

Supporting older people in the community to optimise their medicines including the use of multi compartment compliance aids (MCAs)

A resource to help health and social care organisations to work together to optimise patient care

Executive summary

This resource reviews options for medicines optimisation for older people, focussing particularly on the appropriate and cost-effective use of multi-compartment compliance aids (MCAs). Medicines optimisation is about making sure that any decision that is made about medicines is best for the patient and their particular circumstances. Medicines optimisation involves all the partners (health and social care) and the patient in their care. The document is set out in two sections, headed 'what you need to know' and 'what you need to do'. Working through the resource will help to:

- Raise awareness of the different views on this subject as well as the inter and cross organisational barriers that need to be tackled in order to deliver effective medicines support to older people
- Provide a practical step-by-step approach for those trying to address the problems associated with the increased inappropriate use of MCAs in their localities
- Enable organisations to look at a range of options across the local economy and explore levers in the system which would help to commission appropriate medicines support services for older people
- Provide an up to date resource on the evidence and best practice guidance on the use of MCAs and other support options
- Ensure that the Medicines Optimisation agenda is embedded into the care pathway for older people
- Share examples of what and where things have worked

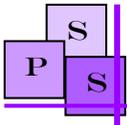
Case example 1: A positive outcome for Mrs P

Mrs P is an older person who lives with and cares for two disabled daughters. She has many long term conditions (LTC) including, hypertension, diabetes and severe osteoarthritis and takes many medicines to manage them. She does not understand when and how to take her medication. She receives her medicines in an MCA (Dosette® box) started by the hospital, but has problems opening it because of limb weakness. There are drugs mixed up in MCA compartments and it is difficult to establish what has been taken on each occasion.

She orders her prescriptions and collects the medication from the community pharmacy but needs help sometimes when she cannot get out of the house. The community pharmacist collects her prescription from the surgery; otherwise she would have to take two buses to get there. She has difficulty with speaking, reading and writing English so her daughter often helps with these aspects.

Mrs P is confused about her medicines and is experiencing side effects which she believes is caused by an increase in dose of the "large" tablets (Metformin). So she takes half a tablet to reduce the side effects; consequently the diabetes is uncontrolled (HbA1c 9.5%). The GP is unaware of this and has referred her for insulin initiation as he feels she is not responding to maximum drug therapy. She is terrified of having to inject herself and has already missed a previous appointment. She has high systolic blood pressure (181/67Hgmm) which further increases her cardiovascular risk. Some medicines have been prescribed on a long term basis with no apparent indications.

Mrs P is typical of many vulnerable older people in the community who need help with managing their medicines in order to continue to live independently and improve their health outcomes. By putting the right systems in place, her medication was reviewed; the side effects stopped and number of drugs reduced. She was no longer confused about what to take, adherence improved and the diabetes was controlled without having to initiate insulin. The changes improved the quality of life for Mrs P and her daughters.



Introduction

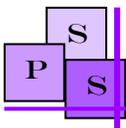
The NHS White paper, *Liberating the NHS*, requires health and social care to focus on securing and delivering services that lead to improved healthcare outcomes for patients as well as supporting the most vulnerable to live more independently at home. It calls for closer integration in how we commission and provide such services. Supporting older people living in the community to take their medicines safely and effectively is important. Commissioning and delivering integrated medicines management services that provide the right support wherever people enter the system is fundamental to delivering better healthcare outcomes. The National Service Framework for older people set the initial framework for this to happen; however, nine years later reports show that health and social care organisations are still failing in this area. As a result many older people are not getting the maximum benefits out of their medicines and may suffer unnecessarily from medicines related problems such as hospital admissions, adverse drug reactions, falls and poor therapeutic outcomes. All of these problems have huge clinical and resource implications for health and social care.

Although many options to support medicines taking are available, multi-compartment compliance aids (MCAs) are probably most widely used to support older people to take their medicines with the intention of enabling them to manage their medicines independently or be cared for in the community. They are popular with care homes, domiciliary care providers (DCPs) and local authorities as they are perceived as a “safer option” for staff involved with delivering medicines related tasks. Although their use is increasing, there is little evidence to support this widespread approach and they can be associated with increased risks of medication related problems and wastage. Decisions made about the use of MCAs in one part of the economy inevitably impacts on the other, so over the years, MCA use has caused controversies and disputes between health care professionals and other organisations such as social care. Also the organisational and professional barriers inherent in different organisations have often frustrated the efforts of those who have tried to address this problem.

At the time of writing some commissioners are commissioning effective medicine optimisation models other than just the provision of MCAs. They involve using integrated community based teams within health and social care to ensure that the medicines needs of older people are properly assessed and the right support delivered. However they are few and far between and ideally a national approach to ensure equity and consistency is needed. The new NHS landscape following ‘Liberating the NHS’ will however offer opportunities for Clinical Commissioning Groups to work closely with local health authorities to consider the needs of their local population and work towards an integrated approach to delivering the services needed to help personalise care and support independent living when that is desired. Pharmacists are well placed to lead or drive this process of medicines optimisation.

This document has been written on behalf of the East and South East England NHS Specialist Pharmacy Services with the aim of facilitating this joint work. It helps the user to consider all the factors that determine how medicines support is provided for older people and how to use this information to drive improvements in their own locality.

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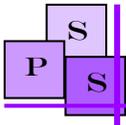
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WHAT DO I NEED TO DO?

1. Section One: Background

1.1. OVERALL AIMS

This document has been developed to:

- ❖ Raise awareness of the different views on this subject as well as the inter and cross organisational barriers that need to be tackled in order to deliver effective medicines support to older people
- ❖ Provide a practical step-by-step approach for those trying to address the problems associated with the increased inappropriate use of MCAs in their localities
- ❖ Enable organisations to look at a range of options across the local economy and explore levers in the system which would help to commission appropriate medicines support services for older people
- ❖ Provide an up to date resource on the evidence and best practice guidance on the use of MCAs and other support options
- ❖ Ensure that the Medicines Optimisation agenda is embedded into the care pathway for older people
- ❖ Share examples of what and where things have worked

What is a multi-compartment compliance aid (MCA)?

For the purpose of this resource, the term MCA covers a variety of devices for re-packaging medicines in individual compartments usually available in the community (including Dosette®, Nomad®, Venalink®, Medidose®, Boots MDS®). These devices can be bought by patients or provided by pharmacists. Usually pharmacists do not receive payments from the NHS to provide these devices and so often resort to requesting weekly prescriptions in an attempt to recover some of the associated dispensing costs.

MCAs are used in the community for many reasons but users will tend to fall into one of the categories below

- Individual patients who self-administer their medicines
- Carers and relatives providing support with medicines
- Domiciliary care workers providing support with medicines
- Care home staff (residential and nursing) for their residents

Exercise 1

1. List one or two main reasons why you are reading this resource
2. Write one or two things you would like to be able to do after you have read it

Exercise 2

Read SECTIONS 1.2 and 1.3 for you to understand who should read the resource and how it should be used to get the best out of it

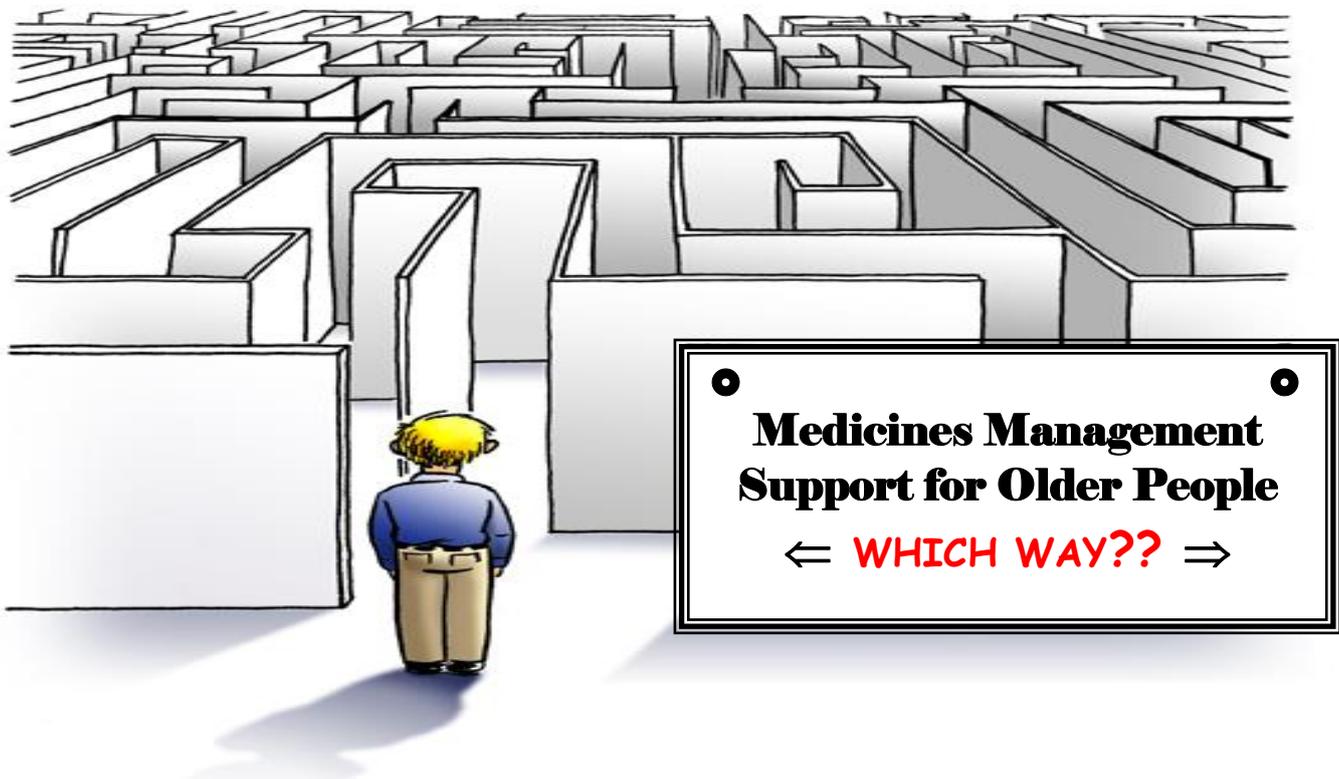
1.2. WHO SHOULD USE THIS DOCUMENT?

This resource has been designed to be used by a group who want to lead change to improve medicines optimisation for older people. It will be important at an early stage to identify an individual to coordinate the group and drive the changes. It is expected that the lead will work through the first two sections and gain a thorough understanding of the pertinent issues before meeting with local partners.

For example the lead can be

- A pharmacist working with older people in primary care (CCGs, CSUs, GP practice, care homes)
- A pharmacist working for local authorities
- A hospital elderly care pharmacist
- Other senior pharmacists (Clinical services or dispensary leads)
- Senior managers in health or social care (commissioning leads)

WHATS IN IT FOR ME?



You probably have an idea of what needs to be in place to deliver improvements for older people, however the difficulty is how to get there; the complexities, difficulties and time needed to overcome the barriers. This resource is the vehicle that will help to get you to your destination at the right pace.

It is important to note that for you to get most out of it, you will have to work through the material. Once you have done that, it is anticipated that you will be able to identify what actions are needed to take the first steps in the journey towards improving medicines management support for your older population. Frontline practitioners, commissioners and providers of adult services where medicines related activities are involved may also find it a **useful information source or reference document** to be used as needed.

