

Service Specification No.	
Service	Concordance Support levels 1 & 2 – Community Pharmacy local service
Commissioner Lead	Pharmaceutical Adviser - Robert Brownsmith
Provider Lead	Community Pharmacy professionally supported by the Local Pharmaceutical Committee
Period	April 2019 – March 2021
Date of Review	March 2021

1. Population Needs

1.1 National context and evidence base

The treatment of most long term conditions includes medication, but up to 50% of medications are not taken as the prescriber intended. The reasons for non-compliance are multifactorial and include both intended non-compliance as well as unintended non-compliance.

This country's ageing population is now receiving about 50 per cent more prescriptions items per head for the prevention and treatment of conditions such as heart disease, stroke, diabetes, COPD and asthma than was so in the early 1990s . Yet problems with taking medicines are exacerbated in the elderly. Polypharmacy is a particular issue, where eight out of ten people over the age of 75 years are prescribed at least one medicine, and three out of ten people are taking four or more medicines; it is not an unusual for some elderly people, with multiple chronic conditions, to be prescribed 10 or more medicines. Not only the quantity of medications can cause problems but also the physical effects of ageing, such as arthritis and failing eyesight and memory, can also cause significant issues in taking medication effectively.

Good compliance with medicine can prevent disease progression and some foreseeable traumatic medical episodes requiring hospital admission. Examples include heart attack, stroke, exacerbations of COPD, asthma and some hyperglycaemic episodes. Numerous studies have been cited about the related costs associated with poor compliance. Increases in both finance related to greater health treatment costs and reduction in quality of life both can be attributed to poor compliance and the associated unplanned treatment of exacerbations and critical events. (York Study 2010 - Estimating the Cost of Waste Medicines in the National Health Service Chapter 5 The Economic Impact of Poor Compliance)

Local context and evidence base

There are 13551 people over the age of 75 living in Portsmouth (census 2011). There are an estimated 4900 people, in this age band, on 4 medicines or more.

Latest statistics show 2142 Portsmouth residents will have some form of dementia. 55% (1178) will be mild, 32% (685) will be moderate, and 13% (279) will be severe. There will be 1669 living in the community. (Portsmouth JSNA 2013)

It is estimated that approximately 800 people in the city receive various levels of social care to support their independence at home.

In 2008 Portsmouth tPCT set up an Intermediate Care Pharmacy service to support medicine taking for the most *vulnerable* people. Due to organisational changes this service

is now hosted by NHS Solent and has been renamed as ‘Medicines Advice at Home’ (MAH). Though there are no age constraints on patients referred to this service, more than 90% of referrals are for the very elderly. These vulnerable patients are often housebound or unlikely to be able to visit their Community Pharmacy.

This pharmacy team has a spectrum of support for any individual with problems taking their medicines using the principles of medicines optimisation.

(<https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/helping-patients-make-the-most-of-their-medicines.pdf>)

This ranges from: medication review, synchronising medicines, auditing medicines taken with GP held records, compliance cards, tick charts and one off aids. However, regular ongoing patient support from their local community pharmacy (which is not within the regular NHS terms of service,) has often been identified as the best option for many scenarios. This support may include provision of Medicine Administration Record (MAR) charts or monitored dosage system with additional monitoring for individual patients.

This associated community pharmacy commissioned service has been developed to support the work of the MAH team to provide the best support for individual patients in taking their medication. The service will remunerate ongoing supply of medication recording charts and monitored dosage systems from pharmacies, against a 28 day prescribing period, for those patients who have been appropriately assessed as in need of this level of support. This service specification allows prescribers to order in 28 day periods and facilitates weekly dispensing of medicines and weekly supply of MDS as recommended by the MAH service.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

To give appropriate support as *designated* by NHS Solent Medicines Advice at Home Service, which complies with national and local guidance.

3.1 Aims and objectives of service

3.1.1 To support independent living.

3.1.2 To help people manage their medicines safely and appropriately.

3.1.3 To support people to access their medicines.

3.1.4 To reduce wastage of medicines.

3.1.5 To improve patient compliance with therapy by:

- improving the patient's understanding of their medicines;
- where possible, simplifying the medicines regimen and ordering process
- identifying practical problems in taking their medicines and where appropriate providing compliance aids
- providing advice and support to the patient and/or carer, including referral to other health and social care professionals where appropriate.

