Services and Commissioning

August 2015

PSNC Briefing 047/15: Supporting frail, vulnerable and older people to live independently

This PSNC Briefing provides background information and statistics on the challenges people face in managing their medicines; and provides examples of locally commissioned pharmacy services which are supporting and empowering people to manage their medicines, while assisting them to live independently and prevent hospital admissions.

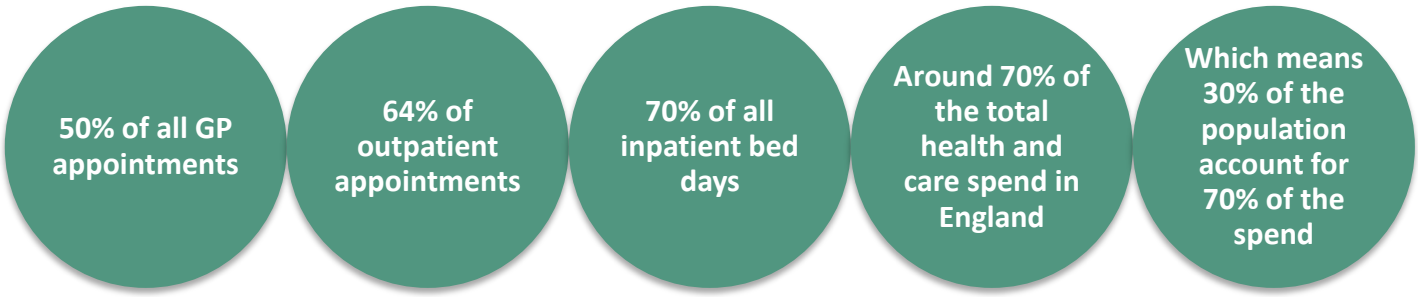
Introduction

Supporting people, particularly frail, vulnerable and older people to manage medicines, live independently at home and stay out of hospital are all things that community pharmacy teams can contribute to and is key to supporting the future of the NHS, at a time when it is facing ongoing constraints on its funding. NHS England Chief Executive Simon Stevens has also made it clear in the NHS Five Year Forward View that people should have access to services closer to their homes.

Supporting people to live independently is one of the four key domains in PSNC's *The vision for NHS Community Pharmacies, the path to improved care*, which describes PSNC's vision for the future of NHS community pharmacy services.

Long-term conditions

Fifteen million people in England have one or more long-term conditions (LTCs), and the number of people with multiple conditions is rising. People with LTCs account for[1]:



People with a LTC typically have contact with healthcare professionals for a relatively small amount of time - around three hours per year - so people and their carers are taking the lead in managing their care. However, people need

[1] 2009 General Lifestyle Survey

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and want more support to empower them so they can self-manage their conditions and are less likely to require emergency care.[2]

Hospital admissions and re-admissions

Keeping people well and out of hospital is a key priority for the NHS and all healthcare professionals. Unnecessary hospital admissions and keeping people in hospital is a massive cost burden; therefore services that keep people well and living independently at home, can help avoid unnecessary hospital admissions and also save money.

Many hospital admissions are medicine related and such admissions, with the correct support, are completely avoidable.

When people are admitted to hospital between 28-40% of medicines are discontinued[3] and 45% of medicines prescribed at discharge are new medicines.[4] The likelihood that an older person will be discharged on the same medicines that they were admitted on is less than 10%[5] and 60% of older people have three or more medicines changed during their hospital stay.[6] Adverse drug events occur in up to 20% of people after discharge[3] and at least 6% of emergency re-admissions are caused by avoidable adverse reactions to medicines.[7]

Providing advice to people when they are prescribed a new medicine and continuing to provide support is therefore extremely important; only 16% of people who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need. Ten days after starting a medicine, almost a third of people are already non-adherent – of these 55% don't realise they are not taking their medicines correctly, while 45% are intentionally non-adherent.[8]

A recent Healthwatch England publication reported that some older people are left confused about the new medicines they have been prescribed in hospital and weren't told how it might fit with their existing medicine. The survey of healthcare professionals in the Healthwatch England publication also said that breakdowns in communication can lead to older people taking multiple drugs simultaneously after discharge, which can result in adverse drug reactions, and re-admission. This lack of seemingly simple provision is putting people at significant risk.[6]

Increased risk of falling

Another example, where medication and lack of support following hospital discharge can cause an issue is the increased risk of falls in older people[6]. Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year.[9]

Carers

There are around 5.4 million carers (a person who provides unpaid care for a family member, partner or friend who cannot cope without their support due to an illness, frailty, disability, a mental health problem or an addiction) in England[10], many of which will be providing support to people in managing their medicines.

