Making best use of medicines

Report of a Department of Health roundtable event hosted by The King's Fund

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Introduction

In response to the National Audit Office's 2007 report *Prescribing costs in primary care*, the Department of Health commissioned the York Health Economics Consortium and the School of Pharmacy at the University of London to carry out research to determine the scale, causes and costs of waste medicines in England. The report, *Evaluation of the Scale, Causes and Costs of Waste Medicines*, was published by the researchers on 23 November 2010.

Following publication, the Department facilitated a roundtable event hosted by The King's Fund in January 2011, where representatives of patients, health professionals, the NHS and industry were invited to consider the findings of the research and identify practical next steps that might be taken to help reduce waste, optimise medicine taking and improve health outcomes.

Chris Ham, Chief Executive of the King's Fund chaired the event. Lord Howe was the keynote speaker.

The research on the scale, causes and costs of wasted or unused medicines[1] acknowledges, that on the whole, the NHS deals well with waste medicines and that avoidable waste is relatively small compared to the total cost. The research estimated the avoidable cost of waste medicines in England to be up to £150 million. However, the costs associated with waste medicines are not just financial. There is also a cost to patients: effective use of prescribed medicines delivers improved health outcomes for patients, which may be foregone if medicines are not used to best effect.

The research showed the complexity of the problem of waste medicines. First, there is the need to engage with individuals and consider the values, beliefs and circumstances that may result in them not taking their medicines as intended. A commitment to a shared decision making approach is outlined clearly in the Department of Health White Paper *Equity and Excellence: Liberating the NHS,* illustrated by the phrase "no decision about me without me", and this will need to underpin approaches for improving patients' use of medicines.

There are system issues which do not always encourage the best and most effective use of medicines, for example in the area of repeat prescribing and dispensing, or in prescribing and supplying medicines to patients in care homes.

Wastage of medicines involves a wide range of different stakeholders who all have a contribution to make to reducing its occurrence and improving the quality of care: they include manufacturers and suppliers of medicines; health professionals and their teams including pharmacists, doctors and nurses, patients and the public.

This report details a wide range of initiatives that were discussed within the following themes:

- Engaging people in the decisions about their medicines.
- Providing targeted support for patients starting new therapies.
- Better use of medicines use reviews (MURs) and prescription interventions.

[1] York Health Economics Consortium and The School of Pharmacy, University of London (2010) *Evaluation of the scale, causes and costs of waste medicines: final report*. London : School of Pharmacy, 2010

- Better communication between health professionals.
- Better systems for managing repeat prescribing.
- Better systems for managing medicines in care homes.
- Better management of medicines at the end of life care period.
- Further research

Any future developments will be subject to the usual impact assessments, if appropriate.

Attendees

Delegates were drawn from a range of clinical professions, health-related charities, patient organisations and academic institutions. These reflect the key areas in which medicines waste is a particular issue.

Lord Howe, Parliamentary Under Secretary of State for Quality in the Department of Health gave the keynote address to open the meeting.

Professor Chris Ham, Chief Executive, The King's Fund, chaired the meeting.

Professor Paul Trueman	Report Author - Professor of Health Economics Health Economics Research Group Brunel University
Professor David Taylor	Report Author - School of Pharmacy, University of London
Dr Keith Ridge	Chief Pharmaceutical Officer, Department of Health
Jill Matthews	Director of Primary Care Improvement, Department of Health
Simon Selo	Asthma UK
Peter Rowe	QIPP – Medicines and procurement workstream, Department of Health
Jonathan Mason	National Clinical Director for Community Pharmacy
Martin Green	Chief Executive, English Community Care Association
Jane Butterworth	Head of Medicines Management, NHS Buckinghamshire for NHS Confederation
Professor Theo Raynor	Leeds University
Vivienne Bennett	Deputy Chief Nursing Officer, Department of Health
Dr Michael Dixon	Chair, NHS Alliance
Dr Phil Koczan	GP – Waltham Forest
Helen Gordon	Chief Executive, Royal Pharmaceutical Society
Gary Warner	Regent Pharmacy, Isle Of Wight and Hampshire Local Pharmaceutical Committee
Ray Jobling	Patient representative
Fiona Smith	ABPI – Abbott Healthcare
Professor Bill Scott	Chief Pharmaceutical Officer, Scotland
Michele Cossey	Pharmacy and Prescribing Lead NHS Yorkshire and the Humber Representing Strategic Health Authority pharmacy leads
Rob Darracott	Chief Executive, Company Chemists Association
Yolanda Fernandes	Health Foundation
Will Slater	Head of News – British Heart Foundation
Gul Root	Principal Pharmaceutical Officer, Department of Health (Observer)
Angus Wrixon	Communications Lead Department of Health (Observer)

