

Why provision of monitored dosage systems must be made a core service

By Toni Orr, a community pharmacist manager in Kilmarnock, Ayrshire

Currently, funding for social care is under the control of each individual local authority social services department. The framework that exists to govern both the NHS and the local authority bodies states that it is “not normally reasonable” to use NHS funds on community care services but some GPs have started to interpret this rule imaginatively by making use of the statement in the 1990 Act, that it can be done where “the provision of such services is necessary to meet a health need” or where there is a formal partnership and pooling of funds between a primary care trust and local authority. However, under new proposals announced on 6 March by Health Secretary Patricia Hewitt, the funding will be rearranged by shifting the money between the NHS and the local authority budgets to facilitate more seamless care for society as a whole.

The proposals represent the biggest shake-up of the rules that govern the commissioning of health and social services since the NHS was founded. Local authority leaders must be feeling concerned about this because it takes total budgetary control for their services out of their hands. Ms Hewitt has set out the Government’s consultative proposals for a commissioning framework for health and well-being, which has been drawn up jointly with communities and the local government secretary Ruth Kelly.

Basically, it means that there are now proposals being discussed for GPs to prescribe support for those people in each community who need assistance, eg, home helps, respite breaks for carers, exercise for patients who are overweight, supply of self-monitoring equipment and making available social work, counselling and occupational therapy services.

Something had to be done and someone had to make the first move because this current system is flawed. It worked once but no longer does because of the demands that are put upon it by a growing and ageing population.

There are three important issues here that are of interest to pharmacy. First, if GPs are going to be allowed to prescribe social care in the UK then it should follow that all independent prescribers would be involved in this process too, including independent pharmacist prescribers. Any pharmacist who has undertaken domiciliary visits and found a clear requirement for MDS support has been frustrated by the red tape that must be dealt with to ensure that they are paid for the service.

Our contract states that we will provide pharmaceutical services as an independent

contractor for the NHS and yet, day after day, we are failing patients.

GPs, social workers and carers constantly approach us to provide domiciliary support for medication for clients or family members and we are under huge pressure to provide an MDS.

Not many people outside the pharmacy profession realises how labour-intensive this service is. To them it is just “a wee box of pills”, but to those providing the service the amount of technical input required is massive.

We have to replicate these boxes accurately week after week, update the records, organise and order (in some cases) the prescriptions, seamlessly change the medicines if someone has been in hospital — and that is often difficult when there are no formal discharge communications to community pharmacy. The numbers of patients requiring this service is high and this section of our population is vulnerable and growing in number. We look after these patients in a way that nobody wants to quantify or recognise.

Expectation

Domiciliary MDS systems started as a free service provided by pharmacists because we recognised the gap in service. But it is groaning under the weight of expectation. People expect us to fill a box or blister for one tablet a day but this is not necessary for health reasons. There has been research that shows that an MDS is only necessary when there are four or more medicines a day but people still ask for them. The reasons for extra support are diverse, and many are valid, but they are not necessarily health needs. Social need is another matter.

The second issue arising from the Government’s statement is that it is different in Scotland, where I work. Because funding streams in Scotland are changing, I wish to highlight a difference across the border. The community health partnerships (CHPs) in Scotland have been developed over the past few years to address these problems and to bridge the divide between health and social care.

In Ayrshire we are trying to tap into funding streams for payment for domiciliary MDS. Our lead pharmacists have raised the issue at the CHP executives’ meetings and the Ayrshire and Arran community pharmacy development team is trying to develop a proposal — but the process is tortuously slow.

One local authority has developed a medication policy that says any more than one medicine should be in a blister. Pharmacy was

consulted but to protect the local authority “home helps” they chose to make their own policy, which causes difficulties in the locality as they have created a demand which pharmacists, as suppliers of this demand, cannot meet. You can see their point but they then complain when contractors refuse to service the numbers of patients for whom they have requested support.

In Scotland, we are paid £98 per contract (pharmacy) per month under the interim contract arrangements to provide not only these MDS systems but also another significantly under-funded service called the chronic medication service. And there are no fee payments for instalment dispensing. Unfortunately, locally, there are often contractors who do not understand the Scottish contract or local developments and who want to increase prescription volume — so they take on new MDS patients for no extra payment while we are trying to develop a properly funded service. This highlights my third point: MDS provision should be a core service. It is an issue that affects the nation as a whole. This is a gap in the service that should not be dealt with on a local level and GPs, pharmacists and nurses should all be able to instigate requests for MDS support.

Mrs Hewitt said her department had evidence that every pound spent on social care saved the NHS 30p. Some research suggested that the savings to the NHS were as much as 80p per social-care pound. Imagine the savings that could result, over and above this, if wastage of medicines, by patients who cannot cope with their medicines and order too much, were avoided. I visited a patient recently for a domiciliary review which had been requested by a social worker. The patient was deaf and did not have a particular health need for an MDS. Then I saw her medicines cabinet: it must have contained about 1,000 co-codamol tablets. It was every pharmacist’s nightmare and her social worker had grave concerns, so I decided to support her and provide an MDS for everyone’s peace of mind. Of course this is a personal story, but many pharmacists will have seen similar situations during their careers.

I concede that pharmacy leaders in Scotland are developing new service specifications but, hopefully, a properly funded service will be organised. Please, will someone listen and understand that pharmacists and members of society are crying out for domiciliary monitored dosage systems everywhere.

Changes to the funding streams are crucial to pharmacy and society’s future.