

NHS and Pharmaceutical Industry Working Together for Patients



Produced in association with, and supported by:



The Association of the British Pharmaceutical Industry

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Foreword

From Dr David Colin-Thome

National Clinical Director for Primary Care and General Practitioner,
Castlefields, Runcorn

I welcome the opportunity to write the foreword and thereby endorse this publication. I do so of course in an entirely personal capacity.

There is a huge task in front of us to both continually improve health care and improve the general health of the public. Only by reforming the NHS to provide more responsive and flexible services will we maintain the support and trust of the British public. And only by working in partnerships with other public services, the private and voluntary sectors will we in the NHS deliver on the daunting yet achievable task set for us.

Trust is all in partnerships and to have trust necessitates a sharing of values, principles and examples of joint working that can demonstrate real benefits for our patients. This publication has all of this and more. It also gives examples of sound audit and thus a transparent accountability.

The history of joint working between the pharmaceutical industry and the NHS is patchy with examples of excellent partnerships but also of mistrust, ideological differences and bad behaviours. This framework helps to move us on. As a GP, and in particular faced with the rise in chronic illness, the prescribing of drug therapy is one of the most effective therapeutic interventions at my disposal.

We need each other and I particularly support the notion that bottom-up examples of good local partnerships are the way to win sceptical hearts and minds.

Web Sites' Availability

This Joint Working Document and the individual project cases are available on the Web Sites of the ABPI and NHS Alliance (please see page 8 of the Joint Working Framework for the Web Sites' details).

A Framework for Joint Working between the Pharmaceutical Industry and the NHS



Introduction

Introduction from the ABPI

From Professor Trevor M Jones

Director General, Association of the British Pharmaceutical Industry

The relationship between the NHS and the pharmaceutical industry is constantly changing. The NHS Plan and other recent DoH publications all point to the benefits that can come from a constructive engagement with the private sector.

In the spirit of the emerging relationship, the ABPI has produced this document to introduce NHS managers and decision makers to the benefits of partnership with the pharmaceutical industry.

The document is comprised of a suggested framework for joint working between the pharmaceutical industry and the NHS, together with case studies as examples of successful co-operative initiatives resulting in direct benefits to patients.

The Framework

The framework is intended as a practical guide to joint working projects. It outlines the principles for co-operation and lists important lessons learnt so far, as well as highlighting pointers for successful joint working relationships leading on to viable projects which benefit healthcare. A suggested framework checklist is also provided to facilitate the planning, organisation and implementation of such initiatives.

Case Studies

The case studies that have been chosen reflect the priorities of the local NHS and range from educational support to implementation of National Service Frameworks. Each case study identifies the challenge facing the NHS and then details how the solution benefits everyone involved.

The usefulness of the project is endorsed in feedback from users. Each case study has a named contact within the participating company, who will be happy to be contacted to explain the concept further and to put you in touch with your local healthcare development manager.

We would be interested in your feedback on this initiative – please contact Martin Anderson at the ABPI.

Executive Statement

The NHS Plan July 2000 (Chapter 11) states:

"The NHS is a huge organisation. Using extra capacity and extra investment from voluntary and private sector providers can benefit NHS patients. The time has now come for the NHS to engage more constructively with the private sector, and at the same time make more of its own expertise available to employers throughout the country.

For decades there has been a stand-off between the NHS and the private sector providers of healthcare. This has to end. Ideological boundaries or institutional barriers should not stand in the way of better care for NHS patients. The private and voluntary sectors have a role to play in ensuring that NHS patients get the full benefits from this extra investment. By constructing the right partnerships the NHS can harness the capacity of private and voluntary providers to treat more NHS patients".

This statement was reinforced by the Prime Minister in the foreword of the Pharmaceutical Industry Competitiveness Task Force (PICTF) report (final report 2001), which states:

"A successful pharmaceutical industry is a prime example of what is needed in a successful knowledge economy. We must work together to ensure that the future of the UK pharmaceutical industry is even brighter. A key feature in maintaining the UK's attractiveness will be effective partnership at the highest levels between Government and industry. I look forward to future partnership and to the pharmaceutical industry continuing to make a significant contribution to the health and prosperity of the UK".

The current DoH web site states:



"PICTF agreed that there should be close joint working between Government and industry on National Service Frameworks (NSFs), which set national standards for the NHS in clinical priority areas. There has been close collaboration between the ABPI and its member companies and teams in the Department of Health leading the development and implementation of specific NSFs. For instance: discussions between ABPI and DoH on the implementation of the Diabetes NSF Standards, published in December 2001. An ABPI representative has been appointed to the NSF Implementation Group. A successful "Champions Conference" in March 2002 to support implementation of the NSF for Older People, organised jointly between the DoH and ABPI. Dialogue has started on the new NSFs under development".



It is clear therefore that the relationship between the NHS and the pharmaceutical industry is developing. The changing nature of the NHS, in response to Government policies and ever increasing demands by the public will create new opportunities for more joint working between pharmaceutical companies and the NHS to deliver better health outcomes for the patient. This framework has been developed to ensure that all parties carefully consider any proposals for joint working and provides a checklist to ensure that potential issues are considered and resolved prior to any agreement to work together.

The pharmaceutical industry acts as a partner, a stakeholder and as a supplier to the NHS, but the behaviours and communications required when acting in each of these capacities is different. Although organisational objectives will differ, the overall objective is the same i.e. to improve health outcomes for both individual patients and wider populations, but the relationship is often predicated by a lack of trust. Partly, this is a result of confusion in language and behaviours.

The following values should underpin joint working and all parties involved are asked to confirm and adhere to these:

- Mutual trust, honesty and respect
- Openness and transparency
- Recognising and valuing the contribution of all partners
- Access and sharing of information pertaining to the project
- Consensus, collaboration and inclusion as the “best way” in decision making
- Acknowledgement of the interdependent relationship between the NHS and the pharmaceutical industry
- Commitment to the framework

This framework aims to act as a practical and flexible guide that can be applied when joint working between the NHS and the pharmaceutical industry is proposed. A fundamental principle is that all joint working between the pharmaceutical industry and the NHS must be for the benefit of patients. The use of the framework should ensure that any agreements between the NHS and the pharmaceutical industry are conducted in an open and transparent manner. Readers should also familiarise themselves with the documents listed below:

1. Commercial Sponsorship, Ethical Standards for the NHS. Department of Health, November 2000
2. A Common Understanding - Guidance on Joint Working Between NHS Scotland and the Pharmaceutical Industry. SEHD 2003
3. Confidentiality: NHS Code of Practice, March 2004
4. Code of Practice for the Pharmaceutical Industry. ABPI 2003

Principles

- All joint working between the pharmaceutical industry and the NHS must be for the benefit of patients
- The interests of individual patients must be protected
- Clinical aspects of care, including the development of guidelines and protocols, should be under local/national NHS control, and industry input is legitimate and offers potential benefits to patients and NHS organisations



- Long term strategic partnership is the desired outcome but work should proceed on a project by project basis
- All patient identifiers should be removed from data to respect and preserve patient confidentiality in line with the Data Protection Act
- Reports or information pertaining to the project/agreement should not be used or published without explicit permission given by all partners entering the agreement
- Joint working should not be seen as an endorsement or promotion of a specific medicine or technology
- Joint working should not undermine or conflict with the ethical requirements of any healthcare professional, including the duty of the clinicians to provide whatever treatment they consider clinically appropriate
- Pharmaceutical companies must comply with the ABPI Code of Practice for the Pharmaceutical Industry at all times
- All NHS employed staff must comply with NHS (and relevant professional bodies) codes of conduct at all times
- Pharmaceutical company size (turnover) should not dictate involvement with the NHS
- If joint working involves research, then best research practice should be applied and consultation with the relevant Local Research Ethics Committee should be sought

Lessons Learnt So Far

The 'devolved' NHS is diversifying rapidly and this will no doubt create many challenges and opportunities for pharmaceutical companies when trying to work in new ways with their customers.

