Primary Care Commissioning Committee

23 August 2017

Details	Part 1	✓	Part 2		Agenda Item No.	**10**
Title of Paper:	Draft Greater Manchester Medicines Strategy 2017/21					
Board Member:	Margaret O'Dwyer, Director of Commissioning and Business Delivery					
Author:	Andrew White, Medicines Lead, Greater Manchester Health and Social Care Partnership					
Presenter:	Margaret O'Dwyer, Director of Commissioning and Business Delivery					
Please indicate:	For Decision		For Information		For Discussion	✓

Executive Summary

Summary	The attached is a first draft of a proposed Greater Manchester Medicines Strategy. This is an early iteration and the intention is for sign off through the Greater Manchester Governance process in September / October 2017. Comments are invited by Cabinet to inform the development of this strategy.					
Risk	**High**		**Medium**		**Low**	✓
Recommendations	The Primary Care Commissioning Committee is asked to: • Comment on the proposed Greater Manchester Medicines Strategy					

Strategic themes

To deliver improved outcomes and reduce health inequalities for patients through better preventative strategies			
To deliver service re-design in priority areas through innovation			
To develop primary care to become excellent and high performing commissioners			
To develop the CCG leadership to work with the Local Authority to be excellent integrated commissioners			
To develop robust and effective working relationships will all stakeholders and partners to drive integrated commissioning			
To deliver long term financial sustainability through effective commissioning and innovative investment across the wider system			
To develop and influence the provider landscape through development of a Locality Care Organisation (LCO)			
Equality Analysis Assessed?		Supports NHS Bury CCG Governance arrangements	

Greater Manchester Medicines Strategy 2017-2021

"Right medicine to the right person at the right time" or "The safest, most effective place to receive and research medicines

DOCUMENT CONTROL PAGE	
Title of document	Greater Manchester Medicines Strategy 2017-2021
Author's Name	Andrew White/Karen O'Brien
Author's job title	Medicines Optimisation Lead
Document status	Version 0.5
Based on	
Signed off by	
Review date	
Distribution	

Contents

1. Executive Summary

Greater Manchester Health & Social Care Partnership is committed to supporting innovative ways of ensuring that services are safe, that they improve the health and wellbeing of our population and at the same time make the best use of available resources. It is recognised that medicines are the biggest health intervention and as such we have developed this Medicines Strategy to enable patients, health and social care professionals to work together to make the most of their medicines.

This strategy provides strategic direction for actions to optimise and innovation of the use of medicines through evidence based services and technologies and seeks to consolidate good practice and support consistency and quality improvement across Greater Manchester.

Some people maintain a healthy lifestyle without using medicines but for others, medicines play an important part in maintaining their health and treating or preventing illness. However, there is evidence that patients do not always gain the optimal benefit from their medicines and a new approach is needed that focuses on optimising health outcomes when medicines are prescribed, dispensed or administered. 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 gain the best possible outcomes from their medicines."

The purpose of the Greater Manchester Health & Social Care Partnership Medicines Strategy is to demonstrate the vision and objectives for the delivery of the medicines strategy. It identifies the purpose of all medicines in research, self-care, and / or treatment. The Strategy seeks to build on past experience, using existing medicines optimisation services across the Partnership as the foundation for improvement where possible.

The term patient is used throughout this strategy and refers to patients, and their carers. The term medication is used throughout this strategy and refers to prescribed medication, oxygen and medical devices.

The Medicines Strategy and related documents will address the following by describing a patient focused approach in which patients are involved in decisions about their medicines and are supported by multidisciplinary professionals working together to deliver best practice. Within this strategy document three main areas are described, namely:

The Greater Manchester Medicines Optimisation Model – outlines what should be done at each stage of the patient pathway in each of four different settings (hospital, general practice, community pharmacy and social care) to help gain the best outcomes from medicines.

The Quality Standards – address the priority issues for medicines optimisation in Greater Manchester within the three overarching quality domains of safety, effectiveness and patient/ client focus. The Quality Standards describe the best practice that should be delivered in each setting, identify gaps in best practice and the actions needed to address them.

Implementation through an **Integrated Innovation and Change Programme** – applying a strategic approach to support and drive continuous improvement through the development and implementation of best practices in medicines optimisation with the parties below:

- Local Professional Networks
- Primary Care Advisory Group
- Hospital Pharmacy transformation
- Local Representative Committees – Medical, pharmaceutical, optical, dental
- Medicines Optimisation Teams within the Localities.
- Innovation- working with Health Innovation Manchester in collaboration with our

Partners in the Pharmaceutical Industry.

2. Introduction

2.1 The overall aim of this strategy is to maximise health gain for patients through the appropriate, safe and optimum use of their medicines. Where medication is taken by patients clinicians are to ensure medication is used in a safe way, that is both evidence-based and value for money for the NHS. A further consideration is innovation which to identify research of new medicines, devices, etc. and how this can be implemented for the greatest impact on outcomes for the population of Greater Manchester.

