RMOC Project Proposal: Achieving a “gold standard” approach to MCCAs in England

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Sheena Vithlani, Regional Medicines Information Manager
John Minshull, Deputy Director Medicines Information
London Medicines Information Service

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Background

In November 2018, the London RMOC requested to see a project scope to suggest how England could seek to implement a "Gold Standard" approach to use of multi-compartment compliance aids (MCCAs). This was following receipt of a topic through a Local Pharmaceutical Committee (LPC) following what they described as 'an unprecedented local increase in demand for MCCAs'. It was this LPC's view that, *"carers and their employers are trying to mitigate their perceived risks and liabilities believing MCCAs to be a panacea of safety"*.[1] This is echoed by the Royal Pharmaceutical Society (RPS) guidance on MCCAs which states that *"use of MCCAs has become regarded as a panacea for safe and appropriate medicines use and is often integrated into practice and service policy without giving due consideration to the alternatives available"*.[2]

The London RMOC requested that a summary report on available guidance and support documents for implementation of MCCAs be produced. However, it was anticipated that despite existence of guidance from different organisations, there remained a barrier to rational use of MCCAs that needed to be addressed.[1]

The RMOC seeks to identify what a "gold standard" approach to MCCAs looks like and to identify the barriers to ideal use of MCCAs. This document describes a proposal to engage all stakeholders involved in MCCA use in order to consider how health and social care commissioners and providers could work together to address this issue.[1]

In brief, what does a 'Gold Standard' approach to MCA's look like?

Following a literature search (see associated document **Summary of Guidance and Evidence for use of Multi-Compartment Compliance** Aids) and initial, exploratory conversations with some stakeholders, some key points include:

- Routine use of MCCAs without patient adherence assessment is discouraged.
- The preference for people with adherence issues is to supply medication in original packaging with an assessment to identify whether support is needed in using these with appropriate adherence aids provided if required.
- MCCAs should only be used in an appropriate manner following such assessment to enhance patient safety and outcome.
- If the best adherence aid for an individual *is* suggested to be a MCCA, then people and their carers must be trained in the use of the aid.
- People and carers using MCCAs should be assessed for adherence and concerns after a few weeks of starting the aid, re-assessed after any changes in their needs and then regularly at 6-12 months.
- There is no legal requirement for an MCCA to be provided to a patient, carer or care facility and it should not be presumed that a patient with a disability, who requires an auxiliary aid, must always be supplied with an MCA, as there are other possibly more appropriate and helpful ways to support people in taking medicines effectively.[5]

The medication adherence benefit with MCCA use is inconclusive and using MCCAs could result in medicines administration being a robotic task.[6,7] In addition, there are risks of error specific to the use of MCCAs[7-12] and there are other concerns such as lack of stability data for medicines in MCCAs[13,14], some medicines being unsuitable for inclusion in MCCAs (e.g. bisphosphonates), patients not having control of their own medicines (e.g. being unable to refuse medicines they don't need regular such as laxatives in MCCAs) and there is the issue of medicines use being off-label in MCCAs.[7,13-16] Hence routine use of MCCAs without appropriate assessment of needs is not advised.

Instead the focus should be on enabling people and trained carers to deliver outcome focussed, person-centred support with their medicines designed to support capability, independence and re-ablement as opposed to care which is designed around dependence.[1, 3,4,7, 17, 18]

There is an overall preference to supply original packed medication with greater patient involvement, regular patient assessment and communication between all staff involved in caring for a person.[17] The CQC similarly emphasises person-centred care and their advice to care providers is in line with RPS and NICE guidance.[17]

Care home providers are advised by NICE to consider the 6 R's of administration in a medicines administration process. Using MCCAs routinely often does not enable these to be incorporated into the process:[32]

- Right resident
- Right medicine
- Right route
- Right dose

- Right time
- Resident's right to refuse

NICE advises that no one particular intervention is able to solve non-adherence and proposed that a wide range of interventions tailored to the individuals need be made available (e.g. pictograms, leaflets, winged caps, requests for increased support from carers, reminder charts, Braille labels, medicines use review and MCCAs where appropriate).[3,7]

Despite guidance already in place from various organisations[1-6], there remains significant and possibly increasing demand for MCCAs[7] in different scenarios which are;

A. Care homes (residential and nursing and intermediate care facilities) providing support to residents.
B. Domiciliary care workers providing support with medicines to people in their own homes.
C. Carers and relatives providing support with medicines to people in their own homes.
D. Individual people who self-administer their medicines to people in their own homes.