3.1.6 To negate the need for 'seven day' prescriptions and to encourage appropriate treatment periods.

3.2 Service description/care pathway

3.2.1 The pharmacy will help support independent living of patients referred by the MAH service.

3.2.2 Patients will be eligible for support from this service through referral from the MAH service.

3.2.3 The pharmacy may support the patient with advice, education, and agreed compliance aids including Monitored Dosage Systems, home delivered if appropriate as specified by the MAH team on their referral form. Due regard should be given by contractors to the detail of the form. Service users will have had a patient-centred consultation and been asked about their lifestyle e.g. timing of care visits, attendance at regular clubs etc. This is to help the Contractor avoid missed deliveries and their patients avoid missed doses. The referral will be sent to the Pharmacy's NHS.net email address.

3.2.5 The payment for the service will be remunerated at staged levels to reflect the costs associated with supplying different compliance aids and the need for ongoing support.

3.2.6 The service offers 3 levels of support:

Level 1 –Medication administration record charts

3.2.6.1 Medication administration record charts will be a printed record describing the complete list of prescribed medication taken/used by the patient and will include sufficient instructions to enable the carer to support medicine taking at the right dose and at the right time.

Level 2 - Monitored Dosage System.

3.2.6.2 Monitored Dosage System

a) The preferred monitored dosage system to be used is Nomad® Clear and/or Nomad® Duo. This system must be used where ever possible to support consistency with secondary care and the training of carers in MDS use. In-house systems used by different pharmacies will be considered for recommendation on a patient basis. The patient will be supported to choose a pharmacy offering their preferred solution if their current pharmacy is unable to help.

b) If a requirement for a compliance aid is identified then this will be provided with training for the patient and/or carer if appropriate.

c) Prescriptions supplied with a treatment period of 28 days will be funded to support the delivery of this service

d) Prescriptions written for 7 day treatment periods will not attract additional funding.

Level 3 - Assistive Technology medication device - See separate service specification for full specification. Not all community pharmacies will have been commissioned to provide the Level 3 service.

3.2.7 The Contractor will ensure that the patient or carer, understand and are comfortable with their medication regimen. Including:-

- How and when the device will be made available
- How to use the device
- Contact details (with a named lead) for the pharmacy for any issues, notification or problems
- Disposal of used/ unwanted MDS systems which still contain medication.
- Particular attention must be given for those medicines not included in the MDS such as eye drops, inhalers and 'when required' medication. The patient and/or their carer must understand how to manage these medicines and how they will be re-ordered and supplied.

3.2.8 The Contractor will discuss, as appropriate, any difficulties experienced with the medication regimen with the patient's GP and/or the MAH service.

Examples of this include;

- When MDS is being returned with significant medication untaken.
- When concerns are raised by delivery staff about the wellbeing of the patient.

3.2.9 After the initial 3 months the contractor will be expected to undertake a medicines use review (MUR) for each patient who is able to attend the pharmacy and is receiving medication in line with one of the national target groups for MURs. (Fees for MUR service are claimed through the national contractual framework mechanism and are not part of this specification.)

3.2.10 The contractor may choose to deliver a MUR service to housebound patients. In these circumstances the contractor must operate within the service specification:-

(The link to the national policies that cover MURs is as follows:

<https://psnc.org.uk/services-commissioning/advanced-services/murs/>

For MURs in people's homes, the pharmacist needs to have a Disclosure and Barring Service certificate and submit a 'Prem 2' form for each patient and on each occasion.

<http://psnc.org.uk/services-commissioning/advanced-services/murs/conducting-murs-off-the-pharmacy-premises/>)

Again, fees for MURs are claimed through the national contract, there are no additional local fees for this level service.

3.2.11 The contractor will regularly make contact (e.g. by telephone or face to face) with the patient and/or carer to ensure that the compliance support is still suitable. In many situations this may be monthly when checking the need to re-order medicines. For those patients who look after their own prescription re-ordering, then contact should be made at intervals deemed professionally necessary and should not be less than every 3 months.

3.2.12 The contractor will support mid-cycle changes to medication in order to keep the patient's medication up to date. Prescription requests should be made in line with CCG and PSNC guidance

<http://www.pip.portsmouthccg.nhs.uk/MedManagement/InformationforCommunityPharmacy/Home%20Visiting%20%20Intermediate%20Care%20Pharmacy%20Team%20Sol/7%20Day%20Prescriptions%20and%20Monitored%20Dosage%20Systems%20Guidance%20November%202016.pdf>

Provided as an appendix for those unable to access nww web addresses.

