Medicines Optimisation
Opportunities and Examples, Challenges on levels of engagement/knowledge

Presented by Dr Jill Loader,
Regional Pharmacist, NHS England South

Optimising the use of medicines for respiratory disease across the South West
1st October 2013
Medicines Optimisation – The Policy Context

• Put patients at the heart of everything the NHS does ("No Decision About Me Without Me")

• Focus on continuously improving those things that really matter to patients - the outcome of their healthcare

• Empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services
“Pharmacists working with doctors and other health professionals, have an important and expanding role in optimising the use of medicines and in supporting better health”

“The community pharmacy contract, through payment for performance, will incentivise and support high quality and efficient services, including better value in the use of medicines through better informed and more involved patients”.
Medicines Optimisation Principles

Improved patient outcomes

Patient-centred approach

Principle 1
Aim to understand the patient’s experience

Principle 2
Evidence based choice of medicines

Principle 3
Ensure medicines use is as safe as possible

Principle 4
Make medicines optimisation part of routine practice

Aligned measurement & monitoring of medicines optimisation
Opportunities and Challenges
Pre April 2013

Commissioning essential, advances and enhanced Pharmaceutical services

Medicines optimisation  
Medicines safety

Pharmaceutical Needs Assessment

Access to medicines out of hours

Contract monitoring

Complaints

Transfers of care

Consultation with LPC

Accountable officer for Controlled Drugs and LIN

Public Health

Pharmaceutical Applications

Medicines QIPP

Waste medicines

Care Homes

Patient engagement

Clinical leadership and engagement

Medicines strategy

Poor performers

Fraud

Accreditation
Post April 2013

Commissioning essential, advanced and enhanced Pharmaceutical services

Medicines optimisation
Medicines strategy
Quality improvement
Clinical leadership and engagement
Patient engagement
Transfers of care
Medicines safety
Access to medicines out of hours
Waste medicines
Safe use of controlled drugs
Patient pathways
Networks

Accountable officer for Controlled Drugs

Pharmaceutical Applications

Consultation with LPC

NHS England

Pharmaceutical Needs Assessment (H&W Boards)

LAs

Direct commissioning of public health services from pharmacy

Care Homes

Medicines QIPP

CCGs

Primary care prescribing

Commissioning services direct from pharmacy e.g. minor ailments, palliative care medicines

Public Health

Contract monitoring

Fraud

Accreditation

Complaints

Poor performers

Contract monitoring
### Different Types of Network

<table>
<thead>
<tr>
<th>NHS Outcomes Framework</th>
<th>Senates [12]</th>
<th>Strategic Clinical Networks</th>
<th>Local Professional Networks</th>
<th>Operational Delivery Networks</th>
<th>Other Local Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The conscious and guiding intelligence&quot;</td>
<td>&quot;Engines for change and improvement across complex care systems&quot;</td>
<td>&quot;Gathering frontline knowledge and expertise&quot;</td>
<td>&quot;Mapping patient pathways to ensure access to specialist support&quot;</td>
<td>&quot;15 AHSNs: Masters of science and evidence based practice&quot;</td>
<td></td>
</tr>
</tbody>
</table>

#### Multi-professional
- i.e. Cancer; CVD; Maternity and Children’s; Mental Health / Dementia / Neurological Conditions
- i.e. Pharmacy; Eye health; Dental
- e.g. Adult Critical Care; Neonatal Intensive Care; Trauma; Burns; Paediatric NM; Paediatric IC
- e.g. Academic Health Science Networks, Research Networks

#### NHSCB Network Support Teams (AT-based)

**Annual national priorities from the NHSCB Medical and Nursing Directorates**
All supported by Improvement Body and Leadership Academy
Effective Patient Involvement

- Clearly define remit of each member of group
- What is needed and why and what they will get out of it
- Make sure patient reps are properly prepared
  - appropriate background
  - a good pre-brief (include roles, jargon, expectations, behaviours)
  - opportunity to ask questions in a non threatening environment
- Ensure support available from both an NHS buddy and another patient rep
- Be clear about training provided, claiming expenses etc.
- Keep engaged and give regular feedback re the difference their contribution is making
Almost 1 million people across London who were eligible for a seasonal flu vaccination had not received one in 2012/13.

Rotavirus and shingles more pressure on existing system.

Outcome needed to decrease overall impact of seasonal flu.

Less commissioning capacity in NHS England.
NHS England - London

- New service level agreement, service specification, single Patient Group Direction
- Agreed criteria for accreditation of pharmacists and premises, list of training providers, assessment of competency of new vaccinators
- IT platforms - Expressions of Interest and distribution of documents, as well as data collection and transfer of certain data to GP systems to allow them to update their information (and thereby inform the NHS England data collection), and invoicing NHS England
Working differently

- The design, production and delivery of posters and leaflets which NHS England has commissioned from the National Pharmacy Association.
- The LPCs taking responsibility for communication with their contractors rather than this coming directly from NHS England.
- The LPCs also taking responsibility for discussions with manufacturers and wholesalers to ensure sufficient supply of vaccine stock for community pharmacies.
Surrey and Sussex Partnership NHS Trust

- Medicine-taking has a huge impact on recovery and outcomes in mental health
- Side-effects, disease symptoms and chaotic lifestyles are real problems and adherence is notoriously poor.

