

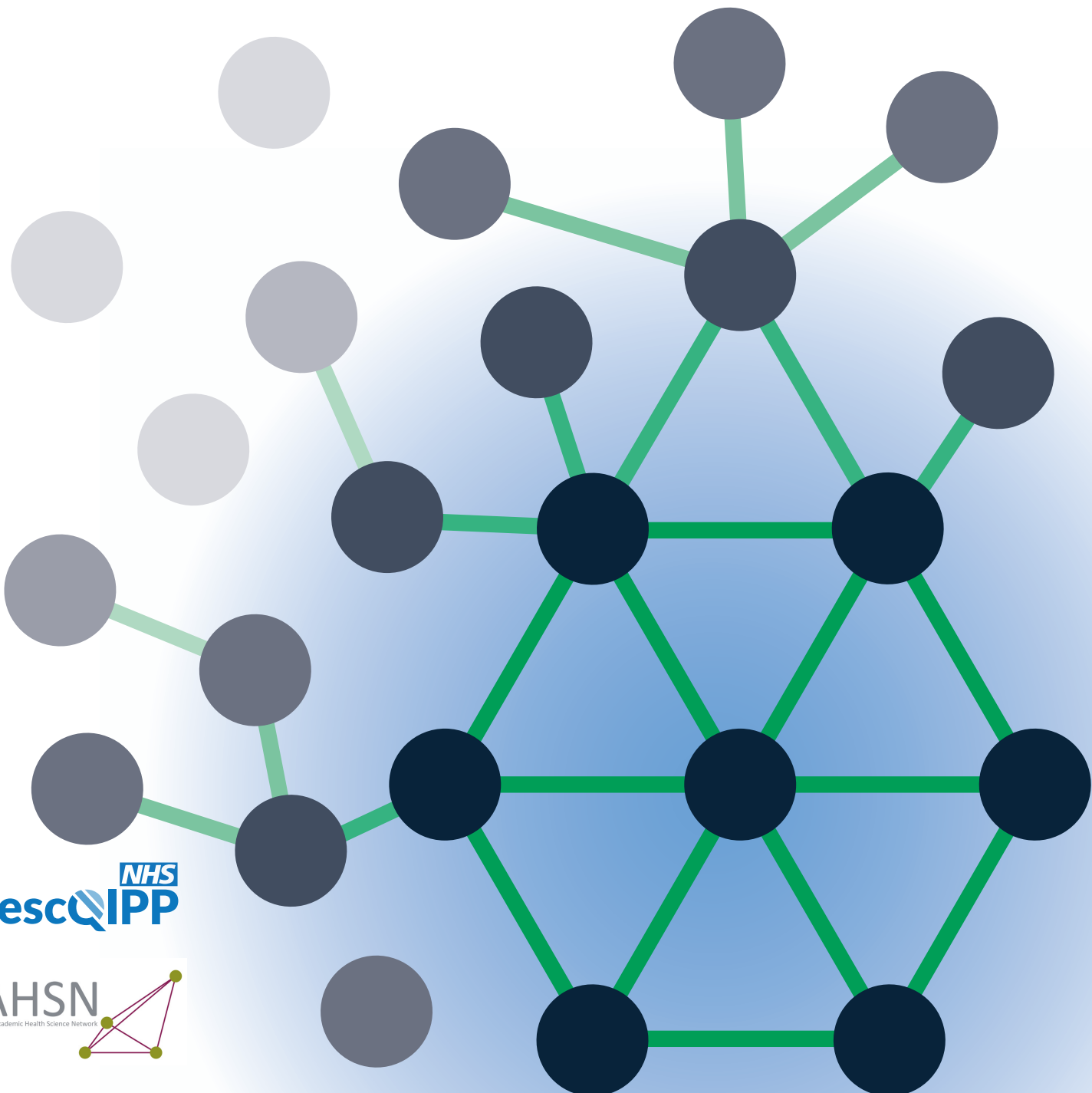
Improving medicines adherence and reducing waste

A collaborative working programme to identify opportunities for future joint working programmes with the pharmaceutical industry

Document written by Rachel Webb, Pfizer Ltd., July 2014, as part of a secondment to the PrescQIPP NHS Programme. This project has been commissioned by, and is delivered on behalf of the Eastern Academic Health Science Network.


PrescQIPP

EAHSN
The Eastern Academic Health Science Network



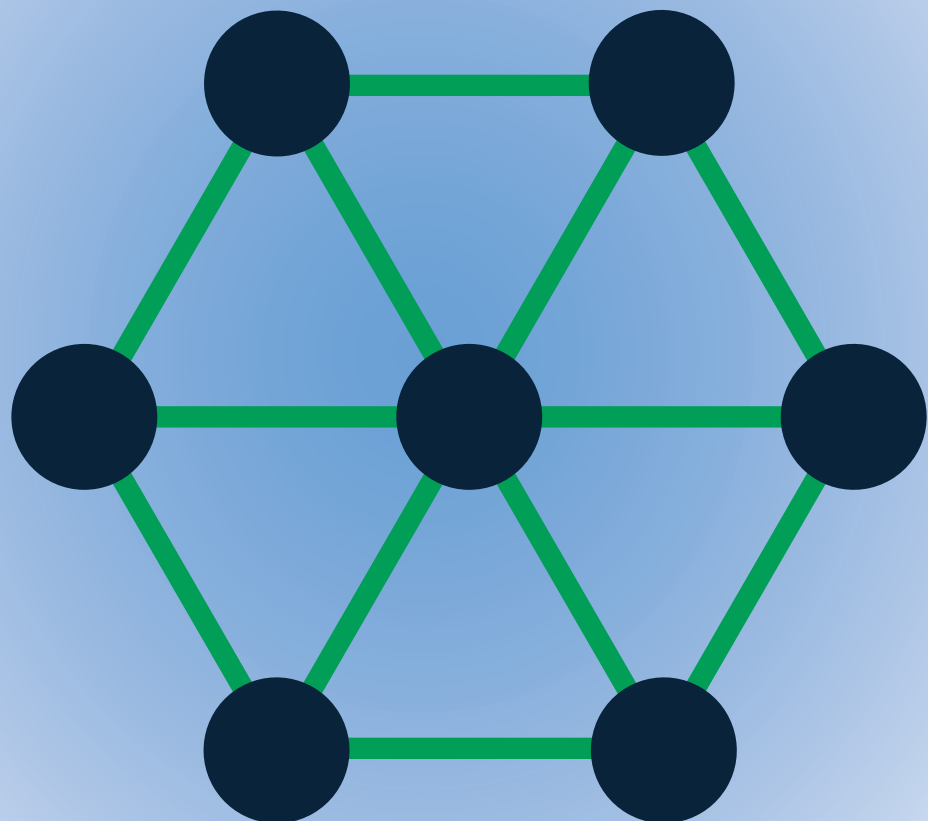
Acknowledgements

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Debbie Wheatley, Practice Manager of the Spinney Surgery, St Ives, Cambridgeshire

Jackie Smith Care Homes Lead Pharmacist, Bedfordshire CCG

Nisha Desai, Head of Medicines Management, PROVIDE community services.



Introduction

Improving medicines adherence and reducing associated waste is one of the great challenges facing modern health systems, including the NHS. It is also one of the greatest opportunities for improvement and outcomes, if correctly tackled by the wider health environment. It is clear that future technological advances and initiatives will change the way that patients interact, and ultimately benefit from, medicines, however this must be built on a strong foundation of care. Much contemporary literature looks to tackle the interdependent, and often complex, elements of the 'House of Care' surrounding the patient and failures are often due to the culture, process, pathway and communication.

As part of our ongoing commitment to support the delivery of Medicines Optimisation within the Eastern Academic Health Science Network area; creating opportunities to tackle the above is one of our key priorities, and has been the focus of the work presented below in this report. This project is very much focused around bringing the NHS and pharmaceutical industry together to generate projects to improve the very foundation of care described above. Medicines adherence and waste is an issue that is important to both the NHS and the pharmaceutical industry, we are collectively responsible for improving Medicines Optimisation and the improved outcomes are mutually beneficial. By generating projects where the NHS and industry can successfully improve how patients interact with their medicines, provides the opportunity to deliver real value for the NHS and patient.

