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# Improving Care for People with Long Term Conditions

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# IMPROVING CARE FOR PEOPLE WITH LONG TERM CONDITIONS

The expertise and clinical knowledge of pharmacists must be fully utilised to support people with long term conditions and help them to achieve the desired outcomes from their medicines, thereby making more efficient use of NHS resources.

This policy document focuses on the essential role of the pharmacist as part of a multidisciplinary approach in tackling the challenges facing the NHS in preventing, identifying, treating and supporting long term conditions (LTCs). The recommendations in this policy are aimed at key stakeholders who have collective responsibility for ensuring the best care for people living with a LTC.

## Vision for Great Britain

1. Pharmacists providing direct patient care should have the opportunity to train to become a prescriber, fully utilising those skills as part of the multidisciplinary approach to managing and supporting people with long term conditions.
2. The patient journey will be made easier by enabling pharmacists to directly refer to appropriate health and social care professionals, improving patient access to care and reducing the number of unnecessary appointments.
3. Patients will benefit from further integration of pharmacists into their multidisciplinary team, ensuring support at every stage of their journey, from prevention through to treatment and management of their long term condition(s).
4. All pharmacists directly involved in patient care should have full read and write access to the patient health record, with patient consent, in the interest of high quality, safe and effective patient care.

*With thanks to contributions and support from:*



# EXECUTIVE SUMMARY – WALES

Long term conditions (LTCs) are placing significant demands on the NHS and other public services. Medicines are the most common intervention in the management of LTCs; they can be life-prolonging and life-saving but can also cause harm if used incorrectly. Patients should benefit from greater access to the clinical expertise of pharmacists, as part of multidisciplinary approaches to care. As the experts in medicines, pharmacists can ensure people get the best outcomes from their medicines, reduce adverse events, minimise avoidable harm and unplanned admissions to hospital, while ensuring resources are used more efficiently to deliver the standard and level of care that individuals deserve.

This policy takes into account the principles of Prudent Healthcare. It also addresses issues highlighted by a number of recent reports regarding the challenges facing the NHS from LTCs, for example those issues raised by the Health Foundation, *The path to sustainability – Funding projections for the NHS in Wales to 2019/20 and 2030/31*<sup>1</sup>.

By drawing on advice from experts within the pharmacy profession as well as other health and social care professionals and third sector groups, this policy takes a principle based approach to the management of LTCs. Taking into account the increased prevalence of comorbidities, it is not condition-specific, but rather takes an holistic and overarching view of the potential contribution of the pharmacy profession to support patients with LTCs.

In order to ensure pharmacists can make a greater contribution to the management of LTCs, this policy identifies key enablers that support and align with current strategic drivers for the NHS in Wales and nine specific recommendations are made (for full information on how to achieve this vision, see page 14).

## The recommendations for Wales are:

### 1. Professional empowerment

- 1.1 Opportunities must be created for multidisciplinary teams to train and develop together.
- 1.2 Pharmacists must have protected time to advance and develop their practice.
- 1.3 LHBs should encourage health care professionals to operate across traditional sectors.

### 2. Workforce re-design and utilising professional expertise

- 2.1 Patients with LTCs should benefit from the integration of multidisciplinary skills in future commissioned services including pharmacist independent prescribers.
- 2.2 All practicing pharmacists providing direct patient care should have the opportunity to train as independent prescribers.

### 3. Co-production

- 3.1 Patients with LTCs must have the opportunity to work with their multidisciplinary team to shape their own care plan
- 3.2 In order to streamline the patient journey, pharmacists must be able to facilitate direct referral to health, social care and other appropriate services.

### 4. Utilising technology

- 4.1 In the interest of safe and effective patient care, all pharmacists involved in an individual's care should have appropriate read and write access to the Welsh GP record.
- 4.2 Patients should benefit from a pharmacy-led medicines service for their LTCs management utilising the Choose Pharmacy IT platform.

Action will be required across NHS Wales to review current service provision for LTCs and to evaluate how services are funded and resources utilised.

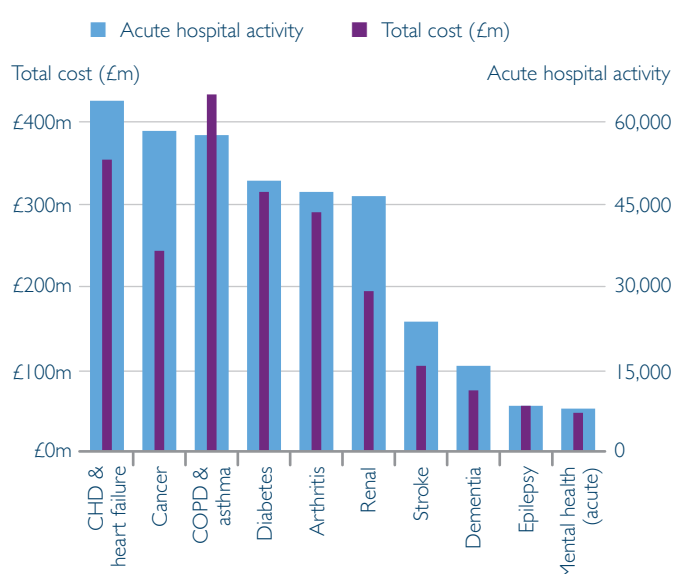
# CONTEXT FOR CHANGE

Long Term Conditions (LTCs), also referred to as chronic conditions, encompass a broad range of conditions such as diabetes, asthma and dementia, which are usually lifelong and cannot currently be cured. Their effects and progression can however often be effectively managed given the right support.

LTCs are placing significant demands on the NHS and other public services<sup>1</sup>. It is widely acknowledged that LTCs are the greatest challenge currently facing the NHS and demand for services is predicted to rise<sup>2</sup>. It is estimated that a third of adults in Wales are currently living with at least one LTC<sup>3</sup>. As well as affecting an individual's health, there can be associated wider social and economic challenges for the individual and implications for family members, who may be providing care.

