

# **Improving the use of medicines for better outcomes and reduced waste**

## **An Action Plan**

**Report and Action Plan of the Steering Group on Improving the Use of Medicines  
(for better outcomes and reduced waste)**

**October 2012**

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# Letter from the co-chairs to the Parliamentary Under-Secretary of State for Quality, Lord Howe

Dear Minister,

Back in the Summer of 2011, you invited us to establish a short life steering group to develop a practical - and implementable - Action Plan based on the themes discussed at a roundtable event hosted by the King's Fund earlier in the year, on the subject of reducing the scale of medicines wastage and improving the use of medicines to help improve patients' outcomes. The roundtable event followed the publication of the York Health Economics Consortium and The School of Pharmacy, University of London report *Evaluation of the Scale, Causes and Costs of Waste Medicines* in November 2010.

Our Group, the Steering Group on Improving the Use of Medicines (for better outcomes and reduced waste) met on four occasions between 23 September 2011 and 23 January 2012 and our report and recommended Action Plan, which delivers on the commission entrusted to us, is enclosed.

We thought, however, it might be helpful to provide you with a little additional background on the process of our deliberations, to describe the approach the group took to the work, and to provide some general further remarks in support of our recommendations and the way we have set them out in the Action Plan.

In addressing the themes from the roundtable, we were pleased, as co-chairs representing professional and patient interests, to ensure that the "no decision about me, without me" patient voice was well represented in our group to ensure that particular context was considered across the various themes. The group had three patient representatives among its membership and others who contributed to the separate workstreams. The patient perspective was a welcome and transformative one. Putting the patient at the centre of their care was a theme considered during the discussions of all four sub-groups and this has been reflected in the Action Plan, as far as possible.

Secondly, the "do-ability" of the various elements of our proposed Action Plan was never far from our minds. We were struck by the recognition that, as we got stuck into the various themes, professionals and patients viewed "waste" as a shared issue, but also an issue where there are lots of ideas and best practice to draw on. There was agreement that, as with any Action Plan, there are likely to be some quick wins (within three months); some of these items have been recognised good practice for long enough, and while some parts of the NHS are doing well, other parts could do better and should "just get on with it". We have also identified some more medium (within a year) and longer-term activities (within a few years) which, by engaging people more effectively in decision-making around medicines use, would result in optimum use of medicines, improving outcomes and reducing waste at the same time. Incidentally, we would not want to see the opportunity for quick wins to be lost in the changes to the NHS architecture.

We have tried where we can, to suggest the “next step” action for some elements in the Action Plan and where contractual arrangements might be developed further. In others, we have identified occasions where the existing contractual mechanisms work against improved outcomes or reduced waste and should be changed. We have also identified areas where primary care contracts could be better aligned to incentivise GPs and pharmacists to help patients use their medicines to best effect.

Some of the recommendations may result in an increase in workload for some clinicians in the short term, until the new ideas become embedded in daily practice. This will require better communications and a change in culture and practices within primary and secondary care. We have identified some specific implications for the education and training of healthcare professionals, but we are aware that patient-centred practice is central to the thinking of Medical Education England (soon to be Health Education England) and its programme boards.

We have not considered the “recycling” of medicines supplied in primary care and returned by patients, in the Action Plan. Whilst anecdotally, there is some public support for considering this, we decided that for practical, technical and ethical reasons, including the possible impact of adverse storage conditions on the integrity of medicines, we should exclude this aspect at this time.

Our recommendations should also be seen in the wider context of the NHS Commissioning Board’s developing focus on medicines optimisation.

We are indebted to our four workstream leads – Jatinder Harchowal, Clare Howard, Simon Selo and Catherine Thatcher – for their part in bringing together wider representative groups, in drafting initial recommendations under our four key themes and in supporting us in this work.

Finally, we would like to thank Gul Root, Principal Pharmaceutical Officer in the Department of Health, for keeping us on track with the task at hand, for facilitating access to key contributors to our programme, and for liaising where necessary with policy colleagues on the viability of our recommendations within the timescale we thought possible.

We are, of course, happy to discuss our proposed Action Plan with you or with colleagues, at your convenience.

Yours sincerely,

Robert Darracott  
Co-Chair

Robert Johnstone  
Co-Chair

# Chapter 1

## Introduction and scope

- 1.1 The NHS is facing financial challenges as never before. In a time of public sector austerity, the NHS has been charged with finding £20 billion in efficiency savings by 2014-15, which will be reinvested in frontline care. This is vital if the NHS is to continue to deliver high quality services, as well as meet the twin challenges of an ageing population and keeping up with the advances in new and innovative medical technologies. In other words, every penny counts.
- 1.2 It is therefore only right that we look to minimise waste in the NHS. With regards to medicines, this means not only reducing the amount of medicines that are sent away to be incinerated, but also improving repeat prescribing and dispensing systems and encouraging rational cost effective prescribing to minimise the reduced health outcomes that result from people not taking their medicines as intended.
- 1.3 The research commissioned by the Department of Health found that the NHS is managing the problem of medicines wastage more robustly than ever before and that wastage of medicines is not a systemic problem in the NHS and is no worse than in other comparable countries. But we should not be complacent.
- 1.4 It was against this background that the Steering Group on Improving the Use of Medicines (for better outcomes and reduced waste) was tasked with identifying how people can be better supported in taking their medicines as prescribed – helping to improve their long-term health outcomes and ensuring better value for the NHS.
- 1.5 We have set out our report and Action Plan in what we hope is a relatively logical sequence. In **Chapter 2**, we start by looking at primary and community care, where most people currently obtain their NHS medicines and where changes are already being made, particularly through service developments in the community pharmacy contractual framework, to improve the focus on optimising the use of medicines by patients as a means to improve health outcomes.
- 1.6 In **Chapter 3**, we focus on secondary care, where in-patient transfers, admission and discharge processes and the use of patients' own drugs present specific challenges to the effective management of medicines.
- 1.7 We turn our attention to care homes and end of life care in **Chapter 4**, where specific medicines use issues have long been recognised.
- 1.8 In **Chapter 5**, we make recommendations about what we see are enablers to the effective use of medicines across the system, including the use of common datasets, standard information sources for patients and professionals and general awareness-raising, alongside revamped professional education, as the mechanism for embedding patient-centred practice in the NHS in the longer-term.

- 1.9 Throughout the report, we make recommendations for further action and these are then brought together into a single Action Plan at **Annex A**. The Terms of Reference for the Group, which were developed directly from the priorities identified by Lord Howe when he asked us to undertake this work, are set out in **Annex B**. The membership of the Steering Group, together with a list of others who contributed to the workstreams, is set out in **Annex C**.

# Chapter 2

## Targeted support for patients in primary and community care

- 2.1 Over 900 million prescription items were dispensed in the community in England in 2011 and a significant majority of these were repeat prescriptions. Nearly every community pharmacist in the country has tales to tell about patients or their relatives returning large quantities of unused medicines in carrier bags and bin bags - medicines that have to be sent for safe disposal.
- 2.2 In this Chapter, we explore some of the ways that more effective use of medicines in primary and community care could be made.
- 2.3 The *Evaluation of the scale, causes and costs of medicines waste* report<sup>1</sup>, published in November 2010, highlighted more rigorously than any study before or since, the scale of medicines waste in primary and community care. In short, the authors estimated the gross cost of unused prescription medicines in primary and community care to be in the region of £300 million a year in England in 2009, with around half of that being economically recoverable. Clearly, GP practices and local community pharmacies should work better together to help patients take their medicines as intended, avoid waste and improve health outcomes.
- 2.4 However, the report makes clear that some of the current processes in primary and community care for the prescribing and supply of medicines contribute to waste and do not routinely promote adherence to medicines regimens or involve patients in the decisions about the medicines prescribed for them, with patients not achieving the intended improvements in their health outcomes.
- 2.5 It is incumbent upon the NHS in England to ensure that the systems, through which patients receive medicines they need, do not in themselves, increase medicines waste. We have therefore looked at how the current contractual frameworks provide support for patients taking their medicines to best effect and how repeat prescribing and dispensing systems might be improved and aligned to reduce waste.

### ***Repeat prescribing***

- 2.6 Repeat prescriptions are defined as prescriptions issued without a consultation between the prescriber and patient. Repeat prescribing accounts for 60-70% by cost and 80% by volume of prescription items dispensed in primary care. Around half of all registered patients receive repeat prescriptions and the rate is rising.

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<sup>1</sup> *Evaluation of the Scale, Causes and Costs of Waste Medicines* (November 2010), York Health Economics Consortium/The School of Pharmacy, University of London

- 2.7 Recent reports<sup>2</sup> have highlighted the gap between formal procedures and what actually happens during the process of issuing repeat prescriptions. Many primary care trusts have carried out rigorous reviews of repeat prescribing systems and have worked with the whole GP practice team to tighten up procedures. However, where there is no review process and where the issuing of repeat prescriptions is poorly managed, there are risks in terms of medicines waste and medication safety. **Good practice in managing repeat prescribing should be developed and implemented across all local NHS organisations to ensure that repeat prescribing processes do not inadvertently contribute to medicines waste. This should take account of the National Prescribing Centre guidance *Saving time, helping patients: A good practice guide to quality repeat prescribing*<sup>3</sup>, published in January 2004.**
- 2.8. Improving the repeat prescribing process should directly benefit patient experience by improving health outcomes and lead to a reduction in the dispensing of medicines that are no longer needed. **Practice-based pharmacists, where in post, should support practices by identifying patients who are on repeat prescriptions and who no longer need the medicines.**