2.2. The Greater Manchester strategic plan, Taking Charge, was published in December 2015. It sets out how we will improve our health and tackle our financial problems at the same time. It says how we are looking at four areas:

- Helping people start well, live well and age well
- Making sure local health and social care services work far better together in our neighbourhoods
- Helping hospitals work together better
- Sharing more across public services

2.3 Our ambitions for the people of Greater Manchester Health & Social Care Partnership over the next five years are:

- Addressing with others the wider determinants of health and ensuring that they contribute to improving health outcomes
- Targeting support for those patients with a higher dependency on health services, to improve the management of the individual's conditions and reduce the burden on the use of services.
- Shift the delivery of services from in-hospital to the community in order to develop a sustainable Health and Social Care System.
- Continually improve the quality and efficiency of seamless care services both in and out of hospital.

2.4. Our quality objectives for the Greater Manchester Health & Social Care Partnership are:

- Patient Safety - Do no harm - keep patients as safe as possible.
- Clinical Effectiveness - evidencing that care/treatment is both clinically and cost effective.
- Patient service user and carer experience of care.

2.5 The corporate objectives for Greater Manchester Health & Social Care Partnership are:

- Supporting our population to stay healthy and live longer.
- Commissioning high quality services, which reflect the populations' needs, delivering outcomes and patient experience within the resources available.

2.6 The high-level national outcomes that the NHS aims are:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care

- Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.7 Greater Manchester Health and Social Care Partnership – The case for change.

- The GM population represents 5.1% of England's population, but we use 5.8% of England's prescription spend, around £950M in 2014/15. £530M in primary care, £430M in specialist care.
- This represents approximately 17% of GM NHS spend, 14% of devolved health and care spend, with net growth around 7% per annum.
- Optimising medicines usage can transform the care and needs of patients and the population, but can also lead to avoidable harms.
- There are 5-8% of national hospital admissions due to medicines problems, of which half are avoidable.
- There is an opportunity to reduce waste, improve outcomes and establish medicines as an investment, as well as a cost, to the health and care system.
- Benchmarking informatics using shared data are required to identify and reduce variation to be routinely used across all sectors of Greater Manchester to ensure a full understanding of the financial, clinical and personal impact of medicines on care for the GM population.
- There is a need to encourage people to think and act differently where medicines are concerned to reduce reliance on medicines, through supporting alternatives to prescribing. This may include 'social prescribing' as an option as accessible as prescribed medicines.
- The development of local care organisations is designed to deliver integrated delivery of care and reduce the current organisational and financial boundaries and different cultures which do not always best serve our people.
- There is a significant investment in medicines without the desired improvement in patient outcomes. This is one of the main reasons to create a Medicines Strategy and establish a Medicine Strategy Board.

2.8 The Medicines Strategy Board will:

- Provide the requisite leadership and oversight to drive a major Greater Manchester economy cross cutting programme of work
- Oversee and support the work of the GMMMG to develop medicines policy and optimisation
- Support the development of the relationship with industry
- Inform a discussion with national partners on flexibilities and opportunities to develop outcomes based pricing methods.

The Board will oversee the development and delivery of this medicines strategy for Greater Manchester to complement, support and accelerate the potential benefits of optimised medicines use and innovation alignment to all elements of the health and care system – primary, community, acute and mental health care, social care and self-care.

2.9 There are a number of associated programmes of work being undertaken by the Greater Manchester Health & Social Care Partnership which directly influence the outcomes linked to our strategy:

- Local Professional Networks
- Primary Care Advisory Group
- Hospital Pharmacy transformation

- Local representative committees – Medical, Pharmaceutical, Optical and Dental
- Medicines optimisation within the Localities.

2.10 Medicines are integral to most of the transformational programmes within Greater Manchester in additional to the business as usual. This Strategy is intended to lead work, in all places where medicines are used or researched to inform better care - whether self-care, social or healthcare in Greater Manchester.

It is applicable to the NHS, Social Care, Independent Contractors, AQP providers, academia and partnership working with the Pharmaceutical and devices / diagnostics industries.