With a growing and ageing demographic in Wales, the strain on the NHS from LTCs is projected to increase by around 181,000 patients or 32 per cent between 2010 and 2026<sup>4</sup>. Primary care has already come under increasing pressure in recent years, with higher demands on General Practitioners (GPs) and increased waiting times<sup>5</sup>. Alongside this, demands on urgent and emergency care are rising<sup>6</sup>. People with a LTC are twice as likely to be admitted to hospital as a patient without such a condition<sup>7</sup>. The Health Foundation have identified that hospital admissions for people with at least one chronic condition accounted for 58 per cent of total inpatient spend in 2014/15 and 72 per cent of spend for those aged 50 and over<sup>8</sup>. Figure 1 illustrates the pressures from individual LTCs on acute hospital activity.

**Figure 1:** Cost of inpatient admissions for LTCs in Wales for 2014/15<sup>1</sup>



Note: data include admissions for people with chronic conditions, not necessarily treatment specifically for those conditions

Source: Roberts, A. and Watt, T. 2016. The path to sustainability Funding projections for the NHS in Wales to 2019/20 and 2030/31. The Health Foundation.

Not only is a hospital admission potentially distressing for patients but it puts unnecessary and avoidable pressure on secondary care resources. With the average cost of a hospital stay for a non-elective inpatient estimated to be £1565<sup>9</sup>, it is becoming increasingly vital for people to be supported in a way that will improve their health outcomes and avoid hospital admissions wherever possible.

Medicines are the most common intervention in the management of LTCs; they can be life-prolonging and life-saving but can also cause harm if used incorrectly<sup>10</sup>. Patients must therefore benefit from routine access to expert advice from a pharmacist. It has been previously acknowledged by the Welsh Government that 'the correct administration and use of medicines is integral to good chronic conditions management and community pharmacists play an important role in supporting this. This includes improving medicines management, providing front line information and support for better prescribing in a community and acute setting and supporting hospital discharge'<sup>11</sup>.

Better utilisation of the clinical expertise of the pharmacist, as part of a multidisciplinary team (MDT), can ensure people get the best outcomes from their medicines, reduce adverse events, minimise avoidable harm and un-planned admissions to hospital, while ensuring resources are used more efficiently to deliver the standard and level of care that individuals deserve.

*"Changes must be made to ensure the future sustainability of our crucial GP and primary care services. With ever increasing demands on GP services it is vital that the skills of the multidisciplinary team, including pharmacists are utilised to ensure people with long term conditions can access appropriate support when they need it. There are excellent examples of integrated working between pharmacists and GP colleagues across Wales which make a real difference to patients. These new ways of working must be extended so that all patients in Wales can benefit equally. Pharmacists can help to ensure that individuals with long term conditions get the most out of their medicines, this in turn will free up GP time and improve patient access to services."*

**Dr Rebecca Payne,**  
Chair Royal College of  
GPs Wales



The development of 64 cluster networks, tasked with ensuring that the health and social care needs of their local population are met, provides new opportunities to think differently about how health and social care is delivered in Wales. All pharmacists within the locality must have the opportunity to input into strategic plans for their cluster, ensuring patients have the opportunity to access pharmacist expertise as part of their routine care.

Increased communication and sharing of information and resources between all registered health and social care professionals is vital to enable an holistic and coordinated approach to care. Utilising advances in technology to allow pharmacists routine access to the Welsh GP Record will enable pharmacists to further contribute to patient care; increasing the safety and quality of care.

The pharmacy profession in Wales has previously voiced ambitions for improving approaches to LTCs management; Your Care, Your Medicines<sup>12</sup> presents a vision for pharmaceutical care in Wales. The engagement model presented in this ambition includes medicines management for LTCs as a key area where pharmacy input is essential as part of MDT approaches to care.

We continue to advocate for the recommendations outlined in the Your Care, Your Medicines ambition;

1. Individuals with LTCs will have regular reviews with a pharmacist who will provide medication advice and coaching in a setting that is most suitable for the individual.
2. A pharmaceutical care plan will be initiated, discussed and jointly managed between the patient and the pharmacist and made available to other health professionals involved in the patient's care.

*"The RCP strongly believes that pharmacists have a vital role to play in delivering a broad range of services, and the ideas in this report will help close the loop between hospital and primary care."*

*"This report also chimes with the RCP's vision for healthcare in Wales. There must be close working between all healthcare professions to enable joined up care to be delivered to patients at, or close to, home. We need to find ways to reduce hospital admissions and improve patient care in the community – collaboration between different parts of the NHS workforce could help services to become sustainable for the future. Our focus should be on developing ways of multidisciplinary team working that enable patients to leave hospital safely as soon as their clinical needs allow – we desperately need a whole system approach across primary, community, secondary and social care to really improve outcomes."*

*"Excellent patient care depends on good communication between professionals – everyone has their part to play. The Welsh NHS needs to break down barriers, and invest in more integration of health and social care. The recent RCP Wales report, Focus on the Future<sup>13</sup> specifically highlights the need for investment in community services, and a new focus on patient experience, recovery and self-management. Patients must be supported to leave hospital and move into primary or community care as soon as possible after hospital admission, and with this in mind, we strongly welcome closer working with pharmacists for the benefit of our patients."*

