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**Summary of Consultation Responses**

**NORTHERN IRELAND MEDICINES OPTIMISATION QUALITY FRAMEWORK**

**February 2016**

**CONTENTS**

 **Page No**

1. **INTRODUCTION 3**
2. **CONSULTATION DOCUMENT 4**
3. **OVERVIEW OF CONSULTATION RESPONSES 4**
4. **SUMMARY OF CONSULTATION RESPONSES 5-19**
5. **FURTHER COMMENTS 20-21**
6. **DEPARTMENTAL RESPONSE 22-26**
7. **HUMAN RIGHTS AND EQUALITY IMPLICATIONS 27**
8. **SUMMARY 27**

**Annex A – List of Respondents (in alphabetical order) 28-29**

1. **INTRODUCTION**

1.1 A draft Northern Ireland Medicines Optimisation Quality Framework (MOQF) was developed with the aim to support better health and wellbeing for all people in Northern Ireland through improvements in the appropriate, safe and effective use of medicines.

1.2 Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditionsand curing disease. Medicines optimisation is defined by the National Institute of Health and Care Excellence (NICE) as “a person centred approach to safe and effective medicines use to ensure that people obtain the best possible outcome from their medicines”. It requires multidisciplinary healthcare professionals working together and with patients to optimise health outcomes every time a medicine is prescribed, dispensed or administered.

1.3 The draft MOQF had three components:

* A **Regional Medicines Optimisation Model** which outlines what should be done at each stage of the patient journey to help gain the best outcomes from medicines;
* **Quality standards** which describe what patients can expect when medicines are included as part of their treatment. These standards identify:
	+ - What best practice should be delivered and any gaps in best practice which need to be addressed; and
		- Recommendations for change.
* **A regional medicines innovation plan** to support the sustainable delivery of the quality standards which identifies the priority areas for research and service development required to address the gaps in best practice in medicines optimisation over a five year period 2015-2020.
1. **CONSULTATION DOCUMENT**
	1. The Department organised a public consultation seeking views and comments on the draft MOQF and included a Consultation Questionnaire. The questionnaire highlighted a number of key areas within the Framework on which the Department particularly welcomed views. The 12 week consultation period ended on 14 August 2015.
	2. The full consultation documents can be viewed on the Department’s website at: [www.dhsspsni.gov.uk/showconsultations?txtid=77646](http://www.dhsspsni.gov.uk/showconsultations?txtid=77646)
2. **OVERVIEW OF CONSULTATION RESPONSES**
	1. The consultation attracted 34 responses from a wide variety of sources including pharmacists in various settings, Health and Social Care Trusts, medical and nursing groups, professional bodies, pharmaceutical companies and charitable organisations.
	2. Responses were welcomed via letter, fax or email:
* 34 responses were received by email;
* 24 responses used the consultation questionnaire template; and
* 10 respondents used their own format.

3.3 When responding to Questions 1 to 16 in the Consultation Questionnaire, respondents were asked to tick one of three boxes: Yes; No; and Don’t Know/No Views. An additional comments box was included to allow for answers to be expanded. Questions 17 to 20 required either a Yes or No answer, with a supplementary question asking respondents to qualify their answer. A Further Comments box was provided to allow respondents to provide additional comments, recommendations or suggestions. A list of respondents is at **Annex A**

1. **SUMMARY OF CONSULTATION RESPONSES**
	1. This section provides a summary of the 24 responses received to each question in the consultation questionnaire[[1]](#footnote-1).

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

* 1. Of the respondents to this question, a majority (83%) agreed that the aim of the MOQF was clear throughout the document, with several respondents welcoming recognition of the importance of medicines optimisation. Some respondents considered the Framework as complementing initiatives such as Transforming Your Care and Integrated Care Partnerships and were optimistic that it would prove beneficial in improving patient outcomes.
	2. Although some respondents were of the view that the Framework contained a lot of useful background information, it was suggested that a final version would benefit from an Executive Summary chart/timeline. As a review on medicines optimisation by the Regional Quality and Improvement Authority (RQIA) had post-dated publication of the draft MOQF consultation document, it was suggested that the RQIA Review should be referenced, within the over-arching framework.
	3. Some respondents suggested that the Framework background should be reconciled against the NICE definition of Medicines Optimisation, guideline recommendations and Quality Standards. It was also suggested that the Guidelines and Audit Implementation (GAIN) Audit 2013 – The Importance of timing in Parkinson’s Medication and the Parkinson’s UK - ‘Get It On Time’ campaign could be referenced. The campaign outlines the importance of people getting their Parkinson’s medication on time, every time in hospitals and care homes.
	4. A small number of respondents regarded the Framework as process orientated, leaning towards the acquisition costs of medicines and that more focus up front was needed on medicines optimisation rather than medicines management. It was suggested that a methodology and timeline for implementation be included, given that many of the best practice outcomes imply new or expanded services through GP and community pharmacy contractual frameworks.