This document aims to:

1. Identify and map all of the key stakeholders (Figure 1)
2. Identify and describe, for each stakeholder (or group of stakeholders), the barriers they face to implementing a "gold standard approach" to use of MCCAs and properly supporting people to use their medicines optimally.
3. Discuss factors which drive requests for MCCAs in each of the above scenarios.
4. Suggest an implementation plan to achieve a "gold standard" approach to MCCAs

Barriers to achieving a 'Gold Standard' approach to MCCAs in England

Many of the barriers identified are multifaceted, longstanding, complex, and often ingrained in current practice. In some areas a change in culture is needed across organisational barriers.[1,4,5,7] A significant barrier for all stakeholders is that there is no clear single national driver[19] to address appropriate use of MCCAs and delivery of person-centred pharmaceutical care.

Barriers common to **all stakeholders (NOT within the pharmacy profession**[19a]) include:

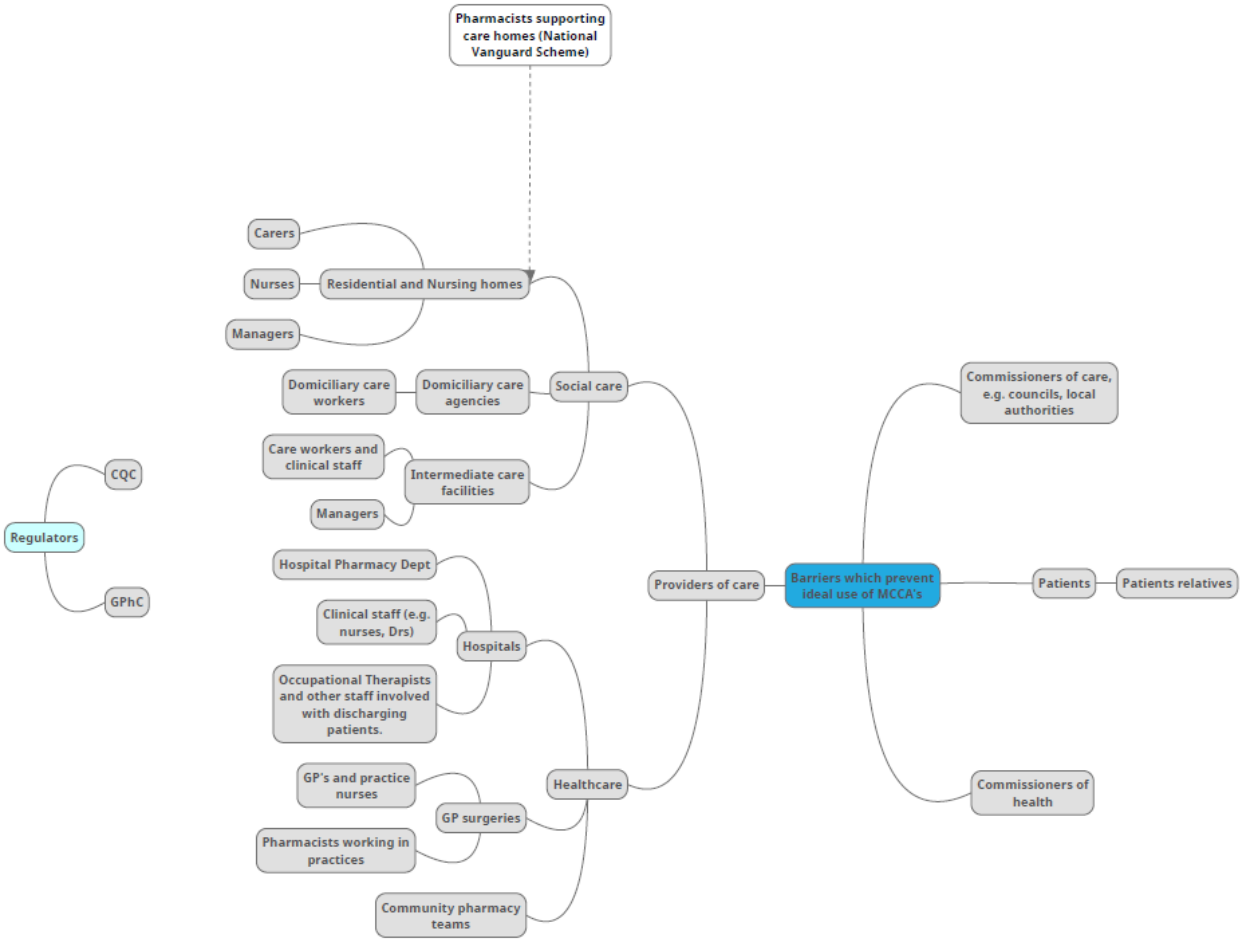
- Misinterpretation of laws around MCCA use is common.[5]
- In some areas and organisations, there is lack of awareness of:
    - Guidance around appropriate MCCA use and around better ways to support person-centred medicines use.
    - How routine and often inappropriate MCCA use is negatively impacting patient safety and person-centred optimal medicines use.
    - How provision of MCCAs is negatively impacting certain providers of healthcare such as community pharmacy contractors.
- The ingrained and misconceived view that use of MCCAs makes medicines use safer is highly prevalent.