Informal feedback from the NHS suggests:

- That increasingly, their focus is on service reconfiguration issues rather than simple acquisition costs of medicines
- Inter-company divisions and hierarchies make companies difficult to work with. (It is also recognised that the NHS is also very difficult to work with)
- That the industry is too product-focused and if companies are now looking to deliver better health outcomes, then this is a big shift in attitude
- That the industry has a lack of understanding of some of the roles of health professionals e.g. seeing pharmacists as a barrier to entry rather than as advisors on how to use medicines most appropriately and *vice versa*
- That there are many examples of good relationships and close working but these are not identified centrally. They occur at a local level and are not reported due to a variety of reasons including competitive advantage, personal advantage, etc.
- That 'partnership' is an easy term to use but is often difficult to achieve in practice. Examples of partnership projects can take a very long time to bring to fruition and often seem dependent on personal relationships rather than organisational commitment. The lesson seems to be to start small and allow projects to develop rather than trying to impose top-down solutions

The Next Steps

The ground rules for successful joint working are simple and need to be openly acknowledged: trust, mutual benefit, added value, reliability, consistency and integrity. Many primary care organisations are developing guidance to manage their relationships with pharmaceutical companies. The precise 'relationship' will vary on a case by case basis, but the 'framework checklist' on the following pages has been developed in an attempt to facilitate joint working.

A Framework for Joint Working between the Pharmaceutical Industry and The National Health Service

Framework Checklist

I. JOINT WORKING PROJECT SUMMARY

1. TITLE OF PROJECT	
2. SUMMARY OF INTENDED AIMS/OBJECTIVES	
3. SUMMARY OF EXPECTED OUTCOMES	
4. NAMES OF JOINT WORKING ORGANISATIONS	
5. NAMES OF THE LEAD REPRESENTATIVES FOR EACH ORGANISATION	
6. START DATE	
7. FINISH DATE	
8. EXIT STRATEGY	

II. FINANCIAL AND RESOURCE IMPLICATIONS

1. WHAT IS THE OVERALL BUDGET OF THE JOINT WORKING PROJECT?	
2. WHAT ARE THE DIRECT AND INDIRECT FINANCIAL/ RESOURCE COMMITMENTS BY EACH ORGANISATION?	
3. HOW WILL THE RESOURCES/COSTS BE MONITORED AND RECORDED?	
4. HAS VALUE FOR MONEY BEEN SHOWN? IF SO, PLEASE INDICATE	
5. HAVE CLEAR AND UNAMBIGUOUS ARRANGEMENTS REGARDING THE LONGER TERM FUNDING IMPLICATIONS OF PROJECTS BEEN SATISFIED?	

III. GOVERNANCE ARRANGEMENTS

1. WHO HAS BEEN CONSULTED PRIOR TO INITIATING THE JOINT WORKING PROJECT AND HOW WAS THIS DONE?	
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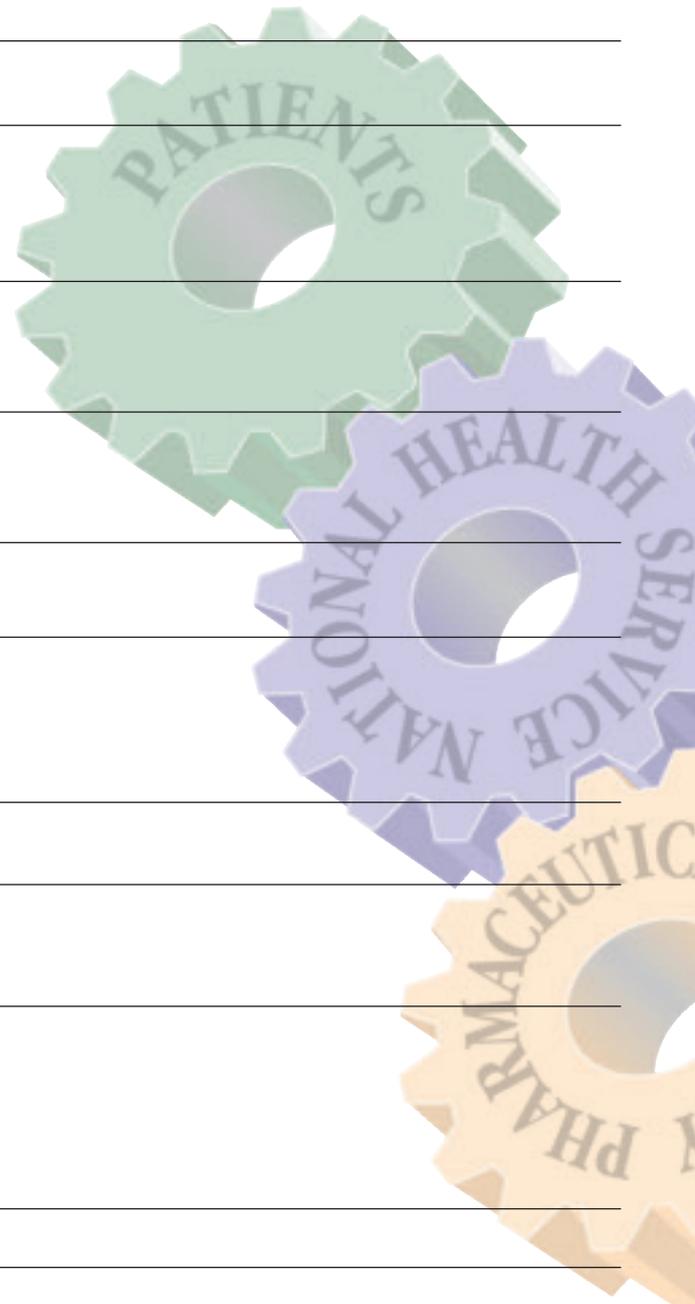
2.	HOW WILL YOU COMMUNICATE THE JOINT WORKING PROJECT TO PATIENTS?	
3.	IS THERE AN OPEN AND TRANSPARENT DECISION-MAKING PROCESS FOR THE PROJECT?	
4.	STATE OPERATIONAL AND MANAGEMENT ACCOUNTABILITIES. WHAT ARE THE POTENTIAL CONFLICTS OF INTEREST?	
5.	IS A PILOT SITE REQUIRED AND IF SO, HOW WOULD THIS BE ACHIEVED?	
6.	FOR CLINICAL SERVICES, WHAT ARE THE PROFESSIONAL INDEMNITY AND LIABILITY ARRANGEMENTS THAT THE PROVIDER HAS IN PLACE?	
7.	IS THERE A WRITTEN AGREEMENT THAT CLEARLY STATES THE OBLIGATIONS OF CONFIDENTIALITY, SECURITY STANDARDS AND LIMITS OF USE OF INFORMATION TO THE PURPOSES SPECIFIED?	