**Q2. Does section 1 provide a comprehensive review of medicines management?**

* 1. Almost 80% of respondents who answered this question agreed that the Framework provided a comprehensive review, clear history and summary of issues, policies and practices which influence medicines management. It was suggested that over time, and with a culture of collaboration, the Framework has the potential to transform the delivery of service within Hospitals, General Practice, Community Pharmacy and Secondary Care.
	2. It was suggested that the section could be enhanced by emphasising the evolution, role and impact of the pharmacist as an independent prescriber in medicines management. It was noted that efficiencies in the drugs budget achieved by secondary care could also be referenced and that clarity could be provided as to whether NICE Guideline NG5 Medicines optimisation or the MOQF takes precedence in terms of implementation. In terms of presentation, it was suggested that this section could be reduced and included as an Appendix.

* 1. Approximately 20% of respondents to this question did not agree that the section provided a comprehensive review of medicines management, commenting on the quotation of outdated statistics and the lack of detail on the development of medicines management in community pharmacy. It was noted that Community Mental Health services/systems and their specific differences were not included with minimal reference to the “fundamental” Hepler and Strands Pharmacy Care Model 1990.

**Q3. Are the key challenges in moving to medicines optimisation comprehensive and clear within the Framework?**

* 1. Challenges in moving to medicines optimisation are clear and comprehensive within the Framework, according to 70% of respondents to this question. However, the challenge for all professionals was noted, but could be achieved through increased patient engagement, better communication, collaborative working and available recurrent funding for medicines optimisation. It was suggested that reference could be made to the RQIA Review of Medicines Optimisation in Primary Care as well as the need for consistency in decision making between HSC Trusts where drugs are not considered by NICE via, for example, a regional Drug and Therapeutic Committee.
	2. The relevance of the inclusion of data relating to formulary compliance was questioned, on the basis that whilst the Formulary will aim to standardise practice and ensure a level of consistency, individual patients may require medicines outside the guidance. Use of the new term ‘de-prescribing’ was suggested and the term “community pharmacists” rather than “pharmacists” be used in the section where the Donaldson Report, Transforming Your Care and Living with Long Term Conditions Framework were referenced.
	3. Some respondents were of the view that the challenges in moving to medicines optimisation were not fully comprehensive within the Framework. Also some GPs were not aware of the Medicines Use Review (MUR) service or how it relates to existing services in general practice. It was also suggested that patient pathways are not well developed across the medicines pathway and some respondents noted a lack of clarity where District Nursing Services, Specialist Nursing Services and those provided by the allied health professionals, sit within the four settings.

**Q4. Do you think the Medicines Optimisation model visually demonstrates the key aim and objectives of meds optimisation?**

* 1. Over 70% of respondents to this question agreed that the draft Framework visually demonstrates its key aim and objectives and that the illustration of the model describes the essence with the patient at the centre and the full range of providers, as well as the vital importance of the safety of medicine management. Support was expressed for the use of pharmacists’ clinical skills to support patients and for proposals around new policies of practice pharmacists and regional consultant pharmacists focussing on poly pharmacy care models. It was proposed that benefits could be achieved in mapping out and linking the various settings e.g. Community/Hospital/Medicines Management Advisors (MMA)/Pharmacists in GP practices and that reference could be made to new roles for Specialist Outreach Pharmacists.
	2. Of the respondents who disagreed, it was suggested that the model didn’t include the primary goal of medicines optimisation to ‘improve patient outcomes’, or the mechanism for measuring success. An implied order of priorities within the concentric rings was also suggested, with the potential interpretation that the draft framework only related to older people.