The tool does not intend to prescribe “a particular solution” to how organisations should address this matter; as it is known from experience that each locality is unique and will be at different points in the journey depending on a number of factors which are often historical.

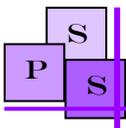
1.3. HOW MAY IT BE USED?

Ideally the document should be worked through in 3 stages. Stage 1 involves working through the first two sections of this resource. In Stage 2 we are suggesting that you get together with those from other localities that are leading change, to exchange ideas, information and support. Stage 3 involves working with partners in your locality to develop a local action plan.

	1 st stage	2 nd stage	3 rd stage
Stage	Pre-work	Joint work with others leading change preferably in a learning set	Develop local action plan
Resource	Section 1 and 2		Section 3
Who	Champions and change leaders (most likely primary or secondary care pharmacists)	One or more pharmacists representing their organisations/localities	Act as a change leader with local partners
Objectives	To develop a common understanding of the background information <ul style="list-style-type: none"> • Myth busting • What is current practice? • What is the evidence for using MCAs and other interventions? • How are patients identified? • How are patients assessed? • What intervention or services are available? • What are the statutory and non statutory responsibilities? • What are some common barriers? • What perverse incentives are there? 	To share and compare information/ideas from the pre-work To Identify what has worked and hasn't To develop a generic plan to take things forward in your locality	To lead and facilitate the development and or implementation of a local action plan with partners
Actions	<ul style="list-style-type: none"> • Read through Sections 1 and 2 • Identify and contact counterparts¹ in your locality to gather the information to fully understand the local picture • Work through the exercises and tasks 	<ul style="list-style-type: none"> • Use the knowledge gained from pre-work and information gathered from the exercises as the basis for discussions and participation in learning set 	<ul style="list-style-type: none"> • Work through Section 3 to develop a local action plan with partners • Use the resource section as a tool to support implementation of action plan

Throughout the text there are **exercises** which allow you to reflect on the information you have read and to find out about what happens in your own organisation. Your response to the exercises can be recorded in the **workbook** that has been designed to accompany this resource. There are also **tips and practical suggestions** drawn from the experience of others, which you may find helpful. The list of **resources with useful contacts** available as a separate document will provide you with as much help as you need to get started.

¹ These are the people in other organisations within your locality that have a lead responsibility for provision or commissioning services involving supporting older people with medicines. See later for examples

**Exercise 3**

- Identify your counterparts in the other care settings because you will need to work together to make this happen.
- Write their names and contact details in the workbook

Exercise 4

- Read SECTION 1.4 for you to understand why this resource has been developed

1.4. WHY DO WE NEED THIS RESOURCE?**Key drivers for change**

- Older people need more support to take their medicines
- Political drivers including more community based services, independence, personalisation, productivity and efficiency.
- Increased use of MCA with the associated clinical and financial risks
- The need for a structured and co-ordinated process to identify, assess and provide safe and effective medicines optimisation for older people

1.4.1. Older people need more support to take their medicines

Older people are a vulnerable group, with over two thirds of those aged 75s and over suffering with one or more long term condition² (LTC). As a result they often require multiple medicines (polypharmacy) and sometimes complex regimens to manage these LTCs. With advances in health and social care, many older people with LTCs can now be managed safely in the community and can choose to remain at home where they would have had to go into hospital or an institutionalised care setting. This means that more complex drugs and regimens have to be managed in the community setting. In addition to this the physical and sensory impairments associated with ageing as well as the increased risk of adverse drug reactions (ADRs) make it more difficult for older people to manage their medicines^{3,4} and inevitably many will need some form of assistance or support³.

In a UK study, 61% (n 1985) of informal carers reported that they were responsible for ensuring that older people took their medicines⁵. Another study found that a fifth of those over 70 years had received some assistance with their medicines⁶. A low level of home support has been listed as a factor that can predispose older people to medicines related problems³. Medicines related problems include non-adherence, therapeutic failures, adverse drug reactions, drug errors ADRs and can lead to hospital admissions and a higher risk of morbidity and mortality³. Inability to comply with medicines can influence the decision to move an older person into a care home⁷. A study that compared patients admitted into care homes and those who lived at home found that the best distinguishing difference was the ability to manage their medicines and 23% of those admitted into care homes had no other high risk factor except inability to manage their medicines on their own⁷.

² Department of Health, Raising the profile of long term conditions care: A compendium of information, 2008

³ Medicines and Older People – Implementing medicines-related aspects of the NSF for Older People. Department of Health, March 2001

⁴ National prescribing centre. Prescribing for the older person. MeReC Bulletin 11:37-40

⁵ Warner L & Wexler S. Eight hours a day and taken for Granted? Princess Royal Trust for Carers, 1998. London.

⁶ Jones D, Vetter N. Formal and informal support received by carers of elderly dependants. British Medical Journal 1985;291:643-5

⁷ Strandberg LR. Drugs as a reason for nursing home admissions. Journal of American Health Care Association 1984;10:20-3

1.4.2. Political drivers for change

National targets and recent white papers focus on promoting independence and, moving towards more community based services. For this to happen, organisations must work together to commission services that are responsive to identified patient needs and meet the challenging NHS goal of personalised care delivered closer to home. Also the *Putting People First 2010*⁸ document highlights plans

- To develop a single community based support system focussed on the health and wellbeing of the local community
- To focus on reablement and post discharge support initiatives including the requirement for NHS and social care services to work jointly to support people in the 30 days after discharge from hospital

The proposed NHS outcomes framework is likely to have indicators that will be common to public health, health and social care and working together on medicines optimisation is a good start.

NICE adherence guidance⁹ (CG76) recommends the provision of adequate support interventions to meet the individual patient's identified adherence needs and commissioners are required to commission services to ensure that the guidance is implemented locally. It found that no one particular intervention was able to solve non-adherence and proposed that a wide range of interventions tailored to the individuals need be made available.

Furthermore with the Quality innovation productivity and prevention (QIPP) agenda the NHS must take steps to reduce wastage and maximise efficiency while still delivering high quality services. The cost of NHS prescribing is growing exponentially as well as the problem of non-adherence and we can no longer ignore the fact that up to 50% of people don't take their medicines as prescribed³. At the same time, the rising costs associated with the use of MCAs and waste medicines (see section 2.2.2) means we have to challenge current practice in our localities and explore safer, less labour intensive interventions. It may be necessary to disinvest in the inappropriate use of MCAs to re-invest in individually tailored interventions that deliver the right outcomes.

With more focus on personalisation and the introduction of personal budgets, services will have to be responsive to the needs and choices of patients. The government's enablement agenda will bring a culture of "doing with" rather than "doing for" which means that there will be pressure from regulators and commissioners to demonstrate that we are enabling older people to manage their medicines. *Medicines Optimisation: Helping patients to make the most of medicines*¹⁰ highlights the crucial role medicines play in maintaining health, preventing illness, managing chronic conditions and curing disease.

1.4.3. Increase in the use of MCA with the associated clinical and financial risks

Historically, one way health and social care organisations have supported older people is through the provision of MCAs; alone or with support from domiciliary care workers (care worker) and their use is increasing despite little evidence to support their effectiveness. One small hospital pharmacy stated that the use of MCAs has increased to 25% of all discharge dispensing and is having an impact on staffing¹¹. One study in 2001 estimated that 100,000 people living independently in the community in the UK were using MCAs¹²

The community pharmacy contract in 2005 highlighted that pharmacist should make "**reasonable adjustments**" to support patients with medicines to comply with the Disability Discrimination Act 2005 (DDA). This has raised awareness but has often been misinterpreted to mean that MCAs must be provided and hence demand had increased.

The implications of the DDA as well as the risks and pressures associated with the use of MCAs are fully discussed in **Section 2.2.2**.

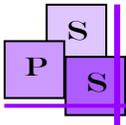
⁸ HM government. Putting People First A shared vision and commitment to the transformation of Adult Social Care 2010

⁹ NICE adherence guidance 2009

¹⁰ Royal Pharmaceutical Society, Medicines Optimisation: Helping patients to make the most of medicines Good practice guidance for healthcare professionals in England. May 2013

¹¹ Email correspondence with Dyson Y, Dispensary and Operations Manager. Newham University Hospital. 2010

¹² Nunney JM, Raynor DKT. How are multi-compartment compliance aids used in Primary Care?. Pharm J. 2001;267:784-789



1.4.4. The need for a co-ordinated, structured approach to the way we assess older people who require medicines support and how we then provide such support

As part of routine NHS care, older people can be assessed and referred to receive appropriate health care e.g. nursing care, physiotherapy, podiatry services etc depending on the needs identified. This is not the case with medicines management needs as there is currently no formal or co-ordinated way to identify, assess, refer or provide support. Despite the NICE recommendation that health care professionals should routinely assess for non-adherence whenever medicines are prescribed, dispensed or reviewed, many organisations still do not have a structured process.

The case example below illustrates the points made in this section

Case example 2: A Complex case resolved

83 year old Mr KM is a retired rail worker who had a stroke that left him bed bound, unable to speak and fully dependent on his wife for everything, including managing and administering his medicines. He is a frequent A&E attendee and regularly seen at home by health and social care staff. He takes many tablets to prevent further strokes, manage his blood pressure, diabetes, cholesterol, pain and resulting constipation. The wife can't read and is in and out of the GP practice to request and collect repeat medicines. Although she struggles, she is quite adamant that she wants to continue to care for her husband in the home they shared for many years and rules out any possibility of a care home. However his medicines system was in chaos and he was not getting maximum benefits from his drugs.

As part of a case management pilot, a community matron identified and referred KM to a pharmacist who carried out a medication assessment and identified the following problems or risks

- Mrs KM can only identify the tablets by shape, size and colour
- She uses different pharmacies and so is not aware of any support the local pharmacy can provide
- Many drugs had been taken out of the original packing and not easily identifiable.
- Mrs KM was unable to give a full drug history or an account of what drugs he took daily.
- Information on the discharge notification did not match her account nor did the GP computer records.
- Drug changes on discharge were not reflected on the GP records
- She was having difficulty getting him to swallow 2 Adcal tablets daily
- Had run out of Metformin tablets and had missed a few doses

A pharmaceutical care plan was developed and a package put in place to support Mr KM. The problems were resolved and his A&E attendance dropped.

