Work smarter, not harder, and make sure patients benefit from their MURs

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The NHS is facing unprecedented challenges. With savings of approximately £20bn required over the next three years and the number of patients who either have long-term conditions or are elderly rising, the importance of improving efficiency and demonstrating value has never been greater. NHS chief executive Sir David Nicholson has suggested that the greatest change necessitated by this challenge will be the shift of care out of hospital and into the community. Notably, he has advised that this should lead to improved management of long-term conditions and a reduction in hospital admissions.

Not taken as intended

In 2008, the NHS spent over £10,829m on medicines alone. Yet research suggests that between a third and a half of all medicines for long-term conditions are not taken as intended.

Additionally, almost 5 per cent of all hospital admissions are thought to be due to adverse events associated with medicines and about a third of all hospital beds are occupied by patients who have at least three long-term conditions. These figures suggest that community-based interventions that help patients understand what their medicines are for and how they should be taken, and those which enhance monitoring of adverse events, could significantly reduce hospital admissions, improve the care received by patients and improve outcomes from prescribed medicines.

The medicines use review (MUR) service is currently the backbone of community pharmacists’ contribution to the management of patients with long-term conditions in England, helping improve patients’ knowledge of their medicines. Yet, despite recent statistics from the Department of Health highlighting that the number of pharmacies offering MURs rose to 83 per cent between 2008 and 2009, in their current form questions continue to be asked regarding their value.

There are examples of where use of targeted MURs, particularly with top-up payments from PCTs for additional interventions (so called MUR-plus services), has delivered demonstrable improvements in patient outcomes. For example, a targeted and integrated
asthma MUR service was piloted in Hampshire and the Isle of Wight between July and December 2007 (PJ, 31 January 2009, pp109–112). With approximately 5.4 million people in the UK currently receiving treatment for asthma and research suggesting that asthma patients only take on average about half of their prescribed medicines, it is not surprising that difficult-to-control asthma costs the NHS £680m a year. With the aim of improving adherence and subsequently reducing the cost to the NHS, the Hampshire and Isle of Wight pilot sought to measure improved access to support, and improved patient adherence resulting from pharmacists’ interventions.

To ensure the outputs of the MURs were used by appropriate members of the broader healthcare team, all participating pharmacists were encouraged to talk to local GPs and nurses. This provided a critical opportunity to provide written information on the pilot and discuss both asthma and other MURs.

A total of 965 patients received asthma MURs during the pilot. These were conducted by 46 community pharmacies and resulted in 1,787 interventions, including patient education, GP or nurse referrals and device checks and demonstrations. Significantly, almost 30 per cent of patients had difficulty using their medicines (this was also cited as the main cause of non-adherence) and 33 per cent used the service to gain confidence in their asthma medicines. Although limited in scope, the pilot highlighted the potential benefit of MURs on patients’ use of asthma medicines and demonstrated the ongoing opportunity for pharmacists to enhance their role.

Better engagement The second change relates to improved engagement with hospital pharmacy colleagues. Although patients who have been admitted to hospital for medical purposes may be seen by a hospital pharmacist for a medication review, and changes to prescriptions will be reported to GPs, rarely is any information shared with the patient’s usual community pharmacist. Following a stay in hospital, many patients remain confused about which of their pre-admission and post-discharge medicines they should be taking, leading to unintended changes to post-discharge regimens.

Since approximately 80 per cent of patients receive some community pharmacy for all their prescriptions, this presents an ideal opportunity for post-discharge MURs to be conducted in community pharmacies and, therefore, to help patients make sense of any changes that have been made to their regular medication.

Hospitals are required to undertake medicines reconciliation (ie, identification of which medicines patient are taking) for all patients on admission. This presents an ideal opportunity for community pharmacists to conduct pre-admission MURs to identify which medicines patients are taking (including over the counter and other non-prescribed medicines), and to help ensure that patients are using their medicines appropriately and are not experiencing any adverse effects. Patients can be provided with a list of all their medicines, which they can take with them to hospital on admission.

A logical extension of such an intervention would be for community pharmacists to undertake asthma education and medication risk assessments and to screen patients for metformin-resistant Type 2 diabetes before admission. The use of pre- and post-admission community pharmacy-based MURs is being piloted in a number of PCTs, including NHS Eastern and Coastal Kent. The appointment of a pharmacist by the success of these pilots is the need for greater communication between hospital pharmacy, community pharmacy and general practice. Specifically, for such a system to work, hospitals would need to send a copy of the discharge letter (which is currently sent to general practice only) to the patient’s preferred community pharmacy with details of why changes to medicines have been made.

The hospital would continue to send the discharge letter to the GP, but this would include notification that a community pharmacy MUR will be scheduled. The patient would simultaneously be advised, while in hospital, to schedule an MUR with their community pharmacist soon after discharge. Should the patient fail to schedule an MUR, the pharmacist would either follow up directly with the patient or alert the GP that the MUR has not been completed. Upon conducting the MUR, pharmacists would ensure patients are aware of any changes to their medicines and are comfortable with how all medicines should be taken. They would also make sure that the changes are reflected on repeat prescriptions.

Conclusions have not yet been drawn from the trial but initial results look promising and the introduction of community-based pre-admission and post-discharge MURs should further support the identification of appropriate patients for MURs and ensure high risk populations are getting the best from their medicines.

Impact assessment The final change required is to ensure that community pharmacy is assessing the impact of MURs on patient outcomes. Although examples of strong, well-integrated MUR services do exist, the standard of MURs offered across England varies considerably and there is little information on the outputs and outcomes of the interventions. Recording and measuring the impact of services on patient outcomes would enable community pharmacists to demonstrate the quality of services being provided and also highlight their impact in terms of patient outcomes and value to the NHS.

With no record of recording and auditing interventions, community pharmacists could help identify patterns or trends relating to specific treatments and may enable pharmacists to identify aspects of their current service that may need a refinement, driving improved care and service.

Opportunities and challenges MURs offer a considerable opportunity to improve the value of medicines and reduce incidence of medicines-related hospital admissions. Yet there are further opportunities to ensure the role played by community pharmacists is better aligned with their professional and training requirements. In particular, there is a significant opportunity for pharmacists to be at the core of the healthcare team, managing patients with long-term conditions such as heart disease, respiratory diseases, rheumatoid arthritis and diabetes. Furthermore, there is an opportunity to support the work of hospital pharmacists by introducing a network of pharmacists with specialist interests and prescribing capabilities. This would be particularly pertinent with regard to long-term conditions and may provide the opportunity for more patients to be managed in the community. For example, NHS City and Hackney is currently piloting such a service model in diabetes. Rather than patients attending an outpatient clinic for more specialist care, for example insulin initiation, they will be referred to a pharmacist with a special interest in diabetes, and who has prescribing capabilities. Although further research is needed, the success of this model would further support the drive for community-based management of long-term conditions.

There is no question that the next three years will bring with them considerable challenge for community pharmacy. I believe the move to community-based management of patients with long-term conditions represents a significant opportunity for pharmacy to become further integrated into the wider primary care team, offering even better support to patients to ensure they are getting the most out of their medicines. It will be challenging, but for those who embrace the opportunities presented to them, the rewards will be considerable.