NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Managing medicines for people receiving social care in the community

Date of quality standards advisory committee post-consultation meeting: 21 March 2018

2 Introduction

The draft quality standard on Managing medicines for adults receiving social care in the community was made available on the NICE website for a 4-week public consultation period between 26 January and 23 February 2018. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 19 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific question:

1. For draft quality statement 4: In practice, who would have responsibility for updating the medicines administration record (MAR)? How could one measure whether changes to medicines are recorded in the MAR?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- It takes an overall sensible approach to managing medicines for people using social care in the community.
- The statements generally reflect the key areas for quality improvement.
- Arrangements for responsibility to provide medicines support are not always agreed between CCGs and Local Authorities, as the quality standard assumes.
- Concerns over a roles and responsibilities for record production and updating, specifically medicines administration records (MARs). Different views for who should take responsibility.
- There is not enough emphasis on supporting people to manage their own medicines.
- The role of informal carers in supporting people to effectively manage their medicines is an important aspect that is not made clear.
- The role of community pharmacists in supporting medicines management should be made clearer.
- Should distinguish between long-term and acute event prescribing.
- There could be more emphasis on outcomes, rather than systems and processes.
- Outcome measures should be more specific to each statement, rather than measuring medicines-related incidents.

Consultation comments on data collection

- Data sharing systems are not sufficiently established to record and share required information between the different services involved in medicines administration.
- Digital records would support implementation and data collection but these are not readily available.

- The national electronic prescription service does not record whether people need additional support with medicines.
- People can nominate a preferred pharmacy but are not registered to a specific pharmacy, which presents challenges around sharing information and collecting data.

Consultation comments on resource impact

- Community pharmacies do not receive funding for some aspects highlighted, such as producing MAR charts. This would need to be commissioned by local authorities.
- There would be a resource impact from producing electronic records.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults having an assessment for social care in the community have their medicines support needs included.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- There is no statutory responsibility on social care providers to do assessments of medicines support needs, whether they do so will vary locally.
- The role of informal carers should be strengthened.
- There should be more emphasis on monitoring of needs.
- Additional suggestions for inclusion in the definition of medicines support needs:
  - Support needed to order medicines
  - Support needed to engage with the prescriber
  - Support for adherence with inhaled drugs, particularly technique
  - Timely administration of medicines
  - Management of over the counter medicines.
- There may be a challenge in measurement because of different parties involved and different data sources. There is currently no system to record that an assessment of medicines support needs has been carried out.

5.2 Draft statement 2

Adults receiving social care in the community that includes medicines support have their general practice and supplying pharmacy informed when the support has started.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- General support for this quality improvement area.
- Should include that the GP practice/pharmacy record that they have been informed.
- Important to include a named individual/organisation who is providing the support, and ideally what the nature of such support involves.
- Should include notifying secondary care teams if they are responsible for day to day management of a person's care.
- Should include communicating changes to support needs and medicines, e.g. if someone has been in hospital.
- Current systems would make it difficult to record, and therefore measure the data.

5.3 Draft statement 3

Adults receiving social care in the community that includes medicines support have information about how and when medicines should be taken included in their medicines administration record.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Challenging to implement because of the variety of commissioning arrangements (including people arranging their own private care), providers and support.
- Concerns around use of MAR for how and when medicines should be taken:
  - MARs are not always available. There could be a significant resource impact from requiring a MAR to record each medicine on every occasion.
  - The statement could lead to unreasonable expectation that pharmacies and GPs produce MAR charts on demand.
  - A MAR is intended for recording the administration of medicines, rather than how and when they should be administered.
  - Could be introducing an extra layer of administration and complication.
  - Different opinions given for who should provide and maintain the MAR, i.e. social care providers/prescribers/supplying pharmacies.
- Suggestions made for refocussing the statement:
  - Details of how and when medicines should be taken could be included in care plans.
  - Could focus on the clarity of information provided about how and when to take medicines, rather than the process for recording.
  - Service providers able to request appropriate information about medicines from relevant healthcare professionals in order to maintain accurate records (with the consent of the person).
- Issues suggested around outcome measures, suggestions for data sources.

5.4 Draft statement 4

Adults receiving social care in the community that includes medicines support have changes to their medicines recorded in their medicines administration record.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- MARs are not always available. There could be a significant resource impact from requiring a MAR to record each medicine on every occasion.
- This information could be included in the person's care plan.
- The statement should have a timescale for updating of records.
- The rationale should be revised. MAR charts and other records are not the primary means of communication between the service and the person they are supporting

Consultation question 4. For draft quality statement 4: In practice, who would have responsibility for updating the medicines administration record (MAR)? How could one measure whether changes to medicines are recorded in the MAR?

- Different views given for whose responsibility it is to update the MAR (prescriber or provider). Overall agreement that the person updating it needs to be trained and competent to do so.
- Various measures suggested, however there was uncertainty over who would take responsibility for ensuring that the process was working.

5.5 Draft statement 5

Adults receiving social care in the community that includes medicines support are given information on how to raise any problems with their medication.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Overall support for the statement.
- This should be widened to include informal carers.
- Suggested change to statement wording to include “or address concerns”.
- Should include communication about medicines-related problems and resolution.
- Outcome should evidence that a formal process is provided to patients/carers.
- Suggestions made for data sources and the level of detail required to understand incidents.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Medicines reconciliation.
- Medication reviews.
- Use of over the counter medications that will no longer be prescribed.
- Supporting the person to ensure that they are taking as few medications as possible.
- “When needed” drugs management to ensure that these are taken correctly.
- Sharing of information about unused medicines.
- Raising awareness of people’s entitlement to pharmacy-based support to help them understand how to get the best from their medicines.
- Tackling inappropriate use of monitored dosage systems as a medicines support solution for patients receiving social care.
- Support for people with a learning disability.
- Personalised care.

Appendix 1: Quality standard consultation comments table – registered stakeholders

Ref	Organisation name	Section	Statement No	Comments
1	Association Of Directors of Social Services		Context statement Page 1	ADASS would once again reiterate that there are a wide variety approaches taken regarding how people are supported by social care in the community with medication support and management and that there is not a single, uniformly agreed and implemented approach in England. ADASS highlight that medication is not one of the 10 Care Act outcomes that fall within the ambit of social care and note that medication was indeed removed from the early drafting of the Care Act. Thus ADASS does not accept that Local Authorities are the proper authority responsible for medication support – indeed ADASS contend that this responsibility lies with CCGs under The Health Act 2006. Nonetheless, we are in a fluid and diverse arena and ADASS is very committed to taking partnership approaches and supporting CCGs with their responsibilities wherever we can – as long as it is safe and lawful for Local Authorities to do so – to achieve the best experience and outcomes for people. We are therefore very supportive of the caveat in the context statement that "The quality standard assumes that the responsibilities for providing medicines support have been agreed between the relevant NHS and local authority commissioners." The responses below are therefore written in the context that such agreements have been reached. Where the relevant agreements have not been reached they will not apply.
2	Association Of Directors of Social Services		Definition of terms page 19	Just in terms of sequencing, perhaps the list on p 19 and 20 could be moved to the start of the standard.
3	British Medical Association		General	The BMA believes that there is widespread confusion about the role of a medicines administration record (MAR). Many people believe that this is an instruction for the