**Q5. Is it clear from the list of activities provided in the table in section 3 of the Framework of what a patient should expect as routine practice with regards to medicines optimisation in the different HSC settings?**

4.14 Almost all of the respondents to this question (96%) agreed that what a patient should expect and the list of activities were clear and easy to follow. However, it was noted that 24hrs was too long for a person to wait to have their medicine reconciliation completed upon admission to hospital. Other issues raised were in relation to the need to fully ensure that patients are fully informed about what they should expect from the HSC; the need for clarity in assessments; and of the role of MURs and Managing Your Medicine (MYM).

4.15 One respondent noted that patients attending outpatient clinics were not included and that there was a gap for patients involved with secondary care services in their community. It was also noted that the role of the pharmacist as an independent prescriber was not included.

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

4.16 There was overwhelming agreement of respondents to this question (92%) that checks on patients’ medicine should occur at each transition of care setting and that this is a critical area for medicines optimisation. Some respondents suggested that the Framework should include RQIA recommendations 4 & 5 and NICE Guideline NG5 Medicines optimisation identifying Best Practice, where patients move from one care setting to another. The importance of community pharmacists and other healthcare professionals having a secure and recognised communication system or mechanism for receiving and sending written information on patients’ medication was highlighted. In particular, it was suggested that having access to the Electronic Care Record (ECR) would assist with safe transfer of information from hospital at discharge.

4.17 It was noted that community pharmacy is not always aware that a patient has been discharged or that a medicine dose has been changed with the suggestion that a process should be developed to flag key changes within the medicines pathway.

**Q6 (b). Do you agree with the recommendations within the Framework in relation to safer transitions of care?**

4.18 There was broad agreement with the recommendations within the Framework in relation to safer transitions of care (87% of respondents to this question). Issues raised included the need to address hospital visits without admission, greater clarity on how community pharmacy would receive information on patients’ medications upon discharge from hospital and the requirement for community pharmacists and other relevant HSC staff to have appropriate access to the ECR system.

4.19 Where there was disagreement with the recommendations, issues highlighted included an absence of accountability, dependence on the resolution of external factors outside the scope of the framework, the absence of a reference to hospital visits without admission (e.g. outpatients clinics) and the need to extend the emphasis on polypharmacy to patients with co-morbidity as well as the elderly.

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

4.20 The majority of respondents to this question (96%) agreed that patients who may be at risk due to the medicines they take, require appropriate help and suggested further steps be taken to help people to take their medicines safely. While there is a long established list of “red” and “amber” medicines supplied through hospitals, it was perceived that a clear list of high risk medicines shared with prescribers, dispensers, patients and carers would help to target support to those likely to need it.

* 1. It was suggested, however, that risk stratification should be more encompassing than just high risk drugs, extending to those taking multiple medicines for co-morbidities and that support arrangements should be clearly set out specifying respective responsibilities of prescriber, patient and dispenser. Account should also be taken of medicines making patients more vulnerable to patient safety issues and that new NI patient safety tools could complement the framework e.g. GRASP.
	2. A view was expressed that patient safety risks were inherent to this recommendation and that it should be reviewed on the basis that “appropriate help” is a role that cannot be discharged or delegated to a domiciliary care worker but rather a registered, trained and accountable health professional e.g. district nurse.

**Q7 (b). Do you agree with the recommendations within the Framework in relation to risk stratification of medicines?**

* 1. Almost 90% of respondents to this question agreed with the recommendations relating to risk stratification of medicines. A number of respondents recommended universal access to lists of high risk drugs and specialist medicines through electronic prescribing and pharmacy computer systems. The inclusion of competencies in staff training was also suggested as well as a similar model to the Scottish Chronic Medication Service (CMS) as an example of how community pharmacists could be utilised to mange patients with long term conditions.
	2. The need to refer to outpatient review as an opportunity to review medicines was also suggested as well as considering the potential role of the pharmacist independent prescriber.

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

* 1. All respondents who answered this question were in agreement. Some referred to for example the NICE guidance regarding systems for identifying and reporting medication incidents and Datixweb (Belfast HSC Trust). The current arrangements where community pharmacies submit anonymised data on ‘near misses’ and dispensing errors to the HSC Board was noted as a means of sharing learning and promoting best practice.