3. Vision and key objectives / recommendations

Our vision is that our population are prescribed, dispensed or administered the "right medicine to the right person at the right time" or "The safest, most effective place to receive and research medicines

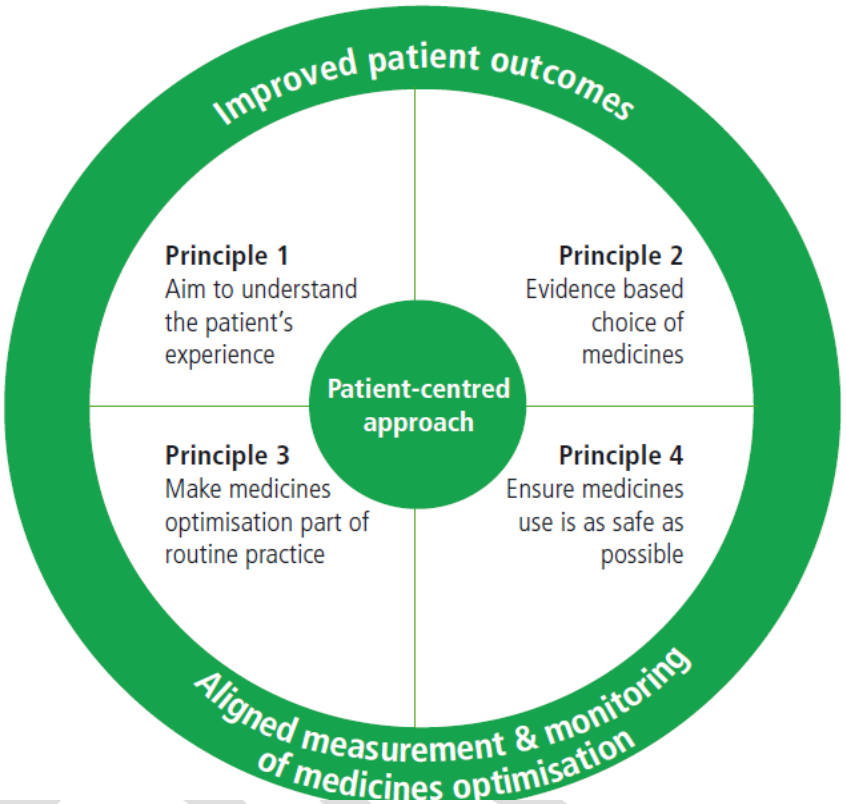
1. A Medicines Optimisation model should be introduced which outlines what patients can expect when medicines are included in their treatment as they access services in Health & Social Care (HSC) settings to improve their outcomes.

2. The model should be delivered by a multidisciplinary medicines optimisation workforce trained and competent in medicines optimisation, with the involvement of pharmacists in all settings. Releasing the Pharmacist from their transactional role and develop and role where they have responsibility to educate patients / carers about their medicines and increase the number of non-medical prescribers.
3. The services and roles should aim to consistently deliver best practices in compliance with new Quality Standards for Medicines Optimisation.
4. Best practices should always be co-designed with people / patients, following the principles of Personal and Public Involvement (PPI); supporting people to take responsibility for their own health and self-care.
5. An innovation and change programme should be implemented, linked to 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.
6. HSC connectivity, electronic transmission of prescriptions and access to the Electronic Care Record, prescribing support, Greater Manchester Formulary and enhanced data analysis. This would be implemented to reduce "post code prescribing" within the Partnership
7. A new database for medicines optimisation should be developed to monitor progress and enable comparisons across Greater Manchester.
8. Develop a culture of reporting of errors so that all providers, people and patients learn from errors / concerns and understand that reporting is a positive act.

9. Develop Greater Manchester as a global hub for real world evidence trials, e.g. provide personalised care through enhanced use of genomics; working with Partners.

4 Patient Centered Approach Model

Figure 2: Patient Centred Approach Model[15]



In Greater Manchester, the intention is to adhere to the principles for a person/patient centred model of care outlined below:

4.1 When medicines are prescribed patients should be involved in why the medicine is needed, understand the expected outcome, the duration of treatment and be informed of any risks or side effects.

4.2 When medicines are supplied, pharmacists should ensure that they are dispensed safely, that patients receive appropriate information to enable safe and effective use and are offered support to help them take their medicines as prescribed and on time, if needed. Pharmacists are also well placed to advise patients when the presentation of their medicine changes and provide reassurance of continued efficacy.

4.3 During treatment, patients should have their medicines reviewed on a regular basis and if a GP or other authorised health professional involved in assessing the patient makes a clinical decision that there is no health benefit or clinical need for the patient to continue taking the medication, the medication should be stopped. When medicines for long term conditions are started, stopped or changed, patients should have their treatment regimen checked to ensure it remains safe and effective.

4.4. In day to day practice, medicines optimisation relies on partnerships between patients and health and social care professionals and aims to help more patients to self-manage, to take their medicines correctly, reduce harm, avoid taking unnecessary medicines, cut down on waste and improve medicines safety. Ultimately it can help encourage patients to take increased ownership of their treatment and support care closer to home.

4.5. In Greater Manchester success in medicines optimisation is reliant on multidisciplinary teams with the correct skill mix working collaboratively, delivering best practices, supported by quality systems and the necessary regional organisational infrastructure (figure 2). The model seeks to deliver consistently across secondary care and expand the pharmacist role into the interface and intermediate care, to general practice, community pharmacy and social care.