Exercise 5

- **Read SECTION 1.5 so you can dispel myths about MCAs, promote best practice and know what statutory obligations there are if any.**

1.5 EVIDENCE BASE, STATUTORY REQUIREMENTS AND BEST PRACTICE

Before going through this section test your current knowledge in Exercise 6

Exercise 6

- Answer true or false to these statements (you will get the chance to check your answers later)

<u>Statement</u>	<u>True</u>	<u>False</u>
1. Legally, domiciliary care workers can only give medicines from an MCA	<input type="checkbox"/>	<input type="checkbox"/>
2. There is a range of effective practical support solutions that improve medicines taking but they must be tailored to the individual and their circumstance	<input type="checkbox"/>	<input type="checkbox"/>
3. Problems with medicines taking can be improved by proactively identifying patients, involving them in the decision making process and providing the right support needed	<input type="checkbox"/>	<input type="checkbox"/>
4. Evidence shows that MCAs are an effective way to support adherence and is recommended for widespread use	<input type="checkbox"/>	<input type="checkbox"/>
5. Many MCAs are initiated without proper assessments with the focus being mainly to meet the needs of care workers or professionals	<input type="checkbox"/>	<input type="checkbox"/>
6. The service provider e.g the domiciliary care agency is responsible for assessing if an older person needs support with taking their medicines and providing the right support	<input type="checkbox"/>	<input type="checkbox"/>
7. A community pharmacist must provide MCAs to support medicines taking for people who meet the Disability Discrimination Act (DDA) disability criteria	<input type="checkbox"/>	<input type="checkbox"/>
8. A community pharmacist must supply an MCA to a patient if health or social care personnel identify that it is necessary	<input type="checkbox"/>	<input type="checkbox"/>
9. A Medicines use review (MUR) can identify problems associated with taking medicines	<input type="checkbox"/>	<input type="checkbox"/>
10. Most older people who cannot /do not take their medicines need to be given an MCA	<input type="checkbox"/>	<input type="checkbox"/>
11. Using an MCA is a “safer” way to administer medicines by domiciliary care workers	<input type="checkbox"/>	<input type="checkbox"/>
12. When drugs are dispensed in an MCA, the domiciliary care worker does not have a legal responsibility if the wrong drug is given	<input type="checkbox"/>	<input type="checkbox"/>

A lot of the literature has focused on the clinical problems of medicines in older people particularly inappropriate prescribing, polypharmacy, adverse drug reactions (ADRs) drug interactions, cost effectiveness and the use of medication reviews to effectively tackle these problems. However more recently with the increasing problem of non-adherence and involvement of more non-clinical staff in medicines related activities, consideration has been given to other medicines related problems in older people such as those who cannot take their medicines without extra help and those who intentionally do not take their medicines.

1.5.1 In what areas do older people have problems/needs with taking medicines?

The NICE adherence guidance 2009 identified intentional¹³ and non-intentional¹⁴ non-adherence as two main reasons why people cannot or do not take their medicines. Research undertaken by Rosenbloom et al (2002)¹⁵ identified four key areas where older people will experience problems and need help with medicines as follows

Areas where older people have problems or needs with taking medicines	
Problem area	Description
1. Access	Problems obtaining supplies of medicines e.g. running out of medicines, problems with ordering and collecting medicines
2. Compliance (now adherence)	Factors that influence the decision not to start or continue taking their medicines e.g. fear of side effects, perception that drug is not needed, previous experience of adverse effect, poor understanding
3. Day to day management	Factors that hinder the patients ability to manage their medicines on a day to day basis and how medicines taking fits into their daily routines e.g. poor dexterity, social isolation, swallowing difficulties, limb weakness, immobility, poor vision, inability to read instructions
4. Clinical aspects	To do with the therapeutic aspects of medicines which healthcare professionals would typically address during a medication review e.g. side effects, polypharmacy, poor symptom control

1.5.2 How should we identify and assess medicines-related needs?

“Appropriate assessment lies at the heart of effective service delivery for a whole range of health and social care provision. Its purpose is to identify and evaluate an individual’s presenting needs and how they constrain or support his/her capacity to live a full and independent life. Councils should ensure that individuals are active partners in the assessment of their needs. Appropriate service provision can then be planned both in the immediate and the longer term to promote or preserve independence. Information from an individual’s assessment should be used to inform decisions on eligibility and services that may be offered”.

Fair Access to Care Services (FACS). Guidance on eligibility criteria for adult social care. DoH 2003

The NSF medicines documents recommends that in order to make the best use of resources and prioritise input, medicines related risk assessment should be carried out at **first order (overview¹⁶)** or **second order (specialist¹⁷)** levels depending on the patient’s need and this assessment integrated into usual care. Also NICE recommends that health care professionals should routinely assess for non-adherence whenever medicines are prescribed, dispensed or reviewed. The London older people service development program (LOPSDP) medicines pilot¹⁸ showed that by asking questions relating to the 4 areas (see 1.5.1) as part of an integrated pathway, trained health or social care personnel can identify and assess an older person’s medicines need.

¹³ Intentional non-adherence is where a conscious decision has been made by the patient not to take their medicines as a result of their beliefs and perception about the need for the drug.

¹⁴ Non- intentional non adherence is where the patient would like to take their medicines but certain barriers prevent them from doing so

¹⁵ Rosenbloom E K, Goldstein R. The development of case finding trigger questions to identify medicines management issues as a part of the single assessment process. Research for change: a healthy outcome for primary care. March 2005. Book of Abstracts.

¹⁶ An overview assessment is usually conducted face-to-face with an older person to collate information and explore some or all aspects of their needs.

¹⁷ A specialist assessment allows the in-depth assessment of a specific problem in any area. A specialist medicines assessment seeks to confirm the presence, extent, cause, and likely development of a medicines-related problem and establishes links to other conditions and problems

¹⁸ London Older People’s Service Development Programme Medicines Management Project 2003. Available online at: http://www.cpa.org.uk/sap/sap_medicinesmanagement_list.html (Accessed 19/11/10)

1.5.2 What are the effective support solutions and is there a role for MCAs?

NICE found evidence that both types of non-adherence can be improved by proactively identifying patients who are non-adherent, involving them in the decision making process about medicines and providing the right support.

With regard to the effectiveness of MCAs to support adherence, NICE found the evidence inconclusive and did not recommend their widespread use. Another report also found little evidence to support their use but also highlighted the associated risks including those that affect stability of the medicines¹⁹. NICE and other publications have found that MCAs are overused in the community^{12,20,21,22}. One study showed that up to about 39% of patients on MCAs would be able to manage their medicines in standard containers and what they wanted was a reminder system not specifically an MCA¹². It also found that many MCAs are initiated without proper assessments mainly to meet the needs of carers or professionals but once initiated patients are reluctant to stop using MCAs even though a few had difficulties opening the devices.

A 'frequently asked questions' paper about the use of MCAs in the community can be found at <http://www.medicinesresources.nhs.uk/upload/documents/Community%20Areas/Primary%20and%20Community%20Care/Community%20Health%20Services/FAQs-on-MCAs-Lambeth-FINAL-June-2009.doc>

Some effective methods to improve medicines taking

- Reminder systems e.g. timed alarms, telephone reminders, fridge stickers, positioning medication in visible places, linking medicines taking with daily routine
- Compliance aids and supervision are the most effective among older patients with cognitive impairments²³
- Automatically generated reminder charts are practical and cost effective²⁴
- Simplifying drug regimens and dispensing into appropriate containers⁹
- Explaining about the importance of their medicines, providing personalised instruction and written information⁹
- Repeat dispensing, prescription collection and medicines delivery services can improve access to medicines
- Patients keeping records of their medicine taking and monitoring their conditions, simplifying the dosing regimen, using alternative packaging or MCAs.
- The use of reminder charts, non child proof tops, large labels, large prints, medicines administration records (MAR) sheets¹
- Reducing the number of medicines, frequency and simplifying the dosage regimen

Note: The methods described here can be provided by health and/ or social care teams depending on what is commissioned locally

Although there may be a role for the use of MCA to support older people with medicines, it is associated with many risks (see below). Therefore the rule of thumb should be that it used only where an assessment has shown that it is the best way to support the particular older person to manage their medicines independently.

¹⁹ Bhattacharya D. Indications for multi-compartment compliance aids (MCAs) also known as monitored dosage systems (MDS) provision. 2005. (Accessed 19/11/10)

²⁰ Oboh L. Joint working between Lambeth health and social care organisations to develop a pathway to provide medicines management support to older people in domiciliary settings.

²¹ Kensington & Chelsea PCT. Review of the Monitored Dosage System (MDS) Scheme 2005

²² Akinwunmi F. Kensington & Chelsea Practice Based Commissioning Medication Compliance Project. Final Report. 2008.

²³ SCIE research briefing 15: Helping older people to take prescribed medication in their own home: what works? 2005. accessed 2/8/10 at <http://www.scie.org.uk/publications/briefings/briefing15/index.asp>

²⁴ Raynor et al. Effects of computer generated reminder charts on patients' compliance with drug regimens. BMJ 1993;306:1158-1161

Top Tips for success

The following guidance should be taken into consideration and used as the starting point

- Local Trusts and Primary care organisations should be encouraged to liaise with social care, to develop shared policies on the use of MCAs, particularly for people living at home. These should include implementing a protocol to assess individual patients' need for compliance aids and targeting their use, and appropriate arrangements for funding the devices and associated dispensing and filling
Older people NSF medicines related document 2001
- MCAs should only be supplied if an individual assessment of a patient suggests they will provide benefits for the patient. They should not be supplied simply for the convenience of patients or their carers
Colin Gable, RPS²⁵

The advantages of MCAs

- It is useful as a support system for the older person who is motivated to self-administer or manage their medicines in the community and needs some help to do so independently. It is
 - A simple visual reminder or prompt for the patient to remember to take their medicines
 - A way to simplify a complicated drug regimen so the patient can manage their medicines safely and effectively
 - A way for carers and relatives to support the older person to manage their medicines independently

The disadvantages and problems associated with MCAs

- Only solid oral tablets can be dispensed in MCA. In addition, some drugs should not be dispensed in MCAs to ensure their therapeutic effectiveness and safety.
 - Drugs that are unstable in MCAs or require special storage conditions e.g. photosensitive, temperature sensitive and moisture sensitive drugs
 - Drugs that have special administration instructions and must be identified individually in-order to do this safely e.g. alendronate, drugs to be taken with or after food such as aspirin
 - Drugs to be taken "as required" (prn) e.g. analgesics or have variable doses e.g. warfarin, prednisolone
- In addition to drugs in an MCA, often older people will have one or more medicines that cannot be dispensed in the MCA so they would be operating two medicines management "systems" which could lead to confusion or some medicines forgotten or not being taken e.g. liquids, creams, inhalers. This is a particular issue when care workers are not permitted to administer medicines except from an MCA.
- Patients can become disassociated from what is being taken and knowledge about their drugs may be poor as a result^{12,19}
- Difficulties when there are changes to drug therapy that require medicines to be added to or removed from the MCA. Good practice is for all the drugs to be returned to the pharmacy and a new script written²⁶. This can lead to wastage
- Restricts patient's choice to take a particular medicine or not as individual drugs cannot be easily identified in the MCA. Anecdotal evidence from author's experience that as a result some patients may decide not to take all the medicines in the compartment
- Not useful for certain patients particularly
 - Those significantly affected by memory loss and/or confusion e.g. some dementia patients are not oriented in time
 - Those that are poorly motivated
 - Those that lack the capacity to take medication due to significant physical or mental disability.
 - Older people who do not have the manual dexterity to open MCAs¹²
- Often patients are not offered a choice of devices to reflect their needs and are limited to what is on offer in the particular community pharmacy or hospital. This could be a problem where the MCAs supplied on discharge is not the same brand as what the patient is used to

²⁵ Barnett N, Athwal D, Vadhav G. Compliance aids: an elephant in the room. *Pharmaceutical Journal* 2011;286:75-76

²⁶ PSNC advice on website:

http://archive.psn.org.uk/data/files/Regulation/DDA/Disability_Discrimination_and_MDS_briefing_October_2011.pdf

- In some hospitals, patients are discharged with 7-days' supply in the MCA and 7-days' supply in standard containers with the expectation that the community pharmacist or district nurse will re-dispense into the MCA. Both situations can lead to confusion, duplication and running out of medication and the secondary dispensing carries a higher risk of errors. (Lambeth and KCW PCT work)
- For MCAs that are unsealed or tamper proof, medicines can migrate from one compartment into another or fall out while the older person is trying to open the device
- There is the risk of contamination with re-usable MCAs
- MCAs don't have child resistant closures
- Difficulty for dispensers to comply with legislation for labelling medicines when using MCAs where there is not enough space for the labels to be affixed. This can constitute an offence for community pharmacists²⁷
- Anecdotal evidence that MCAs are associated with an increased risk of drug errors and incidents^{28,29}
- Does not allow easy medicines reconciliation –Patient's own medicines dispensed in MCAs cannot be re-used on admission as they are not easily identifiable leading to waste and an increased risk of errors.
- The process of repeat prescribing and dispensing MCAs takes longer and is fraught with difficulties, particularly when the patient's medicines change or when they transfer between care settings
 - In hospitals this can lead to delayed discharge³⁰ and increased workload for pharmacy staff
 - Increased workload for community pharmacists and GP staff. Experience in Lambeth is that as a result, repeat prescribing and dispensing procedures are carried out that bypass critical or vital checks, to ensure they meet the demands and deadlines; this sometimes led to errors and drug incidents³¹ (see case example below)
 - Similarly, the CHUM study³² identified that care homes where medicines were dispensed in MCAs are associated with more dispensing errors compared to those with standard containers and some types of MCAs are associated with more errors
- MCA is not funded on the NHS except where a patient is eligible under the DDA (see Section 1.5.4) or where there is a locally funded scheme. So GPs resort to 7-day prescribing to fund the additional costs associated with dispensing MCAs.