Ref	Organisation name	Section	Statement No	Comments
				medication to be administered, whereas it ought to be regarded as a record that a medication has been given, with the instruction being provided by the information provided by the prescriber on the prescription and recorded by the dispenser on the original packet. We do have concerns that many organisations that use MAR charts use them inappropriately as an authority to administer, rather than as a record of that administration.
4	Care Quality Commission Medicines Team.	Overall	General	**Does this draft quality standard accurately reflect the key areas for quality improvement?** The quality statements are welcomed as they provide clear direction for improvements for providers and stakeholders.
5	Ceretas	General	General	There needs to be recognition of the outcomes for administering/taking medications. These standards only look at systems and things going wrong which they will. The role of caring relative/advocate in the taking of medication is paramount these people will understand the intricacies on how people take medication to support their well being which may not be as prescribed, they know the person which often someone who is prescribing medication may not (particularly in a hospital scenario or a locum doctor).
6	Greater Manchester Local Pharmaceutical Committee	General	General	It is also worth noting that community pharmacies provide services and a support network for carers (paid and unpaid) of people with dementia, including flu vaccinations.
7	Harrogate and Rural District CCG	General	General	Medicines related incidents is referred to as an measure of outcomes for the statements - In order to be relevant to the specific statement this would need to a measure of the incidents related to the specific statement rather than medication incidents as a whole (which happen for multiple reasons). Would it be appropriate to state a reduction in incidents related to lack of assessment of needs, for example, rather than just an audit of incidents.
8	Harrogate and Rural District CCG	General	General	When the document refers to “local data collection” is it possible to indicate who this relates to? Is this the social care providers own audit process or is a wider footprint anticipated.

Ref	Organisation name	Section	Statement No	Comments
9	Mencap	General	General	It is vital that all staff supporting people with their medications – whether social care staff or healthcare professionals – have knowledge of the STOMP campaign from NHS England. “It is estimated that every day about 35,000 people with learning disabilities or autism are prescribed psychotropic medicines when they do not have a diagnosed mental health condition, often to manage behaviour which is seen as challenging. This includes medicines used to treat psychosis, depression, anxiety and sleep disorders. It also includes epilepsy medication when it is only used for its calming effect, rather than to treat epilepsy.” NHS England, (2016)
10	Pharmaceutical Services Negotiating Committee		General	We believe the draft quality standard does accurately reflect the key areas for quality improvement, however we wish to comment on the challenges to implementation of the requirements underpinning the quality standards. A number of the standards will require community pharmacy contractors (owners) to undertake additional work which is not funded via the national Community Pharmacy Contractual Framework. In particular, the proposal in Quality Statement 3 that pharmacies should consider supplying printed medicines administration records represents an unfunded cost, unless this is covered by a locally commissioned service. We suggest that local authorities should be reminded of the need to commission such services from community pharmacies, in order to support the implementation of the quality standards.
11	Royal College of General Practitioners	General	General	Overall a sensible approach which needs a digital record if possible to make it easy to use and accessible to the key agents, i.e. patient, carer, Pharmacist, GP, Nurse, Residential provider with essential confidentiality safeguards. Distinction should be made between short term prescribing for an acute event and long term prescribing for chronic problems. There may be problems when medication is determined by a previous test required each time e.g blood sugar, or anticoagulant monitoring

Ref	Organisation name	Section	Statement No	Comments
				It would be helpful to know the current situation of patients needing this support, who provides and reported problems of compliance, missed doses, timings and errors. The problems can be different for the elderly with dementia, the young person with a learning disability, the mentally ill and the recovering addict. The service needs to be regularly audited
12	Royal College of General Practitioners	General	General	Prescription queries should be raised initially with the pharmacist.
13	Royal College of Nursing	General	General	We are keen to have added to these statements the importance to support people with a learning disability in managing medicines. At the RCN we support the NHS England Stop Over Medicating of People (STOMP) with learning disability (LD) guidance which aims to stop the over reliance of psychotropic medication. It is important that these quality statements consider the necessary reasonable adjustments for people with LD so they can better understand their medication and aid effective compliance. This will include healthcare professionals ensuring adequate time is given to explaining medications and in a format that is easy to understand.
14	Royal College of Nursing	General	General	Broadly very positive statements but we would like greater emphasis on monitoring...i.e. the monitoring arrangements both for individual drugs for example, blood tests and monitoring of the person's needs for medicines support, notably if the person has diagnosis such as dementia or exacerbations such as infections which result in a permanent or temporary decline in ability to manage. Annual review is inadequate.
15	South West London and St George's NHS Trust		General	Definition of social care in the community would be useful

Ref	Organisation name	Section	Statement No	Comments
16	Association Of Directors of Social Services		1	ADASS support this QS. There may be challenges in ensuring that the outcomes can be measured in both outcome a) and outcome b). This is because there is a wide range of assessors and providers involved in delivering this QS and the data isn't necessarily held in one place – thus making it challenging to source. For example not all care providers are on the Approved Provider lists of Local Authorities. Additionally, most domiciliary care support in England is directly funded by people themselves rather than through council funding/service routes. Therefore (although this does vary between council areas) the majority of people who receive social care provision around their medication support needs will not be known to the Local Authority and data will not be held by Councils for this cohort. For a) NICE would need to be clear about the most effective way of ensuring the appropriate data source delivers the required evidence. For the outcome in QS1 a) utilisation of the CQC in this regard would be very effective as all providers are registered with CQC. For the outcome in QS 1 b) LA Safeguarding Boards could be the most effective data source. Where medication related incidents occur, they should be reported under safeguarding procedures and LASBs should be able to report on them. It may be worth suggesting that LASBs have a data code specifically for reporting on MRIs in people's own homes where people receive social care. As opposed to, for example, having a single code that reports MRIs irrespective of whether someone lives in a care home or in their own home. Overall, ADASS is not convinced that NICE can be as directive as to name and oblige the CQC and LA Safeguarding Boards to collect this data (if it isn't already held). Perhaps these routes can be suggested as examples? Our concern is that the multi-faceted nature of this provision might lead to inconsistent and unreliable data sources being selected that are not truly representative. In turn, unless there is a consistent set of metrics across all LAs

Ref	Organisation name	Section	Statement No	Comments
				then comparative data will be of little use. If comparative data is not important (although ADASS contend that it is if we are to avoid an ensuing “postcode lottery”) then perhaps NICE can suggest “Health and Social care commissioners and providers should ensure that there are credible and robust local systems in place to measure and report on outcome a) and outcome b)”
17	British Geriatrics Society	page 5-8	1	Standard mechanisms for assessing medicine support needs are needed.
18	British Geriatrics Society	page 5-8	1	National agreement is needed about who will be able to undertake these assessments.
19	British Geriatrics Society	page 5-8	1	Clarity is needed about training for assessment of medicine support. There should be a national competency framework which has to be assessed and signed off.
20	British Geriatrics Society	page 5-8	1	A particular issue is non- intentional adherence with inhaled drugs due to poor technique and it is crucial that this is reviewed by someone trained in the techniques.
21	East Riding of Yorkshire Council	Q1 – Rationale Q2 - Local systems and structures Q3 - Achievable by local services	1	Yes, this statement does accurately reflect the key areas for quality improvement. Support with medication is not an eligible need under the Care Act 2014. Whilst is it not our statutory responsibility, as it is a health need not a social care need, our current practice is that the assessment of support with medication is completed alongside the social care assessment which is mainly due to commissioning arrangements. There is qualitative but not quantitative evidence that local systems and structures are in place to collect data for the proposed quality measures. This could be done through case file audit rather than routine data collection.

