Q12 (a) Do you agree that patients who have their medicines administered receive them on time and as prescribed? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
A number of community pharmacists are also helping to facilitate this through new systems or additional support provided to care homes. It may be worthwhile adding this as another good practice example. It might also be useful to recognise that community pharmacists support administration of medicines through the provision of a variety of medicines adherence support solutions e.g. MAR charts, reminder cards, MDS.

Q12 (b) Do you agree with the recommendations within the Framework in relation to administration? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
As mentioned above, further consideration could be given to future recommendations for additional support in relation to administration provided by community pharmacists to patients living both in their own home and in a care home environment.

Standard 8 – Safer prescribing with patient involvement

Q13 (a) Do you agree that when a medicine is prescribed it should be done in a manner which promotes safety and optimal health outcomes for the patient and with the patient fully involved in decisions about their treatment? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
All too often the patient becomes a passenger in their own care, it is important that in the future they are supported and informed sufficiently to enable them to be involved, wherever possible, meaningfully in decisions about their treatment. In this regard, the RQIA Review calls for compliance with the principles contained in NICE Guideline 76. NICE Guideline 76 – Involving Patients in Decisions about Prescribed Medicines and Supporting Adherence

Q13 (b) Do you agree with the recommendations within the Framework in relation to safer prescribing with patient involvement? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
I note these recommendations have changed since the last version shared with the Steering Group and support the amendments. I absolutely support community pharmacists having access to the ECR, the expansion of the hybrid model and a greater multi-disciplinary approach to prescribing in the most appropriate setting for the patient. Community pharmacy as the most accessible healthcare resource offers a suitable alternative to the GP practice, optimising the use of this resource would relieve pressure elsewhere in the system. In terms of involving patients in their care and supporting adherence, the recent RQIA Review also acknowledges "*the opportunity for an increased role for community pharmacy, as all patients taking a number of medicines will at some time visit their pharmacist, who is ideally placed to explore the patient's understanding of their condition and the medication necessary for successful treatment.*" Some reference to this within the overarching framework would seem appropriate.

Standard 9 – Better information about medicines

Q14 (a) Do you agree that patients/carers should receive the information they need to take their medicines safely and effectively? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
Community pharmacists have an important role in supporting this standard. I note that in the gaps in best practice section under community pharmacy it states "MURs are not hugely available in all community pharmacies". I suggest that this is changed to "*MURs available in community pharmacies are limited to patients with diabetes or respiratory conditions*" or "*MURs available in community pharmacies while offered by over 90% of community pharmacies, are currently capped in number and limited by patient condition."*

Q14 (b) Do you agree with the recommendations within the Framework in relation to better information about medicines? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments
I firmly support recommendation 5, the expansion of the MUR service to include other conditions and suggest the addition of *"this should also be adapted in the first instance to be offered to patients on new medicines or recently discharged from hospital*."

While I agree with what the other recommendations intend to convey, I suggest that some consideration is given to the wording and position of bullet point 3. I note that Questions 6 and 7 in this questionnaire also focus on risk stratification. I refer to my response to these questions where I state that the community pharmacist will also usually be aware of social and/or behavioural factors which may add to the level of risk for patients and that on a routine basis, the community pharmacist is likely to be the most appropriate health professional to provide additional support as they operate closest to patients in their home environment. In my response to Q7 I also agree that a regional risk stratification tool should be developed as a matter of priority and suggest that work with GP and community pharmacy IT system suppliers should then be taken forward to ensure systems, including community pharmacy PMRs are capable of identifying patients who are receiving high risk medicines and are reminded that additional support or intervention may be needed.

Therefore, while I am in absolute agreement that the community pharmacist has a key role contributing to and supporting the risk stratification of patient, and that the provision of appropriate support, information and advice is one element of this, I am not convinced this complex process can be simply translated into a SOP.

Currently pharmacists identify specific patients for additional advice or support by virtue of their medicines, their condition and/or perhaps their behaviour or social circumstances. The need for such an intervention in community pharmacy practice is often intuitive and based on the community pharmacist's knowledge or relationship with the patient. While this is not formal "risk stratification" it is nonetheless an important element of ongoing care which could be simply captured by re-wording the recommendation to, "*Community pharmacists should follow a SOP for the provision of appropriate support, information and advice with supply of medicines. Information sources for patients should be promoted*."

Alternatively if the term "risk stratification" is to be retained to in this recommendation, it would seem more appropriate, to move it to Standard 2 so that it is recognised as a recommendation directly linked to risk stratification, in line with the development of a risk stratification tool.