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[2] IPPR - Patients in control why people with long-term conditions must be empowered
[3] Health care system vulnerabilities: understanding the root causes of patient harm. Am J Health Syst Pharm 2012; 69: 43-5
[4] What happens to long-term medication when general practice patients are referred to hospital? Eur J Clin Pharmacol 1996; 50: 253-
[5] Relationship of in-hospital medication modifications of elderly patients to post-discharge medications, adherence and mortality. Ann Pharmacotherapy 2008; 42: 783-9
[6] Healthwatch - Safely home: what happens when people leave hospital and care settings?
[7] Pirmohamed M, James S, Meakin S, Green C, Scott A K, Walley TJ, Farrar K, Park BK, Breckenridge AM. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. BMJ 2004; 329: 15–19
[8] N Barber, J Parsons, S Clifford, R Darracott, R Horne. Patients' problems with new medication for chronic conditions. Qual Saf Health Care 2004; 13: 172-175
[9] NICE - Falls CG161 Assessment and prevention of falls in older people
[10] Carers UK - Facts about carers 2014

It takes an average of two years for a carer to acknowledge their role as a carer[11]; this means many carers are missing out on local and national support that aims to help and assist them and the people they care for and even then, after they have acknowledged their role, they may not be receiving the recognition and support they need and deserve.

The first priority in the Government's *Carers Strategy: Second National Action Plan 2014-2016* is identification and recognition 'Supporting people with caring responsibilities to identify themselves as carers so they can access the information, advice and support that is available' – this is something that community pharmacy can help the Government achieve.

Examples of pharmacy services that can help

Nationally commissioned services such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS) support people to optimise the use of their medicines, particularly those receiving medicines for a LTC. The recently commissioned national flu vaccination service will also impact on keeping people and their carers well and out of hospital. Many pharmacies also offer other services to support people to live independently in their own homes such as:

- support with re-ordering repeat medicines / the NHS repeat dispensing service;
- home delivery of medicines to the housebound;
- appropriate provision of multi-compartment compliance aids and other interventions such as medicine reminder charts to help people adhere to their medicines regimen;
- signposting people or their carers to additional support and resources.

However, many local commissioners are looking to provide people and their carers with further support from the pharmacy team by improving access to services; additional support in managing medicines; preventing admissions to hospital; and supporting people on leaving hospital to try to prevent re-admission – all of which support the person to live independently at home and reduces the possibility of them needing to access other NHS services. Below are details of some of these locally commissioned services.

Domiciliary Medicines Use Reviews (Croydon)

This service allows housebound people (carers can also be present if the person requests this), who would otherwise not be able to access this service in the pharmacy, to have an MUR in their own home.

During the MUR consultation the pharmacist will aim to:

1. establish the person's actual use, understanding, beliefs and experience of taking their medicines;
2. identify, discuss and try to resolve any problems the person is experiencing with taking their medicines;
3. identify side effects and drug interactions that may be affecting the person's willingness to take their medicines as prescribed;
4. highlight any issues the person has in accessing their medicines and suggest options to improve this, for example, offering them a home delivery service;
5. detect any physical issues that the person may have which may be impacting on how they use or take their medicines and try to offer solutions, for example, problems with eyesight may be helped with large print labels or dexterity problems may be helped by using certain compliance aids; and
6. assess any compliance aids currently being used by the person to help them take or use their medicines and identify if any further support can be offered, for example, medicine reminder charts or medicine administration records.

The service also seeks to reduce unnecessary waste of medicines. During the MUR consultation pharmacists will ask to see all supplies of medicines that the person has in their home. They will proactively query any apparent over-ordering of medicines and will contact the prescriber to reduce the amount prescribed if appropriate.

[11] NHS England - NHS England's Commitment to Carers

Between December 2011 and March 2013 the service led to 215 avoided emergency hospital admissions which would have cost the NHS up to £758,800 and an analysis of the service undertaken over the summer of 2013 suggested that that trend had continued, with the estimated cost avoidance from April 2013 to August 2013 being £67,480.

Similar services have also been commissioned in other parts of the country. In Cornwall, pharmacists have been providing domiciliary community pharmacists visits to housebound people. The pharmacist follows a structured review which includes discussing with the person access to medicines; physical issues that the person may be experiencing with using their medicines; compliance issues; medicines review; removal of unneeded medicines and lifestyle advice. The service can be extended to consider education around areas that the person may need extra help with, for example, this might involve using a peak flow meter to self-monitor lung condition or describing signs of bleeding in people receiving anticoagulants.