**Q8 (b). Do you agree with the recommendations within the Framework in relation to safety/reporting and learning culture?**

* 1. All of the respondents who answered this question agreed with the recommendations in the Framework in relation to safety/reporting and learning culture. The importance of incident reporting to promote learning and ensure improved safety was noted as well as being good medicine governance. There was also a suggestion that the Institute for Healthcare Improvement Quality Improvement methodology be used as a method of improving medication safety, while the importance of electronic transmission of errors and interrogation of data to establish trends was noted. The application of reporting mechanisms for those outside the health system such as carers was also queried.

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

* 1. All respondents to this question agreed that patients should have appropriate, equitable and timely access to quality assured, evidence based and cost-effective medicines. In addition, and where necessary, pharmacists could liaise with prescribers to advise of stock shortages and recommend alternative products. It was also suggested that medicines optimisation should recognise and communicate the value of medicines to the health service, patients and the wider UK economy, with NI patients having a similar level of access to medicines as UK counterparts.

**Q9 (b). Do you agree with the recommendations within the Framework in relation to access to medicines you need?**

* 1. Whilst the vast majority of respondents to this question agreed (92%), it was noted that although the concepts in this section are valuable, more information could be provided on how the recommendations will be delivered, with a timeframe for completion. The importance of NI patients having the same level of access to medicines as in England and Wales was highlighted, although the perceived inconsistency across HSC Trusts in access to non-NICE approved medicines was noted. That was deemed to be due to the absence of a regional scrutiny committee for those drugs not considered by NICE or the NI managed entry process.
	2. It was also suggested that community pharmacists and pharmaceutical wholesalers operating in NI should be involved in drawing up regional guidelines for handling medicines shortages. Finally, some concerns were expressed that the recommendations would address the gaps in best practice.

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

4.30 While there was broad agreement that waste remains a key issue for the HSC, some respondents were split on whether the appropriate, clinical and cost effective use of medicines is the responsibility of patients or healthcare professionals. A number of the respondents were of the view that the framework should embrace and describe “shared decision making” rather than “patient involvement”. It was also suggested that targets to reduce waste should not take precedence over the importance of people getting the right medication.

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

4.31 Of the respondents to this question, a majority (87%) supported the recommendations to use cost effective medicines and reduce waste. Some respondents agreed that while systems should be in place to check the necessity of repeat prescriptions before they are supplied this is not always possible prior to dispensing e.g. where the pharmacy conducts a prescription collection service. The importance of influencing patient behaviour regarding medicines waste was also highlighted.

4.32 A review and re-launch of the repeat dispensing service in an electronic form along with a standardised 28 day prescribing policy across primary and secondary care were suggested as means of reducing waste. It was also suggested that consideration be given to capturing the impact that pharmacist interventions have on reducing waste rather than just monitoring the waste returned from pharmacies and care homes.

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

4.33 All respondents who answered this question agreed that a regular clinical medication review should be conducted for each patient. Reviews should be a routine part of patient care, carried out by a suitably qualified health professional with access to the appropriate level of patient information, in a setting and time convenient to the patient. However, regular reviews, whilst important for those patients with progressive long term conditions, are very challenging. There was also a suggestion that clinical medication reviews could be developed and commissioned through a community pharmacy contractual framework.

4.34 Some respondents queried the frequency of clinical medication reviews and suggested a minimum standard, timescale and format. Others expressed concern, however, at the extensive resources that may be required to carry out, manage and deliver a review process.

**Q11 (b). Do you agree with the recommendations within the Framework in relation to clinical medication review?**

4.35 Almost 90% of respondents to this question agreed with the recommendations regarding clinical medication review with some proposals around strengthening the recommendations. For example, having a common accepted standard for clinical medication review was considered essential. Using the NICE definition was also suggested as well as using an English e-learning package tailored for NI.

4.36 Embedding pharmacists in general practice working with GPs to deliver clinical medication reviews was generally seen as a positive way forward that would potentially reduce the pressure and workload on GPs. Optimising and extending the MUR service to enable a community pharmacist to prescribe for particular conditions or products was also proposed.