Ref	Organisation name	Section	Statement No	Comments
		Statement 1 - Assessing medicines support needs		Social Care providers are not resourced to do this due to financial pressures. It is difficult to say at this stage what the resource requirements would be and any potential cost savings or opportunities for disinvestment.
22	Greater Manchester Local Pharmaceutical Committee	Statement 1	1	We would welcome trained colleagues assessing people's medicines support needs against a national template and then making appropriate referrals to community pharmacy as the experts in providing this support.
23	Greater Manchester Local Pharmaceutical Committee	Definitions: Medicine support needs (page 7)	1	We very much welcome the detail in the bullet points, particularly the importance placed on information-sharing and communication with community pharmacies. This is currently an area that can be challenging – care providers are often happy to share information with GPs but not with pharmacies, despite the importance of them having this detail. As mentioned previously, however, although many people have a nominated pharmacy for repeat prescriptions or a preferred regular pharmacy, they are not 'registered' with a specific pharmacy in the same way as they register with a GP practice and medicines support needs are not recorded in the national NHS Electronic Prescription Service (EPS).
24	Greater Manchester Local Pharmaceutical Committee	Definitions: Medicine support needs (page 7)	1	We are also conscious that people's needs can change over time, particularly if they have progressive or degenerative conditions. It is important that their support needs are reviewed regularly and that updated information is also shared with supplying pharmacies.
25	Mencap	Statement 1	1	There are important support needs missing from this statement which we feel must be included in the definition of medicines support needs on page 7: - the person's aims and goals for how they manage their medicines; - what communication support they need to understand their medication – including easy read or other communication aids; - support they may need to collect and reorder medicines; - requesting reasonable adjustments from the pharmacy to manage their medicines – including disposable dosset boxes; - support they are likely to need to manage new medicines;

Ref	Organisation name	Section	Statement No	Comments
				- support they may need to deal with changes to existing medicines; - how they may manage short term medicines for acute conditions (including over the counter items); - what support they may need to make decisions around their medicines; - what support they need to ensure their medicine is reviewed appropriately – particularly if they are taking psychotropic medicines or others that require regular review; - support they will need to purchase medicines over the counter – particularly in light of policies which may require patients to purchase their own medications such as paracetamol.
26	Parkinson's UK		1	Parkinson's UK does not believe that medication timings are sufficiently acknowledged in this section. In order to optimise medication in the treatment of Parkinson's and other conditions, it is essential medicines are administered on time. We therefore recommend that the Quality Standard makes specific reference to the importance of medication timing within the list of 'medicines support needs'. If people with Parkinson's don't get their medication on time, their ability to manage their symptoms may be lost either temporarily or permanently. For example they may suddenly not be able to move, get out of bed or even walk down a corridor. Such is the importance of medicines timings that if these are not adhered to they can have serious long-term implications for someone with Parkinson's. **Recommendation:** The list of medicines support needs includes a mention of the importance of receiving medication at a particular time and the importance of keeping regular care appointments to facilitate this.
27	Parkinson's UK		1	We are also disappointed that the draft quality standard does not recognise the important role of friends, family and other unpaid carers who regularly support people with Parkinson's to manage their medication, particularly if it falls outside of scheduled social care appointments.

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				This is particularly important for people with Parkinson's, who often rely on loved ones to support them with daily activities, such as managing their medication. A carer of a person with Parkinson's explains: "For years I have been my husband's full-time carer. The progression in severity and complexity of his various health conditions has meant my caring role has had to alter and adapt to his ever increasing needs." In this way, friends and family members can often be jointly responsible for medicines management for people with advanced Parkinson's, alongside social care services. **Recommendation:** The Quality Standard emphasises the role of friends, family and other unpaid carers in supporting and facilitating medicines management and highlights the importance of social care staff liaising with them to ensure medication doses are not missed outside of care appointments
28	Royal College of General Practitioners	Statement 1	1	It is appropriate that assessment for social care needs includes medicines support needs. However, I would question the two outcomes proposed, and in particular what is meant by "number of medicines-related incidents" for outcome B – this could be a relevant outcome, but seems very vague and is likely to be highly unreliable as a measure specifically related to this statement; this similarly applies to the other statements which use this outcome.
29	Royal College of General Practitioners		1	I would suggest that the assessment should include medications that can be purchased over the counter, and do not need to be prescribed. Very often carers request prescriptions for etc medications, advising that they are not allowed to administer them without a prescription. I would argue that this is not cost-effective, and the initial assessment could include this and enable carers to administer these medications without the need for a prescription.

Ref	Organisation name	Section	Statement No	Comments
30	University Hospital Southampton NHS Foundation Trust	Quality statement 1	1	Assessment of medicines support needs should involve a pharmacy professional, either directly or by provision/approval of training to social care service providers. The full range of support options must be considered and the appropriate support provided for each individual patient's need. This requires understanding of the principles of medicines review and concordance. The pharmacy professional time required for this could be released by stopping the widespread unnecessary dispensing into monitored dosage system devices.
31	Voluntary Organisations Disability Group	Quality statement	1	We agree with this quality statement.
32	Voluntary Organisations Disability Group	Definition of terms	1	This should include a definition of medicines support needs.
33	Voluntary Organisations Disability Group	Definition of terms	1	The assessment should also take into account support needed to: Order medication, including obtaining the correct formulation. Engage with the prescriber, including for medication to be reviewed.
34	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 1: Quality statement	1	This is a key area for quality improvement. However, assessment of medicines support needs should be undertaken by an appropriately qualified person with medicines expertise e.g. pharmacist or pharmacy technician. Otherwise there is a risk of in appropriate on unnecessary recommendations being made (such as inappropriate use of monitored dosage systems). Specifying that the assessment is done by a pharmacist with full access to the medical records would enable a full face to face clinical medication review to be undertaken at the same time. This review could include optimisation of medication, deprescribing, implementation of any necessary monitoring, rationalising doses to minimum frequency per day and alignment of prescriptions to facilitate efficient monthly ordering. This would enable, as far as possible, simplification of the medication, improve concordance and may even reduce the need for ongoing medicines support.

