2019/20 Performance Overview: Medicines Optimisation

Medicines Optimisation looks at the value which medicines deliver, making sure they are clinically effective and cost effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.

Primary Care

The pharmacy team in Primary Care consisted of the following in the 2019/20 year:

- Pharmaceutical Adviser
- 2 GP pharmacists
- 1.5 Community Mental Health Pharmacists
- 0.5 Learning Disability pharmacists
- 0.6 Care home pharmacist
- 3 Pharmacy technicians

The Primary Care budget for drugs in 2019/20 was £15,371,000 and the spend was £15,191,000 demonstrating an under spend of £180k. This underspend was made in addition to a £500k reduction in drug budget for the financial year which was made to meet Treasury requirements. Overall, the budget for drugs was reduced by £680k.

The Medicines Optimisation Team record every saving made via any of the cost saving projects undertaken. Cost saving work includes the following activities:

- Brand switches from expensive choices to cheaper brands or generic medicines
- Removal of items which are no longer funded by DHSC
- Reducing excess quantities of medicines, syringes, and diabetic test strips which the patient does not require
- Changing patients from expensive 'specials' medication to licensed and clinically suitable medicines

The savings total in the 2019/20 year was £623,176.11. However, it should be noted however that these savings are not in addition to those stated above but is stated to demonstrate the savings and concur with the financial position provided via the Finance Department.

There remain some therapeutic areas where savings can still be made, and these are an intended focus area in the next financial year.

Activities undertaken in the 2019/20 year

The team undertook several activities in the 2019/20 year.

- **Public Consultation:** The team undertook a Public Consultation via the Government Consultation Hub and via some stakeholder focus groups. Its aim was to provide

guidance for the DHSC on the development of pharmacy services in community pharmacy and Primary Care as a whole

- **Integrated Care project:** The pilot project in the West of the Island commenced in 2019 and was supported by a Pharmacist and a Pharmacy Technician, who offered advice to the team and carried out medication reviews for patients referred to the service

Interventions

The term interventions has been used to cover a variety of clinical interventions that a member of the team makes such as a medication review or a piece of prescribing advice i.e. deprescribing of items, removal of medicines from patients who are no longer funded.

The Intervention Database was made 'live' in November 2019, and between November 2019 and March 2020 there were 447 interventions recorded by the team.

Projects undertaken in 2019/20

The projects undertaken in the year 2019/20 were designed to meet the objectives outlined in the Medicines Optimisation Strategy for DHSC.

1. **Audit on asthma reviews in high-risk patients**: The pharmacy team carried out a detailed review of all patients registered in GP surgeries across the island, who were classified as high-risk. A total number of 3660 patients were identified by the EMIS search and patient records were investigated by pharmacy staff. There was a significant number of patients (908) who were overdue for their asthma review, and 451 of the reviews done we deemed not to be 100% satisfactory. Therefore, there appears to be a clear need for more resource to be designated to the reviews of asthma patients, particularly those in the high-risk group. This has been raised with senior clinical and management staff within DHSC.
2. **Audit on patients taking high dose opioids**: The use of opioid, particularly those classed as 'strong' opioids has been increasing over recent years, and there have been a rising number of deaths related to strong opioids in the UK and across the developed world. There is very little evidence to support the use of opioids in chronic pain (non-cancer pain) and the threshold for risk outweighing benefit is considered to be more than 120mg Oral Morphine Equivalent (OME) a day. They are also associated with potential adverse effects including constipation, drowsiness and potentially fatal bradycardia and respiratory depression. Any reduction in opioid usage will reduce associated side-effects and in patients taking concomitant 'risky' medicines, there should be a reduced risk of overdose. An audit was undertaken on patients who were identified as taking more than 120mg of oral morphine equivalent, and 97 patients were identified. Following reviews of the patient's medical records, 49 patients received interventions and attempts were made

to reduce the level of opioid taken. A repeat audit will be undertaken in early 2021.

3. **Diabetes projects**: Various projects have been undertaken alongside the Diabetes Team including:
    - Rationalising the amount of insulin pens provided based on the daily dose required
    - Rationalising the number and type of blood testing strips based on needs
    - Reviewing patients on GLP-1 drugs
4. **Emollient formulary**: An emollient formulary has been developed with the Dermatology Team, which includes patient education leaflets and GP guidelines for making the choices for their patients.
5. **MHRA Drug Safety Alerts and audits**: The MHRA issues 'Drug Alerts' that a healthcare organisation should implement to protect patients. The pharmacy team have undertaken the following in 2019/20:
    - Valproate in women and girls of childbearing age: Valproate (Epilim, Depakote and other generic brands) is associated with a significant risk of birth defects and developmental disorders in children born to women who take valproate during pregnancy. Valproate is a treatment for epilepsy and bipolar disorder and is prescribed to thousands of women. Since its introduction in 1974, the product information for doctors has included a warning about the possible risk of birth defects. As the risks to unborn children have been increasingly understood, the warnings have been strengthened.
    - The pharmacy team searched and identified every woman/girl of childbearing age who are registered with a GP surgery, and reviewed their medical record to ensure they are prescribed appropriate contraception.
    - Lithium level monitoring: Patients taking Lithium require blood monitoring of the plasma lithium levels on a six-monthly basis as a minimum; to identify any patients at risk of toxicity and patients who may have inadequate levels. The pharmacy team searched all GP surgery records and identified all patients prescribed lithium and cross checked to ensure they had recent blood monitoring done. If any patient did not have recent bloods, they were requested via the GP.