4.5.1 It supports the integration of pharmacists in multidisciplinary teams, providing support with medicines at key points of the patient's journey based on an assessment of need, for example, when a new treatment is started, after discharge from hospital or during a medication review.

4.5.2 At the interface the model includes roles for consultant pharmacists and specialist outreach pharmacists working with intermediate care, nursing home settings and GP practices, with links to community pharmacy. The model includes the recent new role for pharmacists working in General Practice. 'Practice-based' pharmacists integrated with and working collaboratively with pharmacists in community pharmacy and secondary care will utilise more fully the clinical skills of the profession to improve patient outcomes.

4.5.3 In community pharmacy the model includes enhanced roles for pharmacists that will support better outcomes from medicines by working with patients to provide appropriate information and advice when medicines are dispensed and to support adherence and safer transitions through services such as Medicines Use Reviews

4.5.4 The model recognises the role of nurses and care workers in helping people with their medicines in residential, nursing and domiciliary care settings and the need for regional best practices that support role clarification, accredited training and support systems for staff.

4.6 To monitor progress, a Greater Manchester medicines optimisation database is proposed based on the NHS England's medicines optimisation dashboard to identify outcome measurements. This will largely bring together existing data related to medicines use from different sources across Greater Manchester to monitor trends, enable benchmarking and help drive quality improvements using baselines established in recent years from, for example, health surveys. Categories of outcome measurements will include:

- patient/client satisfaction;
- medicines safety incident reporting;
- cost effective use of medicines;
- impact on acute health services; and
- achievement of expected therapeutic outcomes.

5 The Medicines Optimisation Model

4.1 What patients can expect when medicines are included in their treatment? An explanation of what patients can expect is explained below in relation to the different settings, e.g. Hospital, General Practice, Community Pharmacy and Social Care. The activities described are generic and can be applied across

different areas of practice in each setting.

5.2 What a patient should expect when admitted to hospital as routine practice

On Admission

Patients bring their medicines to hospital so that they can be checked and used where possible.

- Within 24 hours of admission or sooner if clinically necessary, patients have their medicines reconciled by a trained and competent healthcare professional, ideally by a pharmacist.
- Medicines reconciliation involves collecting information about current medicines, checking for omissions, duplications and other discrepancies and then documenting and communicating any changes. Patients, family members or carers should be involved in this process.
- Within 24 hours of admission, a clinical management plan is developed which includes discharge planning to help prevent delays on discharge.
- If patients move from one ward to another within a hospital, medicines reconciliation may need to occur again.

Following Medical Assessment/ Accurate Diagnosis

- Patients are involved in decisions about their current and any new medicines, their needs, preferences and values taken into account and receive appropriate, tailored information about new medicines and the expected health outcomes.
- Patients have the opportunity to speak to a healthcare professional and ask questions about their medicines.
- During the inpatient stay, prescription charts are monitored by a pharmacist and reviewed in conjunction with medical notes and relevant medical laboratory results.
- Patient responses to medication therapy are monitored and best practices relating to 'high risk medicines' are followed.

Administration of medicines

- On some wards patients may be able to administer their own medicines. However, if this is not possible medicines are administered on time following a check that the direction to administer is appropriate and other related factors are taken into consideration.

On discharge

Prior to discharge the medicines reconciliation process is repeated.

- Patients receive an appropriate supply of their prescribed medicines which may be a combination of inpatient and discharge medicines dispensed as a single supply labelled for discharge. They are provided with accurate, up-to date information about their ongoing treatment where necessary.
- Patients are educated to ensure that they can use their medicines and devices for example inhalers appropriately.
- Patients know who to contact if they have a query about their medicines after discharge.
- Accurate and up-to date information about medicines is shared with healthcare professionals and communicated in the most effective and secure way such as electronically, ideally within 24 hours of discharge.
- Following discharge from hospital, patients are followed up to ensure that they are completely clear about their medicine regimens.

5.3 Other Hospital/Trust Services

5.3.1 Patients attending outpatient clinics should expect:

- to be involved in decisions about their medicines with their needs, preferences and values taken into account; their response to medicines to be reviewed;
- to have the opportunity to speak to a healthcare professional and ask questions about their medicines; and
- to receive appropriate, tailored information about new medicines and the expected health outcomes.

5.3.2 Patients in Intermediate Care settings (i.e. step up/step down beds) should have the same quality of care as in hospital.

5.3.3 Patients receiving specialist outreach services and other services at the interface should expect:

- links to be established between specialist secondary care clinical teams and primary care; to be followed up in primary care; and to have clinical medication reviews carried out.