I hope that colleagues from across the NHS and industry will proactively support the messages from this report, and the collaborative approach to improve medicines adherence and waste.

Carol Roberts

Director of Strategic Prescribing

The Eastern Academic Health Science Network & PrescQIPP NHS Programme

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Appendix 1 – Process maps

Key to notes



YELLOW: *Challenges*
(how to amend the system)



BLUE: *Opportunities*
(existing best practice)

1.1 Call for Collaboration and PrescQIPP

PrescQIPP, on behalf of the Eastern Academic Health Science Network (EAHSN), published a Call for Collaboration in November 2013 to all pharmaceutical companies, inviting them to initiate in a wider collaborative working arrangement with a specific focus on delivering tangible improvements around improving medicines adherence and reducing waste. The aim was to identify opportunities for future collaborative working and deliver a clear, robust and concrete framework for pharmaceutical companies to engage with, and commit to through defining the strategic objectives, joint commitment to improvement and collaborative mind-set within a framework. This resultant framework, supported by the EAHSN, will then assist companies in engaging with the NHS and Medicines Management teams. This approach is to ensure that all parties have a shared agenda and that specific outcomes will result from the commitment of specific resources.

PrescQIPP already have an established record of working collaboratively with the pharmaceutical industry¹ and improving adherence with medicines taking. The most recent collaboration project explored the opportunities to improve the medicines communication at the point of Transfer of Care and has explored some areas aiming to improve medicines taking. PrescQIPP have also now released a toolkit as a guide to NHS organisations, specifically to establish their approach to preparing for joint working with the pharmaceutical industry.²

In February 2014, Rachel Webb of Pfizer Ltd. was seconded to collaboratively develop the framework for and between the EAHSN on behalf of PrescQIPP and the wider Pharmaceutical Industry.

1.2 Medicines adherence and waste

National reports highlight the need to address medicines wastage.³ Another recent report⁴ suggested that each year between £100 - £800 million worth of dispensed NHS medicines go unused, and are ultimately discarded. This sum represents approximately £1 in every £25 spent on primary care and community pharmaceutical and allied products used, and 0.3 per cent of total NHS outlays. It includes an estimated £90 million worth of unused prescription medicines that are retained in individuals' homes at any one time, £110 million returned to community pharmacies over the course of a year, and £50 million worth of NHS supplied medicines that are disposed of unused by care homes.

¹ PrescQIPP, *Pharmaceutical Industry Joint Projects* <http://www.prescqipp.info/engage/pharmaceutical-industry-joint-projects> Accessed May 2014

² PrescQIPP, *Preparing for joint working and the seven steps. A guide for NHS organisations.* <http://www.prescqipp.info/engage/pharmaceutical-industry-joint-projects#preparing-for-joint-working-and-the-seven-steps-a-guide-for-nhs-organisations> Accessed June 2014

³ Duereden M. et al. *Polypharmacy and medicines optimisation: Making it safe and sound.* The Kings Fund. 2013. <http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation> Accessed May 2014

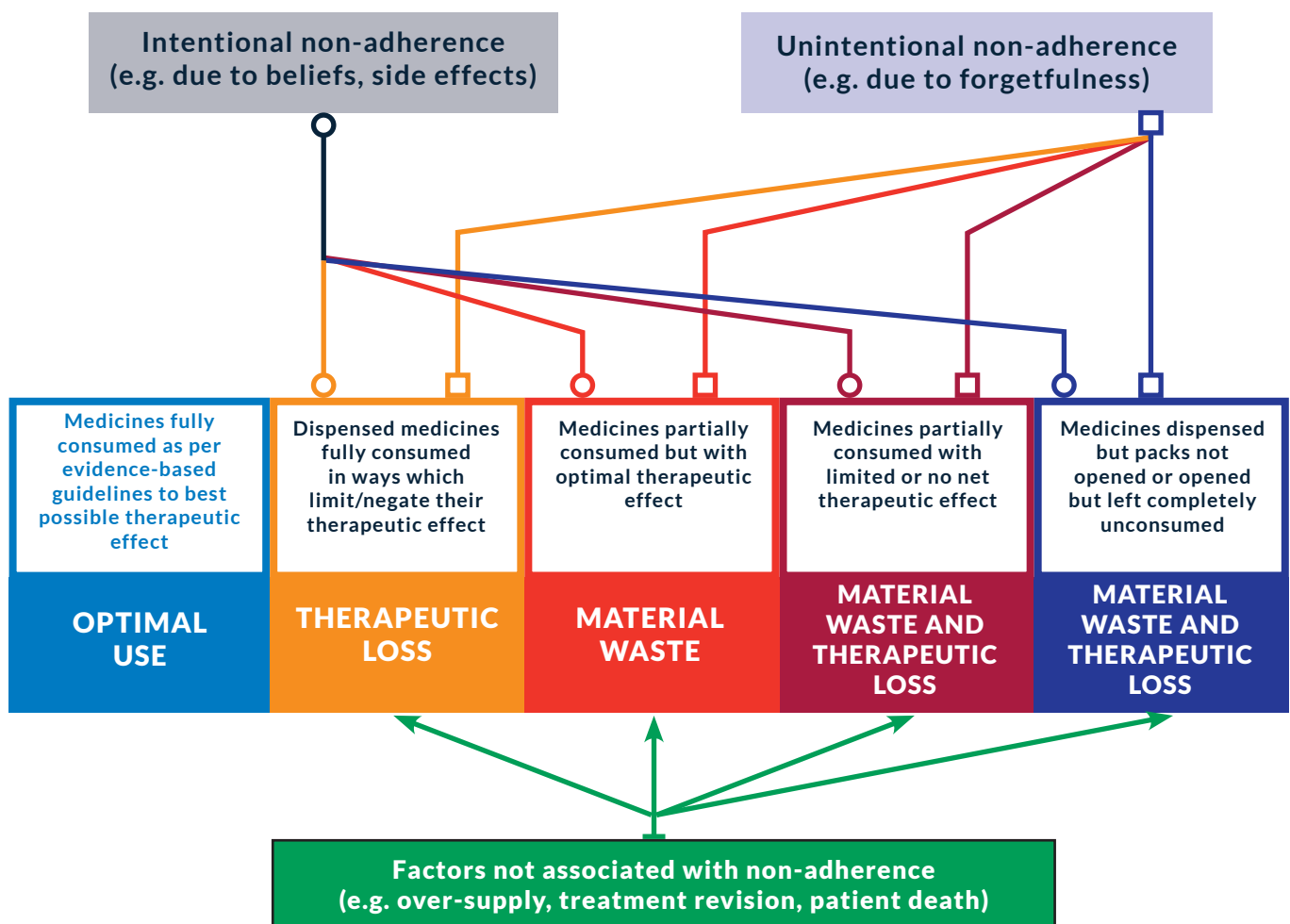
⁴ *Evaluation of the Scale, Causes and Costs of Waste Medicines*, London School of Pharmacy/ York Health Economics Consortium November 2010. <http://eprints.pharmacy.ac.uk/2605/> Accessed March 2014

The authors suggest that prescribed medicines wastage deserves both managerial and professional attention, but also recognised that not all of it is avoidable or the result of poor practice. They estimated that less than 50 per cent of medicines waste is likely to be cost-effectively preventable. Improving adherence in medicine taking can improve health outcomes.

Failures to take medicines to optimum effect are in many instances attributable to either intentional or accidental non-adherence on the part of their users, but patients should not be blamed for the problems they experience in medicines taking or for medicines wastage as it may be related to the system or lack of review. For example:

- Patients recovering before their dispensed medicines have all been taken.
- Therapies being stopped or changed because, for example, of ineffectiveness and/or unwanted side effects.
- Patients' conditions progressing, so that new treatments are needed.
- Patients' deaths, which as well as serving to reveal previously unused medicines, may involve drugs being changed or dispensed on a precautionary basis during the final stages of palliative care.
- Factors relating to repeat prescribing and dispensing processes, which may independently of any patient action cause excessive volumes of medicines to be supplied; care system failures to adequately support medicines taking by vulnerable individuals living in the community, who cannot independently adhere fully to their treatment regimens.