PART 1 – Opening remarks and responses to the research report

The meeting opened with responses to the research report's findings from the perspective of community pharmacy, patients and general practice.

Gary Warner (community pharmacy):

He welcomed the report and made the following comments / observations:

- The quantity of waste brought into his pharmacy was not in the main excessive – but every month or so, a customer would bring in a large sack full of unused or part- used medicines for disposal.

- Effort should be focused on improving adherence rather than the cost of the waste medicines alone.

- People would benefit from having better information and knowing more about their medicines (not the cost) and would potentially waste less.

- Local initiatives designed to reduce waste include:

  - A framework for respiratory patients on the Isle of Wight (IOW) which resulted in better adherence, less wasted medicines and fewer hospital admissions.

  - A "do not dispense" scheme in which the pharmacist is paid a nominal sum for not dispensing a prescribed medicine if it is deemed inappropriate or the patient no longer needs it. Consequently, it removes any perverse incentive to dispense.

- Care homes in IOW have made use of bulk prescriptions, which are allowed under Part VIII of the Drug Tariff, as a way of reducing medicines waste. Using bulk prescriptions for medicines for, for example, pain relief and laxatives then negates the ordering of repeat supplies for individual patients every month.

- The proposed New Medicines Service would provide opportunities for pharmacists and their teams to engage with people and help them to take their medicines more effectively, improve health outcomes and potentially reduce waste.

- There should be more support from GPs for the use of domiciliary medicines use reviews (MURs).

- He supported the report's recommendation that particular effort should be focused on addressing the waste of more expensive medicines.

Ray Jobling (patient representative):

He welcomed the clarity of the report – and made the following comments:

- Waste is not at unmanageable levels. The NHS has been better at reducing waste in the last few years, so saw no point in over investing to address it.

- Talking about medicines is a two-way communication process between patient and clinician. The use of medicines should be aimed at getting the right outcomes for patients – in the right place and at the right time.

- He added that the issue of waste medicines is not the sole responsibility of any one NHS or patient group, it is an issue for everybody.

- The contribution of the pharmaceutical industry is missing from the report – pharmaceutical companies are increasingly developing initiatives that make direct contact with a patient, offering more services, and sometimes bypassing health professionals.

- This is an area calling for more information.

Dr Michael Dixon (GP):

Dr Dixon welcomed the report and made the following comments and observations:

- The issue of waste had become much better managed than it had been in the past.

- Medicines management needs to be an integral part of medical undergraduate training.

- The support of carers was vital in the dialogue between patient, GP and pharmacist.

- The relationship between GPs and community pharmacists is very important – but made more challenging by the increase in the number of community pharmacies that are now in multiples and their use of locums, which makes a personal relationship difficult to maintain.

- Patients commonly continue to order and receive medicines with no intention of using them saying they are too afraid of “upsetting the doctor” to stop receiving them.

- There should be some flexibility in dispensing and prescription length – for example, when a patient is initially prescribed a new medicine, it would be appropriate to try it first for 7 days. Then, having determined the patient’s tolerance to the medicine, a course for 28 days or longer can be prescribed and dispensed.

- When a patient is discharged from hospital, communication between GPs, pharmacists and hospital doctors needs to be better to ensure continuity of medicines for that patient in the community.

PART 2 – Group discussions

Engaging people in the decisions about their medicines

Discussions focused on how to help people understand their medicines and creating an environment that allows for shared decisions about medicines, in an environment that enables honesty between the patient and the clinician and that lives up to the ambition that there should be “no decision about me without me”.