Ref	Organisation name	Section	Statement No	Comments
35	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 1: Quality measures	1	At present existing resources do not include recording of assessment of medicines needs. Ideally this could be one electronically by the pharmacist undertaking the assessment and the completed assessment form could be electronically communicated to the patient's GP and community pharmacy (if the pharmacist was not the supplying pharmacist) to facilitate statement 2. This could be realistically achieved if all community pharmacies had access to medical records and could communicate via nhs.net.
36	Voluntary Organisations Disability Group	Equality and diversity considerations	1 and 3	Services providing medicines support should make reasonable adjustments to ensure that a person with any intellectual disability can be involved in discussions and decision-making about medication; this should not be limited to a person with cognitive decline or fluctuating mental capacity.
37	Association Of Directors of Social Services		2	ADASS support this QS. Again, we believe that the existing data sources may not routinely in all cases have baselines established re this QS. There is variety on the quality of providers' medication policies. The quality measure about detailing within provider's medication policies the need to inform pharmacists and GPs when the support has started is a sensible one. This expectation can be strengthened by obliging health and social care commissioners to include specific reference to this requirement in the commissioning approaches and procurement specifications
38	British Geriatrics Society	page 9-11	2	More specific outcome measures are needed.
39	Care Quality Commission Medicines Team.	Statement 2	2	**Adults receiving social care in the community that includes medicines support have their general practice and supplying pharmacy informed when the support has started.** It might be difficult to retrieve this information depending on how the information is shared locally (standard form, coded by Local Authority/Care Provider) and how it is recorded by the GP and Community Pharmacy. Also not sure how this would be linked to the outcome measure of number of medicines related incidents. There would need to be local governance arrangements to capture incidents.

Ref	Organisation name	Section	Statement No	Comments
40	East Riding of Yorkshire Council	Q1 – Rationale Q2 - Local systems and structures Statement 2 - Communicating that medicines support has started	2	Yes, this statement does accurately reflect the key areas for quality improvement. Social care providers inform the GP and pharmacy when support has started. There is a joint policy with East Riding CCG in relation to the administration of medication in the domiciliary care sector. This policy is currently under review.
41	Greater Manchester Local Pharmaceutical Committee	Quality measure b) (page 10)	2	We fully support the measure of the proportion of adults whose supplying pharmacy has been informed medicines support has started. As noted above, while many people have a nominated pharmacy for repeat prescriptions or a preferred regular pharmacy, they are not 'registered' with a specific pharmacy in the same way as they register with a GP practice.
42	Harrogate and Rural District CCG	Quality statement	2	In order to make the statement more likely to be effective - it would beneficial to include that the General Practice and Pharmacist should actually record the information in their records including who to contact in the actual quality statement.
43	Mencap	Statement 2	2	It is important this section also includes communications about medications support and changes to medication between different providers – for example when someone goes to hospital or is discharged from hospital.
44	Parkinson's UK		2	Although we welcome the principle of this recommendation, we are concerned that the explicit reference to a person's GP is too narrow to be of use for many people with social care needs who will have their conditions managed in secondary care. People with Parkinson's will receive medical management of their condition from their neurologist, with support from physiotherapists, speech and language therapists, nurse specialists and others, as their condition deteriorates. It is therefore crucial that social care staff and organisations implementing these quality

Ref	Organisation name	Section	Statement No	Comments
				standards notify the teams and individuals who are directly responsible for the day to day management of a person's condition. **Recommendation:** We believe the wording of recommendation two should read 'the professional responsible for the medical management of a person's condition'
45	Royal College of General Practitioners	Statement 2	2	Although informing the GP/pharmacist is all very well, It is more important to make sure that this includes a named individual/organisation who is providing the support, and ideally also what the nature of such support involves. Again, I would question the vagueness of the outcome.
46	Royal College of General Practitioners		2	It is important that carer organisations contact the GP practice to inform them that they have taken the patient on. Very often I visit patients, and make changes to their medications, but do not have any contact details for the carers in order to inform them. There is very often no paperwork in the house or patients records to help me.
47	South West London and St George's NHS Trust	Quality Measure	2	Need some standardised terminology regarding different types of medicines support otherwise it is going to be difficult to compare between different service providers
48	Voluntary Organisations Disability Group	Quality statement	2	We do not agree with this quality statement. This is only relevant if the care provider needs to ask the GP or the pharmacist to do something differently. Otherwise this information is not relevant to the GP or the pharmacist.
49	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 2: Quality statement	2	This is a key area for improvement. A process does not currently exist. Resources such as community pharmacist access to medical records and access to nhs.net would facilitate this process. Whether it is achievable and how much resource would require depends on who is undertaking the review. If it is the GP pharmacist or the supplying community pharmacist this should be relatively straightforward. If a third party is introduced it becomes potentially more complex. Ideally, communication needs to be electronic so that records can be updated in a timely

Ref	Organisation name	Section	Statement No	Comments
				manner. Asking patients to register with regular pharmacy and utilisation of electronic transfer of prescriptions would also facilitate the process.
50	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 2: Quality Measure	2	A process does not currently exist to undertake this process. With the resources described above it should be achievable. A defined and agreed read code to describe this medicines support which is not already in current use would be required.
51	Association Of Directors of Social Services		3	ADASS support this QS. Re Outcome a) staff surveys will be useful tools as would training audits of providers (and their staff) responsible for knowing about each medicine Re outcome b) we would make the same comment as per in QS1 a above Re outcome c) we would again suggest LASBs as an effective source but ask that NICE consider how to get to the granular information of what caused the MRI – i.e. can we identify that the MRI was related to QS3
52	British Geriatrics Society	page 12-14	3	Page 13- service providers must ensure not only that mar charts are up to date but also that they contain information about how and when medication is to be taken.
53	Care Quality Commission Medicines Team.	Statement 3	3	**Adults receiving social care in the community that includes medicines support have information about how and when medicines should be taken included in their medicines administration record.** This could also be included in the person's care plan.
54	East Riding of Yorkshire Council	Q1 – Rationale Q2 - Local systems and structures Q3 - Achievable by local services	3	Yes, this statement does accurately reflect the key areas for quality improvement. Information about how and when medicines should be taken are included in the DOMMAR Audits of DOMMAR's are completed on a regular basis. This is currently achieved through the DOMMAR.

Ref	Organisation name	Section	Statement No	Comments
		Statement 3 - Information about medicines		
55	Greater Manchester Local Pharmaceutical Committee	What the quality statement means for healthcare providers (page 13)	3	The potential confusion caused by medicine switches (e.g. from branded to generic drugs, or between different manufacturers) presents a further challenge. It is proving particularly problematic with the current, and ongoing, drug shortages and supply issues. Community pharmacies are spending a significant amount of additional time each day trying to source medicines, and having to switch between suppliers depending on availability. It can be very confusing for people when they receive medication that looks different from their usual supply. There are some excellent examples of good practice, with community pharmacies providing personalised guides that explain what each tablet looks like and what it does (e.g. small white pill – blood pressure) but it is extremely time-intensive, especially given the volume of medication many people take and the frequency of switches. Some pharmacies are investing significant effort in creating personalised guidance like this. This is currently unfunded and, as stated at comment 6, we believe it would be cost-effective for system leaders to fund pharmacy services ensuring consistent delivery of this form of personalised medicines support.
56	Greater Manchester Local Pharmaceutical Committee	What the quality statement means for healthcare providers (page 13)	3	While a number of pharmacies already provide medicines administration records for use by social care providers, this is unfunded. Additional investment in national pharmacy funding will be required to ensure consistent delivery of this form of personalised medicines support in all community pharmacies. We believe it would be cost-effective for system leaders to fund such pharmacy services. It could be funded through cost savings from reduced medicines wastage, incidents and harm, and medication-related attendances/admissions at more expensive healthcare settings.