### ***Repeat dispensing***

- 2.9 Repeat dispensing enables GPs to issue a single prescription for up to a year, which pharmacists are then able to dispense in instalments. It provides pharmacists with a number of opportunities to have a discussion with the patient to determine if they still require the medicine and whether the patient is experiencing any problems with taking it. In 2002, it was estimated that up to 80% of all repeat prescriptions could be replaced with repeat dispensing over time, “yielding savings of up to 2.7 million hours of GP and practice time”. Feedback from areas that have implemented repeat dispensing is that patients find the system more convenient.
- 2.10 Repeat dispensing services were incorporated into the community pharmacy contractual framework in 2005. Nationally, repeat dispensing levels remain low (4% in 2010-11), although recent prescribing data (April to June 2012) show an improvement with the percentage of total items prescribed as repeat dispensing rising to 5.39%. For some primary care trusts (PCTs), repeat dispensing is now a significant method of delivering repeat prescribing services with the top 5 performers being;

<b>PCT</b>	<b>Repeat dispensing rate</b>
Richmond & Twickenham	33.98%
Bristol	30.23%
Hounslow	29.00%
Newham	27.08%
Gateshead	23.73%
<i>Source: Prescribing Analysis and CosT tool (PACT) system supplied by the NHS Information Centre</i>	

<sup>2</sup> Swinglehurst D, Greenhalgh T, Russell J, Myall M. *Receptionist input to quality and safety in repeat prescribing in UK general practice: ethnographic case study*. *BMJ* 2011;343:d6788

<sup>3</sup> *Saving time, helping patients: A good practice guide to quality repeat prescribing* (January 2004), National Prescribing Centre

- 2.11 While some areas have managed to embed this service well, others have not. We think it is unarguable that repeat dispensing could be utilised to much greater effect in the NHS, with community pharmacists playing a more significant role in optimising the use of medicines, improving health outcomes and reducing waste associated with the use of repeat prescriptions. **A repeat dispensing engagement plan for local NHS organisations and GPs - with a key role for the Royal College of General Practitioners and the Royal Pharmaceutical Society to work collaboratively - should be developed to ensure that GPs and community pharmacists understand the benefits of repeat dispensing to them, their patients and their staff.**
- 2.12 Some GPs have not recognised the benefits of repeat dispensing. One of the barriers may be having to use the paper-based FP10 prescription system. This may explain the low uptake of repeat dispensing in some areas. The roll-out of the Electronic Prescription Service (EPS) provides an ideal opportunity to reinvigorate repeat dispensing, particularly since EPS2 provides GPs with the facility to cancel future repeat prescriptions, for example where the clinical condition of a patient has changed. However, practices should not feel constrained to wait for EPS2, as many practices have already successfully introduced repeat dispensing without EPS.
- 2.13 In addition, **software companies should be encouraged to resolve any barriers to repeat dispensing faced by non-medical prescribers.**
- 2.14 The QIPP Medicines Use and Procurement workstream should work with the NHS Business Services Authority to ensure that the number of items prescribed through repeat dispensing as a percentage of total items (currently included in ePACT.net) is incorporated into the QIPP prescribing comparators to measure uptake of repeat dispensing by local NHS organisations. Those areas that have high levels of repeat dispensing should share their experience of implementation and encourage those with low uptake to increase their uptake of repeat dispensing. **In time, national QIPP prescribing comparators should be used to benchmark local NHS organisations on the proportion of items prescribed under repeat dispensing. In the longer term, GP practice repeat dispensing rates could be published nationally or locally.**

#### ***Medicines use reviews***

- 2.15 Medicines use reviews (MURs) were introduced as part of the community pharmacy contractual framework in 2005, as the first advanced service to be provided by accredited pharmacists in accredited pharmacies. During an MUR, the pharmacist has a structured discussion with the patient about the use of their medicines.
- 2.16 MURs got off to a slow start, but in 2010-11, over 2.1 million MURs were carried out with patients in England.
- 2.17 A real breakthrough has been made in areas that have used MURs to provide dedicated support to specific groups of patients where adherence is known to be a problem. National targeted MURs were introduced into the community pharmacy contractual framework in October 2011. The national target groups are:

- patients taking high-risk medicines (on a national list);
- patients recently discharged from hospital who had changes made to their medicines while they were in hospital; and
- patients with respiratory disease, such as asthma and COPD..

### **Case study: NHS South Central on targeting MURs**

NHS South Central's Improved Inhaler Technique programme targeted MURs for people with asthma or chronic obstructive pulmonary disease and has proved effective on evaluation. (*Evaluation of South Central NHS Inhaler Technique Improvement Programme*, (July 2012) The Cambridge Consortium)

It has improved the direct outcomes of treatment (as measured by improved asthma scores, for example), reduced unplanned admissions to hospitals due to acute crises and has identified smokers, the majority of whom have gone ahead and quit smoking.

For further information contact: Clare Howard ([clare.howard@southcentral.nhs.uk](mailto:clare.howard@southcentral.nhs.uk))

### ***Post-discharge medicines use reviews***

2.18 It is essential that patients discharged from hospitals have the information they need to take their medicines as intended and they should receive the necessary support, so they continue to do so, as their care transfers from hospital to the community. The lack of formal communication channels between hospitals and community pharmacies can create challenges for both patients and professionals.

2.19 Post-discharge medicines use reviews were launched as part of changes to the community pharmacy contractual framework in 2011 and a national referral form was developed and launched in 2012<sup>4</sup>. Building on existing good examples of effective joint working between hospital and community pharmacists, the new national referral form is designed to embed, improve and mainstream this good practice. More recently, the Royal Pharmaceutical Society has highlighted the challenges and set out high level core principles and responsibilities that underpin the safe transfer of information about medicines whenever a patient moves between care settings<sup>5</sup>.

2.20 Improving relationships between hospitals and community pharmacies will need to be driven locally. However, we recommend that a wider programme promotes and supports joint working to ensure that patients recently discharged from hospitals are routinely referred to community pharmacies where appropriate, to get the support they need to take their medicines more effectively. The new targeted MUR for recently discharged patients will help. However Local Professional Networks could play an important part in creating an environment where professionals work together to ensure patients are referred appropriately. **A dedicated programme of support should be developed by Local Professional Networks to enable hospital Trusts, community pharmacies, Local Pharmaceutical Committees (LPCs) and local NHS organisations to work together to ensure that local systems work for patients and**

<sup>4</sup> *Working with hospital colleagues to support patients discharged from hospital: Guidance for community pharmacists* (January 2012), Pharmaceutical Services Negotiating Committee/ Royal Pharmaceutical Society/NHS Employers

<sup>5</sup> *Keeping patients safe when they transfer between care providers – getting the medicines right* (June 2012), Royal Pharmaceutical Society

**that, where appropriate, post discharge MURs become an integral part of the medicine pathway.**

***Targeted MURs for patients with multiple, complex long term conditions***

- 2.21 The 15 million people in England living with a long term condition are the main driver of cost and activity in the NHS, accounting for around 70% of overall health and care spend. They are disproportionately higher users of health services – taking up 50% of GP appointments, 60% of outpatient and Accident & Emergency attendances and 70% of inpatient bed days. Support, with dedicated help to optimise medicines use and improve health outcomes for the most complex patients, should be developed with the aim of reducing unplanned admissions, particularly for those 5-8% of admissions related to ineffective or inappropriate use of medicines.
- 2.22 Every GP practice has a relatively small number of patients with multiple, complex long term conditions who are known to be frequently admitted to hospital, don't take their medicines as intended, use significant resource and often don't experience the expected improvements in their conditions. **We recommend that, in each GP practice, efforts are focussed on patients with multiple, complex long term conditions, who could benefit from additional support to help them take their medicines more effectively.**
- 2.23 A clinical community approach, comprising GPs, practice and local organisation-based pharmacists (where they are in post) and community pharmacists, together with practice nurses and community matrons as appropriate, should help to identify patients in each practice with multiple, complex long term conditions who could benefit from additional support from the community pharmacist in taking their medicines. This approach would sit alongside similar focused support using community matrons, but targeting patients where a medicines focus is the main issue for resolution.
- 2.24 **A cost-benefit study should be undertaken into targeting the community pharmacy MUR service to this small, but significant group of patients. Successful testing could then inform the alignment of the General Medical Services and community pharmacy contractual frameworks, to ensure that specific patients or groups of patients are signposted to community pharmacists for additional support.**
- 2.25 **If appropriate, the NHS Commissioning Board, the Department of Health, NHS Employers and the Pharmaceutical Services Negotiating Committee should explore the feasibility of a targeted MUR for patients with multiple long term conditions being introduced under the community pharmacy contractual framework.**

### **Case study: NHS Isle of Wight on supporting local reablement services**

Patients identified by the reablement team as at high risk of being readmitted to hospital within 30 days of their discharge, are assessed by the hospital pharmacy team regarding their ability to manage their medicines. A service co-ordinator then matches and refers patients to a local community pharmacist. Visits by the community pharmacist start within 7 days of discharge with a full MUR service, an assessment of medicines in the home and a capability assessment. A medicines chart, detailing each current medicine, its appearance, when it should be taken and likely side effects, is provided, together with any other support considered necessary as a result of the capability assessment. Two follow up reviews are scheduled at 5 weeks and 90 days.