Barriers commonly encountered by commissioners:

Commissioners of health and social care services (i.e. staff with commissioning responsibilities in CCGs, Councils, local authorities) [4,31]

- Lack of clarity around whether "taking medicine" is a "health" related activity or "social" activity of daily living, thus lack of clarity around responsibility to ensure that the right support systems and services are in place.
- Lack of collaborative working between social and health care commissioners and providers to design services which support people to use their medicines optimally.
- Health and social care policies around medicines use are often disparate and misaligned.
- May lack resource to achieve a "gold standard" approach to MCCAs and person-centered medicines use.
- Lack of emphasis on importance of providing person-centered medicines support. Currently, it is generally uncommon for social care packages to be commissioned if an individual only needs medicines support but this is changing and is something that is being reviewed in some areas.[32]
- Previously the Care Quality Commission (CQC) did not have a specific recommendation on how medicines should be dispensed, particularly when used in care homes (i.e. whether in original packs or MCCAs), but now the CQC advice to care providers is in line with RPS and NICE guidance.[17]

Figure 1: Key stakeholder map



Barriers common to all providers of health and social care organisations and staff: [19a,19b,30,31]

- Staff may lack skills and training to properly support a "gold standard" approach to MCCAs and to assess whether someone needs support with taking medicines and then determining what level of support they need and then providing/ sourcing this support.
- No requirement or systematic way in which to identify people who might need help with their medicines.
- No standardised and validated tool available to help assess people who might need help with their medicines and to suggest different ways to support them.
- Once a hospital or GP practice starts a patient on an MCCA, there is usually no defined process for reviewing this.
- Local policies and SOPs in place around MCCA use may not reflect best practice guidance.

Barriers commonly encountered by different provider types

Social care provider organisations (e.g. care home owners/managers, domiciliary care agency managers)[19a,19b,30,31]

- Ingrained views that use of MCCAs save carer time and makes medicines use safer is highly prevalent.
- Commissioners do not routinely make provision for sufficient resource for systematic adoption of a "gold standard" approach to MCCAs and appropriate person-centered care around medicines use.
- Previously there was no specific recommendation from the CQC on how medicines should be dispensed (i.e. whether in original packs or MCCAS's). CQC now has advice to care providers that is in line with RPS and NICE guidance.[17]
- CQC inspections focus on whether MCCAs are being used safely and properly (e.g. are MCCAs labeled properly, PILs are provided, tablets and capsules are identifiable, medicines given at right time, patients/residents in homes are meeting their outcomes). It is not the role of CQC to assess the appropriateness of each decision to use an MCCA.[32]

Individual carers and nurses in domiciliary care or residential or nursing homes[19a,19b,30,31]

- In some areas, there is limited or no time allocated to providing regular support with medication within social care packages.
- Some carers may need training and support to administer medicines from original packs (e.g. those whose first language is not English).
- CQC inspections focus on whether MCCAs are being used safely and properly (e.g. are MCCAs labeled properly, PILs are provided, tablets and capsules are identifiable, medicines given at right time, patients/residents in homes are meeting their outcomes). It is not the role of CQC to assess the appropriateness of each decision to use an MCCA.[32]
- Carers are not always clear of their own responsibilities around medicines administration.[32]