5.4 What a patient should expect from general practice as routine practice

General Practice

- Patients registering with the practice for the first time have a medicines reconciliation check.
- During consultations, patients are involved in decisions about their current and any new medicines, their needs, preferences and values taken into account and receive appropriate, tailored information about new medicines and the expected health outcomes.
- Patients taking multiple medicines or taking 'high risk medicines' are identified and, where appropriate, receive additional information and advice to help take their medicines safely and effectively.
- Patients on repeat medications have checks carried out before issue of prescriptions to reduce the risk of waste.
- All patients on repeat medication have an annual clinical medication review with a GP or pharmacist. (This may be more frequent depending on the individual's care plan or type of medication).
- Patient responses to medication therapy are monitored. Medicines that are not beneficial and not evidence based are not continued
- Patients with problems taking their medicines as prescribed (non-adherent) are referred for an adherence assessment.
- Patients are involved in decisions about their medicines and are encouraged to ask questions about their treatment and to be open about stopping medication.
- Patients discharged from hospital/other care setting have their medicines reconciled by a trained and competent healthcare professional as soon as possible, before a prescription or new supply of medicines is issued and within one week of the GP practice receiving the information. Patients, family members or carers should be involved in this process and any changes documented.
- Prescribers have up to date information to support clinically appropriate and safe prescribing.
- Prescribers have access to a pharmacist for information and advice about polypharmacy patients taking multiple medicines.

- Practices provide information about prescribed medicines to hospitals and other appropriately authorised health and social care professionals to assist medicines safety during transitions of care.

5.5 What a patient should expect from community pharmacy as routine practice

Community Pharmacy

- On presentation of a prescription the pharmacist will carry out a clinical check of the prescription using the patient's medication record before it is dispensed. This will inform the level of information and advice that is needed for the patient to take their medicines safely and effectively.
- High quality medicines are dispensed safely.
- Patients receive appropriate information and advice with the supply of medicines, particularly if a new medicine or a 'high risk medicine' is supplied.
- If the presentation of a repeat medicine changes, the patient is advised of this change and reassured of continued efficacy.
- Patients are offered a medicines use review after a significant change in their medication. For example, following discharge from hospital or after starting a new treatment regimen.
- Patients having problems taking their medicines as prescribed have their adherence needs assessed and appropriate support provided.
- Patients are asked if they need all their repeat medicines before they are supplied to reduce the risk of waste.
- Pharmacists work closely with other health and social care professionals to ensure patients are on the most appropriate medication and have contact with pharmacists working in local GP practices and hospitals.
- To support safe transitions, pharmacies provide information about medicines supplies to the pharmacist or pharmacy technician conducting a medicines reconciliation check after admission to hospital or to appropriately authorised health and social care professionals in a nursing or residential home.
- On discharge from hospital, community pharmacy receives information on the patient's current medication and medication changes to support safe transfer.
- Pharmacies may provide other services such as clinical medication reviews and monitor health outcomes from medicines to support medicines optimisation.

5.6 What you should expect from social care as routine practice

5.6.1 Nursing homes

- When individuals first move into a nursing home and at each transition of care thereafter their medicines are checked with their GP Practice and Community Pharmacy.
- Adequate supplies of medicines are always available and prescription ordering systems in homes are carefully managed and monitored to avoid over-ordering and waste.
- Individuals with specific medication needs such as Parkinson's Disease or Diabetes or those taking multiple or 'high risk medicines' are identified and receive the appropriate care in line with best practice.
- Individuals who take their own medicines are monitored to ensure they are taking them as prescribed.
- Medicines are administered on time following a check that the direction to administer is appropriate.
- Individuals taking repeat medication have an annual clinical medication review; the frequency of the review may vary depending on the care plan.
- Staff in nursing homes have contact with pharmacists in the community to assist with queries about medication.

5.6.2 Residential homes

- When individuals first move into a residential home and at each transition of care thereafter their medicines are checked with their GP Practice and Community Pharmacy.
- Adequate supplies of medicines are always available and prescription ordering systems in homes are carefully managed and monitored to avoid over-ordering and waste.
- Residential care home staff who manage medicines are trained and competent.
- Residents self-administer their own medicines where the risks have been assessed and the competence of the resident to self-administer is confirmed. Any changes to the risk assessment are recorded and the arrangements for self-administering medicines are kept under review.
- Residential care home staff receive training on 'High Risk Medicines' and have easy access to information about all medicines.
- Staff have contact with pharmacists in the community to assist with queries about medication.

5.6.3 Children's homes

- When a child/young person first moves into a children's home and at each transition of care thereafter their medicines are checked with their GP Practice and Community Pharmacy.
- Adequate supplies of medicines are always available and prescription ordering systems in homes are carefully managed and monitored to avoid over-ordering and waste.
- The management of medicines is undertaken by trained and competent staff and systems are in place to review staff competency.
- Robust systems are in place for the management of self-administered medicines.
- Prior written consent is obtained from a person holding parental responsibility for each child or young person for the administration of any prescribed or non-prescribed medicine.
- Staff receive training on 'High Risk Medicines' and have easy access to information about all medicines.
- Staff have contact with pharmacists in the community to assist with queries about medication.