**Dr Alan Rees,**  
outgoing Royal College of  
Physicians vice president for  
Wales, and consultant physician



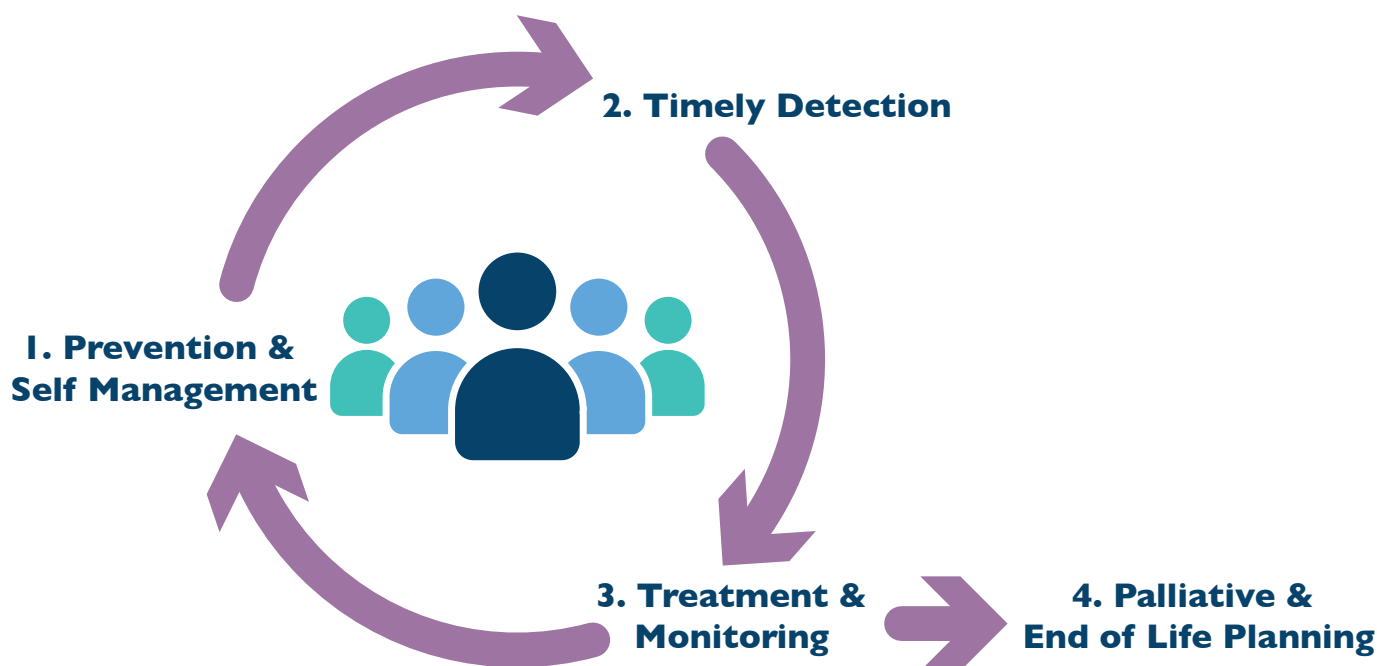
# THE PATIENT HEALTH JOURNEY FOR LONG TERM CONDITIONS

Pharmacists are already making important contributions to the prevention and support for the management of LTCs however the potential of the pharmacy workforce has not yet been fully maximised. Pharmacists as the experts in medicines, must play an essential role in the MDT to ensure a positive impact on the care and lives of people with LTCs.

Patients in Wales do not currently have equitable access to pharmacy services due to inconsistencies in commissioning and infrastructure throughout Wales. Overarching national direction for the management of LTCs that includes pharmacy's contribution will give patients equal access to services where ever the live in Wales. The Community Pharmacy Contractual Framework could be better utilised to help achieve this.

Individuals must benefit from access to the right health and social care skill set at the right time to meet their physical and mental health needs. They must feel empowered to be decision-makers in their own care to help shape their desired outcomes at all points of their LTC journey. A model representing key stages in this journey is represented in figure 2 and the role of pharmacists in this cycle is further explored in this document.

**Figure 2:** Support for people with long term conditions (LTCs Cycle)



# I. PREVENTION AND SELF-MANAGEMENT

All individuals must be encouraged and given the tools to maintain their own health and wellbeing. A 'four pillars of engagement'<sup>14</sup> approach to self-care has been identified. The points below illustrate how pharmacy teams are well placed to support individuals at each point of this engagement model;

1. **Lifelong Learning:** Every week millions of people across Great Britain visit a community pharmacy<sup>15,16,17</sup>. The often informal nature of the contact with a pharmacist means that it is possible to provide opportunistic education, advice and support for people at every stage of life. Pharmacists are ideally placed to make every contact count.
2. **Empowerment:** There are currently 13,616 community pharmacies in GB (11,700 in England<sup>15</sup>, 1,200 in Scotland<sup>16</sup>, 716 in Wales<sup>18</sup>). The accessibility of the community pharmacy network on the high street, supermarkets and rural communities provides a gateway to health and medicines advice from a healthcare professional without the need for an appointment. Pharmacists can offer reassurance and empower people to take greater control of their own health and wellbeing.
3. **Information:** As a trusted healthcare profession, pharmacists provide a reliable and confidential source of health and medicines information. The pharmacy team can also ensure that individuals are signposted to trusted resources and groups for further information about their physical and mental health. Self-assessment tools on how to reduce risk could also be used with individuals, to assess and understand their relative risk of developing a LTC. Obesity and smoking, for example, are linked with many LTCs<sup>8,19</sup>. Pharmacists can advise on reducing risk by providing information on positive lifestyle choices, supporting positive behavioural change, information on self-care and providing services such as smoking cessation programmes.
4. **Local and National Campaigns:** An essential service that a community pharmacy provides is the promotion of healthy lifestyles and wellbeing. One way this is undertaken is via public health campaigns. Each community pharmacy in Wales is contracted to undertake 6 public health campaigns every year. Multidisciplinary national and local campaigns could provide a real opportunity for consistent messages to be delivered to all individuals.