<http://psnc.org.uk/contract-it/pharmacy-regulation/dda/the-equality-act-2010-28-day-prescribing/>

3.2.13 Contractors will notify MAH (via NHS.net or telephone) of requests from secondary care to continue 'Nomads' initiated in hospital for patients that did not previously have one, if indeed the Contractor is able to meet such a request. The tight timescales often involved (QA are contracted to provide 7 days TTO in a Nomad) mean that the contractor may be assured of a Pharmoutcomes® claim reference pending a visit by a MAH technician (MAHT.)

3.2.14 If a Contractor is unable to provide the appropriate necessary support identified then they must inform the MAH team.

3.2.15 Pharmacists may need to share relevant information with other health care professionals and agencies, in line with locally determined confidentiality arrangements. This may require, where appropriate, the permission of the client to share the information.

3.2.16 The Contractor will make necessary referrals to other health and social Care professionals as appropriate using whichever method of communication is agreed locally.

3.3 Population covered

This is a service for patients registered with NHS Portsmouth CCG member General Practices. The service is for vulnerable patients, of any age, who have been identified as needing additional assistance in managing their medicines, which is outside the requirements of the NHS contractual framework. The referral will be made by the MAH Service

3.4 Any acceptance and exclusion criteria and thresholds

There are no additional acceptance or exclusion criteria.

3.5 Interdependence with other services/providers

3.5.1 The service supports the work of the MAH team. Referrals will be directed by that team.

3.5.2. This client group would also represent a target group of patients to benefit from the national Medicine Use Review Service and /or New Medicine Service, if they fulfill national criteria.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.1.1 NHS Contractual Framework for Community Pharmacies Essential Services (particular reference to Dispensing, Delivery of Medicines, Equality assessment and Clinical Governance standards)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.2.1 The contractor should follow guidance and national standards;- Medicines, Ethics and Practice- the professional guide for pharmacists (Royal Pharmaceutical Society (updated annually))

4.2.2 Improving Patient Outcomes – the better use of multi-compartment compliance aids (Royal Pharmaceutical Society July 2013)

5. Applicable quality requirements and CQUIN goals

5.1 The pharmacy reviews its standard operating procedures and the referral pathways for the service on an annual basis.

5.2 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service are aware of and are appropriately trained in the operation of the service.

5.3 The pharmacy can demonstrate that pharmacists and staff involved in the provision of the service have undertaken CPD relevant to this service.

5.4 The pharmacy participates in a CCG organised audit of service provision if requested This will be no more than annually if requested following consultation with CPSC.

5.5 The pharmacy co-operates with any locally agreed CCG led assessment of service user experience.

5.6 The pharmacy should maintain appropriate records to ensure effective ongoing service delivery and audit. The MAH referral form should be kept for reference and proof of a valid claim, even if it is transcribed to a working document.

5.7 The contractor will ensure that suitable Disclosing and Barring Service checks have been carried out on staff and a 'Lone Worker Policy' is in place when it is necessary to visit a patient at home.

5.8 The contractor will submit data, in a timely manner via PharmOutcomes® to support monitoring of the service and payment claims.

6. Location of Provider Premises

The Provider's Premises are located at any Community Pharmacy within the city.

This contract is on offer to any community pharmacy within the city boundaries.

Remuneration will depend on the pharmacy having patients who require this service.

7. Individual Service User Placement

7.1 Payments

7.1.1 Payments will be made quarterly in July, October, January and April following each complete financial quarter

7.1.2 Payments will be based on invoices generated by PharmOutcomes® based on the data entered by each provider.

7.1.3 The current fees are;-

£3 each calendar month for supply of authorised Medication Administration Chart

£15 each calendar month for supply of monitored dosage unit provided against 28 day prescription (please note that monitored dosage systems dispensed against 7 day

prescriptions do not attract any fee)

7.2 Confidentiality

7.2.1 The Pharmacist(s) and their staff must not disclose to any person other than a person authorised by the CCG, any information acquired by them in connection with the agreement or the provision of the service(s).

In particular this concerns;-

7.2.2 Any approaches by the media for comments or interviews may not be answered without permission of the CCG.

7.2.3 Any approaches by media outlets to discuss the service must be directed to the CCG communications team.

November 2016

Local Guidance for GP practices and Community Pharmacies on managing new requests for patients wishing to start a pharmacy filled Monitored Dosage System (MDS).