For more information contact: Gary Warner ([gary.warner@regentpharmacy.co.uk](mailto:gary.warner@regentpharmacy.co.uk))

### ***New Medicine Service (review of which therapeutic areas should be included)***

- 2.26 The New Medicine Service (NMS) was introduced, as part of the community pharmacy contractual framework in October 2011, for newly prescribed medicines for a small number of conditions, namely asthma and COPD, type 2 diabetes, anticoagulant/anti-platelet therapy and medicines for hypertension. Pharmacists providing the service follow up new prescriptions for these long-term conditions with interventions designed to reinforce key messages about medicines use and resolve patients' queries and concerns once treatment has started.
- 2.27 The service has been commissioned until the end of March 2013, and a formal evaluation is underway to determine if the benefits evidenced in the proof of concept research are being delivered. While we understand the service is time-limited and subject to a positive outcome of the evaluation, we would suggest that there are other therapeutic areas where improvements in adherence would improve outcomes and reduce waste, if and when that case is made.
- 2.28 The waste research report estimated that improving the use of medicines in just five therapeutic areas (statins for primary and secondary prevention of cardiovascular disease, hypertension, type 2 diabetes, asthma and schizophrenia) could potentially save in the region of £500 million a year through improved outcomes - over three times the sum highlighted as avoidable medicines waste in the same study.
- 2.29 We feel that two additional therapeutic areas, namely statins and medicines for schizophrenia, should be subject to a formal economic assessment for early addition to the NMS service. **Following the formal evaluation of the NMS and assuming that the service is continued, statins for primary and secondary prevention of cardiovascular disease and medicines for schizophrenia should be considered for addition to the NMS service specification, subject to discussions between the NHS Commissioning Board, the Department of Health, NHS Employers and the Pharmaceutical Services Negotiating Committee.**

### **Case study: NHS Dudley on focusing on new medicines in cardiovascular disease**

A detailed analysis of returned medicines in six community pharmacies in a two-week mini medicines wastage campaign, projected annual costs of wasted medication to be around £1.5m. Medicines management leads put together

- the high proportion of unopened packs of dressings, endocrine drugs and cardiovascular drugs
- an analysis of prescribing data (which revealed that Dudley GPs had the highest prescribing rate of 3-monthly prescriptions in the West Midlands) and
- patient reports that medicines resulting from a medicine change, were not right for them, or that they felt they had been given too much.

As a result, the Prescribing and Medicines Management Sub Committee has

- extended the medicines wastage campaign to all pharmacies
- recommended the prescribing of smaller quantities when initiating new medicines, particularly for cardiovascular disease and pain management, and
- highlighted the New Medicine Service provided by community pharmacies as a way of helping to reduce medicines waste as well as improving health outcomes.

For more information contact: Michelle Dyoss, Community Pharmacy Development Officer, NHS Dudley ([michelle.dyoss@dudley.nhs.uk](mailto:michelle.dyoss@dudley.nhs.uk))

### ***Incentives to not dispense medicines that are not needed***

2.30 There is a perception that, at present, with the current community pharmacy contractual framework focused on volume, there is no incentive for community pharmacists to not dispense medicines the patient says they don't use or need. However, the group were intuitively attracted to a number of local enhanced service schemes that incentivise community pharmacists to **not** dispense medicines that the patient is unlikely to take and where the pharmacist has confirmed with the patient that such a course of action would be appropriate for them and their specific needs. This has benefits for the patient, the NHS and the pharmacist.

### **Case study: NHS Sheffield on “not dispensed” schemes**

NHS Sheffield commissions a “not dispensed” enhanced service, which pays pharmacies £4 per item plus 10% of the cost of each item they do not dispense, after asking patients if they need all the items they appear to have requested on a repeat prescription. If they are not all needed, the relevant items are not dispensed and the patient's GP is notified of those items, in order to keep prescribing records up to date. This service has realised net savings (after payments made under the scheme) of £37.4k in 2011-12 and £36.8k in 2010-11.

For more information contact: Peter Magirr, Head of Medicines Management, NHS Sheffield ([peter.magirr@nhs.net](mailto:peter.magirr@nhs.net))

2.31 Clearly, such schemes need careful assessment and will require clear governance arrangements to ensure that patients are at the centre of any decision not to dispense a medicine they no longer need. GPs must be informed of any medicines that the patient no longer intends to take as there could be clinical implications for that decision.

- 2.32 Such schemes have been examined in the past and deemed too complex for inclusion in the community pharmacy contractual framework as a national service. However, aggregating figures from the rather modest local schemes seems to suggest that there could be savings available to the NHS in the order of £10 million if rolled out nationally. **A scoping exercise of local “not dispensed” schemes should be carried out to look at models currently in existence, with a view to discussing how, or whether, such a service could be incorporated into the community pharmacy contractual framework nationally in the future.**

**Case study: NHS Isle of Wight on “not dispensed” schemes**

NHS Isle of Wight has had two distinct schemes operating for a number of years:

- A “not dispensed” programme pays the pharmacist a one-off fee equivalent to 45% of the cost of an item the patient says they do not need. This generates savings to the NHS from an item that would otherwise appear on a repeat prescription until a future formal review, which may therefore be greater than 55% of the immediate drug cost.
- A community pharmacist who identifies a saving from the provision of an alternative, but equivalent medicine, as agreed with the prescriber, can receive 45% of the difference as a one off fee. Again, long-term adoption of the change to the patient’s repeat prescription should result in further savings to the NHS.

For more information contact: Paul Jerram ([paul.jerram@iow.nhs.uk](mailto:paul.jerram@iow.nhs.uk)) or Linda Tait ([linda.tait@southcentral.nhs.uk](mailto:linda.tait@southcentral.nhs.uk))

# Chapter 3

## Effective use of patients' medicines in hospitals

- 3.1 Total drug spend by the NHS in the hospital sector in 2010-11 was £4.3 billion. In our discussions, we noted that there is some good practice already taking place in some hospitals for the prescribing, supply and administration of medicines and that, if this good practice was shared across other Trusts, there is a real prospect of quick wins.
- 3.2 We believe there is considerable scope for improving the systems and processes for the supply of medicines and their transfer, when patients move from one clinical area to another within secondary care, to deliver better value for money from the medicines budget, and reduce waste. Our recommendations concentrate on two key areas: the use of effective systems, policies and procedures for the supply of medicines and their transfer between clinical areas within the hospital setting, including for discharge; and the use of patients' own drugs (PODs) when admitted to hospital.
- 3.3 Given the size of the investment in medicines in secondary care, Trust Boards should be aware of how the use of medicines in hospitals is being optimised. **The Chief Pharmacist should provide a regular update to the Trust Board on strategies to improve supply and reduce wastage of medicines within the Trust, including an update on progress on increasing the use of patients' own drugs and improving systems and processes for medicines to accompany patients when transferred between wards and clinical areas and on discharge. These reports should inform Trust decisions on initiatives that result in the better supply and use of medicines and reduced medicines waste throughout the patient's hospital journey.**

### Case study: NHS South Central on tackling medicines waste across both primary and secondary care

NHS South Central has recently been short-listed for an Innovation Challenge award for its collaborative approach to tackling medicines waste across both primary and secondary care. This holistic approach to system change has involved a number of innovative and ambitious interventions, delivered as part of a coordinated project structure. Each intervention has been designed to target a specific area of medicines waste through 'improving adherence' and 'improving internal processes'.

Innovations include:

- improving patients' inhaler technique;
- raising medicines waste awareness through social marketing;
- introducing a "zero-tolerance" approach to secondary care pharmacy returns (under this aspect of the work, secondary care Trusts carry out a one off audit to show the cost of wasted medicines in the Trust then implement a policy of ensuring that all medicines returned to the pharmacy from wards that have been dispensed by the hospital are,

- where appropriate, recycled back in to the hospital dispensary);
- increasing the use of green patient's own drugs medicine bags (this involves ensuring that a region-wide programme outlines to all sectors of the NHS the advantages, both in terms of improved medicines reconciliation and reduced waste, of patients bringing their medicines into hospital in a green POD bag on admission);
  - evaluating the financial advantages of medicines reconciliation; and
  - a local medicines waste innovation competition.

Delivered so far:

**Inhaler Technique:** Over 5,000 patient interventions have been completed over 2011-12, enhancing effective self-management of patients with respiratory disease.

**Social marketing campaign:** A three-month campaign reached 694 pharmacies, 494 GP surgeries and 11 hospitals, with widespread media coverage and support.

**Zero tolerance on pharmacy returns in secondary care:** Initial audits of returned medicines (medicines dispensed in the hospital and returned to pharmacies by wards) per annum suggest savings of £100,000 in a moderately sized District General Hospital where the Trust recycled such medicines where possible.

**Medicines reconciliation metrics:** In 2011-12, levels of medicines reconciliation in NHS South Central equated to a cost avoidance of £2.7m. More recently, this medicines reconciliation database has been opened up to teaching hospitals across England with the aim of having most hospitals in England using the tool by the end of the year.

**Innovation competition:** PCTs and Trusts in NHS South Central were asked to enter their own ideas to reduce medicines waste. Four winning pilot projects were initiated within the region, which focus on patient information, self-management and waste avoidance.

Overall, the three key messages were

1. Only order what you need
2. Dispose of medicines safely
3. Take your medicines into hospital with you

For further information contact: Linda Tait ([linda.tait@southcentral.nhs.uk](mailto:linda.tait@southcentral.nhs.uk))

### ***Effective utilisation of supplied and dispensed medicines***

- 3.4 In the normal business of a hospital, large volumes of medicines are returned to hospital pharmacies from wards and other clinical areas, as patients are moved from one clinical area to another or when they are discharged from the hospital.
- 3.5 There are many reasons for returning medicines to the pharmacy, most of which are clinically valid. They include:
- medicines dispensed during inpatient stay, which are not required on discharge;
  - non-transfer of medicines from the point of admission to the ward or between wards and clinical areas with the patient. One Trust estimates that 10% of its overall dispensing workload would be avoidable if medicines were transferred appropriately between wards and clinical areas with the patient and if there were better communication about the medicines needed by patients when transferring from one ward to another;
  - the use of original pack dispensing on admission to hospital resulting in wastage of medicines, if the patient's treatment plan is subsequently changed.
  - patients own drugs not returned to the patient on discharge; and

- medicines returned to the pharmacy when they are no longer required by a patient when their treatment pathway is changed in response to a change in their clinical condition or as a result of the review of their medicines for an existing clinical condition.