Giving people the information and tools to make positive lifestyle choices and to self-care is an essential step to help maintain good health and prevent illness. Shifting resources to further support people to stay in the prevention phase of the LTC cycle (figure 2) for as long as possible will help to move the NHS from an 'illness' service to a 'wellness' service. We acknowledge, however, that such an approach has its limitations, with degenerative conditions such as dementia being a case in point.

*"Ageing population, cognitive impairment, fiscal constraints, service reconfiguration, multi system disease and polypharmacy are some of the factors affecting the NHS. To meet such complex needs, there is a requirement for multi-professional teams to deal appropriately with these factors in an integrated way. Most studies demonstrate that patients and their carers feel better supported and better informed as a result of more integrated care.*

*Timely intervention for those with mental illness is crucial for their recovery and resilience. Harnessing the clinical and prescribing expertise of pharmacists in models of NHS care gives an opportunity to improve access to timely services for those with mild to moderate symptoms of mental ill health. The network of community and primary care pharmacists could be used to make steps to de-stigmatise mental health issues and give individuals an opportunity to speak to a healthcare professional at a time that is convenient for themselves. Pharmacists are also a crucial part of the multidisciplinary team for individuals with more serious and long term mental health conditions. Utilising the skills of all secondary care specialists including psychiatrists and mental health pharmacists could be further explored in community settings."*

**Dr Victor Aziz,**  
Chair, Faculty of Old Age Psychiatry,  
Royal College of Psychiatrists





# I. PREVENTION AND SELF-MANAGEMENT

## Case Study 1 – Smoking Cessation

*"As a community pharmacist, my team and I take every opportunity to provide support and advice on health, wellbeing and medicines to individuals in our community. We are always eager to support individuals to capitalise on the benefits of quitting smoking, and also being an ex-smoker myself, I fully understand the challenges of giving up. My team and I constantly inform people about our smoking cessation programme and its fantastic success rate. The neighbouring GP Practice also refers smokers directly to us.*

*Some of our recent success stories regarding smoking cessation include;*

- *A 79 year old grandmother who wanted to give up smoking for her 80th birthday so she could play tennis again with her friends.*
- *A gentleman who lost a leg in a motorbike accident and wanted to quit so he would have more energy on a sponsored swim.*
- *A gentleman with type 2 diabetes who wanted to give up to slow the progression of his disease. His wife gave up as well to be supportive.*
- *A patient with a recent diagnosis of COPD who was anxious about his diagnosis after an exacerbation.*
- *A pregnant 20 year old who needed two attempts to stop but was determined to have the baby born into a smoke free house.*
- *A lady with a hernia who needed to stop smoking before she could have an operation.*

*The smoking cessation service enables me to build excellent relationships with individuals that are supported by this programme. The feedback from patients has been overwhelmingly positive with our work even featured in local newspapers. The effects of giving up smoking are significant, particularly for individuals with a LTC or who are at increased risk of developing a LTC. This is just one of a range of enhanced services that we offer individuals in West Wales. We are eager to engage with more services that will benefit people in our area as they become available."*

Dave Edwards,  
Community Pharmacist, Hywel Dda UHB

## Case Study 2 – Stroke Prevention

*"I'm a member of a multidisciplinary team alongside a consultant stroke physician and consultant haematologist. Our aim is to prevent patients in the local area experiencing a stroke through the Stop a Stroke campaign we have designed.*

*Atrial fibrillation affects at least 2% of the adult population and is the cause of 1 in 5 strokes in Wales. Our aim is to provide prescribers in general practice with the knowledge, skills and confidence to review high risk atrial fibrillation patients for suitable anticoagulation, and so prevent the occurrence of a stroke in line with current NICE guidance. Anticoagulation medication in these patients has been shown to reduce the risk of stroke by 66%.*

*As well as being a core member of the steering group designing the campaign using quality improvement methodology, my role as lead anticoagulation Pharmacist has been to provide support to prescribers in Primary Care through the provision of;*

- *Practice and GP cluster "virtual clinics".*
- *Educational events.*
- *Guidelines and counselling documentation for Anticoagulation prescribing.*
- *Advice to Primary Care via e-mail and long range pager.*

*Initial data from the project (within Cardiff and Vale UHB) suggest that 40% of patients are not currently receiving appropriate treatment but would be eligible for anticoagulant therapy. Once these patients' medicines have been optimised, we estimate that the stroke risk per year will fall from 10% to 3% among this patient population in Cardiff and Vale UHB, which will prevent 65 strokes per year. This would be a potential 10% reduction in all strokes."*

Tristan Groves,  
Lead Pharmacist for Anticoagulation, Cardiff and Vale UHB



## 2. TIMELY DETECTION

When an individual first starts to experience symptoms of ill-health, they may initially attempt to self-manage. People will often seek advice from a community pharmacy and this is an ideal opportunity for the pharmacist to detect early warning signs of what could become a LTC.

Timely detection and referral can make a significant difference to people's quality of life, particularly at the early stages of LTCs such as rheumatoid arthritis<sup>20</sup> and dementia<sup>21</sup>. Pharmacists see people regularly and are able to detect signs and symptoms of some LTCs on an opportunistic basis.

The current referral process leads to delays in access to treatment for the patient. When people present at a pharmacy with symptoms that require referral, the pharmacist has few options other than the traditional route of referring individuals to their GP. The pharmacist may have already recognised that the patient would benefit from quick access to another health or social care professional.

Pharmacists should be an integral part of referral systems within the MDT, being referred to for common ailments, medicines advice and LTCs support as well as signposting and referring directly to other health and social care professionals. Direct referral arrangements would allow GPs to focus on more complex conditions. This would also ensure the patient journey is streamlined, reducing duplication and improving cost effectiveness and efficiency of services.

