National Institute for Health and Care Excellence

Medicines Optimisation

Stakeholder Comments – Draft scope

Please enter the name of your registered stakeholder organisation below. **NICE is unable to accept comments from non-registered organisation or individuals. If you wish your comments to be considered please register via the NICE website or contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.**	
Stakeholder organisation:	**Royal Pharmaceutical Society**
Name of commentator:	**Heidi Wright**

Comment No.	**Section number** Indicate **number** or **'general'** if your comment relates to the whole document	**Comments** Please insert each new comment in a new row. Please do not paste other tables into this table, as your comments could get lost – type directly into this table
1	3a	**Definition of medicines optimisation**: The definition of medicines optimisation should be more positive and action and patient focused. It should start more along the lines that "*Medicines optimisation is the result of actions taken by patients and their healthcare professionals and carers to obtain the best outcomes…"* This makes it clear that medicines optimisation is about individuals' actions and actions taken for individuals, rather than system wide changes (as in medicines management). The current definition (Para 3a) does not seem to apply to anyone and is unlikely to be helpful in practice (i.e., to those working in patient-facing care). The definition should place greater emphasis on ■ Actions taken by individuals working directly with patients ■ Taking actions that make situations easier or better for patients (in regard of medicines) ■ Keeping situations under review and involving patients and/or carers in decisions ■ Collaborations between healthcare professionals and sharing relevant information about changes ■ Actions not systems ■ That medicines optimisation has to be an issue with pharmacy at its heart

2	General	**Breadth and depth of medicines optimisation**: Medicines optimisation will involve or require high quality prescribing, but that is not enough in itself. For example, the prescription may be clinically correct and in compliance with all relevant NICE, NHS or professional guidance, but if the patient is physically unable or is unwilling to take the medicine as prescribed then the medicine taking cannot be described as optimal. Other issues, beyond prescribing, can affect medicines taking, including the use of other prescription and non-prescription medicines, patients' physical or mental conditions, patients' beliefs, experiences, attitude and cultural influences, care issues, eyesight, etc. Pharmacists are experts in all aspects of medicines development, procurement, supply and support and should be at the heart of the medicines optimisation process. Medicines optimisation is also about minimising harm and risks from medicines. The risks of medicines can change with age so medicines optimisation has to be an ongoing process to ensure patient safety. More thorough and regular medication reviews (undertaken by pharmacists) could have a positive impact on minimising risk and improving patient safety, particularly for those patients who are vulnerable.
3	General	**Groups to be covered**: The guidance should make specific mention of those who supply medicines (predominately pharmacies) and those who give advice about medicines taking (e.g. pharmacists working in community, primary care and secondary care settings)
4	4.1.1 a	**Groups covered:** Patients who reside in Care Homes or other institutions such as patients with learning needs should be a particular additional group that is covered by this guidance.
5	4.1.1 b	**Groups covered**: This should be expanded to specifically cover "All practitioners who supply or administer medicines to patients" and "All practitioners who give advice on medicines and their use to patients and health care professionals" We would consider the term "administer" to refer only to the physical activity of giving medicines to individuals at a specific time of day, rather than those who supply whole courses of medicines to be taken by patients (or administered by other carers or professionals)
6	4.3.1	**Areas that will be covered: Transferring medicines information across care settings (g) and Reducing preventable medicines-related admissions and re-admissions (h).** Referring to *practitioners with a medicines optimisation remit* contradicts the importance of multidisciplinary team working and the role all health care professionals play in medicines optimisation in all healthcare settings. We believe that pharmacists have the skills and knowledge to lead and play a pivotal role in the delivery of medicines optimisation but other healthcare professionals also need to be involved. Referring specifically to practice-based pharmacists and medicines management discharge technicians may limit the perceived applicability of this short Clinical Guideline as medicines optimisation should not be perceived solely for these categories.

7	4.3.2	**Areas that will not be covered**: We strongly believe that it is not possible to separate medicines optimisation and medicines adherence. The ultimate goal of medicines optimisation is to ensure better adherence to medicines with the aim of getting the best outcomes for patients from their medicines. Medicines optimisation without medicines adherence is pointless. We believe that it is perverse to artificially consider medicines optimisation and medicines adherence as separate topics. In our view, the entire aim of medicines optimisation is to maximise medicines adherence with the aim of getting optimal outcomes. The two are inseparable, in our opinion as even if you prescribe the right medicines for the right patient at the right time, if the patient is not supported to take that medicine through a shared decision making process then they are unlikely to achieve the best outcomes possible. Medicines adherence, therefore, Medicines Optimisation, could also result in patients choosing not to take a particular medicine as part of an informed, shared decision making process. Although the NICE adherence guidance will be signposted as an additional resource, it will be one among many and we believe that medicines adherence needs to be integral to the MO guidance. There should be references made, and support of, evidence based interventions on medicines adherence.
8	4.5	**Review questions**: Questions e) and f) concentrate only on "safe and effective prescribing". As described in Comment 2 above, effective prescribing is only a part of the wider goal of medicines optimisation. Good prescribing without medicines adherence will not achieve the best outcomes for patients.
9	4.5	Given that "medicines optimisation" is a relatively new piece of terminology, and that there is still considerable discussion within the NHS as to its full meaning, we question what value will be achieved from a systematic literature search using only this term. The review will need to take account of literature using related terminology, including "medicines adherence", "concordance", "compliance", "pharmaceutical care" among others.
10	General	We believe that the guidance should also examine where interventions to increase medicines optimisation can be undertaken (e.g. GP surgeries, pharmacies, hospitals, clinics, outreach) and who should be involved (e.g. prescribers, pharmacists, patients, carers).
11	General	The guidance should be explicit that medicines optimisation has to happen at a patient level to be effective. It is not a "systems approach". Although having the right environment in which to deliver medicines optimisation will require the right systems, such as contractual arrangements etc, to be in place.
12	General	Prescription charges have been shown to be a barrier to effective medicines-taking behaviour with a survey of nearly 4,000 people with long-term conditions in England (*Paying the Price*, March 2013, www.prescriptionchargescoalition/paying_the_price.pdf) showing that one third of those with long-term conditions who are paying for each prescription item had not collected medication due to the cost. Three quarters of this group reported that their health got worse as a result, with 10% reporting that they were hospitalised as a direct consequence. Survey respondents also reported cutting pills in half, missing doses or substituting cheaper over-the-counter alternatives to eke medicine out for longer because of the cost. This also needs to be taken into account when optimising medicines for individual patients.

Please add extra rows as needed

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Closing date: **5pm on 4 October 2013**

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