Figure 1 *The causes of medicines wastage and lost therapeutic value*



Positive opportunities for the further reduction of medicines waste include targeted support for vulnerable or isolated and appropriate use of support aids (e.g. monitored dosage systems (MDS)), supporting high quality appropriate prescribing, improved communication between primary and secondary care, improved support for terminal care patients and the use of social marketing to support national campaigns on waste medicines.

Specifically building on the themes identified in this report, the Department of Health formed an action group to specifically develop a plan to address the improved use of medicines to deliver better outcomes and reduced waste.⁵ The specific objectives were to address medicines usage in the following settings:

- **Targeted support for patients in primary care.**
- **Effective use of patients' medicines in hospitals.**
- **Use of medicines in care homes and end of life care.**
- **Engage people in the decisions about their medicines and improving communications.**
- **Between health and social care professionals and patients.**

In order to assist local implementation of this action plan, the East & South East England Specialist Pharmacy Services have published a resource package to signpost the availability of additional resources to implement the recommendations.⁶ This work has been further endorsed by PrescQIPP who also led on a 'Waste Summit' for CCGs and trusts in the East of England in July 2013 highlighting best practice in the following key areas:⁷

- **Concordance**
- **Care homes**
- **Managed repeats**
- **Publicity campaigns**
- **Green bags and patients own drugs**
- **Secondary care including tracking high cost medicines.**

1.3 Medicines Optimisation

The Action Plan themes also resonate with the recently published report from the Royal Pharmaceutical Society: *Medicines Optimisation: Helping patients to make the most of their medicines*⁸ recognising that medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease, however in an era of significant economic, demographic and technological challenge it is crucial that patients get the best quality outcomes from medicines. However, there is a growing body of evidence that shows us that there is an urgent need to get the fundamentals of medicines use right. There needs to be a step change in the way that all healthcare professionals support patients to get the best possible outcomes from their medicines. Medicines Optimisation represents the step change.

⁵ *Action Plan For Improving The Use Of Medicines And Reducing Waste* Oct 2012 <https://www.gov.uk/government/publications/action-plan-for-improving-the-use-of-medicines-and-reducing-waste> (Accessed February 2014)

⁶ *Improving the use of medicines for better outcomes and reduced waste. How the Specialist Pharmacy Services supports the action plan.* May 2013 http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Meds-use-and-safety/QIPP/Reducing/SPS_Resouces_Support_DH_action_plan_Vs1/?query=waste&rank=87(Accessed May 2014)

⁷ *PrescQIPP Waste Summit July 2013* <http://www.prescqipp.info/2013-prescqipp-pharmaceutical-waste-summit/viewcategory/106> (Accessed May 2014)

⁸ *Medicines Optimisation: Helping patients to make the most of medicines*, Royal Pharmaceutical Society, May 2013 www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/your-pages/Documents/rps-medicines-optimisation.pdf (Accessed February 2014)

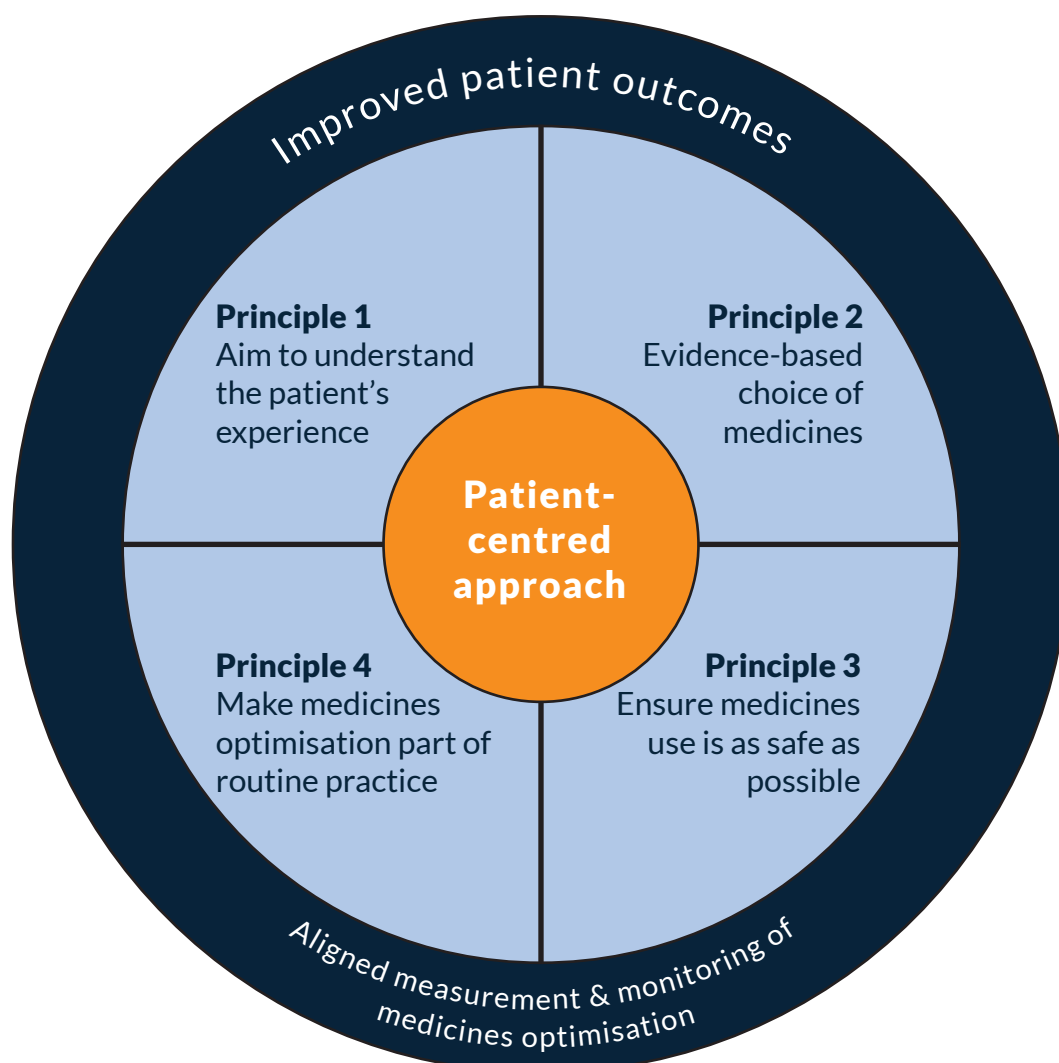
Medicines Optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to improve their outcomes, take their medicines correctly, avoid taking unnecessary medicines, reduce wastage of medicines and improve medicines safety. Ultimately Medicines Optimisation can help encourage patients to take ownership of their treatment.

This report⁸ highlights the following statistics on medicines taking:

- Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.
- Ten days after starting a medicine, almost a third of patients are already non-adherent.
- In primary care around £300 million per year of medicines are wasted (this is likely to be a conservative estimate) of which £150 million is avoidable.
- At least 6% of emergency re-admissions are caused by avoidable adverse reactions to medicines.

This guidance highlights four guiding principles for medicines optimisation that will help all healthcare professionals to support patients to get best outcomes from their medicines use.