3.6 A number of Trusts have systems in place to re-use medicines returned from wards and other clinical areas to the pharmacy department (ie medicines that are initially dispensed by the hospital and have never left the hospital) and which are assessed as fit for re-use. This results in fewer wasted medicines. **All Trusts should consider “investing to save” in a dedicated resource to establish and implement systems and processes to reduce wastage of returned medicines through identifying those medicines fit for re-issue and for transferring medicines between clinical areas when patients are moved within the hospital. Trusts should explore how to incentivise clinical areas to implement effective systems for transferring medicines with patents when they move from one clinical area to another.**

**Case study: Brighton and Sussex University Hospitals (BSUH) NHS Trust on re-use in action**

The BSUH NHS Trust has a dedicated resource in the form of a pharmacy assistant to ensure that there are systems in place to reduce the wastage of returned medicines.

The Trust has estimated that over £450k of medicines originally dispensed in the pharmacy and which have never left the premises, are returned to the pharmacy from wards and other clinical areas each year, representing a significant return on investment for the Trust.

For more information contact: Jatinder Harchowal, Chief of Pharmacy, BSUH ([Jatinder.harchowal@bsuh.nhs.uk](mailto:Jatinder.harchowal@bsuh.nhs.uk))

3.7 **Every Trust should complete a snapshot (one week) audit of medicines returned to the pharmacy from wards, A&E and other clinical areas to identify the opportunity from re-use, feeding back the results Trust-wide to clinicians and managers. This should be repeated annually.** The audit should differentiate the type of medicines that are being returned (PODs, discharge medicines not given to a patient, medicines that were dispensed during an inpatient stay that are no longer required and medicines that were not transferred with patient when they move to another clinical area) and, in line with the Department of Health letter on *Medicines security*, issued on 9 February 2012<sup>6</sup>, include an assessment of the safe and secure storage of medicines at ward level. This audit should then lead to an Action Plan to improve the amount of medicines returned and reissued in Trusts. Local Area teams should be responsible for coordinating responses by Trust, with audit data shared both regionally and nationally to assist in the review and spread of best practice initiatives.

**Case study: Sheffield Teaching Hospitals NHS Foundation Trust on dispensing for discharge**

Sheffield Teaching Hospitals NHS Foundation Trust is rolling out a dispensing for discharge policy across the Trust, which encourages the use of PODs, both for use in the hospital and for a faster discharge process. With average costs per admission of £91.19, implementation of the new policy is already estimated to be saving £50k annually and impacting positively on

<sup>6</sup> *Medicines security* (February 2012), Department of Health Gateway Number 17219

the previous average delivery time from prescription writing to discharge of over 9 hours.

The Trust has recently carried out audits of unused medicines on a wider range of wards. The medicines management technicians on the wards were asked to note down every time they stopped a medicine being dispensed by pharmacy due to:

- the medicine having already been dispensed from pharmacy, following dispensing for discharge procedures;
- re-use of patients own drugs brought into hospital;
- not supplied on discharge as patient had own supply of medicine at home;
- not supplied on discharge as patient in care/nursing home has own supply.

The total savings for two weeks across these wards was £14.4k. This is a projected annual saving of £376.4k for the Trust. The cost of the medicines management staff for the wards is £117.8k per annum, which would leave a yearly net saving of £259.6k.

For more information contact: Damian Child, Chief Pharmacist, Sheffield Teaching Hospitals NHS Foundation Trust ([damian.child@sth.nhs.uk](mailto:damian.child@sth.nhs.uk))

### ***Patients' own drugs (PODs)***

3.8 There is generally wide acceptance of the benefits of the use of patients' own drugs (PODs) during their inpatient stay in a hospital, as patients may be taking a range of medicines, which may not be specifically related to the reason for admission. In general, patients who want to and are able to take their own medicines while in hospital should be encouraged to do so.

3.9 Many Trusts are trying to increase the use of PODs in hospitals because of the known benefits of doing so, including:

- continued familiarity of medicines for patients;
- easier and accurate reconciliation of medicines on admission to and discharge from hospitals;
- faster medicines supply on discharge;
- preventing oversupply of medicines on discharge; and
- encouraging better use of medicines overall.

3.10 Across the country, the use of PODs is variable, and depends on both the amount brought into hospital and the resource in hospitals deployed to encourage their use. **All hospital Trusts should complete a snapshot audit of the percentage of patients bringing in their own medicines on admission. The results should be shared regionally and nationally and each Trust should produce a plan to actively increase the use of PODs that are fit for use during hospital admission and at discharge.**

3.11 We also know some patients are concerned that medicines may be taken away from them or lost when they are admitted to hospital and not returned when they are discharged. In addition, GPs will need to be assured that patients' own medicines brought into hospital will be used during their stay and will be returned to them on discharge, unless there are clinical reasons for not doing so. **Systems and processes need to be developed to maximise the use of PODs that are brought into hospital, where appropriate. Medicines that need to be continued following discharge, should be returned to patients. A review of the safe custody of patients' own medicines should be part of any overall plan to improve use of PODs.**

- 3.12 It may not always be possible for patients to bring in their PODs eg after an emergency, they may not be aware that they should do so, or they may simply forget them. The use of PODs has an impact on improving the overall quality of patient care; However, this needs quantifying. **Further work is required to explore why patients do not routinely bring their own medicines to hospital when admitted and what can be done to encourage patients to bring their own medicines into hospitals.**
- 3.13 **Communications campaigns on making the best use of NHS resources should include a message to encourage patients to bring their own medicines into hospital, for use during their stay.**

**Case study: Derby Hospitals NHS Foundation Trust on improving patients' use of their own medicines**

Derby Hospitals NHS FT has introduced an 'opt-out' self-administration scheme for patients admitted to hospital, where patients are assessed for reasons why they clinically cannot or do not want to self-administer their medicines. The scheme takes a supportive approach, encouraging staff to reassess patients regularly so they then feel more empowered to self-administer one or more of their medicines in a supervised environment. The aim is to develop a responsible partnership with patients to improve adherence, better outcomes and reduced waste.

Local audits have demonstrated that around 50% of patients bring their medicines into hospital (up to 98% in elective admissions) and that up to 50% of patients may self-administer medicines in some specialties. Monthly ward assurance audits conducted between September and November 2011 found that around 85% of patients were assessed as suitable for self administration, with around 55% self-administering one or more of their medicines (compared to baseline audits from the previous 'opt-in' approaches which only achieved around 3%).

As a result, the Trust has demonstrated substantial reduction in waste (37%) and in costs (£140k per annum) through re-cycling hospital medicines.

For more information contact: Bev Youson ([bev.youson@derbyhospitals.nhs.uk](mailto:bev.youson@derbyhospitals.nhs.uk))

***Improving transfer between care settings***

- 3.14 In the absence of an integrated IT system allowing the viewing of patients' medicines records in both primary and secondary care, direct interaction with patients is critical to establishing their medicine needs, for example, determining the medicines that the patients is actually taking and how much they have left. Overall, outcomes for patients can be improved by establishing an accurate assessment of what medicines they may have at home through discussion with a pharmacy technician, pharmacist or nurse. Unfortunately, discharge systems in many acute Trusts are not well enough developed to allow such discussions to take place. This can, and does, result in excess supplies of unnecessary medicines given to patients on discharge. **Local NHS commissioning intentions for medicines supply from secondary care should be tailored to promote the use of PODs and avoid excessive supplies being made on discharge from hospitals. Discharge quantities should be reviewed and the intentions written to allow for pragmatic approaches that respect individual**

**patients' views and needs, including flexibility for smaller amounts to be supplied on discharge where appropriate.**

- 3.15 Some useful work on improving discharge processes has already been done. The *Discharge Summary Implementation Toolkit*<sup>7</sup> developed by NHS Connecting for Health working with the Royal College of Physicians and the Royal College of General Practitioners provides a standardised electronic discharge summary to enable continuity of care for patients once they have been discharged from hospital, with consistent and relevant information in the right place, quickly. The work on transfer of care, carried out by the Royal Pharmaceutical Society with input from other professional Royal Colleges, has resulted in a set of core principles covering transfer of care, supported by organisational guidance and a patient fact sheet<sup>8</sup>. These contributions illustrate the importance of getting this aspect of patients' care right and the benefits of doing so.
- 3.16 Consideration should be given to following up patients' medicines needs after discharge in a more coordinated way. The addition of post-discharge targeted MURs in the community pharmacy contractual framework is a step forward, but will require better communications between hospital and community pharmacy and between hospitals and GPs as outlined in NHS Employers' guidance to community pharmacists, *Working with hospital colleagues to support patients discharged from hospital*<sup>9</sup>, published in January 2012. **Novel approaches to managed discharge, including hospital follow-up (within 28 days) and community pharmacy supply of discharge prescriptions, should be formally reviewed to examine efficiencies, convenience for patients and contribution to better outcomes through integrated care.**

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<sup>7</sup> *The Discharge Summary Implementation Toolkit*, NHS Connecting for Health

<sup>8</sup> *Keeping patients safe when they transfer between care providers – getting the medicines right* (June 2012), Royal Pharmaceutical Society

<sup>9</sup> *Working with hospital colleagues to support patients discharged from hospital*, (January 2012), NHS Employers

# Chapter 4

## Use of medicines in care homes and end of life care

- 4.1 The research report *Evaluation of the scale, causes and costs of waste medicines*, highlighted the residential and care home sector as the contributor of a discrete, but significant element of medicines waste in the NHS in England, suggesting the systems and processes used in the sector account for around £50m of the estimated £300m annual total medicines waste.
- 4.2 Nearly half a million people, including some of the most frail, vulnerable and least visible members of our society, live in care homes in England. Residents in care homes take significantly more medicines than those in the community, and many residents have some degree of cognitive impairment. This has led to a tendency, over a number of years, to reduce medicines taking to an activity routinely managed by care home staff, in which the abilities and/or interest of people in looking after their own medicines are subordinated by the need for oversight and efficiency of the process for the care home staff.
- 4.3 In recognition of the specific needs and circumstances required for the care of older people, the care home sector and health professionals working in it have adopted a number of system approaches to the management of medicines, which we believe may in themselves create waste.
- 4.4 Similarly, the care of people approaching the end of life is commonly associated with the use of accelerating quantities and doses of medicines, particularly to provide palliative relief of pain. While it is arguable whether any medicines remaining after death should be considered as “waste” in the same way as other more avoidable supplies of medicines, it has been suggested that there ought to be more discussion with patients, their carers and families about prescribing medicines for stable long-term conditions at the end of life, about simplifying regimes that support adherence and over the appropriate use of preventative medicines (eg statins) at the end of life.