Community pharmacy teams[30]

- Faced with pressure from other care providers (e.g. care homes, domiciliary care agencies/staff, GP practices and hospitals) to supply MCCAs routinely.
- Under pressure to deliver current services (e.g. dispensing and MUR's) so there is limited time and resource available to review, plan and organise medication support in community to deliver a "gold standard" approach to MCCAs.
- Large numbers of people in various settings currently using MCCAs so capacity of community pharmacy teams to review these people is limited.
- Generally unable to provide routine domiciliary pharmaceutical care due to requirement for responsible pharmacist to remain at premises and lack of resource to deliver this service (i.e. to organise backfill cover for pharmacists or for pharmacy technicians).
- May not hold stock of compliance aids / tools other than MCCAs (e.g. large label printers, Braille label printers, winged caps).

- Report that funding for supply of MCCAs at the volumes being demanded is inadequate and increasingly unsustainable.
- Pharmacy inspections from regulators do not assess whether a "gold standard" approach to MCCAs is systematic and whether appropriate person-centered care around medicines use is being provided.
- Once a hospital or GP practice starts a patient on an MCCA, there is no defined process for reviewing this.

Pharmacists working in care homes (e.g. under the NHS England Enhanced Health in Care Homes scheme)[19b]

- Limited numbers so may be under time pressure to plan and deliver person-centered support with medicines use.
- Faced with ingrained views and policies and processes in care homes which often do not align with a "gold standard" approach to MCCAs and providing person-centered support with medicines.
- May not be able to easily access compliance aids / tools other than MCCAs (e.g. large label printers, winged caps).
- Inspections from pharmacy regulators (e.g. GPhC) do not routinely assess the appropriateness of each decision to dispense an MCCA.

Hospital pharmacy departments[19a]

- Under pressure not to delay discharges so limited time to plan and organise medication support in community.
- Faced with pressure from care providers in community and people/ relatives to supply MCCAs due to ingrained views around MCCA use which often do not align with a "gold standard" approach to MCCAs and providing person-centred support with medicines.
- May not hold stock of compliance aids / tools other than MCCAs (e.g. large label printers, winged caps).
- Report being inadequately resourced to supply MCCAs according to the volumes being demanded.

Clinical staff in hospitals (e.g. nurses, doctors)[31]

- Faced with pressure from care providers in community and people/ relatives to supply MCCAs due to ingrained views around MCCA use which often do not align with a "gold standard" approach to MCCAs and providing person-centred support with medicines.
- Under pressure not to delay discharges.

Staff involved with discharging people in hospitals (e.g. Occupational Therapists)[31]

- Under pressure not to delay discharges.
- Suitability for discharge is based on assessment of activities of daily living (e.g. eating, cooking, washing and dressing) and not at all on ability to use medicines optimally.

Common issues encountered by people taking medicines and their relatives/ friends[31]:

- Some people have complex medication regimens and need help to manage them.
- Lack of access to help and support from skilled and trained health/social care teams which are designed specifically to help people get optimal benefits from medicines without any harm.
- Lack of other compliance aids (e.g. reminder charts or alarms, large labels) or other support (e.g. polypharmacy review) offered to them to help them use their medicines optimally.
- Lack of awareness around where to access professional help or advice on medicines issues.
- May people lack of awareness of how MCCA use is impacting their care and safety
- Many people want to be in control of their medicines (e.g. laxatives, water tablets or pain relief).
- Many people want to know more about the medicines they take.
- Some people (and their relatives/ friends) cannot speak or read English.
- Some people are homebound and cannot access pharmaceutical care in the community easily (e.g. from pharmacies providing MUR's or New Medicines Service [NMS] reviews).

Barriers arising from regulators:

CQC

- No standards in care commissioning frameworks relevant to providing a "gold standard" approach to MCCAs or person-centred support with medicines to audit care provision against.

GPHC

- No standards in pharmacy contract relevant to providing a "gold standard" approach to MCCAs or person-centred support with medicines to audit care provision against.
- Lack of clear position statement on specific role(s) of MCCAs for people who might need help with their medicines.