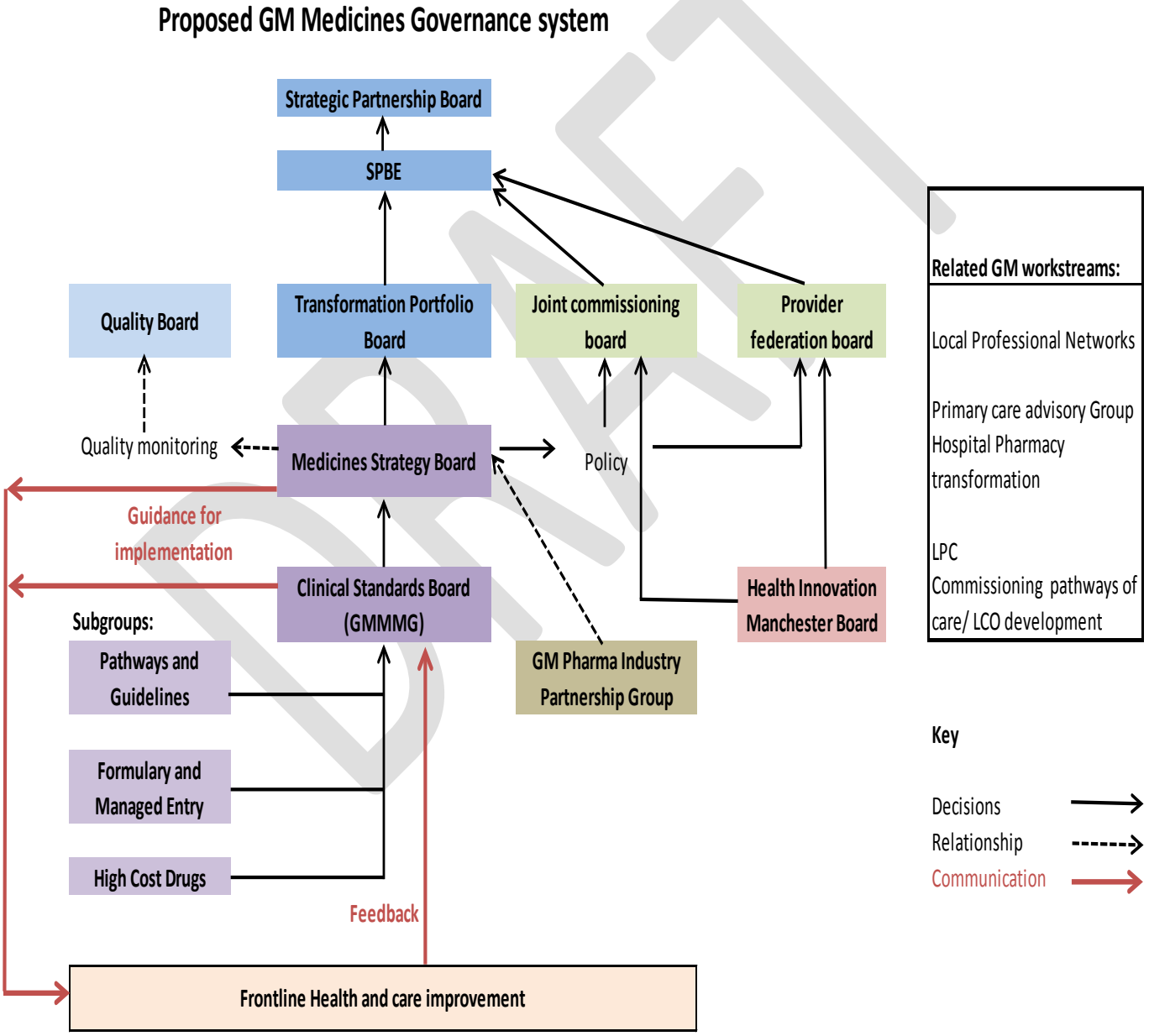
5.6.4 Domiciliary care

- Nurses and care workers have clearly defined roles in helping with medicines taking.
- Administration of, or assistance with, medication is facilitated when requested in situations where an individual is unable to self-administer.
- Administration or assistance with medication is detailed in a care plan and forms part of a risk assessment.
- Policies and procedures identify the parameters and circumstances for care workers administering or assisting with medication. They identify the limits and tasks that may not be undertaken without additional training.
- Care workers who administer medicines are trained and competent. A record is kept of all medicines management training completed by care workers and retained for inspection
- When necessary, training in specific techniques (e.g. the administration of eye/ear drops or the application of prescribed creams/lotions) is provided for named care workers by a qualified healthcare professional.
- The care worker documents, on each occasion, the administration or assistance with medication.