Key messages:

- A personalised approach may be initially costly, but is likely to reap greater rewards. The longer the consultation and the more involved a patient is in the decisions about their treatment, the more likely that the patient will comply with their course of treatment prescribed. These interactions need to be patient focused and patient led.
- Information is important, but there should be a focus on spoken as well as written information. Written information should not replace interaction with GP, nurse or pharmacist.
- Pre-prescription discussion and information is particularly important.
- Honesty is key - professionals should create an environment during the consultation, which allows the patient to express honestly their concerns and accept a patient’s decision not to take medicines if they so wish.
- Pharmacists are not currently incentivised to not dispense medicines if they believe the patient does not want or need them and this should be addressed.
- The potential for a short satisfaction survey instrument for patients could be explored.
- There was no clear support for the indicative pricing of medicines for patients, with a feeling that vulnerable older patients, in particular, may be put off taking expensive medicines.
- Processes should be more widely used that would allow more patients admitted to hospital to keep their own medicines as this would both empower patients and allow professionals to identify any issues with the patients' use of their medicines.
- Work should be undertaken to link solutions to emerging evidence about the most effective ways to engage patients in shared decision-making.
- Incentives for GPs and community pharmacists should be more aligned – professional collaboration and better understanding of each other’s roles is vital for this to be successful.
- Nurses play an increasingly important role in supporting people with long term conditions.

- Compliance aids could be used as a marker for identifying where resources might be directed.

Providing targeted support for patients starting new therapies

The proposed New Medicines Service is designed to support patients who have been newly prescribed a medicine for a long-term condition. The Pharmaceutical Services Negotiating Committee and NHS Employers are continuing to finalise proposals for the service.

Key messages:

- When prioritising the list of medical conditions that the New Medicines Service should focus on, it would be helpful to consider those therapeutic areas where evidence suggests improved health outcomes e.g. some of the medicines listed in chapter 5 of the research report, such as medicines for asthma, diabetes, hypertension, schizophrenia and prevention of cardiovascular disease.

- The New Medicines Service provides a clear role for pharmacists within the clinical team, and should mean that outcomes/findings/actions from the service should be communicated to others within the team, especially prescribers. The consistency of information to the patient from both the prescriber and the pharmacist is key, and should be tailored to the patient rather than relying on use of a standard leaflet.

Medicines Use Reviews and Prescription Intervention

Two separate but linked tools, MURs and prescription interventions are important developments in helping patients to understand their medicines, relay concerns and pick up those patients who are most at risk of making less effective use of their medicines. The emerging evidence base supporting the use of targeted MURs, over opportunistic ones, should be promoted as they would be better linked to defined outcomes.

Prescription interventions are more reactive, being the response to a significant problem with an individual patient's medicines that leads to a review.

Key messages:

- More work should be done to investigate the effectiveness of MURs carried out in patients' own homes.

- There is much scope to improve MURs for mental health conditions.

- GP practice processes for managing patients with long term conditions (such as undertaking six monthly reviews) should be linked to local pharmacies, for example through the timing of targeted MURs.

Communication between professionals

The meeting considered the practical measures that could be taken to encourage health care professionals to communicate better in relation to a patient's medicines.

Key messages:

- GPs, pharmacists and patients should be engaged in a dialogue about trigger points which would indicate when a community pharmacist should contact a GP about a patient who is experiencing problems with a medicine.

- Relationships between local pharmacists and GPs are complicated in areas where pharmacies rely on locums. This can often be true of multiple large corporate organisations. Further work needs to be done to find methods of improving collaboration in this area.

- There needs to be both shared understanding of roles between professionals and aligned incentives.

- A series of examples of good practice in information transfer about medicines between professionals should be developed and disseminated.

- The various education bodies for health care professionals, and Medical Education England, need to consider effective use of medicines as a core part of the curriculum, with joint training for professionals, a key component.

- Current IT solutions were felt to be too complex to enable effective collaboration and simpler solutions are required.

- Domiciliary care workers are often unable either to give medicines or to prompt patients to take their medicines at home - further work in this area should be explored.

- (additional comment after the event) Emerging clinical commissioning groups may see the opportunity of working with medicines as an early win with some of their constituent practices and pharmacies. This is an area to be explored further.

Repeat prescribing

The management of medicines for people with long term conditions, in particular the repeat prescribing and dispensing process, was an important area identified by participants.

