London, Eastern and South East Steering Group on Medicines Management and Older People,

October 4, 2006

Dear Colleague,

Key principles of care to support older people in the safe, effective use of their medicines in their own homes and in care homes.

One of milestones from the National Service Framework (NSF) for Older People, due for achievement by 2004, was that “all Primary Care Trusts (PCTs) should have schemes in place so that older people get more help from pharmacists in using their medicines.” Despite examples of excellent practice, older people are still not consistently enabled and supported to take or use their medicines safely and appropriately. Gaps in support occur in people’s own homes, in care homes and particularly at care interfaces, such as when they move from home to hospital, or from hospital to their own home or a care home.

The London, Eastern and South East Steering Group on Medicines Management and Older People comprises representatives from across the pharmacy profession including primary and secondary care and community pharmacy, as well as representatives from social care regulation and performance management. As a consequence, it is well-placed to take a view on progress toward the NSF milestone. Since publication of the NSF, the group has sought to keep older people and their medication needs on the agenda of pharmacy networks in London, Eastern and South East via the activities of specialist clinical pharmacists for older people and OPNet, a group for discussion and cascade of information. Despite a high level of activity, consistency and joined-up working have yet to be fully realised.

The following principles have been written to guide and support PCTs as they try to meet the NSF milestone and achieve the aims of A New Ambition for Old Age, particularly programme 6 relating to complex needs.

Principle 1
Every individual has the right to an assessment to identify their care needs and such support as is necessary for safe and appropriate use of his or her medicines

Principle 2
Every individual has access to their medicines and is able to use them safely and appropriately
**Principle 3**
Every individual and carer has access to high quality information from a health care professional about their medicines

**Principle 4**
Health and social care organisations provide support for medicines use, in line with the principles of clinical governance and national minimum standards

**Principle 5**
Individuals are entitled to receive coordinated care when moving between different care settings

**Principle 6**
Every health and social care economy has a robust referral system to a pharmacist to ensure a consistent point of contact, communications network and signposting

The principles will be circulated to national organisations, but I should be grateful if you could bring them to the attention of local health and social care services including:

- Lead commissioners for older people and for long term conditions (The principles are also relevant to long term conditions)
- Local leads for the NSF for older people.
- Community matrons and team leaders for intermediate care
- Local older people leads in social care commissioning and care management

Comment is welcome and should be sent to theresa.rutter@kc-pct.nhs.uk

Yours sincerely

[Signature]

Theresa Rutter,
Chair, Steering group
PRINCIPLES FOR OLDER PEOPLE AND THEIR MEDICINES

Statement of principles for supporting older people to use their medicines safely and appropriately in their own homes, in care homes and across interfaces of care

Written by the Steering Group on Medicines Management and Older People of London, Eastern and South East Specialist Pharmacy Services

The Steering Group has representatives from across the profession of pharmacy including primary, community and secondary care and also representatives from social care regulation and performance management.

The current challenge

PCTs must meet the priorities set out in the recent white paper. “Our health, our care, our say: a new direction for community services” sets out five areas for change

http://www.dh.gov.uk/assetRoot/04/12/76/28/04127628.pdf

- More personalised care
- Services closer to people’s homes
- Better co-ordination with local councils
- Increased patient choice
- A focus on prevention as much as cure

To achieve this we need integration of medicines management into current care pathways, the Single Assessment Process (SAP) and case management, including use of medicines questions to identify individuals in need of medicines support.

Failing to meet targets around demand management can increase unscheduled care, and hospital admission. Individuals are not always enabled to live independently in their own homes, resulting in higher costs to health and social care.

Current NHS England targets include:

**Older people**: Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008 and increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

**Long-term conditions (many older people have long-term conditions ‘LTCs’)**:

To improve health outcomes for people with LTCs by offering a personalised care plan for the most at risk vulnerable people; and to reduce overall emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with LTCs.

http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf
Inequity in the quality of medicines management support and services and lack of continuity of care both contribute to individuals being unable to cope on return to their own home or to a ‘step down’ setting. The potential result is readmission to hospital or to a more intensive care setting. In addition lack of a comprehensive medicines management system contributes to treatment failures when an individual’s need for support with their medicines changes and there is no consistent way of picking this up and responding to their needs. The resultant morbidity and mortality has significant resource implications.