Figure 2 Summary of the four principles of Medicines Optimisation

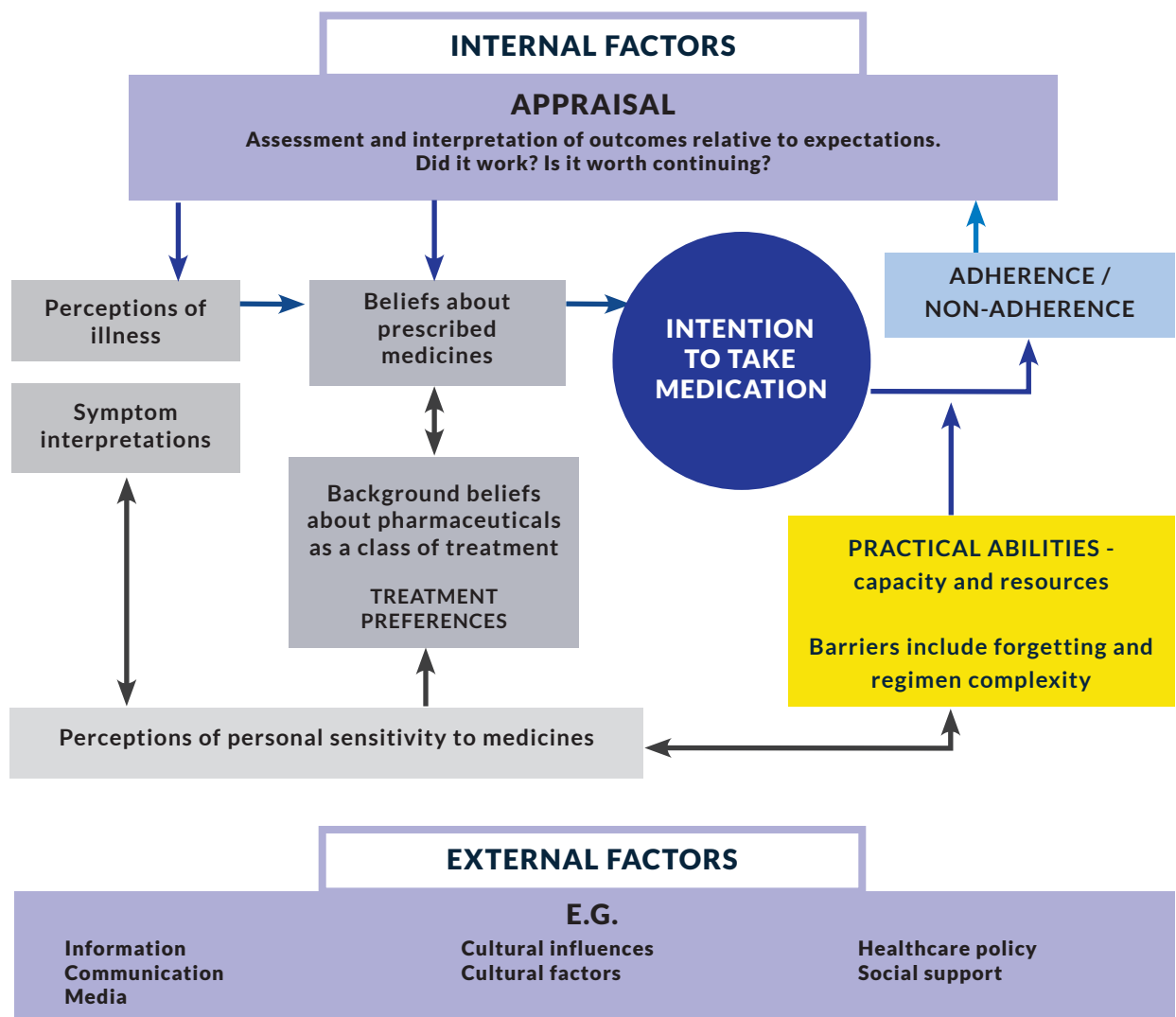


The Medicines Optimisation principles described on the previous page also fit with a number of the domains from the NHS Outcomes Framework particularly relating to the management of long term conditions and improving the quality of life of patients. Understandably the role of medicines are featured heavily in this document as a key element of patient care.⁹

NICE have also included aspects of Medicines Optimisation as part of their work programme. They previously reviewed the evidence for medicines adherence¹⁰ and examined the barriers to medicines taking as either perceptual or practical as shown in Figure 3:

Figure 3 *Factors affecting medicines taking*

Adapted from Horne, R. *Concordance, Adherence and Compliance in Medicine-Taking. Report for the National Co-ordinating Centre for NHS Service and Delivery Organisation R&D (NCCSDO) (2005)*

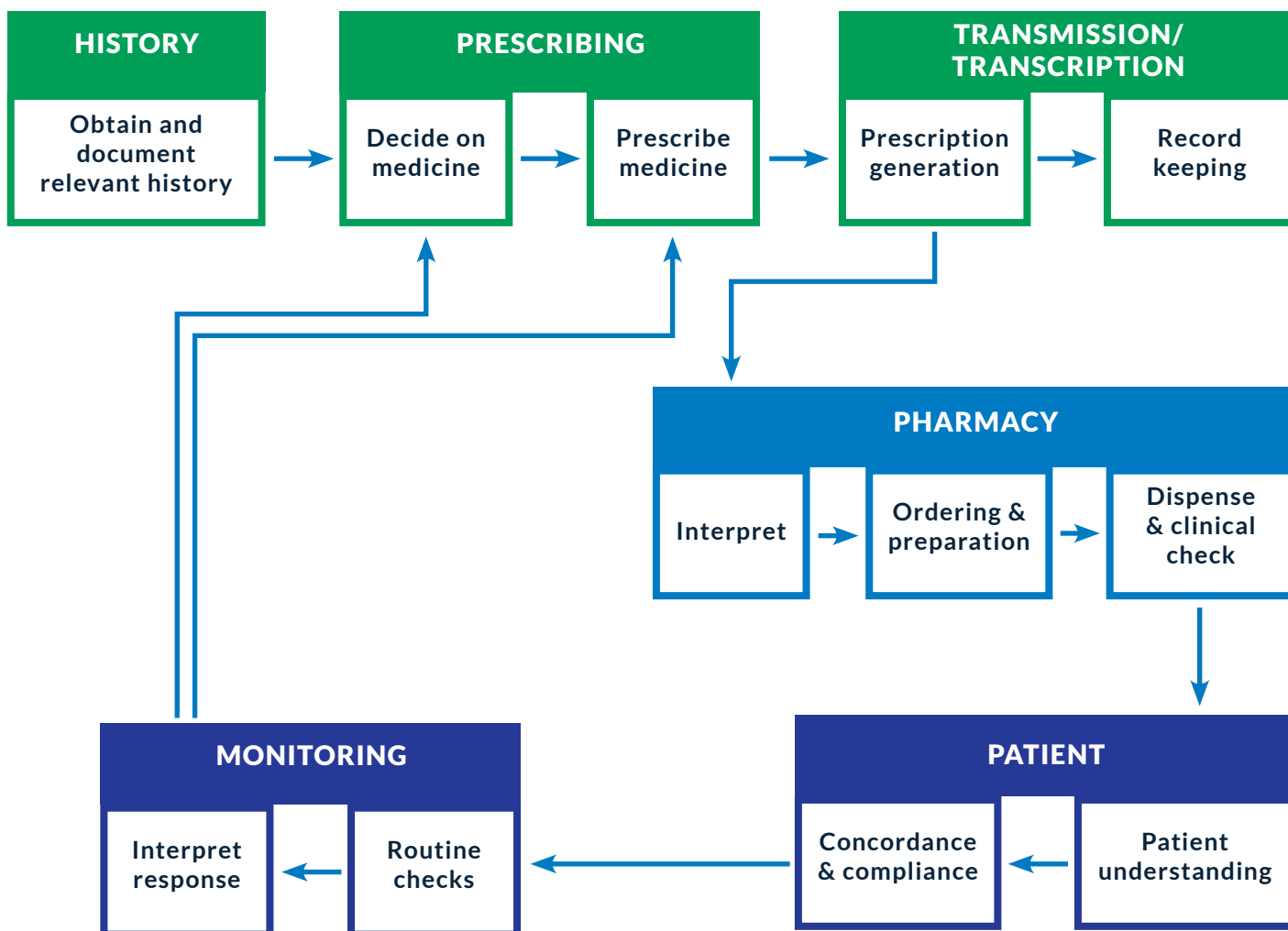


⁹ Department of Health. *NHS Outcome 2014/15*, November 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf (Accessed May 2014)

¹⁰ National Institute for Health and Care Excellence (NICE). *Medicines Adherence Guidance*, January 2009 <http://www.nice.org.uk/CG76> (Accessed March 2014.)

pathway was also explored as part of the Medicines Optimisation review resources, see Figure 4 below which is explored further in the methodology of this project.

