



Pill popping

Medicines adherence is a problem for the whole NHS. What can you do to help tackle the issue, and why should you bother? SUZANNAH WRIGHT finds out

Imagine stroke prevention is a priority in your locality. You've worked hard to improve screening processes and identified a number of patients who have been given appropriate lifestyle advice, and prescribed warfarin. Great work, you think...but not so fast, because of the patients you have helped identify, around a quarter might not be taking their medicines properly. A study presented at the Royal Pharmaceutical Society's conference last year found that of 472 patients on the heart disease register of a GP practice in North East England, 29 per cent failed to take medicines to prevent strokes and heart attacks regularly enough to remain effective. In the same group, 23 per cent missed statin doses.

NICE guidance suggests that between a third and half of prescribed medicines are not used as recommended. This can have a damaging effect on patient health, and also carries significant costs to

the NHS. In 2007, the Public Accounts Committee estimated that at least £100m is lost on wasted and unused drugs each year.

There are a number of reasons why patients might not be taking their medicines appropriately. Broadly, they fall into two categories: intentional (they have chosen not to take the medicine perhaps because of side effects, or they do not believe it is effective) and non-intentional (they wish to take the medicine but either forget or are unable to take it properly).

The complexity of factors which can affect medicines adherence mean there is no simple intervention, nor a simple way to identify non-adhering patients.

IDENTIFYING THE PROBLEM

While non-adherence can be picked up on an individual level if a patient is not seeing the expected improvement or outcome after being prescribed a

medicine, identifying non-adherence in larger groups is tricky because, as Dr Wasim Baqir, who was one of the pharmacists involved with the North East England study, explains "there's no single tool that measures what patients take".

"We have to use surrogate markers instead," he continues. "For our CVD study we used prescription ordering as a surrogate marker: we divided the number of doses prescribed by the number which patients should have had in order to give us a rough estimate of compliance. For example a patient prescribed aspirin 75mg once a day should ideally receive 336 tablets a year."

But that, as he says, is just "the tip of the iceberg" as patients may pick up a prescription and not take it. In addition, adds Adrian Price, clinical commercial manager at The Co-Operative Pharmacy, there can be a number of reasons why patients might pick things up at different times or why people may have twice as much in one month as they do in the next month. Both men agree that targeting specific groups and then working through individual patients is the best way to identify non-adherence.

The groups you chose to target might depend on priority areas for your practice; it might be based on Baqir's research which found slightly higher rates of non-adherence in men than women and in elderly patients; or it might simply be to sort a group of patients by the number of medicines each one is taking and starting to review at the top.

ADDRESSING THE PROBLEM

Both men also agreed that Medicines Use Reviews (MURs) are a good way to both identify non-adherence and tackle the complex causes behind it. An MUR is "a concordance based consultation which takes adherence into account," explains Price. "Normally the pharmacist will identify a patient who is in a situation which might cause an issue with the medication – it can be because they think the patient has ordered too many, or not ordered enough, maybe they've stopped a certain medication or they may have spotted an interaction." After the consultation, a review is produced which is sent to the prescriber and the patient, who may also be referred back to their prescriber to discuss their medications further.

MURs are paid for under the community pharmacy contract, and while it is generally the pharmacist who will identify patients, Baqir and Price both advise that practices and PCTs can encourage targeted reviews to coincide with their own priority groups. "It's quite common to have a partnership whereby the nurse runs a diabetic clinic or annual check and she'll refer those patients for an MUR in one of our pharmacies to go through the

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medication element of the review," says Price.

He adds that for this kind of partnership to be successful there needs to be clear communication channels between pharmacy and practice, advising that inviting pharmacists to focused practice meetings is one way to facilitate this. In addition, there should be clear referral protocols for pharmacists to follow when a patient needs to return to their GP to discuss prescriptions.

Baqir advises that larger PBC groups may commission MUR services – adding an extra fee on top of the standard one in order to encourage targeted reviews. "Inevitably it can boil down to cash," he admits, and the difficulty for many groups will be identifying and monitoring savings associated with reviews.

Aside from MURs, Baqir shares a number of ways in which pharmacists in North Tyneside are hoping to improve medicines adherence. "We're considering asking the pharmacist not to dispense tablets that the patient might not be taking, and to feed back that decision to the GP. We've also agreed with our pharmacists that every time a patient gets new drugs or new medicines for bone protection they're given a bit extra counselling because there's evidence that will improve compliance, and we might not extend that across other conditions."

Another pilot is looking at the use of group clinics to improve compliance. The pilot is focusing on rheumatology, and patients with osteoporosis or rheumatoid arthritis come together for a session in which they are given a short presentation about their condition. "We then get them to break into open groups and talk about their issues: what the condition is and what the treatment is, and so on. At the end they are given an envelope with their prescription in and info about their tablets," he says.

There are also things practices can do, such as encouraging doctors and other HCPs to spend more time focusing on reasons for prescribing medicines and discussing concerns with patients. Improving communications is key to reduce non-adherence and full NICE guidelines can be found at <http://www.nice.org.uk/CG76>. |



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