The DH has stated that potential savings from those PCTs that have many more emergency admissions than the average are almost £2.5m per PCT. It has also been estimated that cutting unplanned emergency admissions by 30 per cent, would improve patient’s lives, enable hospitals to better plan their services and the NHS could achieve savings of over £400m a year.


In addition the percentage of admissions related to medicines has been estimated as 5-17% - NSF for OP.

http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf

**Principle 1**

**Every individual has the right to an assessment to identify their care needs and such support as is necessary for safe and appropriate use of his or her medicines**

**Implementation**

1. Use of medicines is considered an aspect of daily living and therefore medicines support is provided as part of personal care, so that individuals can use medicines effectively and safely.
2. All who need support are assessed by a trained health or social care professional using a (locally/nationally) recognised assessment tool that links with SAP, Disability and Discrimination Act (DDA) and Medicines use Review (MUR) assessments. Services are commissioned by PCTs and SSDs to ensure that those individuals requiring support access it via the most appropriate route. Community pharmacists should be supported to enable them to make reasonable adjustments to dispensed medicines for patients who fall within the DDA.
3. A range of support measures are made available based on the assessed needs of the individual.
4. There is a local agreement between health and social care organisations to recognise assessments carried out by another trained health or social care professional and an agreement that allows the sharing of assessments and record keeping.
5. Community nurses, SAP assessors and social care providers understand the support that can be given via community pharmacists and know how to communicate with and refer to local community pharmacists.
6. Individuals are supported to regain independence in relation to their medicines after any change of circumstances that may have an impact on their medicines e.g. hospital admission and discharge, deterioration in clinical or physical conditions, and this is provided as an integral part of the rehabilitation process.

7. Individuals and their carers (formal or informal) have access to information and support across the whole health economy.

Example of good practice:

**Essex Rivers NHS Trust** has implemented a trust wide Self Administration of Medicines (SAM) procedure as its standard for medicines administration across all in-patient beds. Patients are expected to bring their own medication into hospital with them wherever possible. This is the basis of a medication review on admission which, combined with an assessment of ability, begins the patient pathway to self-administration. If a patient cannot self-administer and is unlikely to at discharge this then forms the beginning of the discharge planning process linked to the SAP. A copy of the procedure can be found on [www.nelm.org.uk](http://www.nelm.org.uk). A nurse training session linking directly to a competency assessment for all ward based staff further supports medicines management.

Contact: david.green@essexrivers.nhs.uk

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**Principle 2**

**Every individual has access to their medicines and is able to use them safely and appropriately**

**Implementation**

1. Support for individuals in obtaining their medicines in all health economies is provided through properly commissioned services.

2. A full range of solutions are available to support medicines use (e.g. information in appropriate print size, coloured labels, suitable containers and reminder charts).

3. Compliance aids and in particular monitored dosage systems are only used following assessment of the individual which identifies that such an aid is the most appropriate solution to meet his/her needs.

4. Policies and procedures are in place to ensure that carer workers receive appropriate training for medicines support, in line with national minimum standards.

**Examples of good practice:**

**Guidance from the Royal National Institute for the Blind**  
E.g. work on the MINOPs (medicines information needs of older people) project.  
Contact pam.turpin@rnib.org.uk or m.j.gibson@leeds.ac.uk

**Cambridgeshire Community pharmacy domiciliary visiting scheme for housebound older people**  
This is a joint scheme between South Cambridgeshire PCT, Cambridge City PCT, Cambridgeshire County Council and the LPC. ‘At risk’ patients are referred to the scheme co-ordinator at the PCT by GPs, DN, HVs, social services, care workers and hospital discharge teams. The co-ordinator contacts a suitably trained community pharmacist who undertakes a home visit. A care plan is written and sent to the patient’s GP. The GP actions the suggestions on the care plan as appropriate.  
Contact: Carolyn Start, Carolyn-Start@southcambs-pct.nhs.uk

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**Principle 3**

**Every individual and/or carer has access to high quality information from a health care professional about their medicines**

**Implementation**

1. All individuals are able to access appropriate information from a pharmacist or other health professional.
2. Signposting to other services is available through their local community pharmacy.
3. Individuals are aware of the range and choice of medicines support services available.