### ***Care Homes Use of Medicines***

- 4.5 The publication of a major study into the administration of medicines in care homes – the *Care Homes Use of Medicines Study (CHUMS)*<sup>10</sup>, published in 2009 – put a focus on the sector and highlighted considerable concerns around the prescribing, dispensing, administration and supply of medicines in care homes.

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<sup>10</sup> *Care Home Use of Medicines Study (CHUMS)*(October 2009), The School of Pharmacy: University of London/University of Leeds/University of Surrey

- 4.6 *A Report on the prescribing of anti-psychotic drugs to people with dementia*<sup>11</sup>, commissioned by the Department of Health, was also published in 2009, revealing unacceptable levels of prescribing of these medicines.
- 4.7 Together, these two studies form a strong call to action to improve the use and safety of medicines in care homes to protect vulnerable older residents.

#### ***The post-CHUMS work programme***

- 4.8 The Group's work had to be set in the context of a major piece of work being undertaken as a follow up to the CHUMS report designed to provide a range of tools to improve the use of medicines in care homes. This work is continuing through 2012.
- 4.9 The Safety of Medicines in Care Homes Project brings together five health professional bodies – the Royal Colleges of Psychiatrists, Physicians, General Practitioners, Nursing, and the Royal Pharmaceutical Society, with five trade bodies representing the Care Home Sector (led by the National Care Forum on behalf of this provider alliance), with Age UK and the Health Foundation from the charitable sector, to examine how systems for the supply of medicines might be improved to reduce the kind of medication errors identified in the CHUMS report. The work also aims to address some of the challenges that arise from the institutionalisation of processes for the supply and administration of medicines that has occurred in the sector over the past 20 years, remembering that care homes are, first and foremost, people's homes.
- 4.10 The Department will continue to work with key partners and build on existing work to improve the use of medicines in care homes. This will include considering the role of technological innovation and commissioning incentives in transforming safety and efficiency.
- 4.11 In 2013-14, the National Institute for Health and Care Excellence will commence work on a 'medicines management in care homes' quality standard, as one of an initial group of social care quality standards formally referred by Department of Health.
- 4.12 The CHUMS report identified a range of issues with the prescribing, dispensing and administration of medicines in care homes and concluded that someone living in a care home has a 70% chance of being subject to a medication error (including missed doses or mistimed doses) every day. Members of the Safety of Medicines in Care Homes Project, pooled their knowledge and expertise to try and develop a range of practical solutions and tools which would help residents, doctors, pharmacists and care home staff to reduce the incidence of medication errors and near misses in care homes. These tools are currently being tested in use for effectiveness, a process that will continue through most of 2012. The final output from this work will be a set of validated activities, processes and programmes for implementation in the sector.
- 4.13 With such a major programme of work underway, there is little point in this Group making specific recommendations for systems and processes for the prescribing, administration and supply of medicines in the care home sector, which would duplicate work being undertaken by this Project. However, we have met with the

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<sup>11</sup> *Report on the prescribing of anti-psychotic drugs to people with dementia* (October 2009), Department of Health

Joint Project Director and have been impressed with the rigour of the work being done and we are supportive of the approach to date and for the rest of the programme.

- 4.14 The post-CHUMS work being undertaken is significant. However, its final outputs are some way off. Once the outputs of this project have been published, consideration should be given as to whether any further recommendations could help reduce the amount of waste medicines in care homes, as well as improve the use of medicines in this sector. **When the outputs of the Safety of Medicines in Care Homes Project are available, consideration should be given to reviewing this Action Plan in the context of the Project’s recommendations, and it being amended accordingly. Consideration should be given to how any recommendations or any recommended processes should be implemented across the sector and force given to that implementation.**

#### ***Multidisciplinary team approaches to care homes***

- 4.15 Care homes are visited by a large number of health professionals at different times, including GPs (often multiple GPs for a single home), community nurses, dieticians, community pharmacists, community services pharmacy technicians, occupational therapists, podiatrists and optometrists. There is often little contact between these professionals and particularly between GPs, pharmacists and nurses, in determining how individual patients’ medicines needs might be supported and improved.
- 4.16 The principle of free choice of GP extends into the care home sector, but there is some evidence that registering the residents of a home with a single GP practice, particularly if that extends to the care of residents being normally undertaken by a regular single GP, can lead to an improved quality of care. Medicines supply is usually managed through a single community pharmacy, so there is a key contact there. While contact between professionals may take place around the detail of the prescriptions, it rarely focuses on individual needs of residents, who may need additional support with their medicine taking.
- 4.17 **The creation of a “key team” approach, to the medicines issues faced by residents in the care home sector, should be properly tested, with research undertaken into whether it improves outcomes for patients, including measures of their ability to manage their own medicines when they want to, supported by the team.**

#### **Case study: NHS Leeds on its Clinical Value in Prescribing project**

As part of the Leeds Health and Social Care Transformation programme, one of the aims of the Clinical Value in Prescribing (CVP) project was to quantify the value of pharmacist-led clinical medication reviews in care homes, focusing on patients with dementia and/or learning disabilities. In six months, two pharmacists reviewed 436 patients, made 1,509 medicines-related recommendations (dose optimisation, medication changes, monitoring) of which 1,209 were acted on by the prescriber, saving £54,000 annually (with a further £17,000 annual savings highlighted to prescribers).

For further information contact: Carolyn Nelson, Head of Medicines Management, Leeds Community Healthcare NHS Trust ([carolyn.nelson@nhsleeds.nhs.uk](mailto:carolyn.nelson@nhsleeds.nhs.uk))

### ***The use of monitored dosage systems***

- 4.18 The use of monitored dosage systems (MDS) in care homes (and in domiciliary settings) is now considerable. MDS can simplify the processes involved in the supply chain, though we have not seen an assessment of the clinical or cost-effectiveness of these systems. They may help in reducing errors and support self-care. They can save care home staff time and represent a safe and efficient dispensing system for pharmacies and an adjunct to pharmacist-led services, such as the NMS and targeted MURs.
- 4.19 However, there is a belief that decisions to implement these systems are increasingly being taken by care home managers on the grounds that their use might save staff time, standardise processes across a home, or in the unproven belief that such systems reduce the incidence of medication errors. They may also be suggested by community pharmacy providers as an “added value” element of the supply of medicines.
- 4.20 MDS are costly to operate and, on agreement with GP practices, may be supported through the provision of prescriptions for shorter periods than might otherwise be written, which in itself could result in increasing costs. The use of 7-day prescriptions as a means of supporting the provision of MDS seems to be routine and unrelated to the specific needs of patients. **The supply of MDS can be driven by patient demand and care home managers. We would encourage health professionals to discuss with the patient/carer/care home manager whether an MDS is the best option for an individual patient or whether some other mechanism to support adherence may better suit them.**
- 4.21 There has been no assessment of the effectiveness or otherwise of the use of MDS in care homes and particularly in supporting individuals’ capacity and interest in managing their own medicines where they want to and are able to do so. In our view, a formal assessment should be conducted to determine whether such systems are the best option for the care of people in residential care. **The effectiveness or otherwise of MDS systems in supporting patients’ use of medicines in care homes and at home, should be investigated through a dedicated research programme. The output would inform appropriate use, commissioning, and funding to incentivise supply properly.**

### ***Bulk prescriptions***

- 4.22 Bulk prescriptions are one means of providing commonly used medicines that might be prescribed for a number of residents. Medicines are still prescribed individually with supply from a bulk pack, rather than being supplied individually.
- 4.23 Bulk prescriptions have been a feature of the NHS for many years, but the facility for bulk prescriptions has been forgotten by many, particularly as the management of medicines in long term care has become increasingly regimented, often with the provision of MDS. As a result, many “as required” medicines, particularly simple analgesics and liquid laxatives, are routinely added to MDS or supplied to individuals on a monthly basis, resulting in waste and handling costs when new supplies are provided. This means “as required” medicines are automatically re-ordered every month even if they have not all been used up, with the unused supplies being discarded.

- 4.24 First and foremost, the Group was keen to recognise that care homes should operate in such a way that people, who can look after their own medicines, are empowered and enabled to do so. We therefore support the Care Quality Commission's focus on individualised prescribing, where appropriate, and enabling self-management.
- 4.25 However, practically and pragmatically, the Group also recognise that, short of this long-term aim, there is an immediate issue in which the use of 28-day prescribing linked to administration support systems is a clear source of waste. Such systems can work well for medicines that need to be taken regularly, for example for long term conditions, but "as required" or "when necessary" prescriptions are, by their nature, used irregularly. Systematically adding them to MDS trays or supplying them on an individual basis, means allocated doses for all days, so those not required and not taken in that month are wasted.
- 4.26 Without contradicting the key intent of ensuring that people, who can look after their own medicines, should be empowered and enabled to do so, **the facility for bulk prescriptions in long-term care facilities should be reviewed and best practice publicised to care home owners, GPs and pharmacists to reduce waste arising from the addition of "as required" medicines to administration support systems, and through individual supply of liquid preparations.** This could be done by producing a "white list" of items deemed particularly suitable for bulk prescriptions in homes where self-management is not appropriate.
- 4.27 It is the view of the Group that "homely remedies" should be provided by the home and not by the NHS, but we have not made a specific recommendation on this pending the outcomes of the post-CHUMS work.