More opportunities for simple testing for LTCs should also be explored as part of preventative approaches to healthcare (e.g. testing blood sugar levels for diabetes or blood pressure measurements to prevent strokes). Timely detection with appropriate information and support and simple lifestyle changes could prevent significant medical interventions and hospital admissions in the longer term.

*"High quality care for people living with long term conditions depends on substantial multidisciplinary working, involving specialist and community nurses, pharmacists, allied health professionals, social care workers, health care assistants, and others."*

*Nurses are often closely involved in the care and assessment of people who are receiving long term care. Particularly in community and primary care settings, a specialist nurse will often assist other healthcare professionals as much as patients: a specialist nurse will support GPs and practice nurses as well as providing advice and support to patients. They often give advice and support which may prevent the need for secondary interventions. Nurses will also work closely with pharmacists regarding medicines management. In this way, their expertise is central in supporting an integrated system of care, from acute and specialist services to self-management.*

*Self-management is also important, and community nurses and community pharmacists can play a crucial role in helping individuals to manage their own conditions. It is vital that people living with long term conditions are given the information and training to make choices about where and how they want to live, and are supported by appropriate, competent staff."*



*"Some LTCs such as dementia require particular consideration. Diagnosis rates for dementia in Wales remain low in comparison to other parts of the UK, and this can result in patients receiving inadequate support for a range of other conditions because their dementia acts as a barrier. Prudent Healthcare principles around co-production are harder to apply to people with reduced mental capacity as a result of dementia or other conditions."*

Sue Phelps,  
Director of Alzheimer's Society



### Case Study 3 – Flint becomes Wales' first dementia friendly town

*"I am a community pharmacist and manager of a busy pharmacy in Flint. We recognise that our local demographic consists of predominately an ageing population. My colleagues and I were keen to gain practical knowledge of how to best support our increasing number of patients being diagnosed with dementia, and their families or carers, so we jumped at the chance to undertake dementia friends training.*

*Once we became dementia friends, I began to research local support groups for people living with dementia and collated this information. We obtained leaflets and contact details to keep and display in the pharmacy so we could signpost people more effectively. We then decided to hold a dementia friends event in store and invited a home help living aids company to the event along with members of social services. We had such a positive response from the local community that we and the social services team agreed to roll this out on a bigger scale across the whole town. I visited local businesses to see if they would be interested in joining me to create a steering group and began the journey of creating a dementia friendly town.*

*We went on to organise a Christmas shopping event which involved a few local businesses and the church. Mini buses came from the local home with residents and their families. We provided a safe environment for them to spend precious time with loved ones and staff in a 'normal' festive setting, enjoying light refreshments, carols and shopping. During this event I had a lady tell me that this was the first time for her to go out shopping with her mother since she went into the home as she was so worried about how people would react (people with dementia can become confused, upset, frustrated and then angry or aggressive). I had another lady from the home who attended with a carer tell me she had not left the home for 7 years; she was so happy and excited to be out and socialising with new people who understood her needs.*

*My team and I now look for early signs and symptoms of dementia in regular customers and are able to offer support if appropriate by sign posting. Unfortunately, dementia does still seem to be a 'taboo' subject for many people, which comes from a lack of understanding. It was amazing that once all the staff were wearing the dementia friends badges how many customers would ask questions or for advice for a family member for whom they had concerns. We had customers return and tell us either they or their partner have now been diagnosed which meant they could now get the help they needed. It was great to be able to give people an opportunity to speak about their concerns and for us to be able to point them in the right direction.*

*People with dementia cannot always remember who you are or where they have seen you but they do remember how you made them feel."*

Emma Hodnett,  
Community pharmacist in Betsi Cadwaladr UHB

### Case Study 4 - Detecting and managing respiratory conditions

*"I'm a pharmacist independent prescriber (IP) working in a GP surgery on a sessional basis. My key role within the practice team is undertaking COPD and asthma reviews along with undertaking spirometry tests to help diagnose various respiratory conditions. I also undertake home visits to patients who are unable to attend the surgery.*

*One of my recent patients was a 72 year old male who came into the surgery for his annual COPD review. His pulse and oxygen levels were within the normal range. He is an ex-smoker having stopped after developing community-acquired pneumonia (CAP). We discussed his current symptoms and he was feeling generally well, but indicated that he gets short of breath when walking quickly or up a slight hill. His spirometry results indicated that he has severe COPD based on the NICE guidelines (2010).*

*Upon review of his medication, I discovered that he was prescribed a preventative inhaler to be used twice a day as well as a reliever inhaler to be used when required. On checking his inhaler technique, I found that he was using his inhalers too quickly and that he was not using his preventative inhaler as intended. Based on his recent medical history and social needs, I was able to change his regular preventative inhaler to a different brand that only required once a day dosing. I was also able to stop two unnecessary items on his repeat prescription which were no longer needed following a change in the management of his condition.*

*As an IP I was able to make all these changes directly to ensure that the patient could benefit immediately from the change in medication. As part of the general practice team, I have direct access to the Welsh GP Record ensuring that I could update the patient's information so that my colleagues in the practice could see an accurate and up to date record."*

Catrin Roberts,  
Pharmacist IP based in a GP Practice, Betsi Cadwaladr UHB

## 3. TREATMENT AND MONITORING

Once an individual has been given a diagnosis of a LTC, ongoing support must be provided by an appropriate MDT. Pharmacists should take overall responsibility for the medicines management aspect of this care. When prescribed and used effectively medicines have the potential to significantly improve quality of life and improve outcomes for individuals with a LTC. By focusing on an holistic approach to pharmaceutical care, pharmacists can support individuals to maintain good health and wellbeing and avoid complications of their existing LTC, as well as working to prevent the development of further LTCs.