IV. MONITORING AND EVALUATION

1.	WHO HAS DESIGNATED RESPONSIBILITY AT EACH STAGE OF THE PROPOSAL? PLEASE LIST	
2.	ON COMPLETION OF THE PROJECT, HOW WILL IT BE EVALUATED IN TERMS OF PATIENT BENEFITS?	
3.	WHAT WILL BE/HAVE BEEN THE LEARNING OUTCOMES/OPPORTUNITIES?	
4.	WHAT AUDIT ARRANGEMENTS ARE AVAILABLE?	
5.	HOW WILL YOU INFORM THE JOINT WORKING GROUP OF SIGNIFICANT PROBLEMS AND HOW WILL YOU MANAGE THIS COMMUNICATION BEYOND THE PROJECT TEAM?	

V. DATA AND PATIENT PROTECTION

1.	WHO "OWNS" THE DATA GENERATED BY THE PROJECT?	
2.	WHO HAS ACCESS TO THE DATA AND IN WHAT FORM I.E. AGGREGATION AND ANONYMISATION CRITERIA?, (bearing in mind the Data Protection Act and the requirements for patient confidentiality of healthcare records)	
3.	HOW WILL THE DATA BE USED?	



VI. DECLARATION OF INTERESTS

YES

NO

If Yes, please qualify below by inserting one tick in column A and B

A	B
Personal <input type="checkbox"/>	Specific <input type="checkbox"/>
Non-Personal <input type="checkbox"/>	Non-Specific <input type="checkbox"/>

Signature _____ Date _____

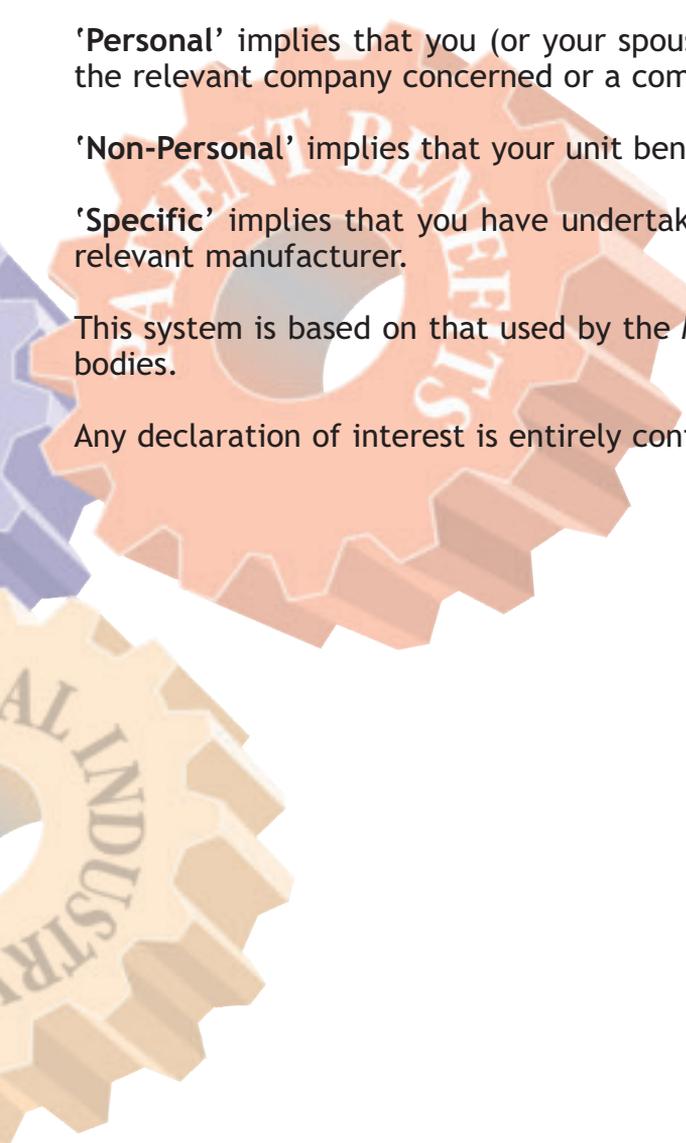
'Personal' implies that you (or your spouse) receive direct payment for services or hold shares in the relevant company concerned or a competitor.

'Non-Personal' implies that your unit benefits by receiving funding from the company.

'Specific' implies that you have undertaken work or given advice on other products made by the relevant manufacturer.

This system is based on that used by the Medicines Commission and other national drug regulatory bodies.

Any declaration of interest is entirely confidential.



Organisations Supporting this Document

The Association of the British Pharmaceutical Industry



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12 Whitehall, London SW1A 2DY; Telephone: 020 7930 3477; Fax: 020 7747 1411;
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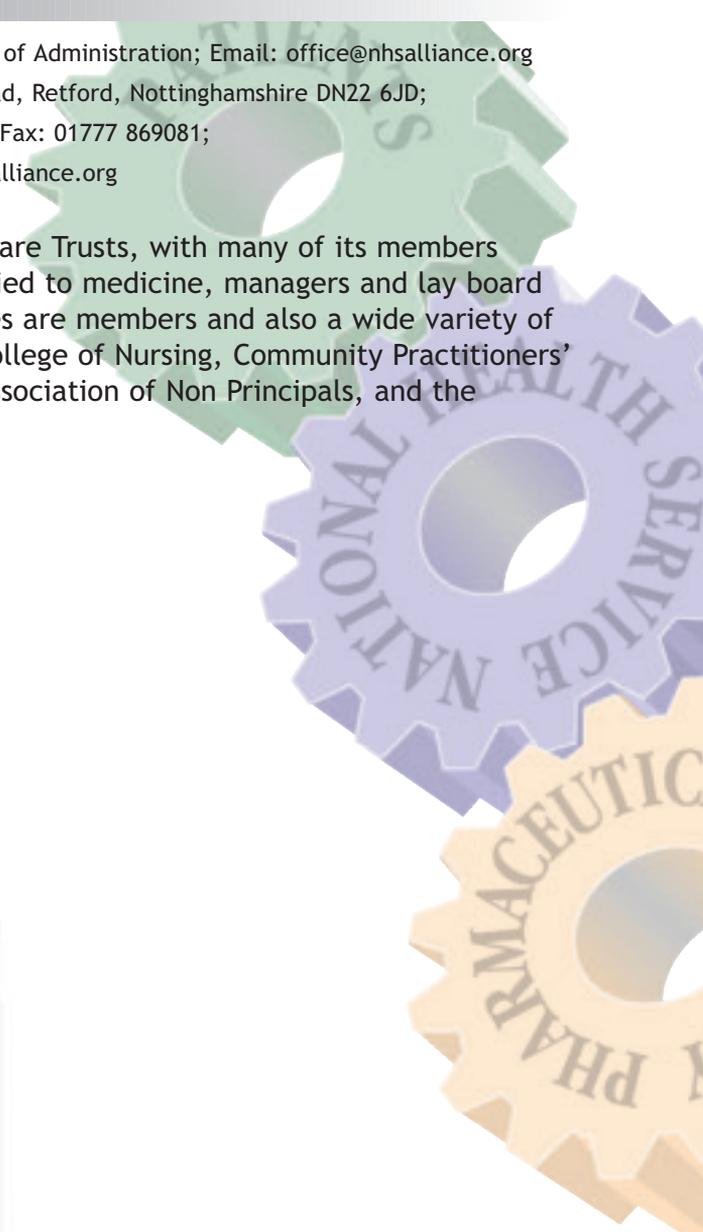
The ABPI is the trade association that represents leading prescription medicine companies involved in every stage of research, development and manufacture of both branded and generic products in the UK. It represents the views of the pharmaceutical industry to Government, the media, the scientific and medical world and the general public. It maintains close and regular contacts with Government bodies and agencies and the UK Research Councils, training and education institutions, NHS health managers, patient advocacy groups and professional bodies.