### ***End of Life Care***

- 4.28 The *End of Life Care Strategy*<sup>12</sup> identifies steps of care along a pathway for people who are identified as entering this stage of life. There is no fixed definition or timeframe for "end of life", though it may be up to one year. There are some predictive tools to assist clinicians in identification.
- 4.29 When a clinician recognises that a patient may be entering the end of life period, the patient should be asked to consent to having their name added to the local electronic palliative care coordination system (EPaCCS). This enables ongoing health and social care to be coordinated across professionals, focused on the patient's needs. As part of the process of entering a patient onto EPaCCS, a series of actions should occur, including discussions with the patient about where they want their place of care, place of death and wish for overall escalation (or not) of intensity of care. Within this process, the prescribing and understanding of medicines needs is particularly important. Furthermore, entry onto EPaCCS is an opportunity to review current medicines through discussion with the person (and/or their carer/family member) about the need for some medicines to be continued during the end of life period. Patient and carer views should be respected as far as possible, provided it does not compromise their care and quality of life as, for instance, they may want to stop certain medicines. Health professionals need to recognise that not all medicines will

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<sup>12</sup> *End of Life Care Strategy - promoting high quality care for all adults at the end of life* (July 2008), Department of Health

be valuable during the end of life period and that stopping some of them, particularly those prescribed for prevention, may even improve the person's quality of life. The decision to stop any treatment needs to be made in conjunction with the patient and/or their family or carer.

- 4.30 Where there is not yet a local EPaCCS, clinicians should use the GP palliative care register.
- 4.31 Anticipatory prescribing in the last few days to assist in managing death at the place of the patient's choice is absolutely key, if the state of health of the patient is monitored regularly. While anticipatory prescribing is promoted to ensure that patients have access to the medicines they need during their end of life period, care of such patients should be monitored and reviewed regularly making it necessary to prescribe for a few days at a time only, addressing patient needs and therefore avoiding any situation where they are on a new or existing medicine for a long period of time.
- 4.32 The *Liverpool Care Pathway for the Dying Patient*<sup>13</sup> is considered the best practice tool to enable care to be managed in an optimum way for those people in the last few days of life, including a review of medicines with patients, knowing the value (benefit) of medicines that they are on in their last days. Its use is by no means universal but should be. It is promoted in the *End of Life Care Strategy* and in the National Institute for Health and Clinical Excellence's quality standard for end of life care<sup>14</sup>, and has recently been endorsed by more than 20 professional bodies, third sector organisations, disease specific charities and organisations representing care homes, hospices, social services and palliative care specialists<sup>15</sup>. **Health and social care professionals should be aware of, and promote the use of, the *Liverpool Care Pathway for the Dying Patient* as THE way to manage care in the last few days of life, including medicines, in a co-ordinated way.**

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<sup>13</sup> *Liverpool Care Pathway for the Dying Patient*, The Marie Curie Palliative Care Institute Liverpool

<sup>14</sup> *End of life care for adults quality standard* (November 2011), National Institute for Health and Clinical Excellence

<sup>15</sup> Accessed via <http://www.endoflifecareforadults.nhs.uk/tools/core-tools/liverpool-care-pathway> (September 2012)

# Chapter 5

## Engaging people in the decisions about their medicines and improving communications between health and social care professionals and patients

- 5.1 If the NHS is to be successful in reducing waste and improving health outcomes by optimising the use of medicines, patients must be at the centre of the decision making process about their treatment. It is also worth remembering that the NHS Constitution gives patients “the right to be involved in discussions and decisions about their healthcare, and to be given information to enable them to do this”.
- 5.2 To ensure this, both patients and healthcare professionals need to be able to access information from a reputable source on how the patient’s medicines work, on any side effects and on how they will improve their health.
- 5.3 We are not the first Group to have considered the importance of shared decision making. A significant cultural and behavioural change on behalf of both patients and healthcare professionals is required to give effect to the intent of “no decision about me, without me”. Better communications between health professionals and between health professionals and patients is key to this. It is recognised that embedding shared-decision making into everyday practice is in itself a long-term recommendation. However, cultural and behavioural shifts need to inform every step along the way in, for example, the education, training and development of all healthcare professionals at all stages, pre- and post-qualification.
- 5.4 Information Technology developments offer great potential for involving patients in their care and helping health professionals to communicate effectively. We have identified some key enablers, including the need for a single, agreed, minimum dataset that could be used in the transfer of patients across care settings, for example, between primary and secondary care. Like shared decision making, the use of IT should be considered an enabler to improving communication between health professionals and patients and between health and care professionals themselves. Similarly, we are conscious that patients can obtain information about medicines from many different sources. We therefore support the promotion of a single, agreed, reference point for information about medicines for patients, and for use by health professionals in dialogue with patients, for example a single approved website.
- 5.5 The Group also considered how patients and the public might themselves be engaged in improving the use of medicines and reducing waste directly. We suggest that a number of the elements within the Action Plan could be brought together in a national public information campaign that highlights the part that patients and the public have

to play to help health professionals and the NHS. This could include the recognition that NHS resources are vital and precious, with people taking medicines having a role to play in avoiding the waste of valuable resources. An important communication message would be:

*“reducing the amount of medicines wasted is everyone’s business. It is not for Government alone to tackle waste. We all have a responsibility to use the precious NHS resource to best effect, so that as many people as possible can benefit from the resources invested in the NHS”.*

#### ***Information available to healthcare professionals at the time of transfer of care***

- 5.6 Standards for sharing information on patients between healthcare professionals when patients move care settings, should be developed as recommended by a Joint Working Group established in September 2010 by the Department of Health Informatics Directorate. Standardising, for example, the minimum information provided in a discharge letter, would greatly assist in the provision of care, by improving the amount of information available to all healthcare professionals.
- 5.7 The Joint Working Group has, in its report *Developing standards for health and social care records*<sup>16</sup>, recommended a set of principles and minimum standards for ensuring the safe transfer of information about medicines when patients move care settings. Consideration needs to be given to determine the practicality of sharing that minimum dataset effectively.
- 5.8 It is important that patients are fully informed about the information that is being shared about them and the reasons for sharing it. They need to be assured that the information provided will be shared in a way that facilitates their care, while protecting the confidentiality of their data.
- 5.9 **The Joint Working Group’s principles and minimum standards, set out in *Developing standards for health and social care records*, should be adopted across the NHS with professional organisations (with support from the Department of Health and the NHS Commissioning Board) given responsibility for implementation. All processes for gathering the information about medicines to be transferred with patients when they move care settings, should explicitly involve the patient.**

#### ***Sharing best practice in engaging people in decisions about medicines prescribed for them***

- 5.10 Some parts of the NHS excel in putting the patient at the centre of decision making about medicines prescribed for them. However, these small-scale successes are often not collated, shared or disseminated in a way that enables easy access across professions, resulting in duplication of effort, information and considerable “reinventing of wheels”. A number of organisations, professional bodies, patient groups and agencies all hold information about best practice in this area, but it is not clear whether there is a single body that collates evidence of practice from such sites.
- 5.11 If we are to really make strides in improving the use of medicines, and in shared decision making about medicines, there should be a means to collate all the evidence,

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<sup>16</sup> *Developing standards for health and social care records: Report of the Joint Working Group* (January 2012), Joint Working Group

determining what is evidentially robust and what is considered less formally to be “best practice” and communicating this information across all health and social care organisations and the public in one place.

- 5.12 A dedicated “improving the use of medicines” section on NHS Networks may be an appropriate mechanism to capture and share best practice, as long as there is a clear lead responsibility for keeping the information up to date and relevant.
- 5.13 **One single body should be identified and given responsibility for collating and publishing best practice initiatives on improving the use of medicines and reducing medicines waste from across health and social care.**

### **Case study: NHS North of England (Yorkshire & the Humber) on Shared Decision Making**

Shared decision making jointly engages the patient and clinician in the decision making process to choose a treatment, screening option or self management programme, which is consistent with the patient’s values and preferences. Shared decision making forms part of a national work stream within the Right Care QIPP workstream.

NHS Yorkshire and Humber (part of NHS North of England), has worked with clinicians, commissioners and patient groups to develop a suite of e-resources to support shared decision making. These are simple, easy to follow and cover the basics for any interested groups or individual in learning more about shared decision making and wanting to put this approach into practice.

- **Shared Decision Making - getting started ... a guide for primary care and community teams**, is a reference for clinical commissioning groups and for training purposes.
- **Shared Decision Making - getting started ... a short guide for practitioners** is a reminder of the purpose, principles and practice from the above resource
- **Shared Decision Making - a resource for commissioners**, is a high level guide to take commissioners through the key areas they need to consider, when supporting a shared decision making approach.
- **“Just Ask Me”**, is a leaflet and poster encouraging patients and the public to ask five questions so that they can make informed choices about their future care.

These resources are generic and not specific to medicines, But they apply to all decisions that patients and clinicians may have to make together. They are all available at: [www.networks.nhs.uk/nhs-networks/sha-shared-decision-making-and-information-giving/project-outputs](http://www.networks.nhs.uk/nhs-networks/sha-shared-decision-making-and-information-giving/project-outputs)

For more information contact: Michele Cossey, Associate Director: Pharmacy and Prescribing & Shared Decision Making Lead ([michele.cossey@yorksandhumber.nhs.uk](mailto:michele.cossey@yorksandhumber.nhs.uk))

### **Information about medicines**

- 5.14 Current Patient Information Leaflets (PILs) can be “patient unfriendly” – the language and terms used can be frightening to patients – and the legal requirement to include all possible side effects may contribute to non-adherence. Without someone to discuss the leaflet with, patients sometimes make the decision not to take a medicine without consulting their GP or pharmacist.