The supply of medicines by a pharmacist provides a touchpoint with patients and enables a direct interaction to take place. The progressive development of pharmacy services is needed however to ensure not only the safe supply of medicines but also to enable pharmacists to take greater responsibility for the individual outcomes from medicines. New opportunities are needed for patients to access more clinical and therapeutic services through the pharmacy team in primary care, secondary care and in their own homes. Refinements to the repeat prescribing system along with other appropriate initiatives will support a more prudent approach to the use of medicines, reducing medicines waste, streamlining processes and ensuring every interaction with the pharmacy team is meaningful, appropriate and effective for patients.

People with multiple LTCs are likely to need complex medication regimens with more intensive support from pharmacists. It is recognised that “the impact of co-morbidity is profound and multi-faceted. Patients with several LTCs have poorer quality of life, poorer clinical outcomes, longer hospital stays and more post-operative complications, and are more costly to health services”<sup>22</sup>.

The rise in the number of patients with LTCs and co-morbidity is known to have increased prescribing rates; the proportion of patients receiving 10 or more medicines has grown from 1.9% in 1995 to 5.8% in 2010 and the average number of items per person has increased by 53.8% between 2001 and 2011<sup>23</sup>.

Using multiple medicines (polypharmacy) can become problematic where medications are prescribed inappropriately, or where the intended benefit of the medication is outweighed by the risk. The more medicines an individual is prescribed, the greater the risk of drug interactions and adverse drug reactions, as well as impaired adherence to medication and a reduced quality of life.

As the number of individuals with co-morbidities become more prevalent, the challenges associated with prescribing the right medicines and supporting patients to use them effectively should not be underestimated. This increase in complexity means that besides developing and maintaining prescribing competency for individual conditions, prescribers have the challenge of dealing with potential interactions between medicines prescribed for different conditions<sup>24,25</sup>.

Managing polypharmacy is where the expertise of the pharmacist is essential as part of multidisciplinary approaches to care. The in-depth pharmacology and medicines expertise of the pharmacist is essential when considering the optimal medication regimen for an individual with co-morbidities. Following condition specific guidelines may not always be the most appropriate course of action for the individual. Pharmacists must therefore play a leading role in the optimisation of medication regimens for people with LTCs; ensuring appropriate use of medicines, stopping inappropriate medicines as well as considering opportunities for lifestyle changes and non-medical therapies.

### Case Study 5: Doing it differently: The South West Wales Renal Medicines Service

"We are a team of pharmacist independent prescribers (IPs), renal pharmacy technicians and a team secretary. We specialise in the treatment of patients with chronic kidney disease (CKD), end-stage renal disease (ESRD) and kidney transplant recipients. We are based in the renal unit in Abertawe Bro Morgannwg University Health Board but our service extends to our neighbouring health board, Hywel Dda.

The growing prevalence of CKD and increasing complexity of medication regimens has increased demand for our specialised renal pharmacy service. We have achieved more for less by evolving without an increase in funding; rather through re-investment of medication expenditure savings. We have removed professional and financial silos to create an integrated multi-disciplinary renal team.

Every day is different for our team. Having redesigned treatment pathways for anaemia of CKD, kidney transplant maintenance immunosuppression and CKD-mineral and bone disorder; we prescribe, dispense and monitor specialised medicines and complex regimens for our patients, as well as requesting and interpreting blood tests, altering dialysis regimens and authorising blood transfusions where indicated. We also prescribe medicines like analgesics, anticoagulants and antibiotics for our renal outpatients.

Effective communication is key for individuals with long term conditions. Our team includes a Welsh speaking pharmacist, pharmacy technician and anaemia nurse specialists, enabling us to offer our service through the medium of Welsh. This is a real asset for enhancing patient care. We co-produce our patient material with patients, considering health literacy to improve our patients' understanding and empower them by providing direct, flexible & personal access to our service.

We have embraced technology. Patients can communicate with us in person or via text message or email. Our patients can also review their blood results online. We now use our renal text message service, which was originally only intended for repeat dispensing of medicines, to send regular automated prompts to patients two, three or four times a day to remind them to take their medicines. Our patients have welcomed this initiative and we have seen the benefits with improved blood test results.

We have a clear strategy predicated on the principles of prudent healthcare. We have modernised our workforce, centralised our service but localised service delivery and empowered patients with supported self care. We are proud of our service which has been acknowledged nationally; championed as an example of prudent healthcare and as a beacon centre for digital innovation. Our pharmacy team is at the forefront of the strategic vision for treating and monitoring renal disease in Wales."

Chris Brown, Consultant Renal Pharmacist at ABMU

Owain Brooks, Specialist Renal Pharmacist at ABMU

Dafydd James, Senior Pharmacy Technician, Renal Services

### Case Study 6 – Community pharmacy stroke prevention

"I recently conducted a discharge medicines review (DMR) for an individual who had been discharged from hospital following a blood clot in the brain and the neck. The DMR service allows me to support to patients recently discharged between care settings, ensuring that changes to medicines are maintained accurately.

Whilst undertaking the DMR, I could see clear discrepancies between the warfarin doses on the patient's anti-coagulant booklet, the discharge advice note sent by the hospital and the patient's latest prescription sent from the GP Practice. I then contacted the GP surgery to arrange for the patient to have her bloods taken and tested as soon as possible to resolve dosage issues.

The outcome was that the patient should have been on a much higher dose of warfarin than she had been taking which increased her risk of a further stroke. As a result of this intervention the patient was started immediately on an injection to thin the blood alongside taking the correct dosage of warfarin. The patient's blood levels are now within a safe range and the injection has been discontinued. Without this pharmacist intervention the outcome could have been fatal."