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

4.37 All respondents to this question agreed that patients who have their medicines administered receive them on time. However, whilst this was an ideal scenario, it was not always possible on a busy hospital ward or in a patient’s home where they are relying on a carer or dependent to administer medication. The importance of ensuring medicines are administered on time and as prescribed was noted as important to minimise waste as well as managing conditions.

4.38 It was noted that a number of community pharmacists already support the administration of medicines through provision of a variety of medicine adherence support solutions e.g. Medication Administration Record (MAR) charts, reminder cards, Monitored Dosage Systems (MDS). Of the omitted dose rates quoted, however, it was questioned whether these were ‘true’ omissions or failure to record an administered dose on the Kardex system.

**Q12 (b). Do you agree with the recommendations within the Framework in relation to administration?**

4.39 Approximately 80% of respondents to this question agreed with the recommendations relating to administration. Proposals for improvement included a regionally agreed process to support community nursing teams and domiciliary care staff to administer medicines on time. It was also suggested that further consideration could be given to additional support for administration provided by community pharmacists to patients living in their own home and in a care home environment, while self- administration schemes in intermediate care was also proposed. The one stop dispensing service was considered to be inefficient and uneconomical without PODS (Patients Own Drugs Schemes), and so a drive to encourage patients to bring their own medicines to hospital was proffered.

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

4.40 Over 95% of respondents to his question agreed with this statement, believing that patients and their carers should be engaged, supported and sufficiently informed to enable then to be meaningfully involved, where possible, in decisions about their treatment. It was noted that this is particularly important for ‘hard to reach’ patients or those who may have language barriers or low literacy. The NICE Clinical Guideline 76 was suggested as a useful principle for consideration.

**Q13 (b). Do you agree with the recommendations within the Framework in relation to safer prescribing with patient involvement?**

4.41 Approximately 90% of respondents to this question agreed with the recommendations in the Framework in relation to safer prescribing with patient involvement. It was noted, however, that resources would be an issue with an increase in GP consultation time. It was suggested that the integration of IT systems including the NI Formulary and the newly proposed ePrescribing & Medicines Administration (EPMA), could significantly increase patient safety. However, the integration of the NI formulary should not be used to enforce formulary adherence and restrict patient and clinical choice. There was also general support for increasing the number of Pharmacist Independent Prescribers (PIPs), with a number of respondents suggesting that community pharmacy would be the most accessible healthcare resource to offer a suitable alternative to the GP practice.

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

4.42 The vast majority of respondents to this question (96%) agreed that patients should receive the information they need to take their medicines safely and effectively. Modern methods of communication were advocated including mobile applications as well as NICE advocated self-management plans and decision aids, with signposting as necessary to more specialist advice. It was also suggested that it would be an opportune time to introduce patient pack prescribing and dispensing, given the EU plan to introduce individual authentication under the Directive on Falsified Medicines. Some caution was expressed, however, that the proposed regional helpline offering advice and information would be unnecessary and potentially dangerous for patients who should only be receiving this information from a prescribing clinician or pharmacist.

**Q14 (b). Do you agree with the recommendations within the Framework in relation to better information about medicines?**

4.43 There was broad agreement (over 80% of respondents to the question) with the recommendations within the Framework in relation to better information about medicines. In particular, there was support for the increased role of community pharmacists and the recommendation that MURs be made more widely available and broadened to include other conditions. It was also suggested that a service similar to the English New Medicines Service (NMS) be introduced in NI, to complement the existing MUR service.

4.44 Whilst it was agreed that community pharmacists play a key role in contributing to and supporting risk stratification of a patient, there was a suggestion that this would not be easily translated into a Standard Operating Procedure. Another proposal was that the term risk stratification either be removed from this recommendation or moved to standard 2 where it is directly linked to risk stratification.

4.45 Some uncertainty was expressed about why social care staff would require access to appropriate up to date information sources for prescribed medicines. It was also queried who would develop, agree, fund and manage the proposed regional helpline system to support patients with their medicines after discharge from hospital.

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

4.46 Almost all respondents to this question (96%) agreed that patients should remain independent and be supported to self manage where possible. There was general support for greater use of targeted schemes such as MURs and MYMs. Some expressed a view that Monitored Dosage Systems wereoften not always effective in supporting patients to take their medicines and that other solutions should be developed to ensure and monitor adherence, particularly in residential and domiciliary care.