Top Tips for success

- Some teams have decided to reduce the risks and confusion associated with running 2 medicines administration systems by limiting the number/ types of medicines that may be supplied outwith the MCA. For example, if a patient has more than a total of 4 of liquid formulations , inhalers, cream, eye/ear drops they are not suitable for using MCAs
- By ensuring the appropriate use of MCAs, demand can be reduced and consequently workload.
- Where patients have a medicines need that can be met with an MCA but are not eligible under the DDA, the commissioners should commission a local enhanced service to meet this need. For example a patients who independently manages their medicines but forgets to take their medicines at times.
- Some commissioners have worked closely with their Local Pharmaceutical Committees (LPC) and Local Medical Committees (LMC) to produce guidance to discourage the use of 7 day scripts to fund MCAs. **See resource section for NHS Cambridgeshire joint statement**

²⁷ Royal Pharmaceutical Society. Legal and Ethical Advisory Service Fact Sheet: Six. Monitored dosage systems and Compliance aids 2007

²⁸ Author's Local drug incident reporting data 2004-2007. NHS Lambeth

²⁹ CHUM study

³⁰ Email correspondence with NHS Trusts on "The challenges of providing MCAs". August 2010

³¹ Author's Local drug incident reporting data 2004-2007. NHS Lambeth

³² CHUM study

Case example 3: Use of MCA puts patient at risk

A patient provided with a MCA continued to receive a regular analgesic from the pharmacy when it had been stopped by the GP because it was no longer needed. Also the pharmacy continued to dispense the patient's medicines in an MCA for an additional 12 days until identified by the GP who had only intended its use for a 2 week period to cover the carer's holiday.

In both cases excessive workload due to large numbers of patients on MCAs was identified as a factor contributing to the errors. The pharmacist had devised a "short cut" process where the medicines were dispensed ahead of time from a "list" rather than waiting for the actual prescription.

Case example 4: Use of MCA can cause delayed discharge

Due to the amount of work involved, many hospitals do not dispense MCAs at short notice (less than 24-48hours), over weekends and bank holidays. This is because the hospital may have to request an SHO or consultant to issue a hospital FP10 so that it can be dispensed in the community consequently leading to delays in getting the medicines and discharge. Also, the pharmacist will have to find a community pharmacist to agree to continue dispensing the MCA for each patient (unless a relative or carer is willing to take on this responsibility). They then have to negotiate with each pharmacy; as the terms of service will vary for each community pharmacy e.g. notice period required to dispense MCA, whether they offer collection and delivery services etc - this in itself is tedious, time consuming and not a good use of a busy hospital pharmacist's time or skills

Case example 5: Poor MCA policies can lead to poor clinical outcomes

A 75 year old bed bound female, with swallowing difficulties was prescribed

- Senna tablets
- Amlodipine 5mg tablets
- Simvastatin 40mg tablets
- Tramadol 50mg capsules qds
- Aspirin 75mg e/c tablets
- Omeprazole 20mg tablets
- Lactulose solution (not in MCA)
- E 45 cream (not in MCA)

She has a care package four times daily which includes support with medicines. However, Lactulose and E45 had not been given resulting in constipation and very dry broken skin. Also Tramadol was administered at less than 4 hourly intervals to fit in with the care worker visits

The issues were resolved after a joint meeting of the pharmacist, community matron, social service and the DCP highlighted the risks with the arrangement.

Case Exercise 6: MCAs can lead to inappropriate and unscheduled episodes of care in the community

Mr AB is an 81 year old Lambeth resident with multiple long term conditions. He is mostly housebound and depends on his wife to manage his medicines although he can take them by himself. He is prescribed 25 medications which include tablets, capsules, liquids, patches. Some have to be taken regularly and others only when required. About half the tablets were dispensed in an MCA and others in original packs. The MCA had been recommended to help manage his many medicines without a thorough assessment of his circumstances. Consequently he was running 2 medication systems leading to more confusion and medication related problems; excessive quantities of some medicines and running out of others, uncontrolled BP, falls, adverse drug effects, drug errors.

Also he relies on the local community pharmacist to order, collect and deliver his prescriptions. Because of the number of medication, the surgery and pharmacy were contacted at least twice weekly and his wife made numerous trips in spite of a regular weekly delivery from the pharmacy. His wife was not coping and the GP surgery and pharmacy were spending a lot of time dealing with the problems.

Following an assessment by a pharmacist and liaison with all involved, interventions and systems were put in place to reduce the risks and reduce demand. Most of the practical support with repeat process relied on the good will of the local pharmacist to provide support without funding.

1.5.3 Statutory obligations and guidance on supporting older people with medicines

The document CQC Professional Advice: The administration of medicines in domiciliary care 2007 (now withdrawn as CQC no longer gives advice and only acts in a regulatory role) gives guidance on how and what support should be provided to people requiring medicines support in domiciliary care, including on the use of MCAs. They require the provider to take responsibility for assessing if an older person requires support with taking medicines, determining what level of support they need and then providing trained and competent staff to deliver this support. The document recommends three levels of support as follows and ideally should be used when deciding what services to commission from providers

Three different levels of support that care worker provide to patients in domiciliary care

- **Level 1: The person takes responsibility for their own medication.** At this level, the person takes the initiative for taking their medicines but can be prompted occasionally or assisted physically. If the need for prompting is a regular occurrence then it is considered a level 2 support.
- **Level 2:** It is considered that the person cannot take responsibility for their medicines and that care staff will need to do this. At this level, the care staff takes the initiative and it may include assisting to physically administer the medication
- **Level 3:** Exceptional circumstances where medication needs to be given by specialised techniques e.g. administering insulin, oxygen. CARE WORKER require extra training to carry out this level of support

Even though many care provider organisations insist that medicines should be dispensed in MCAs in order for staff to provide medicines support, neither the Medicines Act 1968 nor CQC stipulate this as a pre-requisite. In fact, the Scottish Care Commission specifically states that MCAs should not be used where care staff have responsibility for administering medicines but rather endorse that all carers should be trained appropriately in order to administer medicines.

The **Nursing and Midwifery Council (NMC) Standards for medicines management**³³ gives guidance to nurses regarding the risks and responsibilities associated with filling and administering medicines from compliance aids (Standard 16)

- There should be a standard operating procedure (SOP) agreed by the employer, to ensure that dispensing is of same quality as if from a pharmacist
- They must understand their liabilities with regard to filling the MCA
- They must consider how the patient will cope with medicines that cannot be dispensed in MCAs

The **Royal Pharmaceutical Society (RPS)** gives advice to pharmacists regarding the supply of MCAs²⁷. However pharmacists are not obliged to supply MCAs unless they decide that the patient needs one following an assessment, or to fulfil their duties under the DDA or if the pharmacy is part of a locally funded MCA scheme.

Key points regarding the supply of MCAs under Equalities Act EA 2010 (replaces Disability Discrimination Act DDA 1995)

- A Pharmacist contractor's obligation under 'section 21 duty' arises where a practice, policy or procedure makes it impossible or unreasonably difficult for a **disabled person** to make use of a service which they provide. The contractor is then under a duty to take such steps as it is **reasonable**, in order to change that practice, policy or procedure so that it no longer has that effect
- The Act suggests that if the supply of an 'auxiliary aid' would help the disabled person, this should be considered, if it is likely to assist and it is reasonable to supply an auxiliary aid.
- Examples of auxiliary aids might include the use of reminder charts, large print labels or compliance aids, it should not be presumed that a patient with a disability, who requires an auxiliary aid, must always be supplied with an MCA

³³ <http://www.nmc.org.uk/globalassets/siteDocuments/NMC-Publications/NMC-Standards-for-medicines-management.pdf>

- Definition of “disabled person”: A person has a disability if he has a **physical or mental impairment** which has a substantial and **long-term adverse effect** on his ability to carry out normal day-today activities. The impairment is ‘**long term**’ if it has lasted 12 months, or is likely to last for 12 months or for the rest of the person’s life. The ‘**adverse effect** on his normal day to day activities’ includes effects on mobility, manual dexterity; physical co-ordination; continence; ability to lift, carry or otherwise move everyday objects; speech, hearing or eyesight; memory or ability to concentrate, learn or understand; or perception of the risk of physical danger.
- Note that nearly 50% of disabled population are over 65 years and 30% aged 75 or over³⁴

See the full explanation at

http://archive.psn.org.uk/data/files/Regulation/DDA/Disability_Discrimination_and_MDS_briefing_October_2011.pdf

Exercise 7

- Go back to **Exercise 6**. Are there any answers you wish to change now?
- Compare your answers with these: 1- F, 2 -T, 3-T, 4-F, 5-T, 6-T,7-F, 8-F, 9-T, 10-F, 11-F, 12-F.

At this stage you should have more understanding about why we need to support older people to take medicines and how we should ideally be supporting them.

Exercise 8

- **Read section 2.1 and do the exercises to help you to find out about how this support is currently provided in practice and in your locality**

³⁴ Department of Work and Pensions. Disability in Great Britain: results of the 1996/7 disability follow-up to the family resources survey. (Accessed 19/11/10)

2. Section Two: Understanding the environment from health and social care perspectives

2.1. HOW WE CURRENTLY COMMISSION/DELIVER SUPPORT SERVICES TO OLDER PEOPLE

As mentioned in the introduction there is variation in how support is commissioned and provided, even within the same organisation.

The process in social care is more structured than in health and medicines support is commissioned and provided alongside other social care services (home care) rather than separately. Generally social care services are provided for people who need help to live their lives as independently as possible in the community (at home or in a care setting), people who are vulnerable and people who may need protection. Each Local Authority (LA) tailors its services to meet the needs of its local people. An older person (or their representative) in need of social care support can contact the “adult services” department (or equivalent). Depending on the individual situation, it may be decided to carry out a community care assessment (as part of the single assessment process) to identify the individual’s social care needs including medicines management. This is usually carried out by a social worker but health practitioners may also contribute to the assessment if need be.