Discussion of barriers and drivers affecting MCCA use

Despite good guidance already in place from various organisations [1, 3,4,6], there remains significant and possibly increasing demand for MCCAs in different settings.[7,16] MCCAs have become integrated into policy and practice as a panacea for safe and appropriate medicines use, without giving due consideration to the alternatives available.[2] This view is somewhat commonplace amongst a range of providers of health and social care.[7] MCCAs are often initiated, particularly for older people on several medicines; as the population ages and medication regimens become more complex, MCCAs use could increase further if no intervention is made.

There is currently no clear single national driver to address use of MCCAs.[19] Additionally, there is often a lack of collaboration between health and social care, which is essential to address this. The NHS White paper, Liberating the NHS [4] called for closer integration between health and social care to commission services that lead to improved healthcare outcomes and there is provision in the law for health and social care to pool budgets and integrate services[4]. Decisions made about the use of MCCAs impact across the health and social care system, yet it is often difficult to determine why and when decisions about MCCAs have been made.

Outside pharmacy, awareness of guidance about supporting person-centred medicines use and appropriate use of MCCAs is limited. When local authorities commission domiciliary care they do not routinely systematically assess people's ability to take medication, thus it is believed that insufficient time is allocated to support medicine-taking. Use of MCCAs has been employed as a way to mitigate the risks that arise from this. Yet using MCCAs solely for the convenience of care providers is widely considered to be inappropriate.

Similarly, there is no formal and routine assessment of ability to manage medicines taking place on hospital wards prior to their discharge. Engagement is therefore needed with Occupational Therapists who conduct a range of assessments on people to determine care needs following discharge from hospital. Hospital pharmacy departments receive requests from care homes, and from medical and nursing colleagues to supply MCCAs.[19a] In order to avoid accusations of delaying discharges they may find themselves supplying MCCAs. At the November 2018 RMOC meeting, the chaotic, rapid nature of discharge from hospital was considered to exacerbate this problem. Community-based teams to whom individuals could be referred for medicines use assessment are not found widely.

Community pharmacy teams have scope to carry out medication use assessments (e.g. through Medicines Use Reviews (MUR's), New Medicines Services (NMS) and locally commissioned schemes) and suggest person-centred alternative interventions. However volume of people using MCCAs may limit capacity to employ these services effectively. Pharmacists working in care homes are able to carry out medication use assessments, but are not currently deployed in all care homes. In most areas of the country, there is neither routine requirement nor any systematic way in which to identify people who might need help with their medicines and then to find ways to meet their needs.

Some areas have taken it on to develop pathways across health and social care to standardize assessment and intervention implementation (e.g. Lewisham Integrated Medicines Optimisation Service[20], domiciliary pharmacists in Devon and Exeter [21], Norfolk Medicines Support Service[22] and Bristol City Council Short Term Assessment and Reablement (STAR) team[23]). In most other areas the approach is more *ad hoc*.[4]

There are validated assessment tools for use by clinical and non-clinical staff for use in some localities[24-27] but currently none of these have been adopted nationally, despite being recommended by RPS guidance in 2013.[2]

The LPC who submitted this topic report that pharmacy contractors find themselves pressured to provide MCCAs to care homes in order to maintain business, despite being aware of best practice guidance[2,3,5]. Pharmacy contractors find it hard to fund the volume of MCCAs demanded through the single activity fee. Attempts to use 7-day prescriptions to help cover costs can be disruptive, time consuming and labor intensive for GP practices, and leads to frustrations between GP practices and pharmacies.[19]

Recently Boots and Lloyds both announced that they will no longer take on dispensing and support for new care homes which insist on routine use of MCCAs for their residents. They are also working with care homes currently using MCCAs routinely to move from these to original packs.[29] A spokesperson from Boots said that their existing care homes teams are working closely with and supporting individual homes with this move.[30] As Boots is the UK's largest chain of pharmacies, this move in policy may encourage other community pharmacy chains and independent pharmacies to move in a similar direction.

In submitting this topic to the RMOC, pharmacy contractors are seeking support to implement best practice guidance around MCCAs. A recent AHSN report has suggested that support should come from the relevant regulatory authority.[7]

Action plan

Following a review of the literature and scoping conversations with key stakeholders, a proposed action plan has been developed for consideration by the RMOC. This is found in **Appendix One**.