Standard 10 – Supporting adherence and independence

Q15 (a) Do you agree that people are helped to remain independent and self manage their medicines where possible but receive support with adherence when needed? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments

Maintaining independence and supporting self-management strategies need to become a strategic priority to deal with the rising demands of an ageing population. The HSC needs to become sufficiently flexible so that the necessary support can be offered to patients during the times that they need it but equally reablement also needs to be supported so that suitable patients are helped to regain their independence wherever possible. In terms of medicines optimisation there are a number of successful community pharmacy-led reablement programmes across the UK which are worthy of consideration.

There are also anecdotal accounts locally of community pharmacists routinely supporting the reablement of patients. In a recent CPNI survey we asked contractors and patients if they could describe instances where community pharmacy based compliance support services had

improved patient outcomes. Contractors and patients described how compliance support interventions such as the provision of compliance aids for patients with poorly controlled conditions such as diabetes and hypertension resulted in their condition improving to such a degree that it led to their GP stopping a number of medicines, consequently leading to a reduction in the level of compliance support required over time. Fewer medicines and a more stable condition allowed the patient to regain control of their medicines taking.

The recent RQIA Review suggests "*that the areas of patient involvement, patient adherence and medication use review are all intertwined, leading to better patient outcomes*." it also states, *"These areas could be improved by greater involvement of community pharmacy*."

Q15 (b) Do you agree with the recommendations within the Framework in relation to supporting adherence and independence? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments

While the current recommendations are reasonable, it is important that these translate into a practical responsive model delivered in a convenient setting which adequately meets the needs of patients and improves outcomes. Community pharmacy already provides a vital adherence support role, allowing many older patients to live relatively independently in their own home.

Unfortunately in the absence of a commissioned adherence support service most of the ongoing work in this area undertaken by community pharmacists remains undocumented. Research carried out by the University of Ulster in 2012, based on responses from over 300 pharmacists, estimated around 40,000 patients in NI having their adherence supported either through a weekly instalment dispensing arrangement or through the provision of compliance aids by their community pharmacist. The Total average weekly hours spent by pharmacists on delivery of multiple dispensing services was 12.7 hours, with other pharmacy staff spending a weekly average of 16.5 hours. When asked to value the service on a scale of one to 10, patients gave it an average score of 9.75. Pharmacists reported lack of time and costs to their business as being problematic but believed the service provided improved adherence and prevented patients from being inappropriately admitted to secondary care. The survey concluded that community pharmacists in NI were devoting considerable time to delivery of a complex and highly valued service.

I hope that this research, together with the results of the ongoing Medicines Adherence Support Pilot which is nearing completion, will inform the development of a properly commissioned community pharmacy-based adherence service for patients.

I firmly believe that as the most accessible and frequently visited healthcare setting, routine adherence assessment, support and review, must continue to be delivered by community pharmacists. This role is also endorsed by the recent RQIA Review. Such a service could be enhanced by linking with GP practice based pharmacists and others for more complex patients or perhaps where social issues are identified. Further enhancements could involve the use of innovative technologies, such as smartphone apps providing reminders to take medicines and support messages about other aspects of the patient's condition.

I note the addition of the last bullet point recommending the development of self-management plans to support patients with a chronic or long term conditions. Diseases such as asthma, hypertension and diabetes are managed in line with the structured guidelines provided by NICE and other institutions. Even with the appointment of new practice-based pharmacists there will be a need to release capacity in general practice to take on the management of more complex diseases, currently managed in secondary care, or to allow more active case management of high risk patients. This would therefore create the opportunity for community pharmacies, in collaboration with general practices, to manage specific patient groups, or at least to undertake specific elements of disease management detailed in care pathways and quality standards. It would seem to be a sensible approach to develop such a community pharmacy-based model for the management of long term conditions, part of this model should involve the ongoing support of patient self-management plans.

Supporting Continuous improvement and innovation in medicines use.

Section 5 proposes a new strategic approach to pharmaceutical innovation to support and drive continuous improvement through the development and implementation of best practice in medicines optimisation in Northern Ireland,
involving a high level alliance of stakeholders involving commissioners working to provide the necessary leadership and focus for the development and implementation of evidence based best practice associated with each medicines quality standard.