Figure 4 *The Medicines Pathway*¹¹

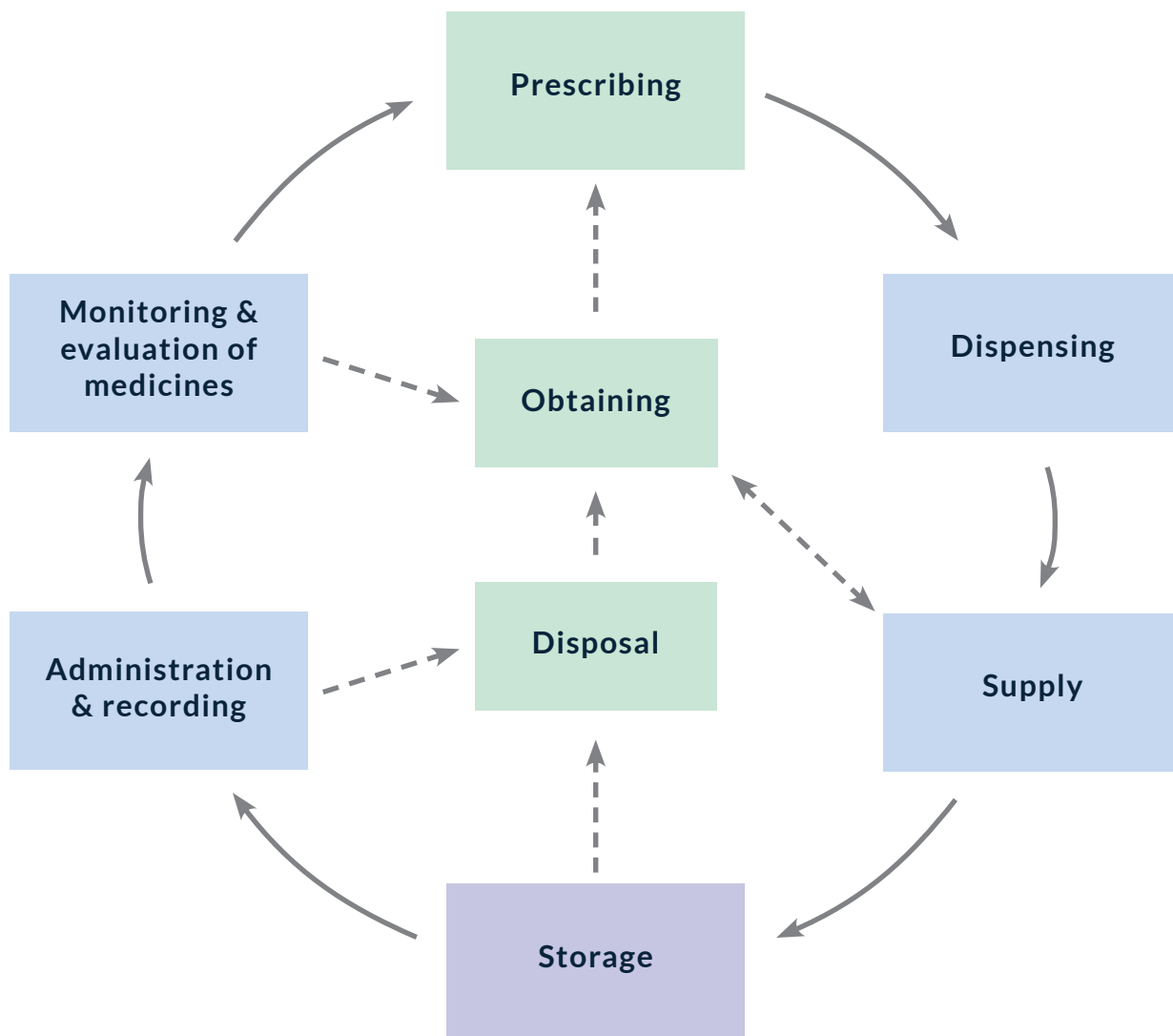


NICE have recently published guidelines on Managing Medicines in Care Homes¹² highlighting the medicines management system (Figure 5) and recommending that care homes have a policy for medicines including processes for transfer of care between care settings, identifying medicines-related problems, medicines review and ordering and receipt of medicines.

¹¹ Royal Pharmaceutical Society, *Medicines Optimisation: The evidence in practice* 2013 <http://www.rpharms.com/promoting-pharmacy-pdfs/mo---evidence-in-practice-presentation.pdf> (Accessed March 2014)

¹² NICE, *Managing Medicines in Care Home*, March 2014 <http://www.nice.org.uk/guidance/sc/SC1.jsp> (Accessed April 2014)

Figure 5 Overview of Medicines Management System



NICE is also due to publish guidance on Medicines Optimisation with the remit to provide further clarity on medicines optimisation to ensure NHS patients get the best possible outcomes from their medicines.¹³

The Care Quality Commission (CQC) also now include medicines management as part of their essential standards on quality and safety and relate this to transfer of information between settings and also a reduction in avoidable medicines related admissions and re-admissions (Outcome 6,9,and 21)¹⁴

1.4 Next steps

The need and the opportunity to ensure that medicines are appropriately reviewed and optimised to the individual patient are greater than ever before. The weight of national evidence and policy documents to ensure that this is appropriately addressed makes medicines adherence and waste an ideal area to explore and identify opportunities for further scope and collaboration.

¹³ NICE *Medicines Optimisation – Clinical Guideline in Development*. Due February 2015 <http://guidance.nice.org.uk/CG/Wave0/676> (Accessed March 2014)

¹⁴ Care Quality Commission, *Essential Standards Quality and Safety*, March 2010. <http://www.cqc.org.uk/content/essential-standards-quality-and-safety> Accessed April 2014.

2.1 Stakeholder engagement

The following stakeholders formed part of the preliminary engagement process to explore the challenges and opportunities of improving medicines adherence and reducing waste:

- East of England Pharmacists (CCG, CSU and hospital pharmacy medicines management teams)
- Pharmaceutical Industry
- Representatives from Local Professional Networks and Local Pharmaceutical Committees

2.2 The East of England Medicines Optimisation workshop

The East of England PrescQIPP workshop on Medicines Optimisation (March 11th 2014) provided the opportunity to explore with medicines management commissioners and providers the key process involved in the initiation, ordering, receipt, taking and storage of medicines. Delegates were assigned to project teams to explore the following areas using a draft process map adapted from Medicines Optimisation: The evidence in practice.¹¹

- Initiation of first prescription
- Repeat medicines
- Care homes medicines management
- Hospital medicines management.

Delegates were asked to undertake the following:

- Use the yellow post it notes to record ideas on the challenges in the process
- Use the blue post it notes to identify best practice to make the system even better
- Review the work of other workshop groups and add additional comments or best practices.

Ideas generated were added to the original process maps to identify the significant challenges but also opportunities to each system.

2.3 Pharmaceutical Industry

Using the regional ABPI industry group, pharmaceutical companies received a detailed overview and brief of the project plan. Companies were encouraged to submit examples of resources or any collaborative work already undertaken in this area so best practice could be shared.

2.4 The patient journey and perspective

It is vital when undertaking a project that is linked to psychological aspects to include the perspective of the patient in their medicine taking journey. NHS England recently explored with patients and carers a workshop to capture discussions on what would make their medicines-taking experience even better¹⁵ and generated ideas about how Medicines Optimisation could be improved. The Patient Representative Forum from the Spinney Surgery, St Ives, Cambridgeshire in April 2014 also captured ideas from their own perspectives of their medicines: exploring their understanding, how they received them and their thoughts on how the medicine system could be improved. It was made clear to the patients that this was not a clinical review and patient

¹⁵ NHS England. *Workshop Report: Making medicines-taking a better experience 2013*. <http://www.england.nhs.uk/wp-content/uploads/2014/04/mo-ws-report-02-14.pdf> (Accessed March 2014).

confidentiality was maintained using the PrescQIPP project manager to collate all reports.

3.1 The East of England Medicines Optimisation workshop

The workshop delegates found the process of mapping the medicines journeys in each context enabled them to identify many aspects of medicine taking that had not previously been explored. The key challenges (yellow post-it notes on how to amend the system) and opportunities (blue post-it notes on existing best practice) are listed verbatim below. The detailed process maps can be found in Appendix 1.

3.2 Care homes

Challenges:

- Care homes to check prescriptions prior to going to pharmacy – doesn't always happen
- Frequently need two pharmacies, one for acute and one for repeats
- Data on waste to focus on care homes – homes recording waste
- Monitored Dosage System (MDS) – help or hinder
- Also need to consider what medicines management systems are in extra-care housing
- Need patient perspective plus patient self-assessment of managing medicines.