- 5.15 Another, more patient-friendly, source of information would be helpful. Ideally, all healthcare professionals should access the same information, so consistent messages are delivered to patients. There are a number of existing databases that have met IS standards, have had input from across the professions, are written for patients and provide links to images of medicines and packages (for example, the Medicines Information Project medicine guides at [www.medicines.org.uk/guides](http://www.medicines.org.uk/guides), with links from the NHS Direct and NHS Choices sites). We understand the Medicines and Healthcare products Regulatory Agency (MHRA) is intending to provide all PILs on its website in due course.
- 5.16 We feel that a single reference point for information about medicines for patients would be helpful. **The National Portal suggested in the DH Information Strategy should include a high quality medicines information resource designed for patients and accessible to all health professionals, which can help make informed choices about the use of medicines and ensure that all professionals are providing the same information to patients. This information should complement the manufacturer's Patient Information Leaflet.**
- 5.17 **Once implemented, consideration should be given to improving the visibility of the medicines information resources in internet searches.**

#### ***Self-management plans and care pathways***

- 5.18 Personalised care planning is at the heart of involving people with long term conditions in decisions about their care and how the health system will support them in achieving goals for the way they want to live their lives, supporting patient choice, increased confidence and greater control.
- 5.19 Self-management plans have been shown to improve adherence to medicines in patients with long term conditions. Template self-management plans are available for many of these conditions, including from patient support and advocacy groups. **These need to fit within care pathways (and have medicines adherence embedded in them), as an integral part of the personalised care planning process.**

#### ***Education and training on inter-professional communications and patient engagement***

- 5.20 The overlapping roles of different professions in optimising the use of medicines and achieving effective communications between them, as well as engaging patients, listening to them and responding to their values and beliefs, needs to be embedded throughout the education, training and professional development of healthcare professionals from undergraduate curricula onwards.
- 5.21 Formation programmes for healthcare professionals are subject to periodic review. Each should include developing inter-professional communication, clinical skills, shared decision-making as key elements in any ongoing review. As an example, the Group recommends that, **given the importance of medicines optimisation, pharmacy programmes should include behavioural change as a component at an early stage of the curriculum.**
- 5.22 Motivational interviewing is a technique that helps to change patient behaviour, supporting adherence with self-management plans amongst other things. Training

for motivational interviewing is a time and resource intensive exercise, but we feel this should be embedded in education modernisation programmes and reforms to ensure graduates have these skills when entering the workforce. **Professional organisations should work with training providers to develop and promote the use of motivational interviewing to support patient self-management and empowerment.**

- 5.23 Deaneries, universities, professional organisations, employers and Health Education England will need to be involved in any new training and development from pre- to post-qualification for healthcare professionals. Regulators that accredit health professional training programmes should ensure courses appropriately address inter-professional communications and patient engagement and communications (shared decision-making) in order to receive accreditation. **Enhanced communications between healthcare professionals and shared decision-making with patients should be embedded in training and development for all health professions. Professional regulators should ensure courses appropriately address inter-professional communications, effective patient engagement and shared decision-making, together with motivational interviewing, in order to receive accreditation.**
- 5.24 Effective inter-professional communications and engagement of patients should also be embedded locally. This may include through Local Professional Networks, continuing professional development and integration with care pathways. There is a role for deaneries, universities and continuing education providers among others, and the potential to build on the existing and developing networks within clinical commissioning groups and the emerging local and national clinical networks.
- 5.25 The Local Education and Training Boards, accountable to Health Education England, should need to demonstrate that they are addressing these elements through their education outcomes framework.

### ***Public information campaign***

- 5.26 The reported success of local medicines waste campaigns, run by a number of PCTs and Health Boards in England and Scotland, suggests that a nationally co-ordinated public information campaign would be an effective way to help patients and the public understand the part they can play in improving the use of medicines and avoiding waste.
- 5.27 There are a number of key messages that would resonate with the public support various elements of the Action Plan. They are supported by DH focus group work with the public, and could include:
- Reducing waste is everyone's business
  - The NHS is a precious resource; use it wisely
  - "It's okay to ask" about medicines
  - It's okay to say to your doctor, nurse or pharmacist that you are not taking your medicines because they do not agree with you or that taking them does not fit in with your daily activities
  - "Stop the stockpile"
  - Dispose of medicines safely. Putting them into waste bins or flushing them down the toilet could have a negative impact on the environment. Take unwanted medicines to your pharmacy for safe disposal.

- If you are going into hospital, take your medicines with you so they can be used during your stay. They will be returned to you on discharge, if you still need them.

5.28 We have considered the suggestion of disclosing the cost of NHS medicines to patients, perhaps by including information on packs or labels, to raise awareness of their value to the NHS and reduce wastage. It was agreed not to pursue this. We have noted independent research commissioned by the Department of Health, which suggests that some patients, for example older people in need of effective treatment could be deterred from taking the medicines they need because they are worried about the impact on the public purse. However, we see no reason why national or local information campaigns could not highlight the total cost of medicines used in the NHS.

5.29 A national public information campaign would require central coordination, funding and marketing expertise and should be delivered inter-professionally with professional leadership bodies contributing. This could extend to the provision of resources for local clinical commissioning groups to conduct additional tailored initiatives.

5.30 **There should be a national public information campaign raising awareness of how the public can help make the best use of their medicines and reduce waste. Building such messages into “business as usual” is also an important consideration. This campaign should be coordinated centrally and delivered across health and social care locally. Input should be sought from those with an interest, including professional organisations, patient groups, industry, the voluntary sector, as well as the NHS Commissioning Board and local authorities.**

#### **Case study: Brighton & Hove Local Involvement Network (LINK) on medicines waste**

Brighton & Hove LINK published a report on medicine wastage in December 2010, to highlight the medicine wastage problem and to consider practical solutions to reduce waste. The report considers that GPs and other health professionals, the local NHS, and the public all have a part to play in reducing the level of medicines wastage.

Following their report, the LINK developed leaflets, which advise patients who take medicines to behave responsibly by adopting a range of good practice, such as:

- only ordering medicines they need
- taking advantage of Medicine Use Reviews
- informing their GP if the medicine is no longer being taken
- taking all medicines with them when admitted to hospital
- returning medicines to their pharmacy for safe disposal

The LINK produced a number of posters for display in GP practices and pharmacies. The LINK also produced some useful information for patients on the Medicines Check Up (MCU) – also known as a medicine use review - and Tips and Tricks to help patients remember to take their medicine.

Further information is available at:

[www.bhlink.org/res/media/pdf/MedicineWastageReportJanuary2010final.pdf](http://www.bhlink.org/res/media/pdf/MedicineWastageReportJanuary2010final.pdf)

# Action Plan

## Targeted support for patients in primary care

Paragraph	Recommendation	Timescale S = within 3 months M = within a year) L = within a few years
2.7	Good practice in managing repeat prescribing should be developed and implemented across all local NHS organisations to ensure that repeat prescribing processes do not inadvertently contribute to medicines waste. This should take account of the National Prescribing Centre guidance <i>Saving time, helping patients: A good practice guide to quality repeat prescribing</i> , published in January 2004.	M
2.8.	Practice-based pharmacists, where in post, should support practices by identifying patients who are on repeat prescriptions and who no longer need the medicines.	S
2.11	A repeat dispensing engagement plan for local NHS organisations and GPs - with a key role for the Royal College of General Practitioners and the Royal Pharmaceutical Society to work collaboratively - should be developed to ensure that GPs and community pharmacists understand the benefits of repeat prescriptions to them, their patients and their staff.	M
2.13	Software companies should be encouraged to resolve any barriers to repeat dispensing faced by non-medical prescribers.	L
2.14	In time, national QIPP prescribing comparators should be used to benchmark local NHS organisations on the proportion of items prescribed under repeat dispensing. In the longer term, GP practice repeat dispensing rates could be published nationally or locally.	S
2.20	A dedicated programme of support should be developed by Local Professional Networks to enable hospital Trusts, community pharmacies, Local Pharmaceutical Committees and local NHS organisations to work together to ensure that local systems work for patients and that, where appropriate, post discharge medicines use reviews become an integral part of the medicine pathway.	M
2.22	We recommend that, in each GP practice, efforts are focussed on patients with multiple, complex long term conditions who could benefit from additional support to help them take their medicines effectively.	S
2.24	A cost-benefit study should be undertaken into targeting the community pharmacy medicines use review service to this small but significant group of patients. Successful testing could then inform the alignment of the General Medical Services and community pharmacy contractual frameworks to	L

	ensure that specific patients or groups of patients are signposted to community pharmacists for additional support.	
2.25	If appropriate, the NHS Commissioning Board, the Department of Health, NHS Employers and the Pharmaceutical Services Negotiating Committee should explore the feasibility of a targeted medicines use review for patients with multiple long term conditions being introduced under the community pharmacy contractual framework.	L
2.29	Following the formal evaluation of the New Medicine Service and assuming that the service is continued, statins for primary and secondary prevention of cardiovascular disease and medicines for schizophrenia should be considered for addition to the New Medicine Service specification, subject to discussions between the NHS Commissioning Board, the Department of Health, NHS Employers and the Pharmaceutical Services Negotiating Committee.	L
2.32	A scoping exercise of local “not dispensed” schemes should be carried out to look at models currently in existence, with a view to discussing how, or whether, such a service could be incorporated into the community pharmacy contractual framework nationally in the future.	M