After the assessment, the social worker will also assess the individual’s eligibility to receive support and funding from the LA. Every LA decides its own eligibility criteria but must follow the principles of the Department of Health *Fair Access to Care Services (FACS)* guidance. For example under FACS, people’s needs will fall into one of four bands; *critical, substantial, moderate* and *low*, but most LAs will only support and fund care for those who have critical or substantial needs

If an individual is eligible, the social worker will agree an individual care plan with them that will ensure that their needs are met. Then they will refer to the brokerage department who will arrange and commission (with the individual) the appropriate services to deliver the care plan. A few local authorities provide their own in-house care services but the vast majority commission these services from domiciliary care providers or the voluntary sector. More often than not, the support options around medicines are very limited; normally involving support by a care worker which may or may not include the use of MCAs. It is uncommon to commission a care package if the individual only needs medicines support.

Once an individual has had a care assessment and is eligible, the Local Authority has a duty of care to fund the support to ensure that the needs identified in the care plan are met

More recently, personalised budgets and direct payments have become the preferred options for choosing, arranging and purchasing services and are part of the government personalisation agenda. They offer more choice and flexibility and will become the norm or preferred option for all eligible people by 2013^{35,36}. There have also been pilots of personal health budgets. “**Direct payments**” is where the individual gets cash payment from the LA to arrange and purchase the services they need by themselves. “**Personal budgets**” is where an allocation of funding is given to the individual to meet their assessed needs. The individual chooses the support they need and may decide to receive the allocation as a direct payment or leave it with the LA to manage on their behalf (but earmarked for their needs) or even decide on a combination of both. Personal budgets can be used to purchase any product or service that helps to meet the outcomes stated in the care plan.

Health is less structured and the services available and the options provided to the individual will depend on which part of the service or the health care professional they present to.

³⁵ Department of Health. A Vision for Adult Social Care: Capable Communities and Active Citizens 2010

³⁶ HM government. Putting people first: a shared vision and commitment to the transformation of adult social care. 2007. Accessed (27/01/11) at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081119.pdf

From information gathered during the development of this resource, a summary of how support services are currently provided in many localities is shown in Table 2.

Table 2. How we currently provide medicines support to older people in their own homes (or at hospital discharge)

Provider ⇒ ↓ Aspect	Local authority (LA)	Domiciliary care agencies	Primary care	Hospital
Identifying older people with medicines needs	Anyone can contact social service and it will be referred to brokerage ³⁷	Not applicable	Nurses GPs Pharmacists Allied health professionals	Nurses Pharmacists Carers Doctors Technicians
Assessing the older persons medicines support need	Social workers and care managers - using overview assessment or bespoke tools	Care managers- using bespoke assessment tools	Nurses, GPs and Pharmacists- Mostly intuitively or less often bespoke assessment tools	Ward pharmacists- using in-house assessment tools Nurses- Mostly intuitively
Providing support with taking medicines	Funded care packages that involve care workers providing variations of Level 1& 2 ³⁸ support with or without MCAs) <i>In the near future, patients will be able to use personal budgets to buy their own care</i>	Funded care packages that involve care workers providing variations of Level 1& 2 ³⁹ support with or without MCAs)	Nurses- usually those requiring specialised techniques e.g. insulin Health care workers- usually variations of Level 1 and 2 (with or without MCAs) Community pharmacists GPs- usually education and prescribing more appropriate formulations, dose regimen, formulations etc	On discharge Pharmacists and technicians liaising with community pharmacists, carers and GPs
Commissioning services	From domiciliary care providers via contracts	Not applicable	Pharmacy support services mostly through specially funded schemes/ initiatives/ pilots	Not applicable

Exercise 9

To help you to think about how these processes work in your locality, use Case example 2 at the end of section 1.4 and assume that Mr KM was in your locality today. Discuss this case with your counterparts in health and social care. Based on your discussions

- How KM would be identified as having a medicines management need?
- Map out a pathway in the workbook to show his journey through health and social care system including communication and referral processes. i.e. who will he come in contact with relating to his medicines needs, how will he be assessed by each person and what support will he receive to meet these needs?
- Write down any thoughts you have

³⁷ Brokerage: This is a function designed specifically to help individuals gain access to the social care and support services they need. A service where individuals called brokers help people gain access to the social care and support services they need.

³⁸ See definitions of level 1 and 2 support with medicines

³⁹ See definitions of level 1 and 2 support with medicines

Types of support provided to older people to help with medicines taking

This depends on how independently the older person is able to manage their medicines. An interview of 12 Lambeth community pharmacists as part of an undergraduate project identified areas where their patients needed support as follows⁴⁰:- remembering to take medicines, understanding the medicines instructions, confusion around medicines use, running out of medicines, inability to open the medicine bottle because of arthritis and not knowing which drugs to take after a hospital stay. Examples of the types of support that could be provided is shown below

Examples of the types of support that can be provided

Non-clinical staff (usually care workers)

- collecting prescriptions or medicines from the GP or pharmacy
- help with remembering to take medicines or prompting
- selecting or administering medicines
- assisting with devices such as inhalers, opening bottles
- assistive technology⁴¹ e.g. electronic reminders and medication boxes can be provided by Assistive Technology teams)

Community pharmacists

- supplying auxiliary aids: mainly MCAs
- printing medication reminder charts and medication administration record charts
- ordering, collecting, delivering prescriptions or medicines
- medicines use review (MUR)
- repeat dispensing service
- education, advice and drug information for patients and carers

Hospital pharmacists

- large print labels, reminder charts
- providing MCAs

These services are usually provided in silos with individual organisations using different access criteria and working within different financial and other constraints making access to the right support inequitable. To overcome this, some organisations have taken a whole-systems approach to develop services that are well integrated into overall care. The following are examples of where this approach has been taken (**See resources section for brief description of schemes**)

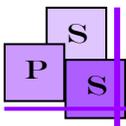
Examples of organisations that have run whole system schemes

- The **LOPSDP medicines management pilot**
- East coastal Kent PCT '**medicines support service**'
- In Brighton the '**take as directed**' scheme
- East Sussex Downs and Weald PCT '**domiciliary compliance assistance**'
- The "**Devon Joint Agency Medicines Support Service**"
- The **Devon-Exeter PCT domiciliary pharmacy service**
- The **Norfolk Medicines Support Service**

Two projects looking at the use of MCAs and support for older people in Lambeth PCT and Westminster, Kensington & Chelsea (K&C) PCT each came to the conclusion that in order to move this agenda forward, health and social care must agree to a joint approach or strategy and be committed to work collaboratively to bring about the transformational and sustainable changes needed to improve outcomes.

⁴⁰ DaNaom D (Pharmacy Student) Supporting informal carers who assist older patients with their medicines. Examining potential service developments. Final results (unpublished) 2009

⁴¹ Assistive technology is any device or system that allows an individual to perform a task that they would otherwise be unable to do, or increases the ease and safety with which the task can be performed (Royal commission of long term care 1999). It includes a wide range of devices from simple low tech items such as calendar clocks to more high tech items such as automatic lighting and telecare sensors



It was acknowledged that things would have to be done differently and solutions jointly resourced, implemented and integrated across the local economy.

Exercise 10

The table below summarises some essential components found in successful localities

- Complete the table to determine the extent to which they are present in your locality.
- Indicate what components you have control over or can influence to drive forward

Note: depending on who is completing this exercise the scores may vary and it may be worth asking a couple of key people to carry out this exercise separately

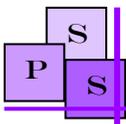
Table 3: Some essential components found in successful localities

Essential components	Use a scale of 1 to 5 to indicate the extent to which each component is present in your locality. 1: not all, 5:fully	I have CONTROL to drive forward	I can INFLUENCE the process to drive forward
1. Collaborative and partnership work across health and social care as well as with regulators; with commitment for a joint vision, strategy and leadership around support with medicines e.g. medicines is mentioned joint older people strategy	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
2. Defining and agreeing roles and responsibilities for the organisations or teams involved	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
3. Well defined criteria and referral processes for older people identified as needing medicines support	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
4. Services are patient centred rather than staff/organisation centred; with flexibilities in the system to genuinely promote independence (e.g. self-administration) and tailor support to individual need	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
5. Use of jointly agreed medicines policy and standard assessment tools across organisations	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
6. Adequate funding/commissioning based on the assessed needs of older people rather than historic	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
7. Medicines support integrated into care pathways and embedded into routine care of older people	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
8. Good performance management of medicines related activities within contract monitoring; with providers held to account for low quality services	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
9. Making the most of community pharmacists and their staff by commissioning services that drive improvements at the coal face e.g. providing auxiliary aids, training care workers, targeted MURs	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>

At this stage, it may become apparent that there is a gap between the ideal and current practice. The next sub section will attempt to highlight some of the reasons for this. However this will not be the case for all organisations and as you work through the exercises you will identify which of these exist in your locality.

Exercise 11

- Read section the following sections 2.2 to 2.4 to help you to understand some of the reasons for the gap



2.2. KEY ISSUES AND BARRIERS ASSOCIATED WITH CURRENT PRACTICE

Many of the challenges identified in this section are similar, common, cross-cutting, longstanding, complex and ingrained in current practice within organisations.

For ease of understanding they are divided into two main groups

- Challenges identifying, assessing and referring older people with medicines support needs
- Challenges with respect to commissioning and providing the right support

2.2.1. Challenges identifying, assessing and referring older people with medicines support needs

Key points

- **Reactive rather than proactive case finding**
- **Lack of standardised assessment tools**
- **Lack of robust and structured referral process**
- **Lack of joint working between health and social care**

- **Reactive rather than proactive case finding**

In social care, older people are usually assessed for help with medicines as part of their overall assessment at the point of entry into services. However in primary healthcare it is more reactive than proactive; depending on the health care professional and where the patient is seen. As a result, some older people slip through the net and we fail to identify their needs until they present with a medicines related problem.

- **Assessment**

When patients are identified in both health and social care, the assessments are usually done intuitively rather than by employing a standardised tool. Some organisations have developed specific MCA assessment tools which focus on the suitability of MCAs rather than a holistic assessment of the individual's medicines management needs. When patients are assessed in this manner, other interventions are excluded from the outset. A study showed that the current assessment techniques used are cannot adequately identify which patients will benefit from an MCA¹⁹

Top Tip for success

- It was identified that successful organisations had developed common assessment tools that can be adapted for use by clinical and non-clinical staff across the locality. **See Appendix** for example in Devon

- **Referral and follow up**

Following assessment there may be no structured way to refer an older person to receive the help they need; except where organisations have a process to refer for the provision of MCAs or a domiciliary care provider. Otherwise it is usually down to the initiative of the individual carer or practitioner or their relationship with the community pharmacist. In Lambeth we found a need to increase awareness of how best to access professional help or advice on medicines issues; many older people, relatives, social care and DCP staff were not aware of the role of the pharmacist in providing medicines information. Social workers and DCP managers will usually phone a district nurse or the GP if they identify a problem. Often the response from the GP is not quick enough, particularly where an answer is required urgently e.g. clarity on dose.