Fundamentally, this action plan revolves around the need for health and social care providers and commissioners to collaborate in order to agree joint principles that they can use to work together to achieve a change in how MCCAs are used.

Implementation Plan Summary

1. RMOC to agree key stakeholders (**Appendix 2**) and convene a working group by **March 2019.**
2. RMOC to provide direction to working group on areas of focus and priority – by **March 2019**
3. RMOC to establish a **joint health and social care** working group to agree 'Gold Standard' approach to MCCAs. **March 2019**
4. RMOC to prioritise interventions that could be taken by considering the feasibility and likelihood of successful and cost-effective implementation of these. **March 2019**
5. RMOC to decide if any work which can begin immediately between **March to June 2019**
6. Working group, guided by RMOC, to produce final detailed implementation plan – from **June 2019 onwards**
7. Working group to deliver final implementation plan – by **March 2020**
8. Working group to implementation evaluation of outcomes of their work – from **June 2020**

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Appendix 1

	Description	Type **A** Engage for info **B** Develop tools **C** Disseminate info **D** Training	How will achieve	Who	Time	Timeline
			Initial stages			
1	Establish a joint **health and social care** working group to collate information, develop resources, disseminate information and agree a joint approach to implementation.	A	Establish stakeholder group (example in Appendix 1) Agree chair for stakeholder group RMOC to determine key deliverables and expected timelines	RMOC Secretariat to co-ordinate	1 mo	Month 1
			Engage for information			
2	Seeking out examples of **adherence frameworks and tools** designed to identify, assess and resolve medicines adherence issues.	A	Literature search Call for examples from across England	SPS Medicines Information SPS Medicines Use & Safety	2 mo	Months 2 to 3
3	Seek out best practice for social care policies that include commissioning of support for patients whose only need is medicines support	A	Call for examples from stakeholders	SPS Medicines Information SPS Medicines Use & Safety	2 mo	Months 2 to 3
4	Identify examples of local services where community pharmacies are resourced to offer provide medicines compliance support to patients	A	Call for examples from stakeholders	RMOC Secretariat SPS Medicines Use & Safety	2 mo	Months 2 to 3
5	Engage with Lewisham Integrated Medicines Optimisation Service (LIMOS) to identify what tools, training and business cases they have in place to do their roles	A	Representation at stakeholder meeting	RMOC Secretariat SPS Medicines Use & Safety	1 mo	Month 2
6	Work with regulatory agencies such as CQC and GPhC to understand where they think development needs are required in relation to appropriate use of MCCAs	A	Representation at stakeholder meeting	RMOC Secretariat SPS Medicines Use & Safety	1 mo	Month 2
7	Work with community pharmacy and social care providers to understand how relationships can be further developed and strengthened	A	Representation at stakeholder meeting	RMOC Secretariat SPS Medicines Use & Safety	1 mo	Month 3
8	Work with commissioners and providers of care to understand how the Equalities Act 2010 is interpreted and implemented	A	Representation at stakeholder meeting	RMOC Secretariat SPS Medicines Use & Safety	1 mo	Month 3
			Develop resources			
9	Publish a clear joint approach or strategy around appropriateness of MCCAs, indicating that MCCAs should only be supplied after a thorough assessment has been carried out that shows there is a justifiable need for an MCCA.	B	Literature search Consolidation of information from search and from representation from stakeholder meeting. Engagement with all stakeholders	SPS Medicines Information SPS Medicines Use & Safety RMOC for approval	6 mo	Months 3 to 9
10	There are few co-ordinated, structured approaches between health and social care organisations to recognise and review people who require medicines support. Work is needed to **develop services** equitably across the country, which can be initiated by local medicines optimisation	B	Information from request and from stakeholder meetings. Engagement among stakeholders when service draft is proposed	RMOC Secretariat NHS England Medicines Policy Subject Matter Expert (SME) – Integrated service	6 mo	Months 3 to 9