Min Iqbal,

Community Pharmacist, Aneurin Bevan UHB

### Case Study 7 – Supporting individuals with Parkinson's Disease

"I am a pharmacist independent prescriber (IP) working in Cardiff and Vale UHB. As a member of the Movement Disorder Team, I work alongside consultant physicians, specialist nurses and a registrar, supported by nurses, a driving assessor, receptionist and a volunteer. Our team aims to provide a high quality, specialist, multi-disciplinary service, to enhance and improve the quality of life of individuals with Parkinson's Disease, and their carers.

My role in the team is to provide patients with a full review of their condition. This includes a medicine review, answering concerns, rating the severity of their motor and non-motor symptoms, as well as identifying medication that may have caused, or be contributing to, these symptoms.

As an IP, I am also empowered to make a diagnosis based on history, symptoms and neurological tests, and initiate treatment if appropriate. I am also able to discuss social issues and advise on care options.

Other key aspects of my clinical role include:

- performing formal cognitive assessments and screening for depression and anxiety.
- requesting and interpreting diagnostic tests including blood tests and CT scans as appropriate.
- referring patients to other Health Care Professionals for care, e.g. Speech and Language therapists, Occupational and Physiotherapy."

Diana Fletcher, Independent Prescribing Pharmacist, Movement Disorder Team, Cardiff and Vale UHB

## 4. PALLIATIVE AND END OF LIFE CARE

People can live well with a LTC, providing that it is managed effectively. Palliative and end of life care may not be an inevitable part of the LTC cycle. Should a patient's condition begin to deteriorate sufficiently however, it could become a necessary extension of their treatment and management plan and their LTC journey, as illustrated in figure 2.

People with palliative and end of life needs must be treated with dignity and respect and empowered to shape their own patient journey<sup>12</sup>. Medicines can be of significant benefit during end of life care to control pain, alleviate symptoms and stabilise people's conditions. It is an area where people can benefit significantly from the support and expertise of a pharmacist to help them make decisions about their medicines and health care.

We recognise that end of life can be a very difficult process for families and carers, some may have to take over decision making for their relative and as such it is vital that families and carers are supported and given as much advice and information as they need, at a time that is appropriate for them. Support for the patient and carer or family must also include dialogue between the whole multidisciplinary health team, social care and third sector to ensure the patient's needs are effectively met in the care setting of their choice. Co-ordination and communication across the MDT is critical to delivering high quality and responsive palliative and end of life care.

Macmillan funds specialist pharmacists across many areas of the cancer pathway in a number of health boards in Wales. The role of these pharmacists varies, depending on the needs of the local service, but all will work to integrate services to improve the experiences and outcomes of people affected by cancer.

Examples of the service provided by Macmillan pharmacists include support with polypharmacy issues and advising on contraindications of cancer treatment and medication prescribed for ongoing conditions.

At end of life, community pharmacists can help patients to access the medication they need in a more timely manner, particularly if their symptoms worsen out of hours through services such as 'Just In Case boxes'.

Offering person-centred holistic care, all Macmillan pharmacists will signpost to local services such as support groups, bereavement and financial advice services and act as a guide to accessing palliative care medication in the community.

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### Case Study 8 – 24/7 access to palliative and end of life medicines

*"My pharmacy is one of 11 community pharmacies in Aneurin Bevan UHB which is registered for out of hours (OOH) provision of palliative care services. This system provides access to specialist palliative care medicines outside of normal pharmacy hours. As part of a rota arrangement, I will be on call for a week at a time, providing 24/7 support and emergency access to palliative medicines for end of life patients.*

*I make sure that the pharmacy holds sufficient stock of essential medicines during the week that I am on call. On average, during an on-call week I will be called 2-3 times to provide medication in an emergency.*

*In order for this service to work, coordination and communication across the multidisciplinary team is essential. I work closely with the GP OOH service to provide appropriate patient care and treatment. This service prevents hospital admissions for the management of palliative care and allows patients at the end of their life to stay in their own homes."*

Geoff Thomas,  
Community Pharmacist, Aneurin Bevan UHB



# ACHIEVING THE VISION IN WALES

In order to ensure pharmacists can make greater contributions to the management of LTCs, key enablers that support current strategic drivers for the NHS in Wales have been identified:

Enabler	Rationale	Strategic Drivers	RPS Recommends
<b>Professional empowerment</b>	<p>Like many royal colleges, the RPS has recognised the need to create programmes that support pharmacists to continually develop (e.g RPS Faculty). It is important for pharmacists to advance their skills and knowledge as well as the services they deliver to patients.</p> <p>Too many health care professionals work in silos and don't routinely operate across sectors even within their own professions. As we try to move care closer to home it is vital that we consider how to utilise the full spectrum of skill mix regardless of where they practice, removing sectorial boundaries.</p>	<p><b>Health and Care Standards (2015)<sup>26</sup>:</b>            "Standard 7.1 Workforce - Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need so that staff are enabled to learn and develop to their full potential."</p> <p><b>Working differently – working together - A Workforce and Organisational Development Framework (2012)<sup>27</sup>:</b>            "NHS Wales Value: Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively."</p>	<p>1.1 Opportunities must be created for multidisciplinary teams to train and develop together.</p> <p>1.2 Pharmacists must have protected time to advance and develop their practice.</p> <p>1.3 LHBs should encourage health care professionals to operate across traditional sectors</p>
<b>Workforce re-design and utilising professional expertise</b>	<p>Recent development of extended clinical roles for pharmacists and primary care cluster developments encourage further integration into MDTs.</p> <p>The workforce must be equipped to provide a seamless pathway of care for individuals. Services must be designed to ensure equitable access, care and treatment, regardless of the day of the week<sup>28</sup>.</p> <p>Over the last fifteen years many health professions have gained independent and supplementary prescribing rights on completion of an approved education programme. This highly skilled workforce has not yet been fully utilised.</p> <p>Independent prescribers such as pharmacists, nurses, physiotherapists and paramedics have the skills to enhance patient care and reduce demands on other parts of the NHS.</p> <p>Pharmacy is the only healthcare profession primarily focused on the effect of medicines on disease and the body. This expertise is essential for prescribing medicines especially where an individual has multiple LTCs and / or receiving polypharmacy where condition specific guidelines may no longer be appropriate.</p>	<p><b>NHS Workforce Review (2016):</b><sup>29</sup> "Greater priority has to be given to the identification and development of the skills and competencies required to address patients' needs as these change over time and the work currently undertaken by the Workforce, Education and Development Services (WEDS) should be reviewed and developed to match the requirements of the service in moving forward."</p> <p><b>Our Plan for a Primary Care Service for Wales up to March 2018 (2014)<sup>30</sup>:</b></p> <ul style="list-style-type: none"> <li>- No GP should routinely be undertaking any activity which could, just as appropriately be undertaken by an advanced practice nurse, a clinical pharmacist or an advanced practitioner paramedic.</li> <li>- Both the primary care cluster and health board plans will set specific goals and actions for improving access to and the quality of primary care to deliver improved local health and wellbeing and reduced health inequalities.</li> </ul> <p><b>Making prudent healthcare happen; Shaping a workforce to serve the people of Wales (2014)<sup>31</sup>:</b>            "Future demand for health and social care will not be met unless we plan, develop and use the workforce differently."</p> <p><b>Prudent principle (2014)<sup>31</sup>:</b> Do only what is needed, no more, no less; and do no harm. Highly-educated and skilled health professionals are used appropriately, spending time on work that cannot be undertaken by other, less expensive members of staff.</p>	<p>2.1 Patients with LTCs should benefit from the integration of multidisciplinary skills in future commissioned services including pharmacist independent prescribers.</p> <p>2.2 All practicing pharmacists providing direct patient care should have the opportunity to train as independent prescribers.</p>

Enabler	Rationale	Strategic Drivers	RPS Recommends
Co-production	<p>There is increasing pressure on individuals to maintain good health and make positive lifestyle choices, it is important that people are supported to do so and to feel empowered in shaping their own healthcare journey.</p> <p>Even people who read well and are comfortable using numbers can face health literacy issues when they receive a diagnosis and feel scared or aren't familiar with medical terms or how their bodies work.</p>	<p><b>Health and Care Standards (2015)<sup>26</sup>:</b></p> <ul style="list-style-type: none"> <li>- "Standard 1.1 Health Promotion, Protection and Improvement: People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported."</li> <li>- "Standard 6.1 Planning Care to Promote Independence - Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being."</li> </ul> <p><b>Prudent Principle 1 (2014)<sup>32</sup>:</b> Any service or individual providing a service should achieve health and wellbeing with the public, patients and professionals as equal partners through co-production".</p> <p><b>Choosing Wisely Wales (2016)<sup>33</sup>:</b> "Embed a broad culture change in healthcare where clinicians and patients regularly discuss the value of treatments and make shared decisions."</p> <p><b>Together for Health – A Five Year Vision for the NHS in Wales (2011)<sup>34</sup>:</b> "Involving individuals in treatment decisions and self management improves outcomes."</p>	<p>3.1 Patients with LTCs must have the opportunity to work with their multidisciplinary team to shape their own care plan</p> <p>3.2 In order to streamline the patient journey, pharmacists must be able to facilitate direct referral to health, social care and other appropriate services.</p>
Utilising technology	<p>Healthcare professionals record important information about a patient's care. Currently, these separate records cannot be routinely accessed by other healthcare professionals.</p> <p>A single patient record, accessible by all registered practitioners, would enable more informed and safer health decisions.</p> <p>Time delays and accuracy issues occur as patients transfer between care settings e.g from community to hospital.</p> <p>As part of a £750,000 investment, the 'Choose Pharmacy' common ailment service provides an IT Infrastructure on which further services can be built.</p> <p>85% of the British public said they want any healthcare professional treating them to have secure electronic access to key data from the GP record<sup>35</sup>.</p> <p>A survey of over 7,000 patients using a pharmacy vaccination service showed that 80% of patients are happy for the pharmacist to have access to their GP record<sup>36</sup>.</p>	<p><b>Informed Health and Care – A Digital Health and Social Care Strategy for Wales, Welsh Government (2015)<sup>37</sup>:</b> "In order to provide safe, high-quality services health and social care professionals must have access to an up-to-date record of care for their patient or service user. It must be accessible wherever and whenever it is needed in the hospital, the community, GP surgery, or in the home and focused on the individual."</p> <p><b>Health and Care Standards, Welsh Government (2015)<sup>26</sup>:</b> "Standard 3.4 Information Governance and Communications Technology - Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services."</p> <p><b>Together for Health – A Five Year Vision for the NHS in Wales (2011)<sup>34</sup>:</b> "Care will be more personal, with all health professionals working better together; supported by state-of-the-art information systems".</p>	<p>4.1 In the interest of safe and effective patient care, all pharmacists involved in an individual's care should have appropriate read and write access to the Welsh GP record.</p> <p>4.2 Patients should benefit from a pharmacy-led medicines service for their LTCs management utilising the Choose Pharmacy IT platform.</p>



## NEXT STEPS

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This policy has been developed to instigate action at national and local levels to ensure people with long term conditions can benefit from greater access to the expertise of pharmacists. The implementation of these recommendations will help to drive quality improvements in the delivery of care by the MDT and will contribute to the changes needed to reduce demands on our health and social care services, including emergency care in Wales.

Action will be required across NHS Wales to review current plans for long term conditions and to address the role that the pharmacy profession can play in the development of effective models of care. The Royal Pharmaceutical Society in Wales is committed to working with the NHS and its other partners to drive this important agenda forward and to evaluate its effectiveness in improving patient care.

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