The NHS Alliance



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Telephone: 01777 869080; Fax: 01777 869081;
Web Site: <http://www.nhsalliance.org>

The NHS Alliance represents most Primary Care Trusts, with many of its members being individual GPs, nurses, professions allied to medicine, managers and lay board members. Some Strategic Health Authorities are members and also a wide variety of primary care organisations e.g. the Royal College of Nursing, Community Practitioners' and Health Visitors' Association, National Association of Non Principals, and the Primary Care Pharmacists' Association.



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Contents

SUPPORTING NATIONAL SERVICE FRAMEWORKS

I. MENTAL HEALTH

A Personal Development Programme for Mental Health Commissioners (Lilly)

A programme for developing mental health commissioning skills (London Development Centre for Mental Health)

Primary Care Link Worker Training (Wyeth)

Central Norfolk induction programme for Primary Care Mental Health Link Workers

Well-being Support Programme for Mental Healthcare (Lilly)

A programme for improving the physical health of patients with serious and enduring mental illness

II. OLDER PEOPLE

Managing Medicines in Older People (Pfizer Ltd)

Review of medications by Pharmacists and improving prescribing in over 65 year olds

Nutritional Screening of Older Patients (Abbott)

A programme for developing improved medicines management practices for District Nursing Services (Gloucestershire PCTs)

Establishing an Older Persons' Mental Health Liaison Nurse (Shire Pharmaceuticals)

Setting up a Mental Health Liaison Nurse service for older people with Alzheimer's disease (Adur, Arun & Worthing PCT)

SUPPORTING OTHER KEY CLINICAL AREAS

III. DERMATOLOGY

Seamless Care in Dermatology (LEO Pharma)

Developing a Nurse Managed dermatology service in primary care for chronic disease management

IV. PAIN MANAGEMENT/PALLIATIVE CARE

Cancer Pain: Optimising Management in Palliative Care (Janssen-Cilag Ltd)

Palliative care pain management for advanced and/or metastatic cancer (Lanarkshire PCT)

V. CONCORDANCE

From Compliance to Concordance (Merck Sharp & Dohme)

Implementing medicines-taking concordance (Medicines Partnership Task Force)

Produced in association with



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A Personal Development Programme for Mental Health Commissioners



The Issue

The London Development Centre for Mental Health is a relatively new organisation, which started work on 1 July 2002. It aims to support the improvement of mental health (MH) and mental health services in London. It is also one of eight regional development centres across England, which are part of the National Institute for Mental Health in England (NIMHE), set up by the Department of Health's Modernisation Agency.

As a statutory sector body, the London Development Centre has a brief that is wider than the NHS, and includes local government and the voluntary sector. It works closely with the Directorate of Health and Social Care, London (DHSC) and London's stakeholders through its stakeholder steering group. This incorporates representation from a range of agencies involved in mental health within London. The group is accountable to NIMHE and its own stakeholders through its Management Board. Although employees of the London Development Centre are not inspectors, performance managers or consultants, they do contribute to performance improvement.

One of the national programmes of NIMHE is Primary Care. In May 2003, the Development Centre ran an event for commissioning managers. Two issues emerged from this day – firstly: "the need to build mental health commissioning capacity in primary care" and secondly: "the need for a development programme".

Focusing on these issues, the London Development Centre approached the actual executives who were presenting the development programme for the South East, and asked for their help in advancing the development programme project. These presenters were Judy Mallalieu from the South East Development Centre, NIMHE, and a member of Lilly LIAISE (Lilly Initiative for Advice, Information Support and Education).

The Challenge

Consequently, Lilly was invited to work in partnership with the London Development Centre on a development programme for the Commissioners of Mental Health. In July 2003, 31 commissioners representing 26 of London's PCTs and social service departments from local authorities met to design their own development programme. Delegates were asked to work together in groups to achieve four primary objectives:

- To identify the knowledge, skills and attitudes that make a "capable commissioner" of mental health services
- To agree a process for delivering a personal development programme for mental health commissioning managers over the next 12 months
- To reflect on their own personal development needs
- To prioritise the programme content for the next 12 months.

The Outcome

Following this meeting, the key development areas were grouped into five themes, each of which is now a focused area of activity for the London Development Centre for Mental Health:

- Primary Care
- Legal
- Outcomes and Pathways of Care
- Personal and Financial Management
- Modernisation

Discussing the achievements of the meeting, Andy Nash, Director of Strategy and Development, London Development Centre for Mental Health explained:

"The joint partnership between the London Development Centre and Lilly UK is centred on the theme of 'Developing the Capable Commissioner'. This is helping us realise one of our core aims of developing mental health commissioning in London. This is being achieved through our joint work and the highly skilled facilitation provided by LIAISE." At the time, Andy also held the position of Joint Director of Mental Health Social Care, Department of Health. Other direct and indirect benefits to emerge from the project are listed below:

PCT NHS Benefits:

- Defines the ideal 'capable commissioner', as a role model for PCTs
- Encourages a focused programme for improving mental health services
- Provides new commissioners with the confidence and advice to take action

Company Benefits:

- Advances Lilly's profile within London's PCTs and the Department of Health
- Provides the company with in-depth information on mental health services
- Expands the influence of LIAISE for Lilly as a PR vehicle

Increasing Opportunities

Several commissioner delegates involved in the London Development Centre for Mental Health were enthusiastic about the new project. One delegate noted: *"This meeting acknowledged that commissioners do have specific development needs and that we had an opportunity to outline our priorities for future meetings."*

Another delegate stated:

"I am a new commissioner and this gave me the opportunity to develop my understanding of the role, network with colleagues and give me confidence."