Ref	Organisation name	Section	Statement No	Comments
57	Harrogate and Rural District CCG	Quality Statement	3	A quality standard on information about medicines would be welcomed; however, the standard proposed appears to focus on where it is recorded (the MAR chart) rather than the availability of the information itself. To administer medication safely social care providers need clear directions and relevant information to be provided by an appropriate healthcare professional, for example, clear directions rather than “as directed” on a medicine. This would seem to be in line with recommendation 1.7.3 in NG67 and recommendation 1.3.3, 1.3.4. Could amending the quality standard to reflect the importance of provision or obtaining of the relevant information be considered? For example, “Adults receiving social care in the community that includes medicines support have clear directions about how their medication should be taken provided by a healthcare professional which are followed by the social care staff supporting them.
58	Harrogate and Rural District CCG	Process	3	This process appears, like the quality standard, to be more linked to limiting where the information is recorded rather than the actual availability and provision of relevant information for the people administering the medication. It may be possible that the full information required does not fit on the MAR chart and is instead included on a separate care plan or protocol. Could revision of the process be considered, for example ”proportion of medicines prescribed to adults receiving social care in the community that includes medicines support that have clear information on how to take and use them which is accessible to the person administering the medication.”
59	Harrogate and Rural District CCG	Numerator and denominator	3	The collection of this data would require a considerable time investment and hence cost to achieve as many care providers will not have electronic or other systems which allow them to easily count how many individual medicines they are supporting people with across the service.

Ref	Organisation name	Section	Statement No	Comments
				To manage this on a wider footprint across services would be challenging due to the variety of commissioning arrangements (including those who arrange their care privately) and variety of providers and types of support being given.
60	Harrogate and Rural District CCG	What the quality statement means	3	**Service providers:** As given this appears to be more about record keeping than the provision of information. Service providers need to be given or be able to request appropriate information about medicines from relevant healthcare professionals in order to maintain accurate records (with the consent of the person).
61	Harrogate and Rural District CCG	What the quality statement means	3	**Healthcare professionals: Please can this statement be reconsidered.** The provision of a MAR chart is the responsibility of the social care provider and is a record of the care and treatment given. It is not a prescription or direction to administer. There is no requirement for dispensing GPs or pharmacists to produce MAR charts, nor is considering whether to or not to do so any indication of the quality of care given by GPs or pharmacists. It seems inappropriate to have this in what the quality statement means to healthcare professionals. It is essential that healthcare professionals do provide appropriate information to the person and the staff supporting them in order for the person to take or be given the medication safely. Directions on the prescription should be unambiguous and timings (where clinically appropriate) clearly stated and transcribed onto the dispensing label. NG67 contains several recommendations about the sharing of information between healthcare professionals and social care staff around the provision of relevant information which would be more relevant to healthcare professionals. (see comment number 5) Even though the word “consider” is used – an unreasonable expectation that pharmacies and GPs “must” produce MAR charts on demand can be created and an impression created that recording and care is not adequate unless the MAR chart is produced by a healthcare professional. This is not the case and creates

Ref	Organisation name	Section	Statement No	Comments
				unnecessary uncertainty for social care providers in producing their own documentation.
62	Harrogate and Rural District CCG	What the quality statement means	3	**Commissioners:** This statement actually appears to be more related to statement 4. There is part of the section in statement 4 which looks more appropriate “They ensure services have robust local processes for sharing information about a person’s medicines that take account of each service user’s expectations for confidentiality.”
63	Nene Clinical Commissioning group	Quality statement 3: Quality statement	3	We understand the reasoning behind the removal of the old “levels of administration “ i.e. to make the medicines support more patient-centred but the requirement for a medicines administration record (MAR) to record this support for each medicine on every occasion it is provided will impact greatly on providers of care with regard to resources of time , money and robust systems to ensure that every single care worker is adequately trained . At present when just a prompt or assistance with medication was required this information is recorded at each provision in the care plan or daily notes not on a MAR . Is it essential that this record is on a MAR ?
64	Royal College of General Practitioners	Statement 3	3	In my view, what is missed here is whether or not a medicines administration record is available in the first place. One could certainly think of the example of a patient who receives help from a carer to open their dosette box and take their pills (presumably this would count as "medicines support", but no formal record is kept. So surely it is not just the nature of what is entered in the medicines administration record that needs to be considered (this seems eminently sensible), but that there is a record kept in the first place. Again, the "medicines-related incidents" outcome is vague.
65	Royal College of General Practitioners	Statement 3	3	This seems to me to be introducing an extra layer of administration and complication with the MAR that will not necessarily result in fewer unnecessary admissions and could cause a lot more work for pharmacists and GPs in particular. Presumably the patient or their representative would give signed permission for someone to support with medication. The record belongs then to social care or the

Ref	Organisation name	Section	Statement No	Comments
				patient? But it is also shared with the prescriber who initiates medication, so the prescriber is ultimately responsible for making changes to the MAR when making medication changes? The patient would therefore need to bring the MAR to every consultation and the prescriber would need to check the MAR at every home visit. At the moment, we depend on the pharmacy blister packs or dosette dispensers which may be managed by the pharmacy or the patient or carer.
66	Royal College of General Practitioners	3	3	As well as when and how perhaps this should record what for? I have several examples of patients with language difficulties missing one or two of their medications through family ignorance.
67	Royal Pharmaceutical Society	Statement 3 Page 13	3	In most of England, community pharmacy is not commissioned to supply printed medicines administration records for a person receiving medicines support from a social care provider. Any local authority commissioning would need to ensure that community pharmacy is commissioned to supply printed medicines administration records.
68	South West London and St George's NHS Trust	Quality Statement	3	It would be great to specify here that medicines administration record should include indication for medication and a picture of the medication
69	Voluntary Organisations Disability Group	Quality statement	3	Suggested alternative: Adults receiving social care in the community that includes medicines support should have information about how and when medicines should be taken included in their medicines administration record and their medicines support care plan.
70	Voluntary Organisations Disability Group	Equality and diversity considerations	3	For people with a visual impairment medicines information and labels should be available in large font.
71	West Bridgford Medical Centre, Musters Road,	Statement 3: Quality statement	3	This is a key area for improvement. Use of electronic MAR forms would facilitate this process. The amount of information to be included on the actual MAR form as opposed to being supplied as separate patient information leaflets would need to be