**Examples of good practice:**

**Signposting**  
*The national Pharmacy contract requires community pharmacists to assist those enquiring about availability of local and national health-related services. Pharmacists are dependent on the quality of information provided to them by the local PCT, and while there is no standard for the range and depth of information provided by the PCT, pharmacists will do their best to ensure any information given to enquirers is as meaningful, up to date and appropriate as possible.*  
themiddlesexgroup@intrapharm.com

**The UK medicines information service supports NHS direct.**  
Around 10% of callers to NHS Direct specifically request advice about their medicines and up to 40% of the 6.5 million calls answered each year involve providing some advice about medicines. Many of these enquiries can be dealt with directly by specially trained NHS Direct staff using a decision support algorithm. This algorithm was developed with support from medicines information pharmacists. However, in cases where more specialist knowledge is required the details of the caller are phoned through to a Regional
Implementation

1. All organisations providing health or social care have a medicines policy which is compatible with current standards and legislation and has had professional input from a pharmacist, e.g. from the local PCT.
2. Clear lines of accountability are in place for all commissioned services, whether through health or social care, with defined quality indicators for monitoring of service provision within service level agreements.
3. All commissioners of services recognise the different levels of medicines support that may be required and reflect this in their service specifications.
4. Social care commissioners and providers understand the support that can be given via community pharmacists.
5. Providers of social care understand that medicines management support is an integral part of packages of care.
6. Providers of domiciliary care have packages of care available that include support with medicines, including administration from the labelled packs working under the provider’s policy and procedure following appropriate training and assessment of competence.

Examples of good practice:

**Southwark Health and Social Care**
Principles of safe practices with medication by homecare workers’.
Contact: Mike.Price@southwark.gov.uk
‘Administration of Medicines. Workshop for Home Care Workers’ (Trainer’s notes and workbook)
Contact: Barbara Adie, Medicines Management & Pharmacy Team.
barbara.adie@southwarkpct.nhs.uk
Medication Training for Care Homes, Nursing
Contact: Bola.Sotubo, Service manager, Care Home Support Team
Bola.sotubo@southwarkpct.nhs.uk
Norfolk Primary Care Trusts with Norfolk County Council have implemented a service to facilitate the care of people in their own home by providing a patient-centred medicines management assessment by a pharmacist that can be linked to SAP and referral for ongoing support e.g. from the community pharmacist or from social care, according to the assessed need. The service works with other teams such as Community Matrons, Health at Home Teams, Social Workers and Home support teams. Contact: ian.charles@norfolk.gov.uk

The Middlesex Group of Local Pharmaceutical Committees, covering most of North and West London, has established the Medicines Training Partnership. The organisation trains practising community pharmacists and arranges for them to deliver training on the safe handling, administration and recording of medicines to carers in a wide range of care settings, including home care, residential and day care. The Partnership liaises with Local Authorities, PCTs, care organisations, including charitable and voluntary bodies, and CSCI on appropriate training for care workers. Contact: Michael Levitan or Jill Gamblin, 020 8492 0592/0692 mailto:MTP@intrapharm.com

**Principle 5**

**Individuals are entitled to receive coordinated care when moving between different care settings**

**Implementation**

1. The assessment of medicines needs and coping methods that the patient finds helpful in their own home are an integral part of the admissions and discharge processes.
2. All care environments have clear lines of responsibility to communicate medicines issues and solutions from one care setting to another.
3. All health and social care professionals need to understand how the pharmacy contract has been implemented locally and how community pharmacists can support patients within the framework of the contract.

**Examples of good practice:**

**Eastern Riding and Hull - Pharmaceutical care for the vulnerable elderly scheme:** Patient hospital discharge information is faxed to community pharmacists for “high risk” patients (e.g. 75 or over on complicated dosage regimens, if admission to hospital is due to medication problems). The community pharmacist visits the patient at home for a medication review, liaises with the GP and produces a care plan, and continues to monitor the patient. There are close links with Social Services. Contact: Graham Hill, Professional Development Pharmacist – email ghill@tinyworld.co.uk
**Implementation**

1. Medicines management is fully integrated into the single assessment process (also assessment for LTC) across social and healthcare organisations to ensure continuity, consistency, a whole systems approach to care and to reduce duplication. It should include the establishment of a formal referral process to resolve medicines issues especially where needs are still unmet.