Opportunities:

- Can Better Care Fund be used to support homes with pharmacy support?
- Each care home should have their own governance pharmacist employed by the care home;
- GP to employ pharmacist to work with home/care provider and hospital discharge unit
- Social care – pharmacy time in contract to support home
- Community pharmacy supports care home – regular visits.

3.3 Hospital admissions

Challenges:

- Green bags – unless complete system working together this tends not to happen
- Manufacturing of medicines e.g. vial sharing for multiple usage
- Sometimes it is not possible to identify the patients' own medicines on admission so they can't be used
- Interdepartmental transfers and pharmacy returns
- Often on admission, instead of just new medicines resupplied all patient medicines are resupplied leading to wastage
- GP reinstating medicines that have been reassessed and stopped in hospital.

Opportunities:

- Specific community pharmacy contracts to supply certain medicines for discharge
- In Chelmsford, technician/senior assistant follows patient as they move and ensure medicines are taken with them to new wards
- Potential re-labelling – wireless re-labelling system based at ward level
- If medicine has been dispensed from pharmacy to ward but not used, remove patient label and use as ward stock
- Hospital confirms patients have a supply of recently-dispensed medicine at home. Hospital then only dispenses sufficient supply for length of stay. Agree with CCGs in discharge contract
- Medicines with frequency of dosing versus supply (28 tablets twice daily) Two packs given for one month's supply. Recommend only give one pack for length of stay
- Admissions wards: dedicated team available 24/7 for medicines reconciliation. Clinical

- pharmacists and technicians on ward
- Reduce quantity of high cost medicines on ward
- Inhalers: 1. Unopened stickers for inhalers dispensed to ward 2. Respiratory consultants agree that combination inhalers don't need to be dispensed at weekend
- Ward technicians bring back medicine returns regularly so they can be reviewed and managed more effectively.

3.4 New prescriptions

Challenges:

- Assumption that if patient had medicine before, no need to talk about adherence
- Community pharmacy needs more input
- Multidisciplinary team – improve communication
- Relevant side-effects should be discussed
- Patient's medicine journey begins – involved in shared decision making?
- Is there a trigger on pharmacy system to initiate New Medicines Review?

Opportunities:

- Source of first prescription – opportunity to educate patient
- Patient information available at time of first prescription initiated
- Honesty in information – prescriber needs to have engaged conversation with patient re new medicine
- Engagement with pharmacy staff to include training of support staff
- Health literacy – targeting and tailoring to appropriate patient groups
- Patient understanding of risk and benefit of their medicine and how this relates to their condition
- Patient registered with named pharmacist
- Concordance needs to be first priority on initiating medicine
- GP surgery to explain to patient the purpose of repeat ordering slip, which drugs are which and how to order without waste.

3.5 Repeat prescriptions

Challenges:

- Carer involved needs support
- Decision about support required (for example use of Monitored Dose System) needs to be made earlier
- Recognition that deriving no health benefit from a medicines needs reviewing as is also considered waste
- Monitored Dose Systems may often lead to waste
- Need referral route to New Medicines Service
- It is not always the patient who requests a repeat medicine supply; pharmacists may often do this on their behalf.

Opportunities:

- Medicines Administration Record (MAR) sheet updated before patient receives it
- MAR sheet to arrive with the medication
- Managed repeats (prescriptions) need to ensure the requirement for prescription to be checked first, but must ask for review at time of supply, not a month before when written
- Dispensing practices often have good process as technician controls repeat prescribing
- Training and level of authority of prescription clerk is crucial
- Medicines reconciliation in and out of hospital is crucial to ensure accurate repeats.

3.6 Pharmaceutical industry

Reckitt Benckiser responded to the opportunity to share existing projects or resources. They have recently undertaken a collaborative project relating to Medicines Optimisation which had recently received recognition from NICE as part of their shared learning awards short list.¹⁶

3.7 The patient journey

Feedback was received from a group of 18 members of the Patient Representative Forum from the Spinney Surgery, St Ives and is detailed in a separate report.

The key themes are summarised below:

A. Understanding medicines and the role of the healthcare professional

There needs to be more suitable information on how medicines work and the information needs to be presented in a more appropriate way for example the use of pictures to improve patients understanding and engagement with medicines. The information may be understood even better if provided with an opportunity to discuss with a healthcare professional (e.g. prescriber or pharmacist) at the point of prescribing. The patient package insert is generally not that helpful as it needs to be more specific for individual patients and presented in a better way.

B. Communication between primary and secondary care

The communication systems between primary, secondary and community care need to be improved since patients are concerned about the transfer of their information from hospital to their GP and vice versa.

C. Managing the supply process of medicines and waste

The processes now available to request and receive medicines is improving but there is scope to potentially over order medicines but this could be exaggerated if the patient loses control on ordering their medicines. If medicines need ordering at different times due to different renewal dates this again introduces more confusion.

Patients need a routine for both getting prescriptions and taking their medicines as prescribed and making optimum use of new on-line systems.

D. Size, shape and packaging of medicines

The packaging and appearance of generic medicines can vary a lot according to the manufacturer supplying them. This is an issue for older people, particularly if they have poor eyesight or arthritis and the brand of the generic drug is different. Size of tablets may also be problematic. If the tablets are too big then they may be too difficult to swallow, conversely if too small, they can be difficult to get out of the blister packs. All this is exacerbated by arthritis or poor eyesight. Blister packs with the days of the week tend to be the preferred option.

There was an issue around how the packaging and appearance changed according to the supplier of a generic drug and many patients reported this as a potential cause of confusion.

¹⁶ *The way to medicines optimisation is through the stomach - tackling high prescribing levels using the NICE Dyspepsia guideline to review proton pump inhibitor (PPI) prescribing.*
<http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=643> (Accessed May 2014)

Taking medicines according to directions

Having a medicines “routine” promotes good compliance. There are many reasons why patients may not take their medicine before their doctor told them to stop including concerns about potential side-effects, being worried by media reports about a specific medicine, and being convinced that they do not need to take medicine any longer since they may feel better.

The presentation of the medicine in terms of size or the coating of tablets can make it difficult to take and could be improved.

Suggestions from the patient forum to help medicine-taking

- Carrying a card that listed all their medicines in case they were admitted to hospital
- Monitored dosage systems
- A text or phone reminder to take medicine
- More use of depot medicines (gradually releasing medicine over a period of time) or polypills (where a combination of medicines are all supplied as one dosage form).

Knowing the cost of medicines

It was thought that, in general, if patients were aware of the cost of the medicines that they were prescribed then they may be more inclined to take their medicines as prescribed.

Framework for joint working partnership projects for pharmaceutical industry

Developing the framework for future projects needs to consider the national priorities and objectives, and especially the target areas identified in the Medicines Optimisation Review resources (figure 4).¹¹ Using this process the key themes identified are:

A. Prescribing and the patient:

- Improve patients' understanding of their medicines:
 - ii. Why is this medicine prescribed for me? How will it benefit me?
 - iii. Information about how their medicines work
 - iv. Importance of medicines taking as per prescribed instructions.
 - ◇ Ensure patients are completely engaged in decisions relating to the use of their medicines using materials and communications that they can understand.
 - ◇ Target in certain patient areas e.g. pain or other LTC exploring better use of resources or development of new resources and more innovative use of new models e.g. New Medicines Review
 - ◇ Explore opportunities to ensure effective medicines compliance e.g. text or phone reminder to take medicine.
 - ◇ Ensure all healthcare professionals are engaged in Medicines Optimisation and the patient's understanding of their medicines to improve adherence.

B. Transmission/ Transcription/ Supply of Medicines:

- Focused support on high risk patients receiving carer support:
 - i. Pharmaceutical support to care homes to include:
 - ◇ Stock control/ordering
 - ◇ Consideration of the use of bulk prescribing
 - ◇ Exploring the use of medicines taking with and without monitored dosage systems
 - ◇ Centralising pharmaceutical care and supply (i.e. one pharmacy for acute and repeats)
 - ◇ Ensuring all medicines requests are checked before ordering at pharmacy
 - ◇ Regular pharmaceutical visits for supply and medicines review
 - ◇ Further engagement with social care (pharmaceutical time part of contract)
 - ◇ Managing transfer of care - home to hospital and home
 - ◇ In accordance with NICE guidance on managing medicines in care homes.
 - ii. Pharmaceutical Care to Extra Care Housing:
 - ◇ Agree package of care for ordering, storage, destruction of medicines
 - ◇ Accurate and appropriate use of Medicines Admission Record (MAR) charts
 - ◇ Regular and targeted new medicines reviews and medicines use reviews
 - ◇ Managing transfer of care - between different care settings e.g. the home, hospital and also to respite care
 - ◇ Exploring the use of medicines taking with and without monitored dosage systems.