Ref	Organisation name	Section	Statement No	Comments
	West Bridgford, Nottingham, NG2 7PX			defined. Some medication requires a lot of information (e.g. oral bisphosphonates) and it may not be practical to put all this on the actual MAR form. So it may be necessary to provide supplementary information in another format where appropriate.
72	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 3: Quality measure	3	This could be relatively easily measured if an electronic MAR form were in use. Trying to measure this from paper or handwritten MARs would be very difficult and time consuming.
73	Royal College of General Practitioners		3/4	If the MAR form could be kept obviously within the house, it would be easy for the GP to update this, however it is very often impossible to find any paper work! I think that (provided the practice have been informed who the carers are) the GP should take responsibility for informing the carers of the change, but the care organisation then has responsibility to update the MAR sheet.
74	Association Of Directors of Social Services		4	ADASS supports the QS. However, in relation to the question 4 on page 16, ADASS does not believe that social care staff can have responsibility for updating the MAR chart. This is a clinical responsibility and the actual responsibility lies with the prescriber. There could be discussions about how this responsibility is delegated from the prescriber to the provider but this should only be on the basis that the provider is willing to accept this responsibility and that they trained and competent to undertake this. Explicit clarity would also need to be provided where cases are so delegated regarding legal liability if something goes wrong. Measuring recorded changes in the MAR could be done by various audit routes – CCG/District Nurses/Providers/Pharmacists
75	British Geriatrics Society	page 15-16	4	Timescales need to be explicitly set for this standard if it is to have value, currently the lag between the prescription amendment and the medication chart amendment causes clinical risk. these timescales should be audited.

Ref	Organisation name	Section	Statement No	Comments
76	Care Quality Commission Medicines Team.	Statement 4	4	**Adults receiving social care in the community that includes medicines support have changes to their medicines recorded in their medicines administration record.** The social care provider is responsible for ensuring they have up to date and accurate information about a person's medicines and this is recorded in a way that is accessible and understood by care staff. MARs do need to be an accurate reflection of the medicines a person is taking but details of medicines support (how a person is to be supported) should be in people's care plans and are not normally on the MAR
77	Ceretas	Question 4 For draft quality statement 4: In practice, who would have responsibility for updating the medicines administration record (MAR)? How could one measure whether changes to medicines are recorded in the MAR?	4	Commissioners or providers have no mandatory competence about medicines or MAR charts (this is not a essential part of their job description); the responsibility for medicines can clearly only be held by a trained medical practitioner or a pharmacist both of whom have many years training specific to medicines. The solution is closer working with GPs/pharmacists and care staff but as present there is no budget that supports homecare/care home visits by either of these professionals so this is unachievable for the housebound. Responsibility must be with a named individual who has the competence to be one.
78	East Riding of Yorkshire Council	Q1 – Rationale Q2 - Local systems and structures Q3 - Achievable by local services	4	Yes, this statement does accurately reflect the key areas for quality improvement. Communication needs to improve from primary care to social care providers relating to changes in medication, therefore, requires GP participation. Resource issues which exist in social care and local authorities are also evident with GPs and pharmacies. Resources to deliver this effectively is a system-wide challenge and not one that could be resolved by looking at an individual element.

Ref	Organisation name	Section	Statement No	Comments
		Q4 - Responsibility for updating the MAR Statement 4 - Keeping records up to date		It is difficult to say at this stage what the resource requirements would be and any potential cost savings or opportunities for disinvestment. The pharmacist has the responsibility for updating the MAR. This could be measured through an audit of records.
79	Greater Manchester Local Pharmaceutical Committee	Question 4	4	We believe this is a matter for social care providers.
80	Greater Manchester Local Pharmaceutical Committee	General (pages 15-16)	4	Hospital discharge systems vary. A community pharmacy may have patients coming from different hospitals with different processes and policies; information about a person's current medications is not currently shared with community pharmacy in a consistent manner. We would welcome the insertion of a statement expressly highlighting the importance of timely information-sharing with community pharmacy on discharge from hospital.
81	Greater Manchester Local Pharmaceutical Committee	General (pages 15-16)	**4**	On a similar note, there should be a medicines reconciliation process by community pharmacy when a person receiving social care in the community moves between care settings.
82	Harrogate and Rural District CCG	Quality Standard	4	Although the MAR chart does need to be kept up to date – the changes also need to be documented in the healthcare professional's records and usually further information is also needed in the person's care records with the social care provider. Can widening the standard be considered? For example, "changes to medication are recorded in the person's records"
83	Harrogate and Rural District CCG	rationale	4	"If services maintain and share change to medicines with the adult receiving social care in the community or their named contact …" should there be an "if" in this statement? Care should be person centred and the person or their representative should be involved in the decisions about any changes rather than it being shared

Ref	Organisation name	Section	Statement No	Comments
				with them afterwards. It is not clear however how this is the rationale for the MAR chart (or other records) being updated as these are not the primary means of communication between the service and the person they are supporting.
84	Harrogate and Rural District CCG	Question for consultation	4	Who is responsible for updating the MAR chart? The responsibility lies and should remain with the social care provider. There should be trained and competent members of care staff available who are able to make this record. Changes can occur outside of the times when a pharmacy or dispensing GP may be available to prepare the MAR chart. If a different pharmacy needs to be used to obtain the supply in a timely fashion, any MAR chart produced may be different to the one used previously which could cause confusion. An artificial delay in starting the medication may occur if care staff cannot administer because they do not have a pharmacy or dispensing GP produced printed MAR chart. For some medications this could have significant clinical implications. If a new prescription is not required it is helpful for the prescriber to confirm the change in writing. NG67 recommendation 1.4.4 supports this. Recommendation 1.4.6 gives advice on dealing with verbal changes which are sometimes appropriate in primary care. This seems a reasonable position to stay with.
85	Harrogate and Rural District CCG	Question for consultation	4	Monitoring the standard: Internal service provider audit of MAR charts to check if the information is documented clearly including being appropriately checked as soon as possible after being written. (This will not necessarily be at the time it is written as there may not be two staff available)
86	Pharmaceutical Services Negotiating Committee	Quality statement 4	4	If a pharmacy contractor agrees to provide a medicines administration record, it is likely that at least part of the responsibility to keep it up to date will fall to the pharmacy contractor. As referenced above, this represents an unfunded cost to pharmacy contractors, unless an appropriate locally commissioned service is put in place by the local authority.

Ref	Organisation name	Section	Statement No	Comments
87	Royal College of General Practitioners	Statement 4	4	This is very important. However, again, there needs to be a "medicines administration record" in the first place. The challenge will be to ensure changes are reconciled across different service providers (e.g. GP prescription record and community pharmacist compiled dosette box need to align with what is documented in the record). I would have thought an important outcome would be to audit the number of inconsistencies (this should be done by a pharmacist or GP, but probably not by the carer/patient), as well as having a record of processes for reconciling differences. The person having responsibility will vary - the prescriber should probably be considered to have the "definitive" record, but I suspect it is impractical to expect GPs to check their own records align with those in the patient's MAR.
88	Royal College of General Practitioners	4	4	Changes are always difficult to negotiate. At the moment, the whole blister pack (for example) goes back to pharmacy which must result in wastage when a new blister pack is made. Another problem is “when needed” drugs for pain or anxiety. The medicines support person cannot be there all the time so some way needs to be found for patients to record when they initiate “as needed” meds. One of my patients with poor sight was given too many “as needed” anxiety medications by her sister resulting in excessive sedation. She was having medication support but they just did the regular meds. There must a computer aided package that would help?
89	Royal College of Nursing	Question 4 & Statement 4	4	The person to update the MAR should be a pharmacist or senior carer/ manager from the social care team supporting the individual. One could measure the changes to medication audit of pharmacy dispensing records and the MAR sheet.
90	Royal Pharmaceutical Society	Statement 4 Page 16 (Question 4)	4	In practice pharmacy is best placed to be responsible for updating the MAR. This would normally be the patient’s regular community pharmacy, but should be pharmacy in the most appropriate setting for the patient at that time. To support patient safety, the pharmacy could only take responsibility for the MAR if there is a