NHS and Pharmaceutical Industry Working Together for Patients

Primary Care Link Worker Training



The Issue

- One quarter of routine GP consultations are for people with a mental health problem¹
- 90% of mental health care is provided solely by primary care²
- Each year, one woman in every 15 and one man in every 30 will be affected by depression, and every GP will see between 60 to 100 people with depression^{3,4}

The Challenge

Working in partnership with Norwich City PCT, and utilising previous joint working, Rebecca Bloor, Health Care Development Manager, Wyeth Pharmaceuticals, and Primary Care Link Worker Team Leader, Ray Baird, Norwich PCT, identified the need to develop an initial training programme for the first wave of Primary Care Mental Health Link Workers in Norfolk. These Link Workers cover 4 PCTs in Central Norfolk, Norwich City, Southern Norfolk, North Norfolk and Broadland PCT.

The main aims of the programme are as follows:

- To develop knowledge of primary care, and the Link Worker role within in it
- To consolidate the Link Workers' knowledge of common mental health disorders and the various interventions
- To ensure the Link Workers know how to access the local networks/communities
- To develop Link Worker skills to ensure they are confident to help/influence practices to develop their mental health service
- To develop a six-month plan of action for each locality
- To develop a supportive environment within the team and mechanism to promote the Link Worker role, to ensure further successful development of the service locally and nationally.

Key Actions

In order to meet the needs of the newly appointed Mental Health Primary Care Link Workers, a 14-day induction programme was developed. Norwich City PCT and Wyeth Pharmaceuticals jointly funded the programme.

The programme was based on previously identified core competencies utilising NHS personnel and Wyeth's industry expertise in training and in mental healthcare. In particular Wyeth provided training to the Primary Care Mental Health Workers on team working, influencing skills and presentation skills. Sessions from Wyeth's local Clinical Liaison Manager and Healthcare Development Manager were incorporated into the induction programme.

The Outcome

In May 2003, the project leads had effectively developed and initiated the running of the induction-training programme for the new Mental Health Primary Care Link Workers. This ensured all workers enrolled on the programme were provided with core skills for their roles in primary care.

After just six months, evidence of the mental health programme's success was evident across all 20 of the primary care practices involved. This saw the establishment of relevant patients groups, referral guidelines, treatment guidelines, an integrated care pathway, joint assessments and training, and the adoption of Neurolink self-help materials with patients, as well as significant reduction in secondary care referral rates.

Patient Benefits:

- Creating greater overall patient choice for those people in primary care with mental health illness
- Ensuring patients are less likely to be referred to secondary care services and are treated in primary care, which is less stigmatising
- Empowering patients to participate in their own care by using self-help materials and patient support groups

NHS Benefits:

- Development of experienced Mental Health Workers, to expand skills to fulfil their new role
- Specifically developed skills of Mental Health Workers to treat patients holistically and work in an integrated way
- Development of skills to support, and developing skills within the primary care team, thereby building capacity into the service

Company Benefits:

- Provided a major opportunity to work with Link Workers and primary care professionals in areas of common interest, such as depression and anxiety
- Increased the company's community profile with regional PCTs and NHS bodies
- Allowed Wyeth to expand its knowledge of the needs and views of Link Workers.

Further PCT Interest

"The overall service development has been extremely successful in building capacity and improving the patient experience with depression and anxiety in primary care. The induction programme was extremely successful and we have been approached by other PCTs – for example Great Yarmouth and Bedfordshire Heartlands – who are interested in the Link Worker model, and particularly with the induction programme" noted Ray Baird, Link Worker Team Leader, Norwich City PCT and NIHME Primary Care Fellow.

References:

1. Goldberg D and Bridges K. Screening for psychiatric illness in general practice: the general practitioner versus the screening questionnaire. *Journal of the Royal College of General Practitioners* (1987);37: 15-18.
2. Goldberg D and Huxley P. *Common mental disorders : A biosocial model*. Routledge, London, (1992).
3. Meltzer H, Gill B, Petticrew M and Hinds K. *OPCS Survey of Psychiatric Morbidity in Great Britain, Bulletin No 1 HMSO, London, (1994)*.
4. Wing J and Bebbington P. Epidemiology of depressive disorders in the community. *Journal of Affective Disorders* (1982); 4: 331-345.

NHS and Pharmaceutical Industry Working Together for Patients

Well-being Support Programme for Mental Healthcare



The Issue

In December 2002, the National Institute for Clinical Excellence (NICE) issued a Clinical Guidance report, which expresses concern about the physical health of patients with severe mental illness (SMI). The report also lays out guidelines for SMI treatment. Its central theme is that mental health services and general practitioners need to pay more attention to SMI patients' physical well-being.

At present, the NSF (National Service Framework) for Schizophrenia defines physical healthcare as a priority for these patients. However, most individuals with SMI actually rarely undergo physical health checks. As a result, the rate of mortality in SMI is 1.5 times higher than the general population. Approximately 20% of deaths in SMI people are due to so-called "unnatural" causes, such as accidents or suicide. Around 80% of SMI deaths are caused by so-called "natural" causes – such as cardiovascular disease, cancer, diabetes and dyslipidaemia. Many experts conclude that it is the lack of physical care that could actually be responsible for such deaths.¹

The Challenge

In March 2003, Lilly UK launched the "Well-being Support Programme" as a pilot scheme for mental health services in the UK. This scheme also involved senior executives from various UK PCTs, including: Leeds; North Yorkshire and Teesside; Birmingham and Solihull; Coventry Mental Health; East London (Hackney); South London and Maudsley; Dorset; and North Glamorgan.

Organisers will seek to enrol a total of 1,200 patients over two years at eight sites across the UK. The programme will then aim to improve the lifestyles of patients suffering with a serious and enduring mental illness. These objectives comply with the recommendations made by NICE and the NSF for Schizophrenia. Lilly's Well-being Support Programme will address these issues by concentrating on three key areas:

- Lifestyle assessment and interventions – e.g. smoking, weight management, and physical activity
- Side effect assessment and management – e.g. understanding the impact of side effects and helping patients to manage them
- Physical health assessment – providing a basic physical health check including blood pressure, weight, height, and pulse rate

The Outcome

Lilly UK launched the programme in March 2003. By the end of 2003, eight national sites had enrolled over 1,000 patients with the aim of recruiting 1,200 patients over two years. Each trust has set up groups for weight management and physical activity. Over 100 patients are now benefiting from these groups each week.

Patient Benefits:

- Improves physical quality-of-life through total SMI patient approach
- Limits distressing medication side effects by formal monitoring/rating
- Encourages health by managing weight, smoking, exercise, activity

PCT NHS Benefits:

- Creates extra highly skilled RMN resource
- Integrates primary and secondary care of SMI cases
- Produces patient data to support local decision making
- Creates replica model for overall health check

Company Benefits:

- Advances Lilly's profile within the local PCTs, primary and secondary care
- Reinforces prescribing of the company's SMI products
- Provides company with in-depth data on SMI healthcare

Development and Scope

Lead psychiatrists and healthcare professionals from the pilot sites have contributed to the project development and scope. They continue to meet regularly to share examples of "best practice" and to determine the future direction of the programme. The data collected through the programme will provide a strong evidence base for professionals wanting to develop similar services elsewhere in the UK.