C. Communication between primary and secondary care:

- Consider opportunities to improve the information relating to patient's medicines between primary and secondary care
- Explore innovative opportunities:
 - i. **Use of green bags for medicines transmission**
 - ii. **Agree medicines supply in CCG contracts**
 - iii. **Written MAR charts provided on discharge for targeted high risk patients or patients receiving carer support**
 - iv. **More innovative use of New Medicines Reviews on discharge including more joined up communication relating to pharmaceutical care.**

D. Effective use of patients' medicines in hospitals:

- Explore use of a dedicated admissions support pharmacist
- Reduce medicines wastage in hospital:
 - i. **Use unopened stickers on inhalers and other medicines so that unused medicines can be returned to pharmacy**
 - ii. **Reduce and tag the supply of high cost drugs to wards.**
 - iii. **Explore the use of dedicated pharmaceutical support to discharge high risk patients on discharge e.g. post MI or stroke patients to ensure effective understanding of medicines.**

E. Engagement of Community Pharmacists in Pharmaceutical Review:

- Explore how to make New Medicines Service or Medicines Use Review more effective in targeted patient groups:
 - i. **Significant opportunity exists to tailor the New Medicines Service or Medicines Use Review more targeted in specific therapy areas or even in specific patient patients e.g. respiratory or pain management so that the optimum use of patients' medicines in these therapy areas can be seen**
 - ii. **Opportunities are welcomed to explore these areas in more detail.**

F. Explore opportunities to ensure that patients understand the cost and value of medicines:

- Consider use of social marketing in targeted patient groups
- In the past various campaigns have been set up to ensure that patients only order their medicines when required and return unwanted medicines. If certain high risk patients on polypharmacy were targeted with specific messages and campaigns then the impact could be explored more widely
- Opportunities are welcomed to explore suggested patient groups.

Concluding remarks

The adoption of Medicines Optimisation into everyday practice creates the opportunity for all healthcare professions and patients to be engaged in medicines adherence. As the UK continues to develop more innovative and cost effective medicines it is vital that patients are totally committed to medicines adherence to ensure that they derive the very best health outcomes from their medicines supported by healthcare professionals.

An effective partnership between the pharmaceutical industry and the NHS may ensure that Medicines Optimisation is embedded in all aspects of healthcare and particularly where the greatest opportunities to address the challenges of medicines adherence and waste is the ideal situation.

This report not only highlights the opportunities and challenges in medicines taking but also creates the ideal scenarios to explore critical areas in medicines taking further to achieve the objective of reducing waste and improving adherence.

Key to notes for Appendix 1



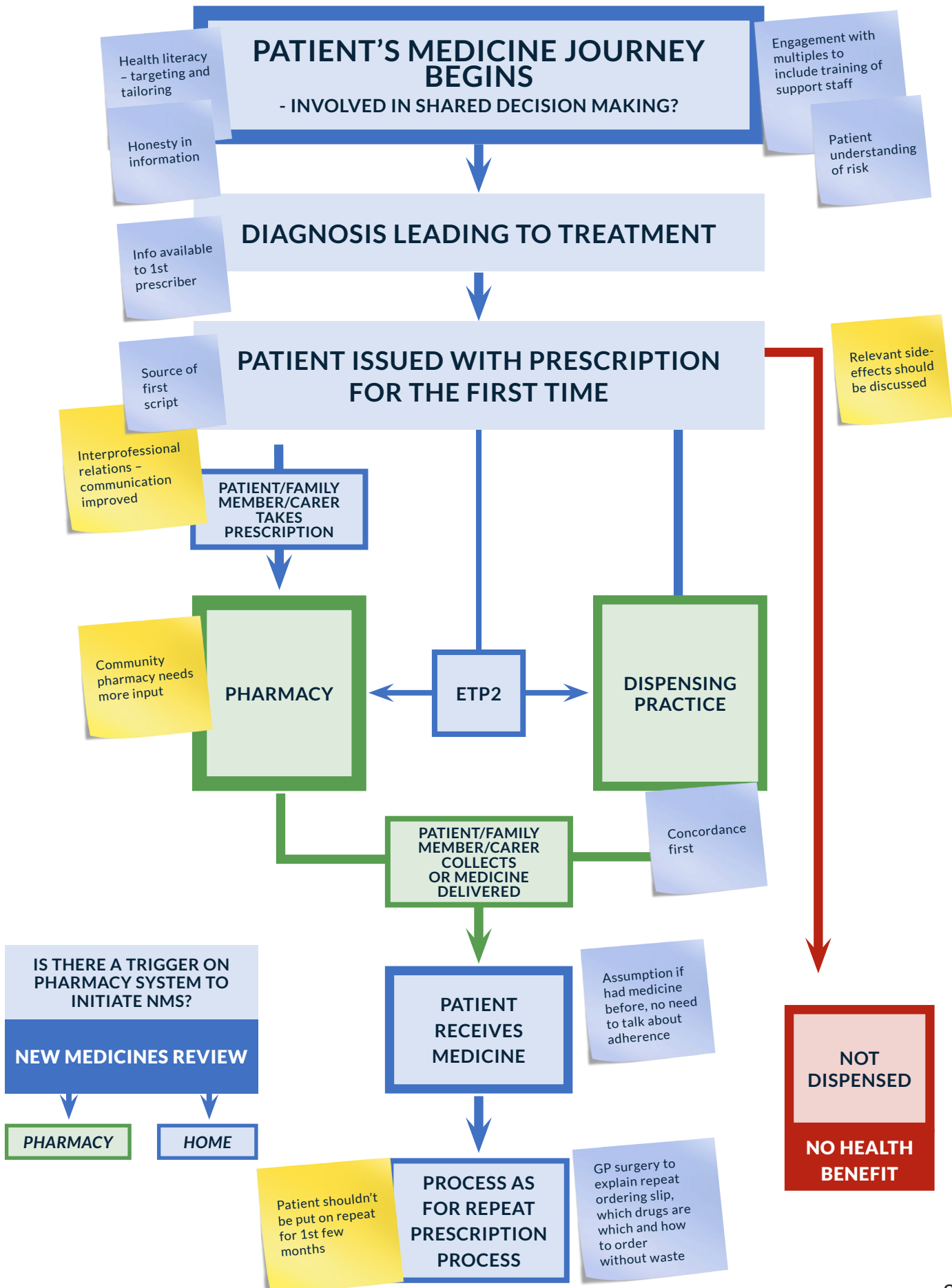
YELLOW: Challenges
(how to amend the system)