Ref	Organisation name	Section	Statement No	Comments
				robust process, including clarity for prescribers of their responsibilities, to communicate any medication changes to the pharmacy. This should include when the patient uses out-of-hours care, or receives changes from hospital treatment and when a medication is stopped. A measure for this could be an audit of the local communication process to inform the pharmacy of changes to medicines, resulting in changes to the MAR.
91	University Hospital Southampton NHS Foundation Trust	Quality statement 4	4	The medicines administration record (MAR) should sit within the Summary Care record (SCR) so that it is visible to all care providers. Editing access should be available to the GP and supplying pharmacy. The GP should be responsible for updating it and the pharmacy for checking that it is up to date at each supply.
92	Voluntary Organisations Disability Group	Quality statement	4	Suggested alternative: Adults receiving social care in the community that includes medicines support have changes to their medicines recorded in their medicines administration record and their medicines support care plan.
93	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 4: Quality statement	4	It is essential that changes to medication are recorded in an accurate and timely manner on the MAR. Otherwise there is a high risk of administration error. It is essential that changes to the MAR are made by a qualified person, either the prescriber or the supplying pharmacist. The prescriber would be required to inform the supplying pharmacist of any changes to medication in a timely manner. Electronic MAR forms would enable timely update/renewal of MAR forms.
94	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 4: Quality measure	4	Use of a defined and agreed read code for updating / amending MAR sheets could be used by the prescriber / supplying pharmacist to identify that changes have been made and this could be used to measure the process. Delivery of updated MAR form to patient would need to be considered within resource allocation. Electronic versions of MAR could be emailed between GP and supplying pharmacy when updates are requested/confirmed. This would require an electronic MAR and use of nhs.net

Ref	Organisation name	Section	Statement No	Comments
95	Association Of Directors of Social Services		5	ADASS support this standard. We suggest that some refinement to the quality measure b on page 17. The metric that could be considered is “whether people report that they have been provided with information regarding how to report problems with their medication”. Such information could be verbal, written etc. and data source could be local data collection i.e. Service user surveys could identify this. Similarly, all care providers could issue information as part of their service offer. Such information could be “signed for “as part of a welcome pack for new service users. Again this can be measured. ADASS would agree that it is important to understand the detail of the MRI so that there is an evidence base beyond anecdotes and generalisations. Therefore, is it possible to confirm with health and social care communities, CQC, LASBs etc. (prior to publication of the Standard) that existing systems exist that record the granular detail listed on p 19 -20. If they do not exist perhaps there is a requirement to establish baselines that get down such granularity.
96	British Geriatrics Society	PAGE 17-20	5	Agree with this.
97	East Riding of Yorkshire Council	Q1 – Rationale Q2 - Local systems and structures Q3 - Achievable by local services Statement 5 - Managing medicines-related problems	5	Yes, this statement does accurately reflect the key areas for quality improvement. Would be good practice to include information on how to raise any problems with medication but this is not currently in place. This could be achieved by including prescriber details on the DOMMAR. It would be easy to do but would need the buy in from the prescriber. It is difficult to say at this stage what the resource requirements would be and any potential cost savings or opportunities for disinvestment.

Ref	Organisation name	Section	Statement No	Comments
98	Harrogate and Rural District CCG	Quality statement	5	Agree that they should be given this information but can this be widened to include the person's nominated representatives, for example, informal carers – where appropriate.
99	Parkinson's UK		5	While the guidance for service providers say that staff providing medicines support should be given information on how to raise medicines related problems, there is a missed opportunity here to ensure all staff providing medicines support are aware of the known risks associated with each medication. Research commissioned by Parkinson's UK on the care of people with Parkinson's related dementias in care homes found that not all care staff were aware of the harm that can be caused by anti-psychotic medication on people with Lewy Body dementia (Improving Care for People with Dementia with Lewy bodies and Parkinson's Disease Dementia in Care Homes, February 2016.). There are potential harmful effects, in regard to neuroleptic sensitivity, of anti-psychotic medication has on people with Lewy Body Dementia (Ballard C, Grace J, McKeith I, Holmes C. (1998) 'Neuroleptic sensitivity in dementia with Lewy bodies and Alzheimer's disease.' Lancet. 1998 Apr 4;351(9108):1032-3.). **Recommendation**: In order to reduce the risk of a medicine related problem, as outlined above, we recommend the guidance is amended to include the following: 'All staff providing medicines support should receive training on the known risks associated with each medication provided.'
100	Royal College of General Practitioners	Statement 5	5	I suggest an outcome is evidence of a formal process existing for individuals to raise problems, and evidence that this is provided to patients/carers.
101	Royal College of General Practitioners	Statement 5	5	Pharmacies must be aware when blister packs are renewed of medications not taken but do not feedback at the moment. This could be an enormous administrative burden unless another person is employed to supervise this. There could be cost savings. There is also tremendous wastage of items used irregularly

Ref	Organisation name	Section	Statement No	Comments
				but dispensed more regularly when not needed. Inhalers and creams are stockpiled.
102	South West London and St George's NHS Trust	Quality statement	5	What about adults who lack capacity – families and carers also need to know this information
103	Voluntary Organisations Disability Group	Quality statement	5	Suggested alternative: Adults receiving social care in the community that includes medicines support are given information and assistance to raise any problems or address concerns relating to their medication.
104	Voluntary Organisations Disability Group	Definition of terms used	5	See NG67 section 1.6.4. We suggest that the list of medicines-related problems is expanded to include: The person declining their medicine Medicines not being taken in accordance with the prescriber's instructions Possible adverse effects The person stockpiling their medicines Possible misuse or diversion of medicines A possible change in the person's mental capacity to make decisions about their medicines Changes to the person's physical or mental health
105	West Bridgford Medical Centre, Musters Road, West Bridgford, Nottingham, NG2 7PX	Statement 5: Quality measure	5	Communication with regard to medication-related problems could be facilitated by registration with a chosen pharmacy and ensuring that the nominated pharmacy is recorded in the GP medical records. If problems are communicated to either the prescriber or the pharmacy, they can quickly and easily communicate with each other in order to resolve the problem and ensure that medical records and MARs are updated accordingly.
106	Ceretas	Question 1 Does this draft quality standard accurately reflect the	Q1	Current system is not fit for purpose as medication errors arise on a daily basis due to systems not being robust. Safeguarding alerts are being raised and staff are being suspended little is known about the effect of these alerts and the effects on