Customer Feedback

As one of the clinical supervisors for the Well-being Support Programme in East Cleveland, Suzanne Hudson shares her thoughts on the programme so far:

"The Well-being Support Programme offers a fantastic opportunity for us to address real quality-of-life issues for our patients with severe mental illness. It also helps us meet a number of NSF targets, not only in mental health but also in chronic heart disease and diabetes. Hopefully, the enormous benefits demonstrated by this valuable innovative project will prompt NHS managers to invest in similar initiatives nationally."

Reference:

1. Harris EC and Barraclough B. Excess mortality of mental disorder. B J Psych (1998); 173: 11-53.



NHS and Pharmaceutical Industry Working Together for Patients

Managing Medicines in Older People



The Issue

In 2001, the National Service Framework (NSF) for Older People¹ set out two important milestones for medication review in its section on Medicines and Older People. These were:

- By 2002, all people over the age of 75 years should have their medications reviewed at least annually, and those taking four or more should have a review six-monthly
- By 2004, every PCT will have schemes so that older people get more help from pharmacists in using their medicines

Helping patients to get more from their medicines has become a common theme since the "NSF for Older People" was originally published. This was reinforced by the Medicines Partnership in their booklet "Room for Review: A Guide to Medication Review"² which identified medication review as 'a cornerstone of medicines management'. As experts in medicines, it is an area where the industry is well placed to work together with the NHS.

The Challenge

Recognising this, Pfizer Ltd established a Medication Review Team in 2003. This team aims to support primary care organisations (PCOs) in improving the quality of prescribing for patients over the age of 65. As a service to medicine a team of pharmacists, employed through a third party (Healthgain Solutions), are specifically trained to undertake medication reviews and work on behalf of the PCO in identified practices.

Following each review, the pharmacist makes recommendations to each patient's GP, in line with national and local prescribing guidelines. The pharmacist will subsequently re-review the patient to assess how effectively the recommendations have been implemented.

Objectives

In designing this programme, Pfizer took full account of the developments in medicines management and the expressed needs of the primary care trusts (PCTs). A pilot project was also conducted over an eight-week period to help define the team's key objectives and the outcomes for the PCTs. The shared objectives for the programme are as follows:

- To address the medication review milestones of the NSF for Older People
- To improve the quality of prescribing for patients by:
 - Ensuring dose and frequency regimes are in line with patients' needs
 - Ensuring specific disease risk factors are adequately addressed
 - Rationalising prescriptions to reduce the number of different medicines each patient takes
 - Identifying any unmet medicines needs
 - Improving patient concordance

Key Actions:

Pfizer Ltd has received highly positive feedback from the pilot project and follow-up sites. During the pilot, which involved two PCTs, 2,330 medicines in 342 different patients were reviewed, of which just over 900 prompted a recommendation for action. Subsequent follow-up identified that 90% of recommendations from the pharmacists were implemented by the practice. It also found that the patients in the target groups took an average of seven different medicines, highlighting the need for effective review in the face of complex prescribing.

Patient Benefits:

- Helps patients to get more from their medicines
- Ensures dosing and frequency are suitable for patients' needs
- Highlights the need for effective medication review in older people
- Reduces the number of different drugs each patient takes

PCT Benefits:

- Supports achievement of milestones within the NSF for Older People
- Improves the quality of prescribing in the target patient population
- Sharing of medication review expertise with the PCT

Anticipated Progress

This programme is currently in the implementation phase and Pfizer is working in partnership with 11 PCTs around the country. It is anticipated that it will extend into supporting PCTs and GP practices by addressing the new quality and outcomes framework contained in the new GMS Contract.

A further part of the programme will be to use the team to train other pharmacists within the PCT on conducting medication reviews, thus ensuring that expertise is shared and developed across each locality. Such actions would maintain the theme, already seen in several PCTs, in which the service is used to complement other activities and fully integrate it into the PCT's ongoing work.

Daily Feedback

Commenting about the programme's impact on a local basis, one PCT pharmacist said: *"From my experience at this practice, leaving reviews with the GP to action was not working well as it could take months to get any feedback. Now we arrange for the pharmacist to have daily meetings with a GP to discuss any recommendations and the GP then asks the pharmacist to action those agreed."*

References:

1. National Service Framework for Older People, Department of Health, (March 2001).
 2. "Room for Review: A Guide to Medication Review, the agenda for patients, practitioners and managers" TASK force on Medicines Partnership and The National Collaborative Medicines Management Service Programme, Medicines Partnership, (2002).
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NHS and Pharmaceutical Industry Working Together for Patients

Nutritional Screening of Older Patients



The Issue

Although the recognition of malnutrition in clinical care is not new, recent research indicates that "malnutrition remains largely unrecognised" and "all too common in hospitals".¹ However, in the last decade, experts have learned much about the nutritional needs and shortcomings in health care for older people. Malnutrition in the elderly is now recognised as an unnecessary burden that can be prevented.

Studies also estimate the significant clinical and economic consequences of undernutrition in elderly hospital patients.² Length of hospital stay is significantly increased in patients who are malnourished on admission to hospital (mean stay = 8.9 days vs 5.7 days ($p < 0.001$)).² Very low nutrient intakes are also a common problem among older people living alone or in nursing homes.³

The Challenge

Acknowledging this nationwide issue on a local basis, Gloucestershire PCTs recognised that the use of nutritional supplements in its regional elderly patients was poorly managed, producing variable access to treatment as well as inconsistent patient outcomes. Gloucestershire's PCTs initially approached Abbott Laboratories for nutritional expertise and support. Together, they launched a new project: "Nutritional Screening of Older People". Their plan was to initiate a nutritional pilot project, which if successful, would then be rolled out across other PCTs. Under this plan, the major objectives were to:

- Investigate existing management and identify patients at risk of malnutrition
- Develop improved nutritional management practices
- Instigate a staged implementation (pilot then full PCT-wide roll-out)
- Monitor the results and evaluate the impact of change

An initial steering group was organised out of the PCT Prescribing Committee – headed by a dietitian, primary and secondary care members, and Abbott representatives. The project was also linked to patient screening in Standard 2 of the NSF for Older People – independent living.

Key Action Points

The new steering group initiated the project by introducing a validated Malnutrition Advisory Group (MAG) nutritional screening tool for the pilot project.⁴ It also assigned the pilot under the care of the District Nursing Services for Gloucestershire PCTs.

All patients on the district nurse caseload were screened and their body mass index measured. Clinical experts compiled the results of the pilot phase, and presented these to the steering group. Following analysis of the pilot data, the group decided to introduce the new screening programme across three PCTs. A structured nutritional education plan was developed with the chief dietitian and the PCT nurse managers. After scheduling

organised meetings for each of the PCTs, the steering committee launched the new programme.