2. This system is accessible to and understood by all health and social care professionals, patients and carers.

3. Pharmacists in secondary care understand the support systems in primary and community settings to facilitate seamless care and discharge planning.

4. Key players in social care understand how to access pharmacy expertise at both an organisational and a local level.

5. Interventions are triggered by risk assessments (e.g. Single Assessment Process) to indicate level and nature of need.

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**Example of good practice:**

**The Southern Derbyshire Medicines Support Service** – Trained community pharmacists (who have completed an MSc module on ‘Therapeutics for Older People) across five PCTs made domiciliary visits to any patient who had problems taking or managing their medicines. It involved joint visits with the key workers for mental health patients and with learning disability nurses for their patients.
The pharmacist reviewed medication regimes, assessed the patients’ needs and discussed the medicines with patients and/or carers based on the principles of concordance, in order to develop an individual, tailored Pharmaceutical Care Plan. Clinical interventions were suggested and compliance issues addressed (examples include reminder/tick charts or compliance aids). A copy of the care plan was given to the patient or carer, referrer, dispensing pharmacist and a letter was sent to the GP. This was a busy service and approximately 3,000 referrals were received.

Amendments to the Disability Discrimination Act recently led to this service being discontinued. However, support and guidance are being provided to the community pharmacists. The PCTs and LPC are exploring the development of a possible new service for people with long-term medical conditions involving linking pharmacists with community matrons. Contact Diane Harris, diane.harris@amberValley-PCT.nhs.uk

This is not intended to be a comprehensive reference source. Please note that some references relate to the experience of steering group members.

Acknowledgements
I would like to thank members of the Steering Group for their hard work and also other colleagues from health and social care across SE England for their contributions.

Please contact Theresa Rutter, Chair of the Steering Group for any further information Theresa.rutter@kc-pct.nhs.uk
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<tr>
<th>Glossary</th>
<th>Definition</th>
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<tr>
<td>Access</td>
<td>The extent to which people are able to receive the information, services or care they need.</td>
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<td>Assessment</td>
<td>The overall process for identifying and recording - the health and social care risks and needs of an individual and evaluating their impact on daily living and quality of life, so that appropriate action can be planned.</td>
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<td>Care package or ‘package of care’</td>
<td>A combination of services designed to meet a person’s assessed needs. The package consists of one or more services, which may be residential and/or community-based. A cost is often attached if provided by social care, and hence needs to be approved by the budget holder; may also require contributions from the individual.</td>
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<td>Care pathway</td>
<td>The services an individual receives on a step-by-step basis following their entry into the system. Agreements between the various professional involved will typically cover the type of care and treatment, which professional will be involved and their levels of skills, and where treatment or care will take place.</td>
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<td>Care planning</td>
<td>Care planning is a process based on an assessment of an individual’s assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.</td>
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<td>Case Management</td>
<td>Case Management is where a named coordinator, e.g. a community matron, actively manages and joins up care by offering, amongst others, continuity of care, coordination and a personalised care plan for vulnerable people most at risk.</td>
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<td>Commissioning</td>
<td>The process of specifying, securing and monitoring services to meet identified needs. Commissioning is more commonly used to describe the strategic, long-term process by which this takes place as opposed to the short term, operational, purchasing process.</td>
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| Community pharmacy contract                                           | The community pharmacy contract consists of three levels of service to be provided by community pharmacists. **Essential services** delivered by all pharmacies. These include dispensing, repeat dispensing, disposal of unwanted medication, promotion of healthy lifestyles, support for self care and signposting patients to other health professionals. **Advanced services**, medicines use review (MUR), provided by community pharmacists who have completed a competency assessment and who have an accredited consultation area. The medicines use review service is designed to maximise the benefits patients get
from their medicines by improving concordance and by reducing the incidence of adverse effects. It is not a clinical review. **Enhanced services** commissioned locally by primary care organisations in response to the needs of the local population. Enhanced services include minor ailment schemes, smoking cessation, specific medicines management schemes etc. It is envisaged that the contract framework will develop over time, to keep pace with the changing needs of patients and the NHS. For more information on the pharmacy contract see [www.psnc.co.uk](http://www.psnc.co.uk)

**Compliance**
The extent to which an individual takes/uses their medicines in line with the directions/instructions of the prescriber or other health care professional.