The approach has three components

- **A regional medicines innovation plan**
- **A regional centre for medicines innovation, research and service development.**
- **A medicines optimisation network**

Q16 Do you agree with the new strategic approach proposed within Section 5 of the Medicines Optimisation Quality Framework? (Please tick a box)

Yes ☑ No ☐ Don't know/ no views ☐

Additional Comments

While I agree in theory with the three components outlined above, I have some concerns about how this may be taken forward.

Medicines optimisation is clearly a multi-faceted programme which to be successful needs to be taken forward across a number of different sectors within the HSC. However for this to make a real difference it must translate into an improvement in the level of services delivered to large numbers of patients on the ground.

My main concern is that in a similar way to TYC, if the implementation of this programme falls to HSC Board, this will result in all significant developments being diverted to Trusts and GP practice, thus missing the opportunity of reaching the large number of patients accessible through community pharmacy, who could benefit.

I strongly encourage the Department to appoint an appropriate leader to take this forward who fully understands practice across the entire HSC. In prioritising actions, consideration should be given to the two key elements of **readiness** and **opportunity**. Integrated IT and access to the patient ECR have been given as essential components to a number of key developments and while these are in place in GP practice and other areas of the HSC they would be the main barrier to some of the services being offered in a community pharmacy setting. However, given this option offers the highest level of patient access to an existing skill base in a suitable location with the capacity to deliver, I suggest that provider readiness and enablement should be prioritised in order to realise the greatest opportunity.

This is also recognised by the recent RQIA Review referring to community pharmacists as "***an immediate, readily available resource***" also firmly stating that "*increased use of pharmacy staff will support medicines adherence, improve outcomes for patients and decrease wastage of medicine."*

I therefore call on the Department to take these clear recommendations into account both within the final Medicines Optimisation Quality framework document and during its implementation.

Human Rights and Equality Implications

Section 75 of the Northern Ireland Act 1998 requires Departments in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between person with a disability and persons without; and
- between persons with dependants and persons without.

In addition, without prejudice to the above obligation, Departments should also, in carrying out their functions relating to Northern Ireland, have due regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group. Departments also have a statutory duty to ensure that their decisions and actions are compatible with the European Convention on Human Rights and to act in accordance with these rights.

In accordance with guidance produced by the Equality Commission for Northern Ireland and in keeping with Regulation 75 of the Northern Ireland Act 1998, the Framework has been equality screened and a preliminary decision has been taken that a full EQIA is not required.

The Department is inviting responses to the following questions:

Q17 Are the actions/proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998?

Yes		No	x

If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals

Q18 Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations?

Yes [ ] No [x]

If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Q19 Is there an opportunity for the Medicines Optimisation Quality Framework to better promote equality of opportunity or good relations? Is there an opportunity to better promote equality of opportunity or good relations?

Yes [ ] No [x]

If you answered yes" to this question please give details as to how.

Q20 Are there any aspects of this where potential human rights violations may occur?

Yes [ ] No [x]

Any other comments.

Further Comments

Please use the box below to insert any further comments, recommendations or suggestions you would like to make in relation to the Medicines Optimisation Quality Framework.

Thank you for your comments.

You should send your completed consultation response questionnaire to:

Post:
Department of Health, Social Services and Public Safety
Medicines Policy Branch
Room D3.22
Castle Buildings
Belfast
BT4 3SQ

Fax: (028) 90 522335
E-mail: medicinesoptimisation@dhsspsni.gov.uk

Completed consultation response questionnaires must be received by the Department by **5.00pm Friday 14th August 2015.** Responses received after this date will only be considered with prior agreement from the Department.

If you have any queries regarding the consultation please email your query to: medicinesoptimisation@dhsspsni.gov.uk

Appendix 1

FREEDOM OF INFORMATION ACT 2000 – CONFIDENTIALITY OF CONSULTATIONS

DHSSPS will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Department can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations, they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act 2000 gives the public a right of access to any information held by a public authority, namely, DHSSPS in this case. This right of access to information includes information provided in response to a consultation. DHSSPS cannot automatically consider as confidential, information supplied to it in response to a consultation.

However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential. **If you do not wish information about your identity to be made public, please include an explanation in your response.**

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Secretary of State for Constitutional Affairs' Code of Practice on the Freedom of Information Act provides that:

- The Department should only accept information from third parties in confidence, if it is necessary to obtain that information in connection with the exercise of any of the Department's functions, and it would not otherwise be provided;

- The Department should not agree to hold information received from third parties "in confidence" which is not confidential in nature; and

- Acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see the web site at: https://ico.org.uk/)