A domiciliary medicines optimisation project has also been commissioned in Bury, where pharmacists are working alongside other service providers in the area. In addition to assessing the person's use of their medicines and providing enhanced lifestyle advice, environmental factors such as trip hazards, poor storage conditions or missing smoke alarms are also identified.

Falls prevention (Doncaster)

The aim of this service is to identify people at risk of experiencing a fall, prevent this from occurring and as a result prevent them from suffering a fracture and possibly being admitted to hospital.

The service is offered to people aged 65 years or over who:

- are taking three or more medicines;
- have been prescribed high risk medicines that may contribute to a person having a fall; or
- have had a fall or been frightened of falling within the past 12 months.

During the consultation the pharmacist will:

1. establish whether the person has experienced any falls in the past;
2. enquire if the person is suffering with any side effects that may increase their risk of falling;
3. identify any high risk medicines, which may increase the risk of the person falling;
4. assess the person's gait/balance using the 'Turn 180° test';
5. ask the person about any problems they may be experiencing with vision or continence.

People are then provided with falls and prevention advice and are also provided with a leaflet on this topic to take home.

If people have fallen in the past 12 months they will be referred to the Specialist Falls Clinic. GPs will be notified of any people who are identified as having risk factors that may lead to a fall and also any people who are having adherence issues with taking their bone protection medicines that the pharmacist cannot resolve.

An evaluation of the service in May 2014, showed 95% of the people reviewed were taking one or more 'high-risk' medicines; 32% were experiencing fall-inducing side effects; 22% had fallen in the past year; 23% had balance/gait problems; 22% vision or continence problems; and 17% were afraid of falling. Of those people who reported experiencing side effects 31% had fallen in the last year and 43% of people with balance/gait problems had fallen in the last year, both of which were statistically significant. Over 50% of people who had suffered a previous fragility fracture were not currently prescribed bone-sparing medication and 37% of people prescribed bone-sparing medication had compliance problems.

Due to the results and potential cost savings that this service has demonstrated, an application was submitted for funding via the Better Care Fund to enhance the service and a notice of approval for funding has been granted. The service will be enhanced to provide a two level service; the first level of the service will be similar to that already commissioned, with the second level providing a more in-depth medication review testing the principles of using

STOPP (Screening Tool of Older People's Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment) indicators as well as including follow-up appointments.

A similar falls service is also commissioned in Dudley for people aged 65 years or over who are at risk of falling. Trained members of the pharmacy team can complete a community falls prevention and exercise programme referral assessment screening tool with the person and the person is then provided with a falls prevention information pack to take home as well as being signposted to relevant services. The service also offers slipper replacements, where members of the pharmacy team have been trained to measure the person's feet to ensure that slippers are well fitted.

Improving medicines management and patient safety at the interface for vulnerable patients (Nottingham City)

This service is due to start in October 2015 and aims to provide advice and support to particularly vulnerable people with their complex medication needs during their transition back into the community from both secondary and intermediate care.

The service will be available to vulnerable people who:

- are deemed vulnerable due to having more than one of the following: being elderly, housebound, disabled or mentally ill;
- are on high risk drugs for side effects/adverse reactions;
- have been flagged by a healthcare professional as needing an enhanced level of care with their medication due to risk of admission/re-admission to hospital;
- are receiving medication either from a secondary or primary care setting and are having difficulty taking the medication supplied in a safe and effective manner; or
- are having frequent changes to their medication regimen, i.e. more than once per month.

The majority of people referred to the service are likely to have their medicines in a multi-compartment compliance aid or will require an alternative compliance aid to assist them with taking their medicines.

When a person is referred to the service, the pharmacist will meet with the person (and their carer if appropriate) either at their home or in the pharmacy to discuss their medicines and any issues they may have with using or taking them. The conversation will identify how the person manages their medicines and whether a compliance aid is required. If a compliance aid is recommended, the pharmacist will explain the benefits of using such an aid and how to use it.

If the person has any changes made to their medicines by the GP, the person or the GP will contact the pharmacy to make the team aware. The pharmacy team can then obtain an up-to-date prescription and arrange to deliver a new compliance aid. The pharmacist will explain the changes to the person about their medicines and answer any queries they have. They can also remove the old compliance aid from the person's home to ensure this does not accidently get used. Once this visit is complete the pharmacist should inform the GP and feedback on the outcomes of the visit and also inform other relevant healthcare professionals if they have concerns about the person.