**Compliance aids**
These are devices designed to help the patient to access and use their medicines as intended by the prescriber. They can either be a device to help someone use a specific dosage form e.g. eye drops or inhalers or more commonly a daily dosing device or sealed ‘Monitored Dosage System’ to help the individual remember to take his/her tablets and/or capsules.

**Concordance**
Shared decision making between a patient and a health professional in which an agreement is reached about whether and how medicines are to be taken/used so that an individual gets the most benefit from his/her medicines.

**Disability**
The Disability Discrimination Act 1995 defines disability as ‘a physical or mental impairment that has a substantial and long term adverse effect on a person’s ability to carry out normal day-to-day activities’.

**Disability Discrimination Act 1995 (DDA)**
The legislation that is in place to promote civil rights for disabled people and protect disabled people from discrimination. Disabled people share the same general rights of access to health and social care as other people. Importantly the right of access to health services and social services (such as doctors’ surgeries, pharmacies, hospitals) and the right to information about healthcare and social services in a format that is accessible to them where it is reasonable for the service provider to provide it in that format.

**Local Pharmaceutical Committee (LPC)**
The LPC is an official body set up under the NHS Act to represent all NHS pharmacy contractors in one or more PCT areas. Illness, which lasts longer than a year, usually degenerative, causing limitations to one’s physical, mental and/or social well-being. Includes Diabetes, COPD, Asthma, Arthritis, Epilepsy and Mental Health.

**Medicines management**
There is no single definition of medicines management. A definition from the University of Keele is used here: Medicines management seeks to maximise health gain
through the optimum use of medicines. It encompasses all aspects of medicines use, from the prescribing of medicines through the ways in which medicines are taken or not taken by patients.

**Medicines review**
A structured, critical examination of a patient’s medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste.

**Medicines use review (MUR)**
A structured review with patients receiving medicines for long term conditions, to establish a picture of their use of medicines –both prescribed and non-prescribed. The review helps patients to understand their therapy and identify any problems that they are experiencing with possible solutions.

**National minimum standards**
These are standards for care, published by the Department of Health, that set out achievable outcomes for care homes, agencies etc registered with the Commission for Social Care Inspection. They identify what care providers need to do to meet their legal obligations and medication is included in the group of standards concerned with health and personal care.

**Person centred approach**
Ways of commissioning, providing and organising services rooted in listening to what people want, to help them live in their communities as they choose.

**Personalised care plan**
An individual’s integrated health and social care requirements based on the summary of their risks and needs after a holistic assessment has taken place. It includes details of the services to be provided, the individual and their carer(s) participation, the objectives, a review date and consent from the assessed person to share the plan with the care team.

**Primary care trust (PCT)**
A local health organisation responsible for commissioning and managing local health services. PCTs work with Local Authorities and other agencies that provide health and social care locally to make sure the community’s needs are being met.

**Single assessment process (SAP)**
Standardised holistic assessment framework across health and social care to minimise duplication and ensure that an individual receives timely and proportionate assistance appropriate to their risks and needs. It aims to put individuals at the centre of their own assessment and subsequent personalised care planning.

**Social services**
Social services are provided by 150 local authorities in England through their Social Services Department (SSD). Individually and in partnership with other
agencies they provide a wide range of care and support for people who are deemed to be in need.

Unmet needs Care needs that are not met either because there are not enough resources or because the services are not of a sufficiently high standard.

References

1. NSF for older people http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf
3. Room for review –A guide to medication review :Task force on Medicines Partnership and the National Collaborative Medicines Management Services Programme

Acknowledgements
The Steering Group thanks Lelly Oboh, Senior Prescribing Adviser, Lambeth PCT, for permission to adapt this glossary