Secondary Care

The pharmacy team in Secondary Care consisted of the following in the 2019/20 year:

- Chief Pharmacist
- 4.6 WTE Lead Pharmacists (procurement + operations, aseptics, oncology, clinical, medicines information + IT development)
- Three specialist pharmacists (admission/discharge, anti-infectives, Surgery + Critical Care)
- Four pharmacists (mental health + general)

- Chief Pharmacy Technician
- Lead Technician – aseptics
- Lead Technician – systems and business information manager
- 5.6 Pharmacy Technicians
- 7.5 Pharmacy Assistants
- One Pharmacy Porter
- 0.5 Administrative Officer

The Secondary Care medication spend in 2019/20 was £7.5 million.

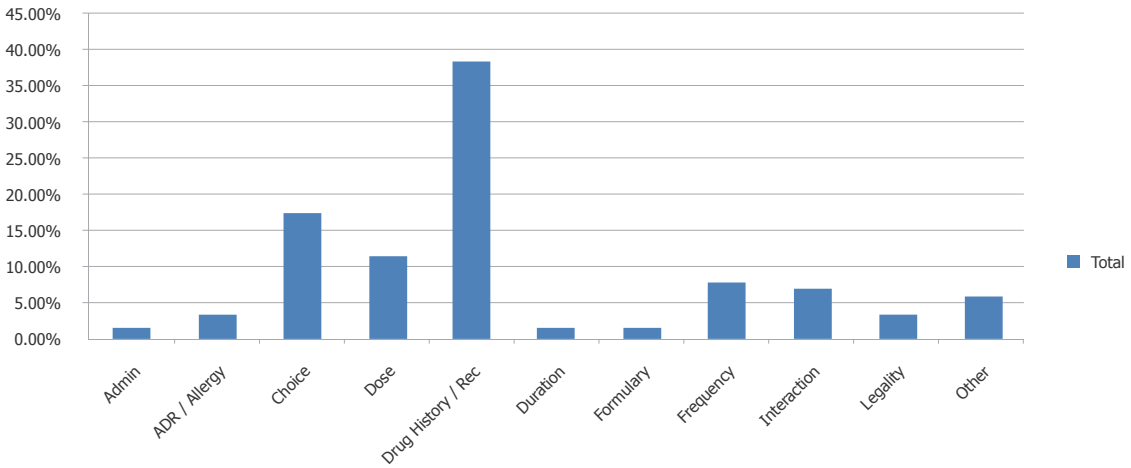
Activities undertaken in the 2019/20 year

Figure 1 shows the associated supply activity for the above drug spend and Figure 2 shows (by percentage) the type of pharmacy interventions made during this time. There were 2683 recorded pharmacy interventions during the year.

Figure 1 Medication supply transactions for 2019 - 2020

Patient specific In patient transactions	Patient specific Outpatient transactions	Patient specific Discharge transactions	Aseptic Unit Transactions	Ward/ Dept stock transactions
16 255	16 347	19 048	4200	72015

Figure 2 Percentage of the types of Medication related pharmacy interventions



2019/20 Key Highlights

A highlight of the 2019/20 year in Secondary Care has been the successful introduction of the updated inpatient prescription chart which improves safety by providing greater clarity on:

- Medicines reconciliation (drug history): making sure that the right drug and dose is prescribed for the patient on admission to hospital improving safety[1]
- Antimicrobials/antibiotics: making sure that the reason for using the drug is known and the need is regularly reviewed to slow the development of antimicrobial resistance
- Venous Thromboprophylaxis: making sure that the risk assessment actions are recorded, and appropriate prevention taken to avoid patients developing venothromboembolism, a leading cause of preventable in-hospital death
- Oxygen: making sure that this medical gas is prescribed and given safely
- Flushes: making sure that sodium chloride 0.9% is prescribed and given for maintaining the patency of peripheral intravenous catheters

2019/20 Key Challenges

To carry out medicine's optimisation, pharmacy professionals need to have the opportunity to be both patient facing and be part of the multidisciplinary team. An area of focus for the 2019/20 year was trying to increase Pharmacist and Pharmacy Technician time on the wards to facilitate this, whilst ensuring the robust supply function was maintained.

1 National Institute for Health and Care Excellence, *'Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes (*2015)