Local community pharmacy staff have a vital role in making sure that medicines support is delivered on a day to day basis. In particular, for pharmacies located near residential areas, the non-clinical staff like the delivery drivers and counter staff often live locally and may have useful information and considerable knowledge as a result of their contact and involvement with older people and their carers around medicines use.

Top tip for success

- We found that referral and follow up worked better when the care managers or care worker have good relationships with the local community pharmacist.

Case example 7: Personalised medicines support for SH

75 year old Mrs SH has a history of severe COPD, pulmonary embolism, depression, OA, asthma, hypertension, heart failure among other LTCs. She regularly takes 14 medicines; including tablets, liquids and inhalers. She lives with her daughter who helps with managing her medication. The daughter would usually take out medicines from the original pack and put them into a cup for her mum to take and the system worked well. Lately Mrs SH has become increasingly breathless and has been admitted to hospital a few times. The daughter struggles with amount of time it takes to co-ordinate, order and collect repeat medicines. She has been advised that having the medicines in an MCA would make things easier.

The patient was identified as needing medicines support by the community matron during a routine assessment and referred Mrs SH to a pharmacist. It was identified that drugs were not synchronised which resulted in the frequent visits to the pharmacy. The patient's inhaler technique was poor leading to frequent exacerbations. Following the assessment a joint decision was made against having an MCA as the daughter wanted to be able to identify and know what specific medicines her mum was taking at all times. Also it became apparent the daughter was unaware of services such as MUR, repeat collection/delivery and repeat dispensing which could have helped.

Exercise 12

To understand what happens in your locality, find out from your counterparts what happens currently when older people with medicines support needs are identified and assessed when they have been in contact with

- A Social worker
- A GP
- A Community matron or District nurse
- An Elderly care ward pharmacist

If they do need support describe how they are then referred to the right person/team to get the support they need (not just MCAs)

N.B. Table 2 may help you with this exercise

Suggestions

- Raise awareness among frontline practitioners and senior managers in health and social care that this is a common problem and they have a joint responsibility to ensure that older people with medicines needs are identified, assessed and referred to receive the support they need wherever they enter the system. The Older peoples Partnership Board, Age Concern, Pensioners forum, safeguarding adult partnership board or similar meeting are good places to initiate these discussions
- Find out if medicines management is specifically mentioned in the joint strategy for older people and use this as a starting point to work together. **See Appendix** for examples of medicines targets in Lambeth OP joint strategy
- **The 4 medicines trigger questions and Count® tool** are overview assessment tools used successfully by clinical and non-clinical staff. Also the **Colchester RAT tool (validated), Fuller and LOPSDP in-depth assessment** tools have been used as specialist or in-depth assessment tools used by pharmacy staff. **See Appendix**
- Ideally specific MCA assessment tools should be used after a holistic assessment shows that an MCA may be indicated.
- The use of a **single point of access**⁴² for referrals regarding medicines support may help to ensure that older people don't get missed

⁴² Central point across a range of services to which referrals are sent

- Give consideration to medicines support issues when redesigning services or commissioning care pathways so that older people don't fall through the net. **See Appendix** for Commissioning medicines management redesign toolkit For example poor adherence to Vitamin D and bisphosphonates in osteoporosis management and the negative effect on outcomes are well known. Therefore it makes sense that support with medicines taking should be part of the falls care pathway to improve therapeutic outcomes. Also COPD exacerbations are a common reason for frequent A&E admissions and the appropriate use of medicines can help to reduce these exacerbations **See Appendix** for City and Hackney COPD MUR plus scheme

Exercise 13

- Find out if you have a single point of access for older people or adults in the community
- Describe how the system works in your workbook

2.2.2. Challenges in commissioning and providing effective solutions

Key points

- **Ambiguity as to whether “medicines taking” is a health or social care related activity**
- **Problems with providing MCAs**
- **Poor commissioning of support services other than MCAs**
- **Inconsistencies and variations within medicines policies**
- **The different cultures within health and social care that impact on delivering medicines support services**

- **Is medicines support a health or social care task?**

Currently local authorities (LAs) are responsible for commissioning services to support an individual's social care needs. For example home care, sitting, meals, support with medicines taking etc. On the other hand healthcare commissioners commission services to meet the healthcare needs of the individual. At the time of writing it remains unclear whether “taking medicine” is a “health” related activity or “social” activity of daily living, thus it is difficult to decide who should take the responsibility to ensure that the right support systems and services are in place. In recent times there has been a push for LAs and healthcare commissioners to form closer partnerships and produce joint teams to meet the needs of people with LTC and complex needs. NICE however, places the onus on health to take responsibility for ensuring that patients take their medicines appropriately

In practice, depending on who initially identifies the need, the history of services provision, the availability of resources or expertise, and the support offered varies from organisation to organisation. Generally those individuals in contact with social services will receive support from care workers and those in contact with health will receive support from a range of individuals including community pharmacists and nurses. Poor collaboration, communication or referral between the two systems can lead to duplication, conflicting advice and a break down in care so it is important for discussions to take place early in this process to clarify roles and responsibilities as well as map a local pathway for medicines support.

Exercise 14

Make a note to ask your counterparts about their views on whether taking medicines is a health or social care activity. Write these views in your workbook. It may help you to understand why services are funded in a certain way and present the opportunity to start discussions for joint working.

- Make a list of key people you want to involve in initial discussions?
- Make a list of what support services health and social care commission or provide in your locality

- **MCA issues**

The need for MCAs is often driven by social care and sometimes older people and their carers without full appreciation of the wider issues. **Section 1.5.2** highlights the main problems with MCAs gives suggestions for effective alternative solutions.

▪ **Poor commissioning of support services other than MCAs and perverse incentives in the system that favour the use of MCAs**

Health and social care staff are often unaware of these alternative solutions mentioned in **Section 1.5.2**. Also many of these solutions are not readily available in the community or funded by the NHS (except for those who qualify under the DDA) and so may have extra resource implications for the community pharmacists who provide them. For example winged caps are not available for arthritic patients who struggle to open child proof caps, therefore MCAs may be recommended as an alternative. Also a number of community pharmacists have no facilities to print an A4 size medicine reminder chart or large print labels at the time of issuing dispensed medicines. In cases where patients have been given a supply from the hospital there is often no continuation in primary care.

Exercise 15

- Do you currently commission community pharmacists to provide MCAs?
- Do you have a problem with large numbers of 7-day prescriptions?
- Approximately how much is spent on dispensing fees for MCAs i.e 7day scripts (Tip: **See Appendix** for how NHS Lewisham estimate this figure)?
- If there is a commissioned service has it been evaluated, audited or reviewed to show benefits to older people or value for money?
- Is there scope to re-consider disinvesting in a scheme that is not delivering the outcomes needed to re-invest in other support services
- Do you commission a targeted MUR service? Which?
- Find out how your contractors and provider arm provide medicines support to older people who fit the DDA criteria

Exercise 16

Contact a couple of your local community pharmacists

- Find out what involvement or support they provide to older people and their carers with medicines
- Do they have facilities for example to print out large print labels or reminder charts?
- Make a list of the barriers they encounter and constraints in delivering these services
- Make a list of what they would like to see commissioned to improve medicines support for older people

Exercise 17

“MCAs should only be initiated in hospital as a last resort i.e. only if there a real and immediate perceived risk of harm to the patient if an MCA is not given on discharge” is a statement made by a hospital pharmacist.

- What are your thoughts or comments about this statement?
- Make a note to liaise with your counterparts in health and social care to discuss ways you get this message across to those requesting MCAs inappropriately and get it implemented in your locality

Suggestions

- Pharmacist can provide better education and information about the range of options and their pros and cons. Organisations like the Royal National Institute for the Blind, Age Concern, and NPA etc have resources that give practical solutions. East Sussex Downs & Weald PCT has developed a resource on the availability of a wide range of devices to support medicines taking. (**See Appendix**) These can be available as a reference for frontline staff.
- **See Appendix** for the document written by London, Eastern and South East NHS Steering Group on Medicines Management and Older People to enable organisations support people who need help with medicines. It also lists examples of good practice and highlights the potential risks associated with failure to apply these principles.

Exercise 18

- Write a list of the pressures currently facing your/their practice/department/organisation to deliver MCAs?
- What are the implications for your service in terms of finance, resources, increased risk etc?

▪ **Inconsistencies in medicines policies**

Although many organisations had medicines policies, the Lambeth project found that some were outdated and procedures were not being followed in reality. In some cases certain aspects did not comply with guidance or best practice and occasionally were contrary to the Medicines Act. It found that guidance was subject to interpretation and hence the variation within and across organisations. The Medicines Act is not detailed enough with regard to medicines administration by non-clinical staff and therefore also subject to interpretation. For example, in Lambeth it was found that even within the same organisation there was variation in the definition or scope of the medicines support provided; the terms “**administer**”, “**prompt**”, “**assist**” had a different meaning to the terms used in guidance. Although the terms were used interchangeably in patient records and care plans, the interpretation by staff and managers differed. This led to confusion about what support should have been provided by the care worker and what support was received by the patient

Many hospital policies acknowledged that the acute setting is not the ideal environment to initiate MCAs and state that it should be the exception not the rule, however the lack of guidance to back it up means they give in to social care requests. Some hospital policies list “*carers refusing to give medicines except from an MCA*” as a valid reason to supply an MCA. This may be a pragmatic approach to prevent delayed discharge but adds to the long term problem and needs to be addressed

Case examples 8: MCA myths

- An Acute Trust decided not to supply MCAs for patients unless they had been admitted on them. As the domiciliary care provider medicines policy will not allow their care workers to administer the medicines from standard containers, the patient was kept in hospital until a community pharmacist who would fill the MCA was identified.
- In the Lambeth project, one care provider agency policy will not allow carers to administer medicines from standard containers but allow them to do so in the neighbouring PCT.
- One LA policy stated that “*Home Care Assistants cannot give you your medication, but can remind you to take it, provided it is in a dosette box*”.
- Another acute trust stated in its policy that community pharmacists should dispense medicines in an MCAs from a faxed discharge summary

Exercise 19

- Liaise with your counterparts and obtain a copy of the **medicines policy** for each organisation in your locality e.g. community services provider, hospital, mental health trust, LA and DCP. Also ask for a copy of the “medicines section” in the LA contracts with the DCPs
- Find out what they say about administering medicines from MCAs
- Does each policy follow good practice guidance like the RPSGB guide, CQC guide?
- Find out if providers actually do provide support as it states in the policy?
- Make a list in your workbook of any poor practices, conflicting messages etc, that you may want to raise with partners

Suggestions

- Standard 10 of the National Minimum Standards⁴³ recommend that DCP medication policies should be approved by a pharmacist with suitable experience where appropriate

⁴³ NMS identify a standard of service provision below which an agency providing personal care for people living in their own home must not fall. Domiciliary care: national minimum standards, regulations. DoH 2003. Accessed 5/11/10

Exercise 20

- Obtain a copy of the medicines training programs that care providers/agencies use in your locality. (Tip: Think carefully about how you ask for this, as not all agencies may be willing to share this information)
- Do they meet the CQC minimum standards?
- Make a list of any issues you may want to discuss with partners

Top Tips for success

- Most successful schemes have used pharmacists to deliver training for care workers on safe handling and administration of medicines. There is usually initial training followed by ongoing training on a regular basis. **See Resource Section** for examples
- PCTs that developed joint medication policies with LA which the providers are signed up to, reported that it was a big step towards achieving better and more cohesive support. **See Resource Section** for Southwark PCT, Norfolk PCT joint medication policies