- Care workers involved in the management of an individual's medication agree the arrangements for the safe storage within the individual's home. Appropriate information is available about the individual's current medication and staff are aware of any changes following a transition of care, such as discharge from hospital.
- Training on 'High Risk Medicines' is provided and staff have easy access to information about all medicines.
- Staff have contact with pharmacists in the community to assist with queries about medication.
- If an individual is having difficulties in managing their medicines, staff can refer them to the community pharmacist for assistance.

6 Governance Framework

6.1 The Governance structure.



6.2. The functions of each Board / Group are:

Board / Group	Purpose	Meeting Frequency	Chair
Medicines Strategy Board	➢ Provide leadership and oversight to drive programme of work ➢ Oversee and support the work of the GMMMG to develop medicines policy and optimisation ➢ Oversee and support the work of the Hospital Pharmacy Transformation programme. ➢ Support the development of the relationship with industry ➢ Inform a discussion with national partners on flexibilities and opportunities to develop outcomes based pricing methods	Bi-monthly Odd Months Starting May 2017	**Dr Richard Preece** **GMHSCP**
Clinical Standards Board (GMMMG)	➢ To support the commissioning of outcomes and packages of care, viewing medicines and treatments as an investment in improving health and wellbeing rather than a cost. Though: ➢ Make recommendations to ensure that the most appropriate choice of clinically and cost effective medicines are used to meet the needs of the GM population. ➢ Define, monitor and report against standards to reduce clinical variation and promote improvement with better utilisation of data and analytics and sharing of best practice. ➢ Oversee a Greater Manchester Joint formulary, manage the introduction of new drugs, define safe prescribing practices and work with other stakeholders to facilitate the development of evidence based treatment pathways.	Bi Monthly Even Months	**Dr Helen Burgess** **SM CCG**
GMMMG subgroups **All will monitor and report against standards set to reduce clinical variation and promote improvement as defined by the CSB.**			
a. Pathways and guidance	➢ Work with other stakeholders to facilitate the development of evidence based treatment pathways and shared care guidelines for implementation across the GM health economy.	Bi Monthly Odd months	**Margaret O'Dwyer** **Bury CCG**
b. Managed entry and formulary	➢ Assess applications and manage the introduction of new and existing drugs to the GM formulary. ➢ Make recommendations to ensure that the most appropriate choice of clinically and cost effective	Bi Monthly Odd months	**Dr Pete Budden** **Salford CCG**

Board / Group	Purpose	Meeting Frequency	Chair
	medicines are used to meet the needs of the GM population. ➢ Formulary will only consider the adult population ➢ RAG lists cover adult and paediatric patients. ➢ Devices may also be considered if they can be prescribed.		
c. High cost drugs	➢ Will ensure the clinical and cost-effective use of existing high cost medicines (PbR tariff excluded), CCG commissioned) across the Greater Manchester health economy ➢ Will facilitate joint working between provider trusts and CCGs on high cost drugs to ensure best use of NHS resources.	Initially monthly	**Charlotte Skitterall** **Dir of Pharmacy, UHSM**
Health Innovation Manchester Board	➢ Map all research and development ➢ Identify those studies and technologies that show greatest promise to transform mainstream care and generate clinically and financially sustainable models of care. ➢ Accelerate innovation into practice.	Quarterly	**TBC** **Lead by HinM**
Greater Manchester and the Pharmaceutical Industry Partnership Group	➢ Increase the pace and affordability of health improvement within GM, through effective and sustainable collaboration that will: ➢ Transform health and wellbeing of the population, encouraging self-care ➢ Accelerate the discovery, development and delivery of innovative solutions - promote R&D in GM, as an international leader, particularly the 'real world, near real time' capabilities ➢ Ensure appropriate use of medicines (adopting medicines optimisation principles) ➢ Ensure flexible and fair funding of innovative medicines ➢ Drive inward investment - NHS an economic driver.	Bi monthly initially	**Co-chaired:** **Jon Rouse, GMHSCP** **Mike Thompson ABPI**

7. Ongoing Monitoring: Reporting process

7.1 Clinical reporting / measurement

Report	Frequency	To whom
Regular reports on overall progress of 2 year action plan	Quarterly	• Medicines Strategy Board • Transformation portfolio board • GMMMG • Local Area Prescribing/ Medicines Management Committees • Disseminated to local clinicians
Benchmarking analysis to standardise care	Quarterly	• GMMMG • Then dissemination and action to standardise
Regular reporting through BI	Monthly	• CCGs,

Portal(s) to allow granular analysis: **GM, CCG, Cluster, GP practice levels**	Quarterly Bi-annual Annual	• Locality clusters, • GP practices • NHS Trusts
Innovation reporting?		
Patient reporting?	Annual	• Patient & Public Involvement forums, • Healthwatch, Quality surveillance?