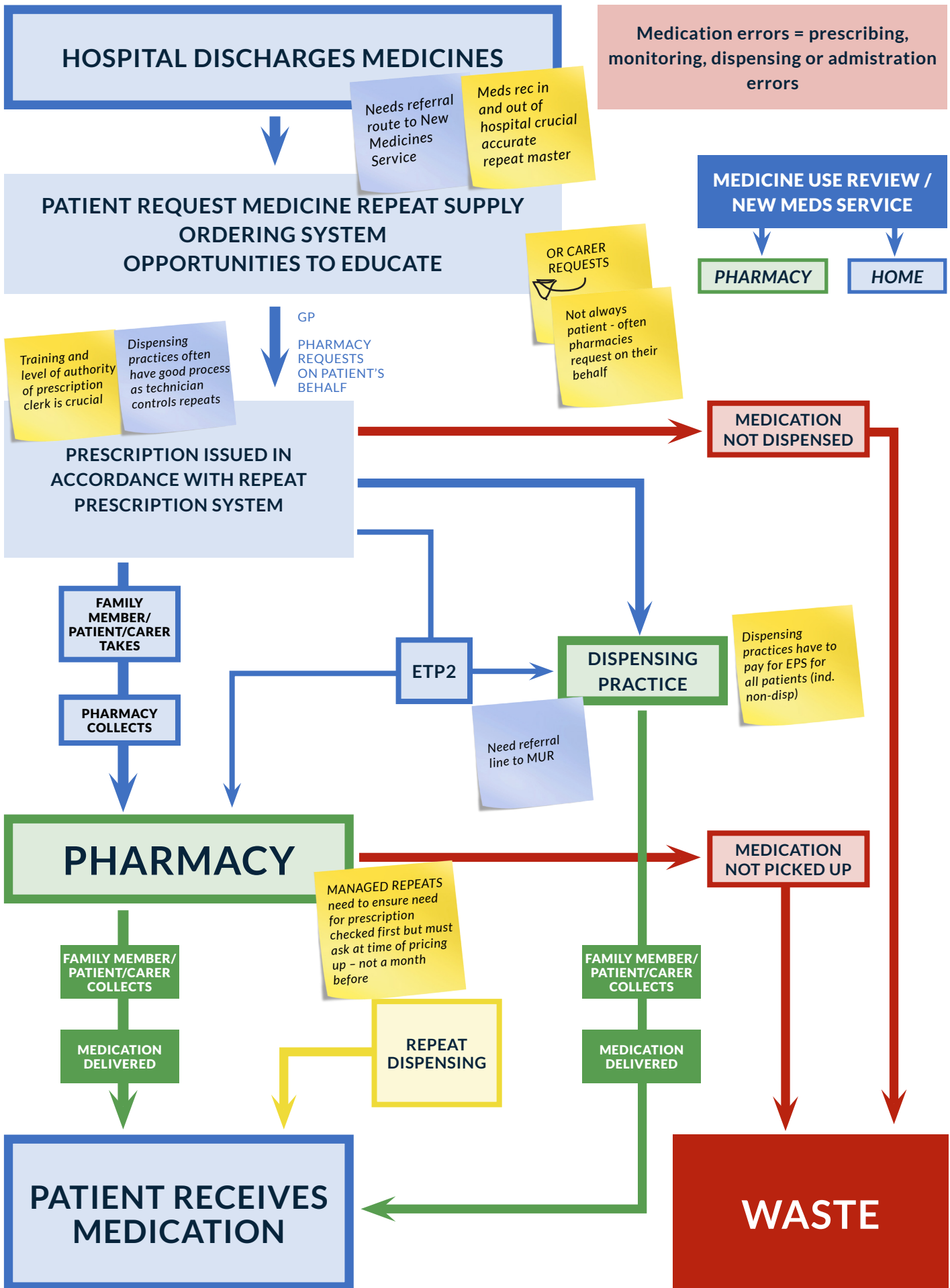
BLUE: Opportunities
(existing best practice)

Appendix 1 Process flow charts

Patient issued with prescription for first time

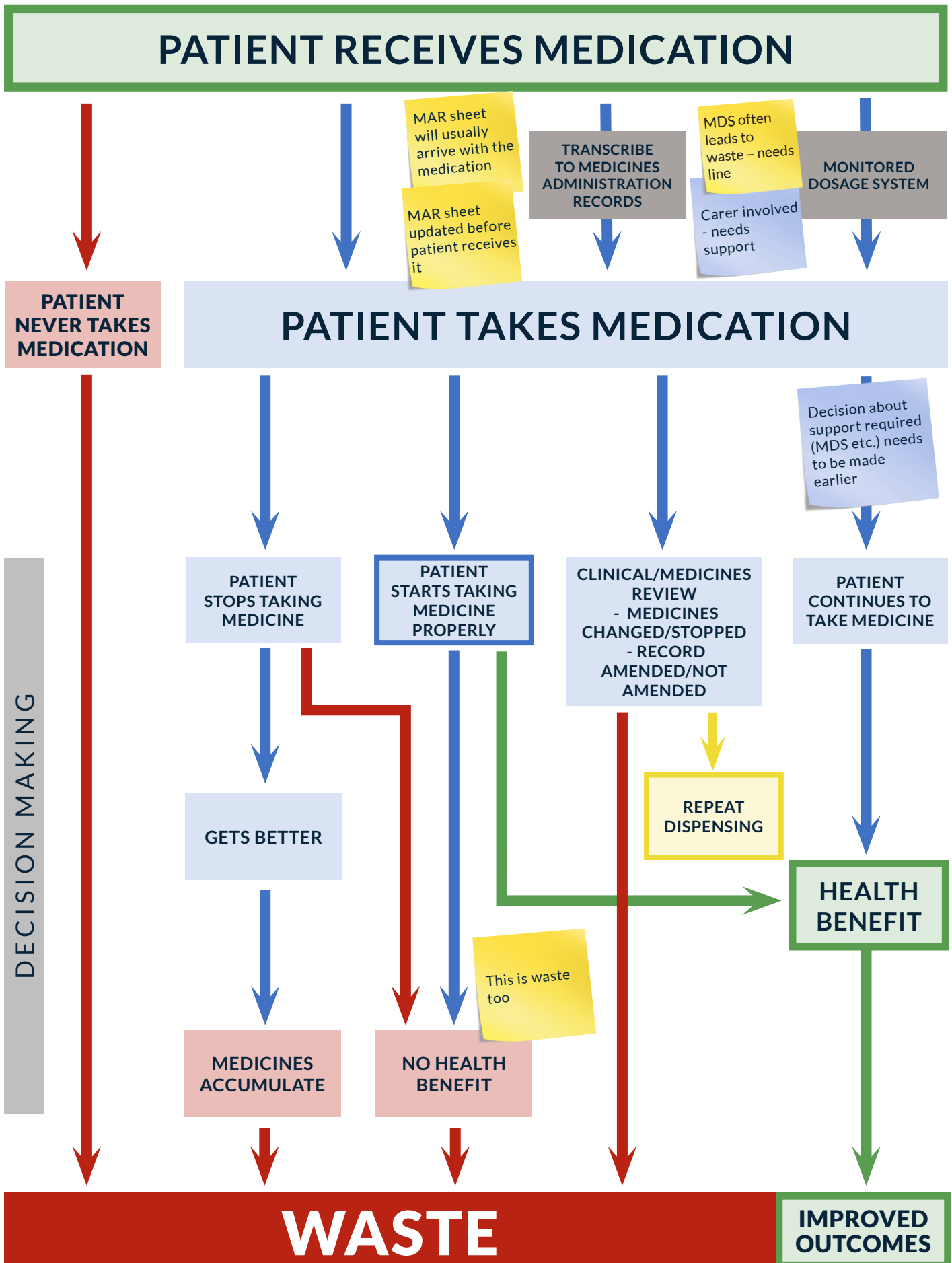


Repeat prescriptions Part 1



Repeat Prescriptions Part 2

Medication errors = prescribing, monitoring, dispensing or administration errors



CARE HOMES In care homes 8-10% chance of error (higher than people in their own home)

REPEAT MEDICINE REQUESTED

Care homes to check stocks before ordering
Bulk rx to reduce waste

MAR CHART TICKED TO INDICATE MEDICINES REQUESTED

ELECTRONICALLY ORDERED HOME ORDERS SYSTEM 1

GP SURGERY

Community pharmacy supports care home - regular visits
Social care - pharmacy time in contract to support home

COPY KEPT AT CARE HOME AND MAR CHART

PRESCRIPTION

TO DISTANCE SELLING PHARMACY

PRESCRIPTION TO DACS (DISPENSING APPLIANCE CONTRACTORS)

LOCAL PHARMACY FOR ACUTES

Frequently need two pharmacies, one for acute and one for repeats

PHARMACY

DISPENSING PRACTICE

GP to employ pharmacist to work with home/CP and hospital DISCU

Each care home should have their own governance pharmacist employed by CH

EPS 2 - need a separate process for this, complex and very different

MDS
MDS: help or hinder?

Can better care fund be used to support homes with pharmacy support?

UNUSED MEDICINES

Data on waste to focus on homes - homes recording waste

ADMINISTRATION

NEED PATIENT PERSPECTIVE
Plus patient self assessment of managing medicines

WASTE

Patient Admitted to Hospital for the First Time