1. **New patients** – For requests made directly to GP practices (or patients identified by GPs) to start a supply of MDS, then it is recommended that the practice contacts the Intermediate Care Pharmacy team via Single Point of Access (SPA). (See attached leaflet). This team is able to carry out an assessment of the patient's medicine management needs and make recommendations to improve compliance. They are also gatekeepers to the funded MDS service commissioned by the CCG. If an MDS is needed then a 28 day prescription would be requested from the practice.
2. **New patients discharged directly from Queen Alexander Hospital** – For patients who are started on MDS in hospital, arrangements are being made for the hospital pharmacy to directly inform the Intermediate Care Pharmacy Team, GP practice staff will not have to make the referral through SPA. However patients discharged from step down units such as Victory and Spinnaker will require a referral.
3. **Existing patients on MDS-** The majority of patients receiving an MDS system, in their own home, are accessing its use from outside the provisions of the CCG locally commissioned service. It is estimated about half of these patients have 28 day prescriptions and half 7 day prescriptions. **Arrangements between GP practice, patient and community pharmacy that are already in place should not be changed unless there is agreement between all three parties to do so.** This may include provision of 7 day prescriptions, in these circumstances pharmacies should dispense and supply the device on a weekly basis and should not supply 4 x 7 days at a time.
4. **Patients in care or nursing homes-** A request to supply medicine in MDS for care or nursing homes is for the benefit of their care staff. These arrangements are between the community pharmacy and the care home. GPs should not give 7 day prescriptions for this purpose unless there is a clinical need.
5. **Requests made at community pharmacy.** The responsible pharmacist should carry out an assessment of the patient needs that complies with the Equality Act 2010. If the patient has a relevant disability then an MDS system may be an appropriate adjustment to help them manage their own medicines for themselves, (depending on the type of medicine taken and the cognitive problems the patient is coping with.) It is anticipated this adjustment should usually be provided against a 28 day prescription.

Patients not covered by the Equality Act assessment should be signposted to their GP, who can make the decision to refer the patient into the Intermediate Care Pharmacy team service. Occasionally a pharmacy may choose to supply an MDS under goodwill, eg a long term customer or for commercial reasons, or can even choose to charge the patient for a private service. There should be no adjustment of prescription duration by the GP practice in these circumstances.

Further guidance for Community Pharmacy is available on the PSNC website;

<http://psnc.org.uk/contract-it/pharmacy-regulation/dda/the-equality-act-2010-28-day-prescribing/>

This additional guidance is to support the management of patients across a wider range of scenarios as NHS Portsmouth CCG only has a limited service for providing MDS not eligible under the equality act.

Frequently Asked Questions on use of Monitored Dosage Systems in the community.

The following attempts to answer some of the commonly asked questions about MDS.

a) What are Monitored Dosage Systems, MDS?

MDS describes a range of medicine storage devices divided into compartments relating to days of the week and times of the day. Tablets and capsules can be 'popped' into these compartments. The device then acts as an aid memoire as to when medicines are due to be taken.

Many patients do choose to purchase their own devices and fill them once a week from their own supply of medicines. This is acceptable, the patient is managing their medicines in a manner that suits them best and they have full access to original pack directions and leaflets. If their own bespoke system works well for them and does not create a potential patient safety risk then it is advised to leave these arrangements in place.

However there is a range of devices designed to be filled, labelled and checked by community pharmacy staff. They are often known by their commercial names eg Nomad®, Dossette® and Venalink® systems. There has been a rising demand for these devices that is becoming unmanageable and this guidance helps to identify when they may be appropriate to be used.

b) What are the demand and the main drivers of MDS use in Portsmouth?

The demand for MDS is increasing in the city and it's estimated that there are between 1500- 2000 of these devices being supplied each week into the community.

There is very little national evidence to support their effectiveness but there is a continuing drive to have medicines supplied in these devices by patients, their family, employed domiciliary care providers, warden controlled homes, social services and some rehabilitation and discharge teams.

c) What are the problems associated with GPs being asked to provide 7 day prescriptions?

GP practices should only issue 7 day prescriptions when there is clinical need. Examples include where there is anticipated a changes in dose or type of medicine over a short period of time. Some patients, typically with learning difficulties or mental health conditions, may require only 7 days' supply (or less) for safety reasons.

There are many problems with issuing 7 day prescriptions to support MDS. These include problems of increased paperwork and administration for both GP and pharmacy practices, the use of electronic repeat dispensing is affecting the way pharmacies can manage these prescriptions, the impact on number of items issued within the CCG which in turns influences some of the overheads charged back to the CCG by NHS England. Both the Pharmaceutical Services Negotiating Committee and General Practitioners Committee agree that issuing 7 day prescriptions is an inappropriate way to manage these devices. It is anticipated there will be updated guidance issued jointly by LMC and LPC in the next few weeks.

d) What is the Portsmouth Intermediate Care Pharmacy team?