If the person has changes made to their medicines by healthcare professionals in secondary care, the person should notify the healthcare professional that their community pharmacist should be contacted when they have been admitted and when they are discharged from hospital. On discharge, the pharmacist can then liaise with the person's GP and any changes made to the person's medicines can be made as soon as possible. The person should be discharged with seven days of medicines and the person should contact the pharmacist to ensure they are aware that they've been discharged and to answer any questions or concerns the person may have about their new medicine regimen. The community pharmacist will then obtain an up-to-date prescription from the person's GP and will follow the same process as stated above when changes have been made to the person's medicines by the GP.

The pharmacist will be required to continue to offer the person this service until all stakeholder healthcare professionals agree that the person is able to self-manage their medicines appropriately, at which stage the person can be discharged from the service.

Reablement service (Isle of Wight)

The aim of this service is to help keep people well and to prevent further admission to hospital following their return home.

This service is offered to vulnerable people while in hospital who are considered to be at high risk of being re-admitted to hospital within 30 days of discharge.

Before being discharged people are assessed by a member of the hospital pharmacy team on their ability to manage their medicines. A copy of this assessment is forwarded to the service coordinator who will make contact with a community pharmacy who offers this service; whenever possible this will be the pharmacy that the person regularly uses if the pharmacy offers the service.

The pharmacist will be sent a copy of the assessment form and will contact the person to arrange to visit them, and their carer if appropriate, ideally within seven days of them being discharged from hospital.

At the visit the pharmacist will:

1. conduct a full MUR;
2. check the person's medicines to ensure they have enough to last them until their next GP appointment;
3. collect any medicines that have been discontinued and return them to the pharmacy for disposal;
4. complete a medicines compliance chart for the person; this should detail each current medicine, when it should be taken, the appearance of the medicine, common side effects and any other relevant information;
5. carry out a full capability assessment; and
6. discuss possible support services aimed at helping the person to manage their medicines such as a home delivery service, compliance aids, large print labels, easy open lids or other aids that may assist the person.

The pharmacist will then conduct two follow up appointments, the first after five weeks and the second after 90 days to assess if the person is taking their medicines correctly and that there are no issues with adherence to the medication regimen.

An evaluation of the service showed that over a period of two years there was a 37% reduction in re-admissions; 63% reduction in total number of admissions; 67.5% reduction in hospital bed days; and a 48.43% reduction in average length of stay. In addition, 8,850 hospital bed days were saved, which resulted in a £1,885,050 saving (£213 per excess bed day).

Carer-Friendly pharmacy pilot

The Carer-Friendly pharmacy pilot, led by Carers Trust and PSNC, was part of a programme of work funded by the Department of Health and forms part of the Supporting Carers in General Practice Programme involving Carers Trust, the Royal College of GPs and Carers UK. A total of 44 pharmacies were involved in the pilot across nine LPC areas.

The aim of the project was to increase the identification and support of unpaid carers within primary care and community settings so that carers receive support before they reach crisis point. Carers could be referred to their local carers service to find out how they could support them, have their details passed onto their GP to have a note added to their medical records that they were a carer, as well as receiving information from the pharmacy team about what additional services that could offer that may support the carer and the person they care for. The project tested the concept of a 'Carer-Friendly Pharmacy', which pharmacies participating in the project aimed to become.

An evaluation of the service is due to be published later this year.

More information on how community pharmacy teams can help carers can be found at www.psnc.org.uk/carerfriendly

Further details on all of the above services can be found on the PSNC Services Database www.psnc.org.uk/database

Four or More Medicines Support Service

The Four or More Medicines (FOMM) support service was a six month research project which was part of the Community Pharmacy Future programme. The service was aimed at people aged over 65 years taking four or more medicines. People were invited to regular consultations with a pharmacist where they discussed the person's risk of falling, pain management, adherence and general health. The pharmacist also reviewed the person's medicines using the STOPP/START criteria.

The service was offered in 25 pharmacies across Wigan and 620 people were recruited across all socio-demographic areas. Pharmacists made 142 recommendations to prescribers for 110 people largely centred on inappropriate prescribing of non-steroidal anti-inflammatory drugs (NSAIDs), proton pump inhibitors (PPIs) or duplication of therapy.

Headline figures showed a potential annual saving of £36 million from reduced prescribing costs and hospital admission as a result of adverse drug reactions and a potential annual saving of £34 million in hospital costs by reducing falls associated with fractures.

Further details on the FOMM service can be found on the Community Pharmacy Future website

Further reading

- HSJ LGA Pharmacy supplement: Close to home how local pharmacies can play a pivotal role in bringing services closer to the patient
- Briefing 001/15: Support for carers – how community pharmacy teams can help

If you have any queries on this PSNC Briefing or you require more information, please contact Rosie Taylor, Pharmacy and NHS Policy Officer.