**Q15 (b). Do you agree with the recommendations within the Framework in relation to supporting adherence and independence?**

4.47 Just over 90% of respondents to this question agreed with the recommendations within the Framework in relation to supporting adherence to medicines and independence. It was suggested that further investment from industry on adherence and support solutions was necessary and that there was a need to address appropriate clinical pharmacy staffing levels. It was also suggested that a community pharmacy-based model for the management of long term conditions be developed and that the MUR service should not be limited to patients with respiratory disease and/or diabetes.

**Q16. Do you agree with the new strategic approach proposed within Section 5 of the Medicines Optimisation Quality Framework?**

4.48 There was broad agreement amongst the respondents to this question (almost 80%) for the new strategic approach. Strong support was expressed for the establishment of the Northern Ireland Medicines Optimisation Innovation Centre (MOIC) for innovation, research and service development. Some considered that if it was to be successful, the work of the MOIC should involve a comprehensive network of key stakeholders across all sectors within the HSC including community pharmacy.

4.49 A view was also expressed that achievement of the strategic objective should be mainstream business for the HSC sector and that any issues with ill informed decisions regarding medicines optimisation should be addressed with commissioners.

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

4.50 Of the 24 respondents to this question, two thirds believed that the MOQF was unlikely to adversely affect any of the equality groups identified under section 75 of the Northern Ireland Act. The remainder had no views or were unable to comment.

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

4.51 Of the 24 respondents to this question, just over 70% said they were not aware of any indication or evidence that the consultation document would adversely impact on equality of opportunity or good relations. The remainder had no views or were unable to comment.

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

4.52 Of the 24 responses to this question, over half had no views, while almost 30% disagreed but offered no reasons for their answer. A minority (4nr - 17%) agreed that there was an opportunity to better promote equality of opportunity and good relations. Of these, some qualified that they felt that this would be achieved through wider engagement with patients, their carers and community based organisations, as well as discussions with healthcare professionals to clarify roles and responsibilities regarding medicines.

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

4.53 There were 24 responses to this question. Almost 60% of respondents perceived that there was no potential for a violation of human rights, while the remainder either did not have any views or were unable to comment.

**5. FURTHER COMMENTS**

5.1 This section reflects additional comments made by the 24 respondents who used the questionnaire template and also captures some views and recommendations received from the 10 respondents who used their own format.

5.2 Respondents generally welcomed the opportunity to provide comment on the MOQF and considered it highly beneficial with the potential to deliver healthier outcomes and better informed patients. There was recognition of the extensive work invested in compiling the framework and commendation for its comprehensive recommendations, with some respondents anticipating publication of the final version including an implementation strategy. Only one respondent indicated that whilst they supported individual recommendations and policies within the Framework, they could not support the Framework in its entirety.

5.3 Some respondents reiterated issues they raised previously in their answers to the individual questions regarding e.g.: structure and presentation of the document; referencing additional material; resources; governance; accountability; and implementation.

5.4 Those expressing the patient voice recommended that the framework should embrace the concept of ‘shared decision’ making (as endorsed by the Kings Fund White Paper). In their view, patients living with long term conditions or rare diseases are in essence ‘expert patients’ by virtue of their personal experience, which should be utilised to inform health decisions and medication plans. It was suggested that a dependency on patients/their carers and families to self manage their care was increasing due to a rise in long term conditions and rare diseases. In this respect it was felt that patient involvement and empowerment was undervalued and not clearly outlined within the framework, as the standards with greatest relevance to patient involvement are placed at the end.

5.5 The view was also expressed that patient engagement should promote the values underpinning Personal and Public Involvement (PPI) i.e. dignity, respect, inclusivity, diversity, equality etc. It was also noted that mental health patients need extra support and advocacy and should be involved in decision making where possible.

5.6 Some respondents deemed that it would be helpful to have a definition of Medicine Reconciliation including an indicative timeframe for commencement and completion, allowing for the correction of any discrepancies. A few respondents felt that in order to achieve the standard of having medicine reconciliation taking place within 24 hrs of hospital admission, secondary care need additional input from pharmacists.