Fundamental differences in health and social care organisational cultures and how they function

An understanding of these differences may determine the ease and extent to which you are able to agree and make the changes needed to improve the way medicines support is commissioned and delivered in your locality. Raising awareness of the risks from a health care perspective and providing information and support where there are gaps help to build bridges and overcome barriers

- In social care **accountability and governance processes** relating to medicines are not as robust as in health care. An understanding of how these processes work and the individuals accountable may be helpful to push the safety agenda. For example there are usually no performance indicators or requirements within contracts for providers to audit systems for safe handling of medicines and drug errors/incidents. The Lambeth project found that although some agencies keep records of drug incidents, it was more “good practice” rather than mandatory. Also where refusal to take medication was documented it was not always followed up by notifying the GP.
- **Assessing and funding medicines support needs** - Unlike most of the care provided by the NHS, social care is usually means tested. When a social worker assesses an older persons medicines needs, it is mainly to determine their eligibility to receive medicines support as part of the care package (only those patients that have a care package can receive medicines support) Once eligibility is confirmed, they determine what type of support should be provided. The assessor may not understand all the factors to take into account when selecting the appropriate support. For example an assessor may not allocate extra time within the care package to support an older person taking 12 medicines in the morning compared to another taking only 2 medicines. It is usually down to the DCP managers to reassess and negotiate for extra time if they feel the tasks will take longer than what is commissioned.
It is important to note that the provider is paid according to the time allocated to deliver the care package, including medicines related tasks. Also medicines administration is not allocated a specific time within the care package so medicines related tasks have to be carried out within the time constraints of providing other personal care.
- **Workforce and training** -Most of health care delivered within the NHS is by professionally qualified staff. But social care is mainly provided by less qualified staff from independent and voluntary sectors. For example in Lambeth social care managers and DCP managers carrying out assessments gave feedback that they are often pressurised into make decisions about medicines that they felt they hadn't been trained to make. Also the high turnover of care workers particularly in London has implications for training and retention of staff with the right skills and competencies. In Lambeth one agency stated that they adopted the policy where carers only administer from MCAs in order to “reduce the risks” because of the skills of staff they employ coupled with the little time allocated to complete medicines related tasks as part of a care package.

Care workers training is an issue that comes up often in discussions with LA and providers and there is scope to work collaboratively with health. Some DCPs provide in-house training and others utilise external trainers but the quality of training varies from agency to agency. Skills for Care no longer provide a definitive list of what should be covered as part of medication training as each care organisation has different needs. However they suggest a list of what should be considered as part of staff meeting the *Care Certificate* requirements⁴⁴, The “Safe handling and medicines administration” for adults in social care settings (RPSGB) documents⁴⁵ give guidance on the minimum requirements for a training program in, but there is no nationally accredited course. The Lambeth work found that the scope of medicines related tasks that the care workers carried out in practice did not always reflect that they had met the objectives of the training programs. For example one program involved training the care workers to administer oral liquid formulations however in reality were not allowed to carry out this task as liquid formulations are not dispensed in MCAs.

Case example 9: A patient centred package of care for DW

Mrs DW is blind and lives alone at home. She recently spent a couple of weeks at an intermediate care centre following a hospital admission for a fall. She has a twice daily care package of 25 minutes each. She takes many medicines including Alendronate 70mg every Thursday to prevent a fracture. The social care assessor is not aware that Alendronate should be taken 30mins before any other medicines/food to ensure maximum effectiveness; consequently, the care worker gives all the medicines within the allocated 25 minutes. As part of routine follow up, the intermediate care pharmacist identified and raised it as a risk. After discussions with the LA and provider, the pharmacist was able to secure an extra 30mins on Thursdays to ensure that Alendronate is given safely and effectively

Case example 10: Lack of planning causes readmission

85 year old Mrs FQ receives medication support as part of her twice a day care package. She was admitted into hospital with cellulitis and discharged on flucloxacillin four times a day as well as several medicines which she was taking prior to the admission. Five days later she was readmitted to A&E with the same problem. It was found that the antibiotic had been given only twice a day when the district nurse visited as the care workers will not administer from standard containers.

An understanding of these issues and an attempt to address them is an absolute necessity if we are to limit such risks

Exercise 21

- Find out how your LA assures itself that its providers are providing adequate support e.g. arrangements to support patients with medicines that cannot be packed in MCAs

At this point, you should have a better understanding of how older people are supported in your locality. You should have made contact with the relevant people in other organisations and understand how their processes work. You should know the key issues that need to be addressed in order to move on. Before you go on to section 3 you may wish to carry out the following suggestions;-

Top tip for success

- It is important to understand your local situation since when you meet with the partners such as social care in Section 3, you may want to make trade-offs e.g. offer pharmacist time to help out with training managers and care workers, developing tools and writing policies etc
- Involving your regional CQC pharmacist in discussions may help to drive the process

⁴⁴ Skills for care. Skills for Care Recommendations for CQC Providers: Induction related training (accessed 10/5/15) <http://www.skillsforcare.org.uk/Document-library/Standards/Care-Quality-Commission/Recommendations%20for%20CQC%20Provider%20Guide%20Section-5---Induction-Related-Training.pdf>

⁴⁵ <https://www.rpharms.com/social-care-settings-pdfs/the-handling-of-medicines-in-social-care.pdf> (accessed 10/05/15)

WHAT DO I NEED TO DO?

3. Section Three: Practical steps to tackling the problem in the local economy

Key steps

- Identify partners
- Review information and knowledge gained from Sections 1 & 2
- Be clear about where you would like to get to
- Consider the various possible options for change
- Develop a case for change
- Explore levers in the system that support a case for change
- Agree a joint action plan (this may involve making a business case or proposal see below for more information)

3.1 IDENTIFY ALL THE PARTNERS

In identifying partners, consider the right mix of practitioners, managers and older people representatives. Full engagement with frontline practitioners and senior managers is important to ensure that every perspective is taken into consideration, solutions are workable and everyone has the ownership and commitment needed. Clear leadership by enthusiastic and motivated individuals is a must to influence practice at the coal face. Involvement of senior management and decision makers will ensure that the vision is reflected in strategy and that the group is able to make decisions. It is important to note that a group of pharmacists alone will struggle to implement the changes needed across health and social care

Case example 11: Engaging with the most appropriate partners

After several meetings of the Lambeth OP MM multidisciplinary group it was decided to carry out a joint pilot between health and social care to test the use of a generic medicines assessment tool within an integrated pathway. The social service representatives agreed to this proposal but senior managers back at the Local authority would not sign up as they were not aware, not been part of the decision making and didn't understand the background issues. Separate meetings had to be arranged with the decision makers to seek agreement. This slowed down the process considerably.

Suggestions

- Partners should represent their organisations or teams and take messages to and from the group
- Practitioners should be from different disciplines with the right expertise and knowledge
- Representatives of older people, and their carers can be recruited from community groups, patient forum, age concern, help the aged, pensioners group or similar
- It is best that the multidisciplinary group is accountable to or reports regularly to a joint strategy group for older people or similar
- See resources for an example of a list of stakeholders in the Lambeth, Chelsea & Westminster, Devon projects.

3.2 WHERE IS YOUR ORGANISATION IN THE JOURNEY?

The reflection and exercises in **Section 1 & 2** will have given you a good idea of where you are in this journey. If you have been able to attend a learning set or facilitated discussion group you may have a range of solutions or options that have worked in other organisations and can be adapted for your local use.

Suggestions

- You will want to spend some time at the first meeting checking what is the current position and this will help you to contribute and confirm what you have found while you were working through Sections 1 & 2

3.3 WHERE WOULD YOU LIKE TO GET TO?

It is important to be clear about where you want to get to in the journey and to set the right targets and timescale to get there.

The ideal place to be is where your health and social care organisations protects older people against the risks associated with the unsafe use and management of medicines, by making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. This means that older people will have their medicines at the times they need them and in a safe way with the right information

Characteristics of a locality providing exemplary medicines optimisation for older people

- Processes and systems follow published guidance, are jointly developed and agreed at every level (including older people and their representatives).
- Medicines support is integrated into mainstream care, joined up and seamless across organisations
- Interventions are recommended only after a thorough assessment of the older person’s need and taking into account their choices and medicines safety
- Sustainable solutions and a range of support options that are evidence based, ensure value for money and provided by a variety of health and social care staff are commissioned
- Funding mechanisms are agreed for the service required
- Frontline practitioners are supported to deliver quality care by providing the appropriate training tools, policies and resources

Work towards a joint policy/system/pathway across a local economy that enables older people with medicines needs to be identified, assessed and referred to the most appropriate service/practitioner in health or social care.

3.4 HOW WILL YOU GET THERE AND WHAT ARE THE OPTIONS?

Irrespective of where you are, it is best to start with small, incremental changes that are sustainable as you move towards your final goal. A project management approach will ensure that there is an overall aim, targets to achieve and an action plan to get there with appropriate reporting and monitoring upwards and downwards. Before developing an action plan it is essential to explore the options and the pros and cons of each option.

Exercise 21

- Highlight or summarise the key points from **Sections 3.2, 3.3 & 3.4**
- Work with your other partners to draw a journey map path to get to your final destination

3.5 DEVELOPING THE CASE FOR CHANGE

What are the consequences of doing nothing?

Think about the clinical and financial risks associated with the current situation. For example

- What will happen in the next few years if things continue as they are? For example what are the implications for capacity to continue to deliver services safely and effectively with the increasing demands of providing MCAs, the impact of individual budgets and personalisation
- What are the financial implications?
- Failure to meet medicines related targets in the NSF, white paper
- Increased hospital admissions or delayed discharge due to medicines problems.

- Consider the missed opportunity to effectively contribute to managing long term conditions and enabling older people to be more independent and live at home

Raise awareness of the risks from a health care perspective and providing information and support where there are gaps help to build bridges and overcome barriers

Gather local evidence to support the need for change

Depending on what has been identified in your organisation, in exploring other options consider what data/evidence you have to support or justify the changes proposed

- **What data is already in the system?** Drug incidents related to use of MCAs, complaints, aspects relating to medicines from patient satisfaction surveys, evidence from NICE, SCIE and other reputable papers, the current volume of activity e.g. number of people on MCAs, number no of care packages that include medicines support.
- **What other data can you collect?** Suggestions from older people's forum or voluntary groups like Age Concern, Help the Aged, audit of drug wastage, individual case studies.
- Consider a joint review, audit or survey of medicines support services in a small sample of your population to gain further insight about your locality. Alternatively patient survey, questionnaires, case studies etc. can be used. Present or publish the results to a health and social care forum with key influencers and decision makers. For example a survey done in Lambeth showed that 94.5% of the 338 older people receiving medicine support from the two main domiciliary care providers (DCPs) were using MCAs. This highlighted the extent to which MCAs were being used.
- **What savings can be realised if the changes are made?** Think across organisations instead of just one organisation e.g. reduction in hospital admission or admission into care home. A change in one part of the economy can lead to savings in another so consideration should be given to pooling resources across the health economy. Think about wider savings not just from cost of medicines e.g. less use of MCAs. Commissioning new services may involve an initial cost for pump priming but existing services could be redesigned to make them more effective and modernised.