Lisa Stanton, Specialist Pharmacist Early Intervention & Learning Disabilities
We are really getting to understand views and beliefs of individuals and their families about medicines at the outset of treatment, using evidence-based motivational interviewing techniques and joint decision-making to increase the likelihood that medicines will be taken and ultimately improve recovery and long term outcomes.
Adherence therapy intervention in early psychosis: effect on relapse rates, Prof Richard Grey UWE

The best medication in the world is ineffective unless people take it.

http://www.adherencetherapy.co.uk/clinical-evidence.php 25/9/13
Key elements of adherence therapy

- A structured assessment
- Dealing with resistance
- Exchanging information
- 5 key skills: problem solving; looking back; exploring ambivalence; talking about beliefs about medication; looking forward.
Case study 2

Medication: Olanzapine

Olanzapine (often known by one of its trade names Zyprexa®) is an antipsychotic or neuroleptic, used to help treat the symptoms of schizophrenia, psychosis, mania or hypomania in bipolar mood disorder (manic depression) and to prevent these symptoms coming back. It can also be used for many other symptoms and conditions.

Olanzapine is available as tablets, melt-in-the-mouth tablets, a short-acting injection* and a depot (or long-acting) injection (Zypadhera®), which has its own section and Patient Information Leaflets. Olanzapine was first made available in the UK in 1996. It is widely used across the whole of the world for many symptoms and is one of the most prescribed medicines of this type.

If you want to see all the questions and answers in full click the “Show answers too” button.

*The short-acting injection was discontinued in UK in August 2012 for economic reasons (i.e. it wasn't being used enough) but is still licensed in UK and available in the rest of the world.

Updated 11.12

Where can I print information about olanzapine?
WHAT IT IS:
What is olanzapine used for?
What is the usual dose of olanzapine?
What are the alternatives to olanzapine?
How does olanzapine work?
STARTING, TAKING AND STOPPING:

http://www.choiceandmedication.org/sussex/medications/21/
Case study 3

Impact Bristol in partnership with Teva

Cumulative Total Admission Episodes (Asthma Primary Diagnosis) 10/11 and 11/12

- 09/10 Admissions 533
- 10/11 Admissions 495
- 11/12 Admissions 375

Chart shows the number of admission episodes for asthma primary diagnosis from April to March, with a comparison between 10/11 and 11/12.
**Results of Asthma Directed Medicines Use Review (MUR)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient had an asthma review in the last 12 months?</td>
<td>Yes: 63.4</td>
</tr>
<tr>
<td></td>
<td>No: 36.6</td>
</tr>
<tr>
<td>Is the patient experiencing symptoms of poor asthma control? (Using the 3 RCP Asthma Control questions)</td>
<td>Yes: 55.9</td>
</tr>
<tr>
<td></td>
<td>No: 44.1</td>
</tr>
<tr>
<td>Is the patient adherent to their inhaler medication regime?</td>
<td>Yes: 72</td>
</tr>
<tr>
<td></td>
<td>No: 28</td>
</tr>
<tr>
<td>Did the patient have the correct inhaler technique?</td>
<td>Yes: 68.8</td>
</tr>
<tr>
<td></td>
<td>No: 31.7</td>
</tr>
<tr>
<td>Did the pharmacist provide advice to the patient, as a result of something they identified during the MUR?</td>
<td>Yes: 89.6</td>
</tr>
<tr>
<td></td>
<td>No: 10.4</td>
</tr>
<tr>
<td>Did the pharmacist demonstrate correct inhaler technique to the patient?</td>
<td>Yes: 56.3</td>
</tr>
<tr>
<td></td>
<td>No: 43.7</td>
</tr>
<tr>
<td>Is the patient using their peak flow meter at least once a week and recording the results in their diary? (Once weekly as recommended by respiratory clinicians)</td>
<td>Yes: 12.5</td>
</tr>
<tr>
<td></td>
<td>No: 87.5</td>
</tr>
<tr>
<td>Does the patient have an asthma action plan (so they know what to do in an asthma attack)?</td>
<td>Yes: 19.5</td>
</tr>
<tr>
<td></td>
<td>No: 80.5</td>
</tr>
<tr>
<td>Is the patient a smoker?</td>
<td>Yes: 27</td>
</tr>
<tr>
<td></td>
<td>No: 73</td>
</tr>
<tr>
<td>If smoker, did the pharmacist sell NRT to the patient or refer them to smoking cessation services?</td>
<td>Yes: 75.3</td>
</tr>
<tr>
<td></td>
<td>No: 24.7</td>
</tr>
<tr>
<td>Did the pharmacist identify any concerns during the MUR which necessitated referring the patient back to their GP/Asthma Clinic?</td>
<td>Yes: 54.2</td>
</tr>
<tr>
<td></td>
<td>No: 45.8</td>
</tr>
</tbody>
</table>
ACT on Asthma Programme

- 90% of deaths from asthma are potentially preventable (Asthma UK)
- 75% of hospital admissions for asthma are avoidable (Asthma UK)
- Non adherence results in poor outcomes, Lasmar et al, 2009
- Non-adherence aggravates airway inflammation which may result in exacerbations, need for health care intervention and even death. Williams et al 2004, Bender et al 2004

Rowlands Pharmacy and GSK
Case study 4

ACT on Asthma

- 419 community pharmacies, 3737 asthma patients
- Intervention ACT 1 $\rightarrow$ tMUR $\rightarrow$ ACT 2
- 1445 patients tMUR (or CMS) and both tests within timescale
- 982 (68% improved ACT score)

<table>
<thead>
<tr>
<th></th>
<th>ACT 1</th>
<th>ACT 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total control (25)</td>
<td>5.3%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Well controlled (20-24)</td>
<td>29.2%</td>
<td>48.0%</td>
</tr>
<tr>
<td>Uncontrolled (&lt;20)</td>
<td>65.5%</td>
<td>41.9%</td>
</tr>
</tbody>
</table>
The causes of medication non-adherence are complex but observational studies suggest that failure to elicit and address patients’ individual circumstances and goals or preferences regarding their regimen may contribute to treatment non-adherence. Osterberg and Blaschke, 2005