The Outcome

An audit of the new programme clearly indicated its outstanding success. In total, 66 patients were evaluated with the nutritional screening tool (86% over the age of 65). Of these, 27 patients (40%) were identified in the medium-to-high-risk categories of malnutrition. Structured nutritional advice was given to 22 patients, and nutritional supplements were recommended for 10 patients.⁵ Specific patient, PCT and company benefits from the programme are listed below:

Patient Benefits:

- Increased treatment access: all patients identified at risk received appropriate care
- Enhanced patients' clinical outcomes (e.g. pressure sore resolution)⁵

PCT NHS Benefits:

- Improved medicines management in supplementary feeding for elderly patients
- Complies with nursing standards set out in Essence of Care⁶
- Increased awareness of nutrition within primary care
- Reduced inappropriate referrals to dietitians, and improved service capacity

Company Benefits:

- Reinforces appropriate prescribing and usage of Abbott Laboratories' nutrition products
- Increases Abbott's profile within the local PCTs, with patients and district nurses
- Expands Abbott's insight into nutritional requirements of the elderly

Current Status

The Nutritional Screening of Older People project continues to thrive in Gloucestershire PCTs. Based on its audited results, it could potentially be used in any PCT or local health economy, with the aid of a support package.

References:

1. McWhirter JP, Pennington CR. Incidence and recognition of malnutrition in hospital. *British Medical Journal* (1994); 308: 945-948.
2. Edington J, Boorman J, Durrant EJ, *et al.* Prevalence of malnutrition on admission to four hospitals in England. The malnutrition prevalence group. *Clinical Nutrition* (2000); 19(3): 191-195.
3. National Diet and Nutrition Survey: people aged 65 years and over. Finch S *et al.* London Stationery Office (1998); 193, 195, 197, 270.
4. Malnutrition Advisory Group of the British Association of Parenteral and Enteral Nutrition.
5. Data on file.
6. The Essence of Care – patient-focused benchmarking for clinical governance. Department of Health, April 2003.



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NHS and Pharmaceutical Industry Working Together for Patients

Establishing an Older Persons' Mental Health Liaison Nurse



The Issue

The medical management of older people with both mental and physical health problems can often be sub-optimal. Service initiatives for this group fall between two disciplines, and are not typically prioritised by general acute or mental health trusts. In 1997, the success of a mental health liaison nurse for adults of working age in the Adur, Arun & Worthing area, which includes a population of 227,000 people, suggested a similar post was needed for its older people's services. Although supportive, however, the local area was unable to provide funding due to other budget pressures.

In 2001, the NSF for Older People further confirmed a national need for this service, when it recommended that "general hospitals must meet all the health needs of older people" but without attention to their mental health this could not be achieved. In January 2002, the Adur, Arun & Worthing Teaching PCT Older Persons' National Service Framework local implementation team (NSF-OP LIT) was formed, and supported setting up the project.

The Challenge

In March 2002, Dr Catherine Quinton of West Sussex Health & Social Care NHS Trust and consultant lead for the project, presented this proposal to the local development manager for the Dementia Link initiative. Dementia Link facilitated a series of service development projects during 2002/2003, operated nationally by Shire Pharmaceuticals.

The OPMH nurse liaison project in the Adur, Arun & Worthing area aimed to provide better awareness of how to support Alzheimer's disease patients and carers in the general hospital setting. Dementia Link provided Adur, Arun & Worthing with one year's "start-up" funding, and ongoing project management support, including evidence-based assessment of the project outcomes. A G grade 1FTE nurse was employed by the independent agency, Healthgain Solutions of Newbury.

Key Actions

The project began in January 2003, and the role was divided between two local NHS nurses as a job share. A multi-disciplinary steering group was formed to meet fortnightly, with five hours of added secretarial time. The project's core objective was to meet the NSF-OP targets by providing evidence of the following:

- An older people's focus throughout the hospital
- Improvements against access and capacity targets
- Creation of a whole systems approach, improving patient experience, while alleviating pressure on clinical time in the outpatient memory clinics

The Outcome

By January 2004, the project had already proved highly effective: 1) referral rates had increased by 10%; 2) most patients were seen within 3 working days; 3) customer surveys confirmed an increase in the quality of liaison care; 4) evidence showed that the nurse alone could manage 75% of the cases, without specialist psychiatry time; 5) resource efficiency increased as referrals were no longer seen *ad hoc* by whichever psychiatrist was available. Moreover, the success of this OPMH liaison nurse project means the PCT have confirmed funding for a further year. Longer term funding is being sought as part of the PCT's local delivery plan.

Patient Benefits:

- Increased access to specialist psychiatry services
- Increased follow-up consultations with a specialist OPMH liaison nurse
- Faster access to a psychiatry assessment

NHS Benefits:

- Provided staff recruitment; supported personnel management
- Project management expertise supplied on an ongoing basis for the year
- Promoted longer-term goal of local NHS/voluntary sector funding
- Shared knowledge of best practice procedures from other locations

Company Benefits:

- Increased knowledge of dementia management in hospitals
- Better understanding of competing pressures, which may affect future business
- Personal development opportunities for staff involved in the project education
- Increased credibility as a genuine partner in dementia service provision

Relieved Pressures

Commenting on the project's outstanding results, Dr Quinton says: *"This initiative has relieved pressures on both psychiatric services and general medical wards, whilst allowing more elderly mentally ill patients to be seen more quickly. The nurse assessments are of high quality and the nurse presence is highly valued by all staff"*. Colin Lindridge, Head of Service OPMH AAW and Mid Sussex, adds: *"This pilot has demonstrated the need for OPMH professionals to be working in acute hospital settings to ensure that older people in these care settings have all of their needs met appropriately"*.

Current Status

The Adur, Arun & Worthing Liaison project was one of a series of several service support agendas supported by Dementia Link during 2002/2003. This community programme continues to evaluate the medium-to-long-term impact of these different service initiatives.



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NHS and Pharmaceutical Industry Working Together for Patients

Seamless Care in Dermatology



The Issue

In 1997, the All Party Parliamentary Group on Skin (APPGS) issued a report that recommended major changes for the development of dermatology services in primary care.¹ The APPGS stated that many skin disorders, such as eczema and psoriasis, could be effectively managed at primary care level, with sufficient staff training and expertise. This would increase dermatologists' and clinics' time for more serious or rare cases, make better use of scarce resources and, most importantly, provide "speedy and effective treatment for patients close to home".

The Group also suggested that health authorities and primary care groups should reconsider the role of the different medical professionals, such as GPs, specialists, nurses and pharmacists for a more rounded care of skin problems. Unlike asthma and diabetes, dermatology has often "missed out on funding of chronic disease management clinics in primary care". The APPGS therefore recommended that this should attract an additional payment from local health authorities for specialist clinics.