Key messages:

- There are perverse incentives that may benefit pharmacists through having the length of prescriptions fairly short. This should be addressed through the national community pharmacy contractual negotiation process.

- Pharmacies could be enabled to determine the appropriate length of prescriptions - it was suggested that the Electronic Prescription Service could facilitate the spread of

repeat dispensing - but with pharmacies then making the decision about what intervals to dispense this prescription to an individual patient.

- The length of prescriptions influences pharmacies' remuneration. Consequently, it has an impact on forward business / financial / staffing planning. Changing remuneration from a volume-based model to a capitated model may help to address this.

- Prescription length is currently not related to patient need. A patient led process, designed to support better use of medicines, might mean more regular prescriptions/contact where adherence is poor (supervised administration is an extreme form of managed adherence!) and prescriptions for longer periods where adherence is not a problem.

Use of medicines in care homes

Medicines management in care homes as a potential source of wastage is explored in detail in the research report. The group discussed practical measures that could be taken to ensure better health outcomes, greater efficiency and less waste of medicines in a care home setting.

Key messages:

- Bulk prescribing in care homes can be beneficial (for example in the prescribing of laxatives or pain killers).

- It was strongly felt that some of the current Care Quality Commission (CQC) regulatory requirements can contribute to less effective use of medicines in care homes, as they can institutionalise poor practice. It was felt that there may be inconsistency of interpretation among local CQC inspectors about the process used for ordering medicines. The CQC should clarify the requirements for care homes, particularly around bulk prescribing. Further joint work between representatives of care homes, GPs, CQC and pharmacists is needed.

- Some medicines may be held in care homes to allow treatment "if needed", particularly for end of life care.

- A checklist should be developed for the information needed for care home visits by GPs which could simplify these visits and make them more effective.

- Further research on how a care team approach to medicines use in long-term care could benefit patients.

End of life care

Anticipatory prescribing for patients at the end of life can help to keep patients in their own homes and ensure more effective pain management. Unused medicines in the context of end of life care should not necessarily be considered to be waste because they enable better care for patients.

Further research

The group discussed areas for more research that may help to shape and inform the ongoing debate. Ideas included:

- Is there an instrument in the community that will help to identify high-risk patients who are most likely to have problems with their medicines and who should therefore be targeted for more support?
- What are the most effective ways to create local networks where patients who might benefit from targeted support can be identified and discussed?
- Should the most commonly used prescription length be changed? What should it be and for which groups of patients?

Next steps

Dr Keith Ridge gave a summary;

There is a wide range of initiatives that have been identified in these discussions that would help to make more effective use of medicines. Prioritisation is necessary and there will also be an even greater array of best practice across the country, which could be harnessed and spread. Dr Ridge encouraged the King's Fund to continue the debate and to reconvene a similar forum in six month's time.

Further consideration will need to be given as to how to capture this best practice and the views of patients, public and professionals.

Specifically, he noted:

- The ambition is for the group who attended the event to take ownership of the outputs and actions it generated – and to continue to engage in the debate in the future.
- Patients and the public should be encouraged to become more involved with their medicines – there is a role for patient and public groups to support this engagement.
- The issues raised also need to become embedded in the education of healthcare professionals in the future through Medical Education England.
- The implications of the issues and actions need to be considered by the Department of Health in discussions relating to the community pharmacy contractual framework.
- There are compelling reasons for supporting a communications campaign that would raise awareness of the issues and change people's behaviour.
- Any actions will need to be implemented in a planned and considered way as interventions also cost both time and money and must therefore deliver adequate returns.

Annex A – Organisations and individuals involved in the development and support of this document

This document has been developed and is supported by the following organisations and individuals:

School of Pharmacy, University of London
Brunel University
Asthma UK
English Community Care Association
NHS Confederation
Leeds University
NHS Alliance
Royal Pharmaceutical Society
Isle of Wight Local Pharmaceutical Committee
Association of the British Pharmaceutical Industry
Company Chemists Association
British Heart Foundation
The Health Foundation
Lay representative
GP representative
PCT representative
SHA representative
Chief Pharmaceutical Officer, England
Chief Pharmaceutical Officer, Scotland
Pharmaceutical industry representative
The Department of Health