	Description	Type **A** Engage for info **B** Develop tools **C** Disseminate info **D** Training	How will achieve	Who	Time	Timeline
	leaders in any organisation.					
11	Identify funding requirements for the services to be developed, so they can be delivered in a sustainable manner.	B	Representation at stakeholder meeting	NHS England	1 mo	Month 9
12	Map out a formalised and funded pathway (within the co-ordinated, structured approach to address and provide medicines support) via which non-clinical staff in social care settings can refer the patient to receive additional support with medicines from trained and competent staff such as pharmacy teams.	B	Information from request and from stakeholder meetings. Engagement among stakeholders	SPS Medicines Use & Safety SME – carer organisation SME – community pharmacy	3 mo	Months 7 to 9
13	Develop a medicines compliance assessment with guidance on how to select a compliance aid type based on an individual's needs.	B	Literature search Consolidation of information from search and from representation from stakeholder meeting. Engagement with all stakeholders	SPS Medicines Information SPS Medicines Use & Safety	3 mo	Months 7 to 9
14	Work with **care providers (domiciliary care agencies and providers of residential and nursing care)** together with community pharmacy leaders to develop the resources that would be required to transition to original packs from MCCAs.	B	Representation at stakeholder meeting Drafting by project team Engagement with all stakeholders	SME – carer organisation SME – care home Royal College of Nursing Community pharmacy organisation	1 mo	Month 10
15	**Develop a national standardised and validated multidisciplinary tool** (or different tools for different user groups if a single tool is found to be inappropriate) to assess people who might need help with their medicines and to identify the best ways in which they can be supported.	B	Literature search Consolidation of information from search and from representation from stakeholder meeting. Drafting by project team Engagement with all stakeholders	SPS Medicines Information SPS Medicines Use & Safety SME – community pharmacy SME – Occupational therapy SME – carer organisation	3 mo	Months 7 to 9
17	Work with **Hospital Chief pharmacist networks** to develop a discharge system where people who need support with taking medication are identified with their needs assessed and addressed prior to discharge, identifying and providing additional resource for this if needed.	B	Information from request and from stakeholder meetings. Engagement among stakeholders	RMOC Secretariat SME – Transfer of Care Around Medicines AHSN	3 mo	Months 10 to 12
18	Work with **Community Pharmacy leaders** to develop tools and resources to support community pharmacy to review use of MCCA's in line with best practice guidance. This could include use of existing or developed pharmaceutical care services, policies and information resources.	B	Information from request and from stakeholder meetings. Engagement among stakeholders Commission from training developer	RMOC Secretariat SME – community pharmacy SME – trainer	3 mo	Months 10 to 12
19	Work with **Specialist Pharmacy Service** to update information hosted on its website about Medicines Compliance Aids to include information about different types of aid to compliance	B	Literature search Consolidation of information from search and from representation from stakeholder meeting.	SPS Medicines Information SPS Medicines Use & Safety	1 mo	Month 4
20	Work with health and social care commissioners to prompt review of social care policy so that social care packages *can*	B	Representation at stakeholder meeting Engagement with stakeholders	RMOC Secretariat	6 mo	Months 13 to 18

	Description	Type **A** Engage for info **B** Develop tools **C** Disseminate info **D** Training	How will achieve	Who	Time	Timeline
	be commissioned more easily if an individual only needs medicines support and adequate time is able to be allocated for providing regular support with medication for tasks.					
21	Develop business case templates for areas to introduce integrated medicines optimisation services such as LIMOS	B	Representation at stakeholder meeting Drafting by project team	RMOC Secretariat SME – Integrated Care SME – Commissioner SME – Care provider	1 mo	Month 4
Disseminate Information						
22	Agree clear dissemination plan for developed material with RMOC. In part this will be in the form of an RMOC Recommendation to enable dissemination and implementation.	C	Could include publishing guidance in pharmacy, medical, nursing and social care journals; engaging with LPCs and LMCs; working with inspectorate; national and local carer organisations	RMOC Secretariat AHSN	1 mo	Ongoing until end
23	Share RMOC recommendations with health and social care providers and commissioners so they will review their medicines and discharge policies in line with the approach to MCCA use identified by the working group	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
24	Share RMOC recommendations with organisations that commission care that they will update commissioning frameworks and policies so that they align with the best practice guidance around MCCA's and include a specific recommendation on how medicines should be routinely dispensed (i.e. in original packs)	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
25	Share RMOC recommendations with organisations that commission care that they will integrate principles/policy for appropriate medicines use (to include appropriate role of MCCA's) into provider contracts and audit performance against this. Policies should include arrangements for funding devices including filling/dispensing of MCCA's as well as other tools which support medication use (e.g. winged caps, large label printers).	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
26	Care commissioners to define expectations about how patient's medications needs should be identified, assessed and addressed. This should put forward the use of original packs of medicines supported by appropriate pharmaceutical care as the preferred intervention for the supply of medicines in the absence of a specific need for an MCCA in all settings, and should include disseminating the information that an MCCA is one adherence intervention amongst many.	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	Stakeholders	6 mo	Months 13 to 18
27	Share RMOC recommendation with health and social care	C	Representation at stakeholder	RMOC Secretariat	6 mo	Months 13 to 18