3.6 EXPLORE THE LEVERS IN THE SYSTEM TO SUPPORT CHANGE

Not all changes proposed will require huge financial investments to deliver. In the current financial climate, organisations must be willing to be innovative and be willing to make current resources go further by doing things differently and disinvesting in inefficient services. There is scope to utilise existing resources and redesign services. Some examples that have been used include.

Suggestions

- Pharmacy contract- essential services and advance services (MUR) are already funded but not fully utilised. Local enhanced services and LPS services can be developed. **See Resource section for examples in East Sussex & Downs and Harrow PCTs**
- Clinical commissioning groups - opportunities exist when redesigning care pathways e.g. falls, frail elderly
- The new CQC regulation process is more patient than process focused. Providers will have to demonstrate that they are delivering the right patient outcomes to be registered and continue to remain on the register. CQC have powers to remove from register or impose sanctions on those who are not meeting standards so providers will be held accountable to deliver real improvements. Some of the changes proposed will enable providers to demonstrate this.
- QIPP agenda- changes that demonstrate innovation, financial savings and efficiency may be more acceptable in the current climate

Opportunities within recent health and social care policies to fund and deliver improve medicines management changes and patient outcomes

The Health Act Flexibilities (1999) already made provision for health and social care to pool budgets and integrate services to improve response for vulnerable people. Also one of the key actions to implement the NHS and Social Care LTC model was to plan and commission new and integrated services using the primary care and pharmacy contracts, practice-based commissioning as well as pooled budget arrangements between health and social care⁴⁶. However uptake has been low for older people services.

Recently the *Putting People First* paper set out a vision for the delivery of a personalised adult social care system and a long term plan for every locality to have a single community based social care support system for the most vulnerable. As a result of this and the Spending Review 2010 extra funds have been made available to social care over the next few years in the form of government grants and NHS contributions⁴⁷ ring-fenced to

- help to facilitate seamless care for patients on discharge from hospital
- prevent avoidable hospital,
- develop current re-ablement capacity according to local needs
- avoid hospital admissions.
- ensure that people leaving hospital have access to the appropriate levels of professional support that will enable them to live independently and, as far as possible, fully return to their way of life prior to hospital admission

In addition NHS will also provide funds to LA to be spent on social care services that benefit health Partners are expected to work together to develop local plan and it is up to them how much they spend on health and social care. Initiatives will have to take into account the joint strategic needs assessment (JSNA) and commissioning intentions of health and social care partners.

Access to appropriate medicines management support can enable older people to live at home more independently, prevent readmission, improve their health outcomes etc and there is no reason why these funds cannot be spent on providing improved support. Pharmacists working with older people can offer professional advice and expertise to ensure that the right resources are in the right place to prevent avoidable admissions, long stays in hospital and prevent use of long term social care.

Exercise 22

- Find out what is happening in your locality with these extra funds. Who is in charge of deciding how and on what these moneys are being spent
- Ask how you can access some for these funds to improve medicine management support. See **Section 3.7** on how to write a business case/proposal to access these funds or support commissioning

⁴⁶ DoH. Supporting people with long term conditions. 2007

⁴⁷ DoH. Dear colleague letter 2011. NHS support for social care: 2010/11 – 2012/13. Accessed 02/02/2001 at http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_123460

Below are suggestions about what health and social care could contribute in relation to medicines support

Service or activity	Who and example	Advantages and justification
Funding community pharmacists to produce MAR sheets for patients whose medicines are administered by care workers	Health	Reduces the risks of transcribing errors by care managers and time spent carrying out a task that many feel is out of their scope Facilitates good record keeping Instils confidence that a healthcare professional has been involved in writing the drug list. Also presents the opportunity for medicines problems to be identified and resolved earlier on in the process rather than later
Funding a range of compliance aids (not just MCAs) to be available through community pharmacists e.g. haleraid	Health	Reduce the cost and risks associated with inappropriate use of MCAs (see section 1.5). Allows provision of the support that is tailored to the individuals specific need and delivers improved outcome
Targeted MURs for older people identified as needing medicines support	Centrally funded by health Additional funding can be given to community pharmacists to follow up these patients	Allows social care and health care staff to refer patients who have been identified as needing support with medicines. The pharmacist is able to tailor the support to meet their individual needs. (personalisation and outcome focused) Also pharmacist is able to follow up these patients
Telecare	Joint	Personalised support, promoting independence
Pharmacist advice and input into policy development and input into medicines management assessments as part of care assessments, rehabilitation and post discharge services	Joint See example of a local authority pharmacist http://www.pjonline.com/files/rps-pjonline/pdf/pj20110115_my_career-52.pdf	Ensure the right expertise into policy and strategy Better patient outcomes; access to expert input/care- patient able to manage medicines independently, reduced risk of medicines related hospital admissions, facilitates seamless care post discharge e.g. medicines reconciliation, better communication at interface
Innovative services for pharmacist to provide support for a caseload of vulnerable older people with medicines support needs	Health	Better outcomes from the use of medicines, reduced risk of medicines related adverse effects, hospital admissions. Better partnership working More complex patients needing more pharmaceutical care
Training for care workers and care managers around assessment, safe handling and administration of medicines	Joint	Better assessment of medicines management need by care managers, Care workers trained and competent to handle medicines and administer from any container- reduced inappropriate use of MCA

Other Suggestions

- See resources section for a list of useful training tools, policies and resources that have worked in *other organisations*
- Get evidence or data from similar projects and highlight benefits or adapt for your own population. See resource section for a process map used to develop the Medicines Support Service (Norfolk PCT)
- Propose to your counterparts that you jointly develop and agree principles/policy for medicines administration locally which is built into the provider contracts. Standard 10 of the National Minimum Standards recommend that DCP medication policies should be approved by a pharmacist with suitable experience where appropriate
- Offer to help develop performance indicators for medicines management with LA when contracts are reviewed or renewed or as part of contracts monitoring. The medicines management outcomes (9) of the CQC *Essential standards of quality and safety* and RPSGB *handling medicines in social care* guidance are good places to start
- Offer to work with your local authority (LA) when contracts are reviewed or renewed with DCP to ensure that they provide appropriate levels of support as described by CQC guidance and is flexible enough to meet the individual need of the patient. How can you link medicines support with the LA personalisation agenda?

Suggestions specific to the use of MCAs

- Create shared policies on the use of MCAs
- Implement a protocol for assessing individual patients need for compliance aids for non-clinical as well as clinical staff
- Include *Arrangements for funding devices including filling/dispensing*
- Explore and discuss the practical issues they face; think about realistic solutions to these problems. E.g. not all care workers may be able to undertake medicines support tasks at the levels described by CQC. You can work with the DCA to skill them up or a realistic solution may be to help identify those who have the right competencies and allocate them to the older people who need medicines support as part of their care package.
- Think about how you can dispel the myths of MCAs being a safer option and get them to think about wider support options in the system. Don't underestimate the amount of work required to get people to understand the risks associated with MCAs!
- Propose a policy or an interim holding statement jointly agreed by health and social care stating that MCAs will only be supplied after a thorough assessment has been carried out that shows there is a real need. **See Appendix** for example of a statement from Essex
- Review existing MCA services and consider commissioning a locally funded scheme to offer a wider range of choices that can be tailored to meet the individual needs of older people. Explore the levers in your locality to help with this. This could be commissioned as part of NICE guidance implementation, community pharmacy LES, LPS, Re-ablement scheme. **See Appendix** for examples.

3.7 PULL IT ALTOGETHER IN A BUSINESS CASE OR PROPOSAL

Once you have gathered all the right information, it needs to be presented in a way that it can be communicated to the right people who would support the changes needed and ensure its implementation. A business case or proposal is one way to make this happen. Presentations to key groups, committees and older people related forum may also be necessary to help drive change. It important to be able to justify the need for the approach compared to the current situation and be able to articulate the risks and benefits linking it with QIPP, personalisation and reduced hospital admissions, re-admissions and unscheduled episodes of care.

Suggestions

It is best to use a template from business cases that been successful that start from scratch. See resource document for an example of a business case to support the delivery of additional medicines management across health and social care in Norfolk. Also the proposal for the LOPSPD medicines management pilot.

Exercise 23

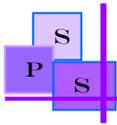
- Make a list of how you can raise awareness about these points and rally support from “movers and shakers” to drive the changes needed e.g. older people forum, Age Concern etc
- Take your proposed plan to the (joint) older people strategic group (or equivalent) and other relevant strategic groups or committees that have overall accountability or responsibility for commissioning or providing services for older people
- Set clear targets that are linked to strategic objectives with regular monitoring and feedback on progress
- **Get started on making those changes. Good luck!**

Section Four: Workbook (Separate document)

Section Five: Resources and contacts (Separate document)

Section Six Glossary

Assessment	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.
Brokerage	Brokerage is the process by which the support required for a person is commissioned. It is the process that assists the person to decide how they are going to put their support plan into action and how they are going to ensure their outcomes are being met.
Care Certificate	The Care Certificate is an identified set of standards that health and social care workers (mainly non regulated staff) adhere to in their daily working life
Care package	Services designed to meet an individual's assessed needs as part of the care plan arising from their assessment. Consists of one or more services, which may be residential and/or community-based.
Care plan	A written record that describes which services are to be provided for an individual following and assessment
Commissioning	The process of specifying, purchasing and monitoring services to meet assessed needs.
Community care assessment or needs assessment	An assessment that enables social services to find out what the person's care needs are, and to decide which services could help to meet those needs (includes personal care)
Compliance aids	Aids or devices that make it easier for a person to take their medicines correctly e.g. reminder charts, inhaler aids, eye drop aids, winged or easy screw tops on bottles, large print labels etc
Domiciliary care provider	An organisation or agency that employs people to provide assistance to a person in their home, including home care, equipment and adaptation, and meals-on-wheels
Domiciliary care worker	Non clinical staff, employed to provide personal assistance to a person in their own home.
Eligibility criteria	Locally set rules about the level of needs the local authority will fund meet for an individual. The local authority must provide services to meet the needs of the person, if those needs fall within their eligibility criteria
Local Authority or local council	Elected body responsible for providing public services such as education, housing and social services within a particular area
Long term condition	A long term condition is one that cannot currently be cured but can be controlled with the use of medication and/or other therapies.
Medicines Administration record (MAR) charts	A document on which details of all medicines given in a care setting are recorded. Usually designed to show the dose give, the time when given and the identity of the person who gave it
Medicines management support	Medicines related activities which includes the process and support to assist a person to take their prescribed medication after it has been dispensed, to enable them gain optimum benefits from their medication. It may involve input from the patient, use of compliance aid, care workers and health professionals



Multi compartment compliance aids	Systems for packing medicines to make it easier to take by putting medicines for each time of the day in a separate compartment
Re-ablement service	A short-term social care rehabilitation service to assist people to become or remain independent in doing everyday tasks. Support is provided for up to eight weeks while longer-term arrangements are explored. The team includes Occupational Therapists, social care workers and regaining independence assistants.
Single assessment process	Standardised holistic assessment framework across health and social care so duplication is minimised and an individual receives timely and proportionate assistance appropriate to their risks and needs. The Single Assessment Process aims to put individuals at the centre of their own assessment and subsequent personalised care planning
Single point of access	Central point across a range of services to which referrals are sent.

FURTHER READING

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