5.7 A few respondents raised the issue of prescription charges. Specifically this was regarding the potential financial impact such charges may have on those suffering with long term conditions and rare diseases and their ability to adhere to their prescribed medicines and to effectively manage their condition.

**6. DEPARTMENTAL RESPONSE**

6.1 Comments arising from the consultation relating to the framework document have been considered by the Departmental Project Team with some specific issues addressed below.

Presentation, Structure and Content

6.2 In addressing comments regarding presentation and structure, the framework is being restructured and redesigned. The main body of the document will be shorter, with the framework containing more referenced material to strengthen and complement both its content and also existing health policy e.g. Controls Assurance Standards, Transforming Your Care principles, RQIA Review, recommendations contained in the Donaldson Report and Quality 2020 strategic themes of safety, effectiveness and patient/client focus.

6.3 History of Medicines Management and Moving to Medicines Optimisation, previously the first two sections of the document, will be appended. The quality framework itself will therefore have its primary focus as the introductory section.

6.4 Within the four settings, social care distinguishes between nursing homes, residential homes, children’s homes and domiciliary care.

6.5 The draft MOQF included recommendations for each of the ten Quality standards, which have been renamed and will be taken forward as ‘Actions needed to address the gaps’.

6.6 The revised MOQF has nine overarching key recommendations to introduce and support the Regional Model for Medicines Optimisation:

(i) A Regional Model for Medicines Optimisation should be introduced which outlines what patients can expect when medicines are included in their treatment as they access services in health and social care settings;

(ii) The model should be delivered by a multi-disciplinary medicines optimisation workforce trained and competent in medicines optimisation, with the involvement of pharmacists in all settings;

(iii) The medicines optimisation workforce should deliver regional services and roles which are commissioned and co-ordinated across all HSC organisations and related agencies involved in the prescribing, dispensing and administration of medicines;

(iv) The services and roles should aim to consistently deliver regional best practices in compliance with new Quality Standards for Medicines Optimisation;

(v) Regional best practice should always be co-designed with patients, following the principles of Personal and Public Involvement (PPI);

(vi) An innovation and change programme should be implemented, linked to HSC commissioning plans, to support the development, testing and scaling up of technology and service solutions to deliver consistent best practices related to the Quality Standards;

(vii) Regional systems should be implemented supporting HSC connectivity, electronic transmission of prescriptions and access to the Electronic Care Record, prescribing support, Northern Ireland Formulary and enhanced data analysis;

(viii) Within the HSC a regional organisational infrastructure for medicines optimisation should be maintained that incorporates the Medicines Governance Team, Pharmacy and Medicines Management Team, Regional Pharmaceutical Procurement Service, Medicines Information Service, Medicines Optimisation Innovation Centre (MOIC)

(viiii) A new regional database for medicines optimisation should be developed to monitor progress and enable comparisons regionally and with other UK countries.

6.7 The Framework includes roles for consultant pharmacists and specialist outreach pharmacist working with intermediate care, nursing home settings and GP practices, with links to community pharmacy. The role of nurses and care workers in helping people with their medicines in residential, nursing and domiciliary care settings is recognised as is the need for regional best practices that support clarification of roles, accredited training and systems to support staff.

Patient Focused Approach

6.8 To ensure a more patient focused approach, the initial Standards 1 – 3 inclusive will relate to patient involvement with PPI and their core values underpinning patient engagement including dignity, respect, inclusivity, diversity, equality etc.

6.9 In response to suggestions raised by some respondents, recommendations will be embodied in the better information about medicines standard, including ensuring language relevant to patients is in a style accredited by the plain English campaign. The standard relating to safer transitions of care will include recommendations that patients will have access, wherever possible, to ECR and/or a patient passport and are aware of whom else has what information, under what circumstances and with what safeguards.

6.10 Some respondents suggested wider engagement with patients and community based organisations, as well as discussions with healthcare professionals, to clarify roles and responsibilities regarding medicines. It was suggested that the work of the MOIC should involve a comprehensive network of key stakeholders across all sectors within the HSC including community pharmacy. To this end, the revised framework will contain a more comprehensive list of key stakeholders contributing to the work of MOIC, including patients and their representative bodies.