	Description	Type **A** Engage for info **B** Develop tools **C** Disseminate info **D** Training	How will achieve	Who	Time	Timeline
	providers and commissioners so they will raise awareness amongst their members around best practice guidance around MCCA's and provision of person-centred support around medicines use.		meetings Project manager Recommendation from RMOC Engagement with stakeholders	Stakeholders		
28	Share RMOC recommendations with stakeholders to integrate the use of the tool(s) into the health and social planning processes.	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
29	Work with key stakeholders to introduce the medicines compliance assessment into routine, cross-sector practice. Agree a process to get this assessment embedded into routine clinical practice across different care settings.	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
30	Work with **organisations which represent the interests of carers** (e.g. National Care Forum, National Care Association, Care England, National Association of Care and Support Workers, United Kingdom Homecare Association) to ensure recommendations are incorporated into practice on a local level	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
31	Work with **leaders of Medicines Optimisation In Care Homes Programme** to raise awareness of this programme so it can support care homes with implementation of medication review, de-prescribing, adherence and review of MCCA's.	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
32	Advocate appointment of local Medicines Support Champions in Care Homes and amongst carers to drive changes relevant to MCCA's.	C	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat Stakeholders	6 mo	Months 13 to 18
	Training					
33	Advise **hospital chief pharmacists** on training requirements to encourage a better understanding amongst all hospital staff on the selection of different medication adherence aids and how to communicate risks and benefits of MCCAs to different staff groups	D	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat SME – training Chief Pharmacists Network AHSN	3 mo	Months 19 to 21
34	Work with **leaders of Medicines Optimisation In Care Homes Programme** to consider how training could be delivered to support care homes implement medication review, de-prescribing, adherence and review of MCCA's.	D	Representation at stakeholder meetings Project manager Recommendation from RMOC Engagement with stakeholders	RMOC Secretariat NHS England SME - training	3 mo	Months 19 to 21
35	Recommend that all health and social care providers	D	Representation at stakeholder	RMOC Secretariat	3 mo	Months 19 to 21

	Description	Type **A** Engage for info **B** Develop tools **C** Disseminate info **D** Training	How will achieve	Who	Time	Timeline
	develop or amend local staff training programmes or protocols/ SOP's to align with the 'Gold Standard' approach to MCA's. This should include training to administer medicines from original packaging and how to refer a patient for pharmaceutical assessment of their compliance aid needs.		meetings Project manager Recommendation from RMOC Engagement with stakeholders	Stakeholders		
36	Request that Health Education England commissions training for carers and care provider organisations to administer medicines from original packaging, and seek endorsement from CQC, RPS	D	Representation from stakeholder meeting Recommendation from RMOC Communicate with HEE	RMOC Secretariat Health Education England	3 mo	Months 10 to 12
37	Commission training aimed at enabling non-clinical staff in social care to recognise medicines management issues.	D	Representation from stakeholder meeting Recommendation from RMOC Communicate with HEE	RMOC Secretariat Health Education England	3 mo	Months 10 to 12

Appendix 2: Proposed stakeholder list for joint health and social care MCCA work

- Specialist Pharmacy Service Medicines Use & Safety Team
- Specialist Pharmacy Service Medicines Information Team
- Community pharmacy contractor (LPC or RPS)
- Carer representative organisations
- Care providers
- Primary care GP (LMC or RCGP)
- Care Home organisation
- Local Authority (care commissioners)
- Clinical Commissioning Groups (care commissioners)
- Integrated Care Service
- Care Quality Commission
- General Pharmaceutical Council
- NHS England Health in Care Homes
- Hospital Chief Pharmacists
- Occupational Therapists
- AHSN working on TCAM

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