### Effective use of patients’ medicines in hospitals

Paragraph	Recommendation	Timescale S = within 3 months M = within a year) L = within a few years
3.3	The Chief Pharmacist should provide a regular update to the Trust Board on strategies to improve supply and reduce wastage of medicines within the Trust including an update on progress on increasing the use of patients’ own drugs and improving systems and processes for medicines to accompany patients when transferred between wards and clinical areas and on discharge. These reports should inform Trust decisions on initiatives that result in the better supply and use of medicines and reduced medicines waste throughout the patient’s hospital journey.	S
3.6	All Trusts should consider “investing to save” in a dedicated resource to establish and implement systems and processes to reduce wastage of returned medicines through identifying those medicines fit for re-issue and for transferring medicines between clinical areas when patients are moved within the hospital. Trusts should explore how to incentivise clinical areas to implement effective systems for transferring medicines with patients when they move from one clinical area to another.	M
3.7	Every Trust should complete a snapshot (one week) audit of medicines returned to the pharmacy from wards, A&E and	M

	other clinical areas to identify the opportunity from re-use, feeding back the results Trust-wide to clinicians and managers. This should be repeated annually.	
3.10	All hospital Trusts should complete a snapshot audit of the percentage of patients bringing in their own medicines on admission. The results should be shared regionally and nationally and each Trust should produce a plan to actively increase the use of PODs that are fit for use during hospital admission and at discharge.	M
3.11	Systems and processes need to be developed to maximise the use of PODs that are brought into hospital, where appropriate. Medicines that need to be continued following discharge, should be returned to patients. A review of the safe custody of patients' own medicines should be part of any overall plan to improve use of PODs.	M
3.12	Further work is required to explore why patients do not routinely bring their own medicines to hospital when admitted and what can be done to encourage patients to bring their own medicines into hospitals.	M
3.13	Communications campaigns on making the best use of NHS resources should include a message to encourage patients to bring their own medicines into hospital, for use during their stay.	M
3.14	Local NHS commissioning intentions for medicines supply from secondary care should be tailored to promote the use of PODs and avoid excessive supplies being made on discharge from hospitals. Discharge quantities should be reviewed and the intentions written to allow for pragmatic approaches that respect individual patients' views and needs, including flexibility for smaller amounts to be supplied on discharge where appropriate.	M
3.16	Novel approaches to managed discharge, including hospital follow-up (within 28 days) and community pharmacy supply of discharge prescriptions, should be formally reviewed to examine efficiencies, convenience for patients and contribution to better outcomes through integrated care.	M

### Use of medicines in care homes and end of life care

Paragraph	Recommendation	Timescale S = within 3 months M = within a year) L = within a few years
4.14	When the outputs of the Safety of Medicines in Care Homes Project are available, consideration should be given to reviewing this Action Plan in the context of the Project's recommendations, and it being amended accordingly. Consideration should be given to how any recommendations or any recommended processes should be implemented	M

	across the sector and force given to that implementation.	
4.17	The creation of a “key team” approach to the medicines issues faced by residents in the care home sector, should be properly tested, with research undertaken into whether it improves outcomes for patients, including measures of their ability to manage their own medicines when they want to, supported by the team.	M
4.20	The supply of MDS can be driven by patient demand and care home managers. We would encourage health professionals to discuss with the patient/carer/care home manager whether an MDS is the best option for an individual patient or whether some other mechanism to support adherence may better suit them.	S
4.21	The effectiveness or otherwise of MDS systems in supporting patients’ use of medicines in care homes and at home, should be investigated through a dedicated research programme. The output would inform appropriate use, commissioning, and funding to incentivise supply properly.	L
4.26	The facility for bulk prescribing in long-term care facilities should be reviewed, and best practice publicised to care home owners, GPs and pharmacists to reduce waste arising from the addition of “as required” medicines to administration support systems , and through individual supply of liquid preparations.	S
4.32	Health and social care professionals should be aware of, and promote the use of, the <i>Liverpool Care Pathway for the Dying Patient</i> as THE way to manage care in the last few days of life, including medicines, in a co-ordinated way.	S

### **Engaging people in the decisions about their medicines and improving communications between health and social care professionals and patients**

<b>Paragraph</b>	<b>Recommendation</b>	<b>Timescale</b> S = within 3 months M = within a year) L = within a few years
5.9	The Joint Working Group’s principles and minimum standards, set out in <i>Developing standards for health and social care records</i> , should be adopted across the NHS with professional organisations (with support from the Department of Health and the NHS Commissioning Board) given responsibility for implementation. All processes for gathering the information about medicines to be transferred with patients when they move care settings, should explicitly involve the patient.	M
5.13	One single body should be identified and given responsibility for collating and publishing best practice initiatives on improving the use of medicines and reducing medicines	M

	waste from across health and social care.	
5.16	The National Portal suggested in the DH Information Strategy should include a high quality medicines information resource designed for patients and accessible to all health professionals, which can help make informed choices about the use of medicines and ensure that all professionals are providing the same information to patients. This information should complement the manufacturer's Patient Information Leaflet.	M
5.17	Once implemented, consideration should be given to how to improve the visibility of the medicines information resource in internet searches.	L
5.19	Self-management plans need to fit within care pathways (and have medicines adherence embedded in them), as an integral part of the personalised care planning process.	M
5.21	Given the importance of medicines optimisation, pharmacy programmes should include behavioural change as a component at an early stage of the curriculum.	L
5.22	Professional organisations should work with training providers to develop and promote the use of motivational interviewing to support patient self-management and empowerment.	M
5.23	Enhanced communications between healthcare professionals and shared decision-making with patients should be embedded in training and development for all health professions, and professional regulators should ensure that courses appropriately address inter-professional communications, effective patient engagement and shared decision-making, together with motivational interviewing, in order to receive accreditation.	M
5.30	There should be a national public information campaign raising awareness of how the public can help make the best use of their medicines and reduce waste. Building such messages into "business as usual" is also an important consideration. This campaign should be coordinated centrally and delivered across health and social care locally. Input should be sought from those with an interest, including professional organisations, patient groups, industry, the voluntary sector, as well as the NHS Commissioning Board and local authorities.	M

# Terms of reference

## Steering Group to Improve the Use of Medicines (for better outcomes and reduced waste)

### Aim

The Group will provide leadership for the development of an Action Plan for improving the use of medicines by patients and reducing waste in the NHS. The Action Plan will include recommendations:

- To involve patients in decisions about their treatment to better help them use medicines as intended
- To directly reduce the scale and cost of medicines waste
- To contribute to improved health outcomes through optimising the supply and use of medicines
- To reduce harm associated with taking or not taking medicines

The Action Plan will clearly identify organisations and individuals that can deliver aspects of the Action Plan within specific timelines.

### Expected Outcomes

The pragmatic and practical Action Plan will identify:

- Ways of optimising the use of medicines by NHS patients
- How the improved use of medicines can be better incorporated into care pathways and self-management plans, as a fundamental contribution to the QIPP work programme
- How optimising the use of medicines through full patient participation and shared decision-making might be embedded in the education of health and social care professionals in the future
- Synergies with the work programme on Care Homes being led by the Royal Colleges of Physicians and Psychiatry and the Academy of Medical Royal Colleges
- Policy implications for the Department of Health, and implications for NHS contracting arrangements
- Whether a communications campaign might raise awareness of the issues of improved medicine taking and reducing waste and contribute to behavioural change, building on current knowledge of patient and public views.
- The cultural, diversity, health literacy and other barriers or challenges in taking forward any of the suggested initiatives, and recommend actions to mitigate them
- Recommendations and priorities for further work that might need to be undertaken in the future

### Process

In order to achieve the expected outcomes the group will:

- Work with relevant stakeholders who have been involved in initiatives to improve medicine taking and reduce the scale and cost of medicines, or who may be required to deliver elements of the Action Plan

- Engage with the QIPP work programme to identify synergies that can be built into the Action Plan
- Consider the value for money implications of any proposed interventions
- Suggest mechanisms to monitor progress of delivery of the Action Plan

### **Focus**

In advising and reporting to Ministers, the Steering Group will focus on the themes discussed at the roundtable event hosted by the King's Fund in January 2011. These will include:

- Engaging people in the decisions about their medicines
- Targeted support for patients starting new therapies
- Better communication between health professionals
- Better use of medicines use reviews (MURs) and prescription interventions
- Better systems for managing repeat prescribing
- Better systems for managing medicines in care homes
- Better management of medicines at the end of life care period
- Use of patients' own medicines brought into hospitals
- Further research

### **Deliverable**

The Steering Group will deliver a completed Action Plan to Ministers in early 2012.

# Membership of the Steering Group and Sub-groups

## Steering Group

- Robert Johnstone (Co-Chair), Trustee, National Voices
- Rob Darracott (Co-Chair), Chief Executive, Pharmacy Voice
- Gul Root, Principal Pharmaceutical Officer, Department of Health
- Jonathan Mason, Clinical Adviser (medicines) NHS N East London and the City
- Helen Gordon, Chief Executive, Royal Pharmaceutical Society
- Jatinder Harchowal, Chief Pharmacist, Brighton and Sussex University Hospitals Trust
- Simon Selo, Assistant Director, Policy and Service Development, Asthma UK
- Clare Howard, National Lead QIPP medicines use and procurement
- Catherine Thatcher, Deputy Director of Primary Care, NHS Airedale, Leeds & Bradford
- Ian Cubbin, Community Pharmacist and PSNC member
- Tim Williams, Marketing and Sales Services Director, MSD
- Catherine Armstrong, English Pharmacy Board, Royal Pharmaceutical Society
- Dr Katherine Darton, Information Officer, Mind
- Linda Tait, Project Manager for Medicines Use, NHS South Central

## Sub-group members

- Dennis Lauder, Chief Pharmacist, Heatherwood and Wrexham Park Hospitals
- Chris Acomb, Chief Pharmacist, Leeds Teaching Hospitals NHS Trust
- Caroline Lecko, Patient Safety Lead, Learning and Development Institute, RCN
- Kevin Noble, Community Pharmacy Lead, NHS Isle of Wight
- David Andrewes, Committee member of Eastleigh Southern Parishes Older People's Forum, Age UK representative
- Alistair Murray, Community Pharmacist, Greenlight Pharmacy
- Gary Warner, Community Pharmacist and PSNC member, Regent Pharmacy
- Gillian Arr-Jones, Chief Pharmacist, Care Quality Commission
- Steve Turner, Cornwall Partnership NHS Foundation Trust
- Michele Cossey, Associate Director of Pharmacy and Prescribing at NHS Yorkshire and Humber
- Susan Went, Health Foundation Quality Improvement Fellow, Senior Expert in Healthcare Quality Improvement, RCP/RCGP/RCPsych
- Dr Phil Koczan, Royal College of General Practitioners