Regional Action Plan

6.11 A Regional Action Plan for medicines optimisation will prioritise activities in a regional change programme of research, service development and translation with clear outputs and timelines for developing, testing and implementing solutions.

6.12 The action plan methodology will include:

* Baseline assessment of activities either commenced or in development relating to each quality standard;
* Stratification of activities identifying those capable of informing regional versus local best practice;
* Agreement with commissioners of the priority and timescales related to the activities;
* Analysis of the activities identifying required actions, timescales and costs and whether they are immediate, short term, long term.

Monitoring Progress, Governance and Accountability

6.13 A proposed new regional data base will allow commissioners and policy leads to monitor progress and enable comparisons regionally and with other UK countries.

6.14 Development of the regional data base will include: a Medicines Optimisation Dashboard based on that devised by NHS England and relevant NI health surveys relating to patients’ experiences of medicines.

6.15 To support governance and accountability, implementation of the Framework will be monitored by DHSSPS through existing arrangements that are in place for HSC commissioning plans.

6.16 While formal and continuous monitoring of targets and compliance with quality standards will be undertaken by DHSSPS throughout the life span of the Framework, it is envisaged that a fundamental review of its implementation will be conducted in 2021.

6.17 There was some ambiguity among some respondents as to whether the NICE Guideline NG5 Medicines optimisation or the MOQF would take precedence in terms of implementation. The MOQF will set the overall strategic direction for reform in the HSC over the next 5 years. NICE guidelines will support the MOQF and help inform practice during that period. NICE Quality Standards may also be useful although they are not currently endorsed by the Department and are not mandatory within the HSC.

Issues Outside the Scope of the Framework

6.18 The potential for reintroduction of prescription charges is outside the scope of the Framework.

**7. HUMAN RIGHTS AND EQUALITY IMPLICATIONS**

7.1 There were 24 responses to each of the 4 questions (numbers 17 to 20 inclusive) relating to human rights and equality of opportunity. No new equality implications have been identified which would have a significant impact on any of the Section 75 groups of the NI population.

7.2 Pre consultation and in accordance with guidance produced by the Equality Commission for Northern Ireland and in keeping with Regulation 75 of the Northern Ireland Act 1998, the Department had reached a preliminary decision that a full Equality Impact Assessment was not required*.* Following a review of the consultation responses the Department has updated the equality screening and has reached a final decision that a full Equality Impact Assessment is not required.

1. **SUMMARY**

8.1 The Department would like to thank all organisations and individuals who participated in this consultation and values the views of those with professional or personal experience in this area.

8.2 All comments and suggestions have been noted, are being considered and will continue to shape the way in which medicines optimisation is taken forward in Northern Ireland as well as informing the final Medicines Optimisation Quality Framework.

**Annex A**

**Respondents to the consultation**

Belfast Health & Social Care Trust (Head of Pharmacy & Medicines Management)

Belfast Health &Social Care Trust (MPH)

Boehringer Ingelheim

BMA NI

British Heart Foundation NI

Community Development and Health Network

Community Pharmacy NI

Crohn's and Colitis UK

General Medical Council

GlaxoSmithKline

Guild of Healthcare Pharmacists

Integrated Care Partnership, Antrim/Ballymena

Kinnear Consulting

Northern Health & Social Care Trust (Interface Pharmacist Specialist Medicines)

NI Practice and Education Council

NI Rare Disease Partnership

NPA

Parkinson’s UK

Patient Client Council

Pharmacy Forum NI

Prescription Charges Coalition

PSNI

RCGP

Royal College of Nursing

Royal College of Physicians

Southern Health & Social Care Trust (Palliative Care Pharmacist)

Southern HSCT (Clinical Pharmacy Services Manager)

South Eastern Health & Social Care Trust (Lead Pharmacist)

UCA

Walgreens Boots Alliance

Western Health & Social Care Trust (Consultant Psychiatrist)

Western Health & Social Care Trust (Head of Pharmacy & Medicines Management)

Western Health & Social Care Trust (Lead Nurse Governance and Performance)

Western Health & Social Care Trust (Pharmacist)

1. The other 10 responses could not be included in this summary as they used their own format. Their responses were considered separately.
 [↑](#footnote-ref-1)