Ref	Organisation name	Section	Statement No	Comments
		key areas for quality improvement?		the individual people receiving services. What is known is that most people do not take medication as it is prescribed due to many and various reasons. Just because people are old they must also be able to be in control of the medication that they are taking. The key role in the provision of medication to people in receipt of social care is that of advocacy whereby those who have an interest in representing the view of the person is the one that is coordinating the care including the administration of medicines.
107	Greater Manchester Local Pharmaceutical Committee	Question 1	Q1	We agree with the five standards and believe they represent key areas for quality improvement. We would suggest the addition of a sixth standard focusing on raising awareness of people's entitlement to pharmacy-based support to help them understand how to get the best from their medicines. (This was highlighted as a current gap in the background briefing paper but is not included in the draft quality standard.) For example, the statement could say: "Adults receiving social care in the community that includes medicines support have been provided with information about relevant pharmacy services to help them get the best from their medication, such as NHS Medicines Use Reviews and the New Medicine Service."
108	Harrogate and Rural District CCG	General	Q1	Does the quality standard reflect the key areas for improvement? The quality standard assumes that the arrangements for responsibility to provide medicines support have been agreed between CCGs and Local Authorities. This is not always the case and is a vital area that needs improvement in order to prevent people being a situation where they are not supported by either system. There appears to be an over emphasis on the mechanism of recording of information (covering both quality standard 3 and 4) to the exclusion of the opportunity to promote improvements in appropriate information sharing between the person, social care providers and healthcare systems.
109	Royal College of Nursing	Question 1	Q1	Yes, the quality standards seem to reflect key areas for quality improvement.

Ref	Organisation name	Section	Statement No	Comments
110	South West London and St George's NHS Trust	Question 1 for consultation	Q1	Does this draft quality standard accurately reflect the key areas for quality improvement? – Yes but need to ensure that we aim to support patients to manage medicines independently wherever possible and this does not come across
111	University Hospital Southampton NHS Foundation Trust	Questions for consultation (Question 1)	Q1	This quality standard omits any reference to a key issue within this area, which is the widespread inappropriate use of monitored dosage systems as a medicines support solution for patients receiving social care. The majority of social care organisations insist on these devices for all patients for whom they provide medicines support, usually without any assessment as to whether this will be helpful or appropriate for the patient. They are seen as a tool to assist care providers and a replacement for adequate training. Over-use of these devices exerts unnecessary workload pressure on dispensing services in community and hospital pharmacies, provides false confidence and does not add value or quality to patient care.
112	Ceretas	Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?	Q2	Local systems only include a medical model including a MAR chart. A more personalised system needs to be put in place that records what the person wants recording and not a medical system that is delivered in hospital.
113	Greater Manchester Local Pharmaceutical Committee	Question 2	Q2	Community pharmacies have systems in place for recording information about people's support needs. The IT system used for recording community pharmacy activity and service provision allows pharmacies to send and receive referrals and patient-sensitive data in a secure manner. This is key as we look to the future and could facilitate better two-way communication, enhancing people's care especially at initiation and if their condition worsens.

Ref	Organisation name	Section	Statement No	Comments
114	Greater Manchester Local Pharmaceutical Committee	Question 2	Q2	While people may have a preferred regular pharmacy, however, or have nominated one for repeat prescriptions, they are not registered to a particular pharmacy in the way they are registered with a GP practice. People may get medication from different pharmacies. This presents challenges for information-sharing and data-sharing.
115	Greater Manchester Local Pharmaceutical Committee	Question 2	Q2	The national NHS Electronic Prescription Service (EPS) does not currently record whether a person needs additional support with medicines. That means a person who receives a blister pack from their usual pharmacy would not receive the support they needed if they presented at a different pharmacy. Information about a person's needs are recorded on each pharmacy's individual system and it is not currently recorded on the national EPS system.
116	Greater Manchester Local Pharmaceutical Committee	Question 2	Q2	There are also challenges around data-sharing between different organisations involved in a person's care. Although community pharmacies have 'read' access to the summary care record (SCR), systems and structures for data collection (and the quality of medicine support for this group) would be much enhanced if community pharmacies had greater access to patient records: for example, GP electronic health records and/or read-write access to SCR.
117	Royal College of Nursing	Question 2	Q2	We are unsure how much is in place to collect the data as described, reported medication errors, patient satisfaction and social care assessments would be easier to audit than timely accuracy of medicines administration record (MAR) charts. Also we are not sure if GPs are aware of who is on managed or supported medication, pharmacists would be aware of who has a dispensed medication system but not necessarily know who is supported with their medication. Systems would need to be put in place to enable sustainable audit(s).
118	South West London and St George's NHS Trust	Question 2 for consultation	Q2	Not sure if local systems in place to collate this data

Ref	Organisation name	Section	Statement No	Comments
119	Greater Manchester Local Pharmaceutical Committee	Question 3	Q3	Most community pharmacies take great care to support people with compliance aids, monitored dosage systems, prescription deliveries (even weekly deliveries, rather than monthly, for people with particular needs), medicines administration records, etc as appropriate. However, this is unfunded and the time involved and cost to individual pharmacies is becoming increasingly unsustainable within current pharmacy capacity and funding constraints. Demand is only set to increase as people live longer with complex comorbidities, and national/regional policy aims to help keep people out of hospital and support earlier discharge. We believe there is a very strong invest-to-save case for system leaders to provide community pharmacies with appropriate resources to deliver consistent, high-quality, optimal medicines support of this kind. This would result in cost savings for the system, through reduced medicines wastage, poor adherence, patient errors, and medication-related health attendances and admissions. Pharmacies could be commissioned to provide personalised medicines support.
120	Royal College of Nursing	Question 3	Q3	Please see above comments re systems which would need to be put into place, initially there would be a cost to this. At present, it is difficult to see a cost saving but hopefully a robust system (i.e. shared electronic systems and alerts) would reduce the time taken at present to ensure that all involved with the process are informed of any changes to medication.
121	South West London and St George's NHS Trust	Question 3 for consultation	Q3	Yes, may lead to increase in support for patients, which may well be appropriate
122	South West London and St George's NHS Trust	Question 4 for consultation	Q4	MAR charts are generally provided by the community pharmacy

Ref	Organisation name	Section	Statement No	Comments
123	Royal College of General Practitioners	Statements 6, 7 & 8	Additional areas	There needs to be another quality statement about medication reviews and responsibilities – ethically.
124	Voluntary Organisations Disability Group	Guidance	Additional areas	In addition we think that the guidance should be reviewed to include: Over-the-counter medication that will no longer be prescribed. Supporting the person to ensure that they are taking as few medications as possible.

Registered stakeholders who submitted comments at consultation

- Association of Directors of Social Services
- British Geriatrics Society
- British Medical Association
- Care Quality Commission Medicines Team.
- Ceretas
- East Riding of Yorkshire Council
- Greater Manchester Local Pharmaceutical Committee
- Harrogate and Rural District CCG
- Mencap
- Nene Clinical Commissioning group
- Parkinson’s UK
- Pharmaceutical Services Negotiating Committee
- Royal College of General Practitioners
- Royal College of Nursing
- Royal Pharmaceutical Society
- South West London and St George’s NHS Trust
- University Hospital Southampton NHS Foundation Trust
- Voluntary Organisations Disability Group
- West Bridgford Medical Centre