7.2 Corporate reporting / measurement

Report	Frequency	To whom
GM Medicines report	Annual	SPB AGG of GM CCGs Provider federation
Report of GMMMG outcomes	Bi-annual	GM Heads of Commissioning GM Heads of Finance
Policy and guidance outputs	Quarterly	GM Heads of Commissioning GM Heads of Finance
Research and development		Health Innovation Manchester Board
Joint working with Industry		GM and Pharmaceutical Industry Partnership Group

8. Responsibility for delivery of the objectives

Objectives	Date to be achieved	Responsible Delivery Group
1. A Medicines Optimisation model should be introduced which outlines what patients can expect when medicines are included in their treatment as they access services in Health & Social Care (HSC) settings to improve their outcomes.		Clinical Standards Board - Greater Manchester Medicines Management Group and subgroups (GMMMG)
2. 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. Releasing the Pharmacist from their transactional role and develop and role where they have responsibility to educate patients / carers about their medicines and increase the number of non-medical prescribers.		Primary Care Advisory Group
3.The services and roles should aim to consistently deliver best practices in compliance with new Quality Standards for Medicines Optimisation		Primary Care Advisory Group
4.Best practices should always be co-designed with people / patients, following the principles of Personal and Public Involvement (PPI); supporting people to take responsibility for their own health and self-care.		Local Professional Network (LPN) for Pharmacy
5. An innovation and change programme should be implemented, 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.		Local Professional Network (LPN) for Pharmacy
6. HSC connectivity, electronic transmission of prescriptions and		Clinical Standards Board - Greater Manchester Medicines Management

access to the Electronic Care Record, prescribing support, Greater Manchester Formulary and enhanced data analysis. This would be implemented to reduce "post code prescribing" within the Partnership		Group and subgroups (GMMMG) / Primary Care Commissioning
7. A new database for medicines optimisation should be developed to monitor progress and enable comparisons across Greater Manchester.		Primary Care Advisory Group
8 Develop a culture of reporting of errors so that all providers, people and patients learn from errors / concerns and understand that reporting is a positive act.		Local Professional Network (LPN) for Pharmacy
9 Develop Greater Manchester as a global hub for real world evidence trials, e.g. provide personalised care through enhanced use of genomics; working with Partners.		Greater Manchester and the Pharmaceutical Industry Partnership Group / HInM

Appendix 1

Examples of Quality Standards for Medicines Optimisation

Quality Domain	Medicines Optimisation Standards
Patient/Client Focus Patients are involved in decisions about their treatment with medicines.	1. Safer Prescribing with Patient Involvement
	2. Better Information about Medicines
	3. Supporting Adherence and Independence
Safety Preventing and minimising harm related to medicines use.	4. Safer Transitions of Care
	5. Risk Stratification of Medicines
	6. Safety/Reporting and Learning Culture
Effectiveness Right patient, right medicine, right time, right outcome, right cost.	7. Access to Medicines you Need
	8. Clinical and Cost Effective Use of Medicines And Reduced Waste
	9. Clinical Medication Review
	10. Administration

STANDARDS

Standard 1 - Safer Prescribing with Patient Involvement
Prescribing is carried out in a manner which promotes safety and optimal health outcomes, with patients involved in decisions about their treatment.

Standard 2 – Better Information about Medicines
Patients/carers receive the information they need to take their medicines safely and effectively.

Standard 3 – Supporting Adherence and Independence
People are helped to remain independent and self-manage their medicines where possible but receive support with adherence when needed.

Standard 4 – Safer Transitions of Care
Checks occur at each transition of care to ensure that the transfer of medicines and medicines information between patients, carers and health and social care workers is safe, accurate and timely.

Standard 5 – Risk Stratification of Medicines
Patients who may be at risk because of the medicines that they use receive the appropriate help to take their medicines safely.

Standard 6 – Safety/Reporting and Learning Culture
Organisations 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.

Standard 7 – Access to Medicines you Need
Patients have appropriate, equitable and timely access to quality assured, evidence-based and cost- effective medicines.

Standard 8 - Clinical and Cost Effective Use of Medicines and Reduced Waste
Within organisations a culture exists promoting a shared responsibility for the appropriate, clinical and cost effective use of medicines supported by systems for avoiding unnecessary waste.

Standard 9 – Clinical Medication Review
Clinical medication reviews are carried out with the patient and occur on a regular basis, at least annually.

Standard 10 – Administration
Following an initial check that the direction to administer a medicine is appropriate, patients who have their medicines administered receive them on time and as prescribed.