This team was set up in 2008 to provide a home visiting service for patients having problems with taking their medicines. There are no restrictions on age of patients they see but the core group of patients are elderly and frail housebound people. They also see patients with learning difficulties and patients with severe mental health problems. The team has also taken on the role of gatekeeping a limited, locally funded service of MDS provision,

commissioned from community pharmacy. This year they will also have some access to digital technology devices e.g. Pivotell®.

Often there are other solutions to their medicine compliance problems, including education, medicine reconciliation, prompt charts, setting up a repeat ordering service with their pharmacy, mobile phone alarms etc. They are many methods available to support people who have difficulty in taking their medicine and sorting out an MDS is only one of many interventions, and one of the most expensive interventions they can make.

NHS Portsmouth CCG has increased the level of funding for this team in view of the increased number of referrals. The previous backlog of referrals has now been dealt with and the team are seeing new referrals within times stated on their leaflet.

The team will accept referrals from GPs, adult social care and community based NHS staff for any compliance problem. More details can be found in the attached leaflet.

e) Is a community pharmacy obliged to dispense medicines in a MDS?

The NHS does not directly fund community pharmacies to dispense medicines in MDS or to supply these devices free of charge. These devices are expensive to buy, costly in labour to fill and label.

However following an assessment of a patient who cannot manage their medicines and meets Equality Act criteria then the pharmacist can make 'reasonable adjustments' to facilitate access by the disabled person, to help them manage their own medicines. This could range from home delivery for housebound patients, easy opening lids; large print labels and possibly this may be an MDS.

The majority of local pharmacies have signed up to the NHS Portsmouth Local Commissioned Service for concordance and so will provide MDS through this scheme for patients who are ineligible for this adjustment via Equality Act assessment. Typically the demand seems to be driven by patients with carers who supervise or prompt their medicine taking.

f) What are the problems with MDS?

- i) They can only be used to store some oral tablets and capsules that are taken regularly. However many people will be taking other medication such as inhalers, liquids, dispersible tablets and when required medication. This means that the patient is running two medication systems and evidence suggest that there is a high risk of missing medicines such as acute antibiotics, liquids and when required medicine. This a key concern for many health practitioners.
- ii) Individual drugs are not labelled, but HCP are relying on descriptions printed on the information sheet supplied with the device. Often patient information leaflets are not stored with the device and can be difficult to find and relate to the individual drugs in the pack.
- iii) Wastage of medicine is high, particularly when 'when required medicines' such as pain relief and constipation are included in the device. If there are any changes to one medication then all the medicines have to be discarded and the prescription for all medicines will have to be re-issued.
- iv) Many medicines are not suitable for including in the device including medicines that are prone to picking up moisture, light sensitive medicine, medicines that need to be stored in the fridge, medicines that are harmful when handle.

- v) Most devices are not tamper proof and so there are increased risks of errors where medicines are moved from one compartment to another either intentionally or non-intentionally.
- vi) If a patient is disinterested or not motivated to take their medicines then packing medicines in MDS is unlikely to make a difference.
- vii) The large number of devices supplied in the city is leading to unmanageable workload for some community pharmacies and GPs.
- viii) There is minimal academic evidence of the effectiveness of these devices in improving compliance and/or reducing hospital admissions.

The exponential increase in use of these devices needs to be addressed to manage these problems and the use of MDS should be reserved for those who most need the device.

g) Can carers give medicines from original packs and not rely on MDS?

The law is the same for medicines dispensed in original packing and MDS and covered by the Medicines Act 1968. Anyone acting under the directions of a prescriber, with the patient's consent can give medicines. Domiciliary care workers must be trained and competent in the administration of medicines before they give any medicines.

h) How should we manage existing patients on MDS being issued with 7 day prescriptions?

Arrangements between GP practice, patient and community pharmacy that are already in place should not be changed unless there is agreement between all parties to do so. These arrangements may have been set in place over many years and may include provision of 7 day prescriptions. Making any changes without proper consultation and assessment would risk the patient being unable to access their device and/or incur considerable extra cost to the pharmacy in supplying these devices, which have been set up under existing arrangements.

However a pharmacy in receipt of 7 day prescriptions should dispense and supply the device on a weekly basis and should not supply 4 x 7 days at a time.

NHS Portsmouth CCG will continue to work with partners including GP and pharmacy practices, LMC & LPC and wider stakeholders including adult social care to reduce the demand and reliance on both MDS and 7 day prescriptions.