The Challenge

LEO Pharma followed up the APPGS dermatology recommendations in March 1999 by initiating a pilot project in cooperation with GP Dr Ian Greaves and his primary care team at Gnosall Surgery (PMS Plus site), Gnosall, South Staffordshire.

The project, "Seamless Care in Dermatology", was designed to create and analyse the development of a nurse-managed dermatology service for the management of chronic skin problems in primary care. Its main objectives were to improve patient outcomes and optimise the therapy that patients receive for eczema, psoriasis and acne by developing a nurse-managed, patient-centred, primary care-based service. The service would also offer advice on topical management as well as patient education.

Initial Findings

As part of the project, analysis of dermatology services in Gnosall Surgery revealed a very high demand for skin care consultations. This included unacceptably long waiting lists for a specialist opinion – in some cases up to 38 weeks. PACT (Prescribing Analysis & Cost) analysis also illustrated high use of topical steroids. Furthermore, patient compliance with topical therapies was found to be poor. The need for better dermatology training to meet Continuous Professional Development (CPD) requirements for all medical staff was also highlighted.

Key Actions:

"Seamless Care in Dermatology" was carried out from March 1999 to June 2000. Clinical, educational and corporate governance standards were maintained at all times. The following key actions were undertaken to achieve its objectives.

Dermatology

Dermatology

- **Dermatology nurse training:** LEO Pharma provided a Dermatology Nurse Specialist to educate and train the Gnosall medical and nursing staff over a 12 month period.
- **Provision of project managers:** Gnosall and LEO provided project leads who worked together to develop the project and service issues.
- **Use of patient feedback:** Quality of life and patient satisfaction questionnaires were developed and used to gather patient feedback.
- **Patient involvement:** To encourage patient involvement, the project created individual skin care plans and encouraged patients to keep diaries of their conditions.
- **Audit assessment:** An audit of dermatology patient management at Gnosall regarding the project was conducted. A subsequent PACT analysis was also carried out.

The Outcome

These actions generated various benefits for chronic skin care patients and Gnosall Surgery.

Patient Benefits:

- High positive patient feedback
- Full booking of all nurse-managed dermatology clinics at the surgery
- Dramatic improvement in quality of life, at a minimal increase in prescribing cost
- Accessible and prompt primary care service for patients who would have previously been referred to secondary care

Surgery Benefits:

- Developed an enthusiastic, motivated nursing team
- Produced 13% reduction in specialist referrals during the project phase
- Currently no waiting list for uncomplicated acne, eczema or psoriasis
- Increased medical and nursing education and awareness
- Increased medical-patient communication and therefore fluidity of care

Company Benefits:

- Enhanced understanding of NHS service reconfiguration processes and project management
- The ability to refer other interested NHS managers and clinicians to a proven, replicable, care template
- LEO topical dermatologicals are used properly by patients, optimising clinical outcomes

Dr Ian Greaves, Lead GP, Gnosall Surgery says: *"The nurse-run clinics have proved popular with patients and improved patient education and patient compliance, which in turn have improved outcome measures for common dermatological conditions. We have also been able to work with our local pharmaceutical advisers to meet their required prescribing criteria"*.

Reference:

1. All Party Parliamentary Group On Skin (March 1997) – An investigation into the adequacy of service provision & treatments for patients with skin diseases in the UK, London: APPGS.



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Cancer Pain: Optimising Management in Palliative Care

The Issue

Recent European and US studies show that pain management in cancer centres, including palliative care, is “frequently suboptimal”.¹ Pain often increases towards the final stages of advanced cancer, causing a negative impact on health-related quality of life (HRQL). Most patients with advanced cancer spend the last year of their lives at home. Therefore, GPs, district nurses, and other members of the primary care team have an important role in maintaining continuity of palliative care, and reducing cancer pain to maximise HRQL. In many patients, dealing with cancer pain is also an “unnecessary burden” that can be prevented with efficient palliative care.²

Recognising a Need

Janssen-Cilag Ltd recognised the need for improved guidance for primary care professionals regarding pain management in advanced cancer cases. Therefore, in 2000, the company established an ongoing partnership with Lanarkshire Primary Care Trust who provide a range of services, including mental health, learning disabilities, paediatric and primary and community care to the people of Lanarkshire (550,000 population). At that time, an audit of pain management in advanced or metastatic cancer was being piloted as a support mechanism, with funding from the Scottish based Clinical Resource Audit Group (CRAG) for a six-month period. To further develop the project, Janssen-Cilag Ltd awarded an educational grant to Lanarkshire PCT.

The Challenge

The aim of the study was to provide the PCT palliative care team with practical guidance on pain management using a local guideline. It also aimed to audit the efficacy of the guideline by use of a simple audit form. The audit form was designed to both encourage implementation of the analgesic stepladder and to provide a record of pain management for independent audit.

Mutual Goals and Methods:

Working together, this industry-PCT partnership aimed to achieve the following goals:

- An audit of current practice: through the development and redesign of a pilot audit tool and the relaunch of the general initiative across the PCT
- Appropriate prescribing in line with recommendations: using the development of guidelines in line with the latest evidence (SIGN 44), and an audit of the results
- Educational support based on audit results: via the identification of those areas of educational need for the whole care team, and provision of monthly feedback
- Improved patient care: achieved by first ensuring appropriate prescribing, educating the palliative care team practice and improving their knowledge and awareness. Accordingly, this would improve patient care.



The Outcome

After a collaborative team-effort, the project produced a range of advantages for the study's patients, Lanarkshire PCT and Janssen-Cilag Ltd:

Patient Benefits:

- Improved pain management
- Better patient education strategy
- An opportunity to provide patient feedback
- Increased health-related quality of life

PCT NHS Benefits:

- Creation of baseline audit data
- Improved multi-disciplinary working
- Enhanced patient care
- Publication of the project
- Use of project design to inform SIGN 44

Company Benefits:

- A higher profile within the local Primary Care Trust and NHS
- Reinforcement of appropriate prescribing of the company product

An Ideal Model

The initial Janssen-Cilag educational grant allowed this study to move from the pilot phase through to full project status. It also complemented the Scottish Cancer Plan and the National Cancer Strategy, and has been published as a clinical paper in the journal, Palliative Medicine. Furthermore, the project was recently considered as an ideal model for palliative care and pain management studies for other PCTs in Scotland, and PCOs in England.

Overcoming Scepticism

Although the initial project is now finished, the partnership between Lanarkshire PCT and Janssen-Cilag Ltd still continues. Commenting on the study's success, and on the PCT's involvement, Robert Duncan, Clinical Governance Co-ordinator and Pain Management Audit Lead says:

"I had initial scepticism about working as closely as this with the pharmaceutical industry. However due to the professionalism of the individuals concerned, I was reassured enough to set about writing a formal business plan, in conjunction with the local BDM Fiona Hamill. Throughout the life of the project this collaborative working has evolved into a 'true partnership' with all that it entails."

References:

1. Larue F, Colleau SM, Brasseur L, Cleeland CS. Multi-centre study of cancer pain and its treatment in France. *BMJ* (1995);301(6986):1034-37.
2. Bostrom B, Sandh M, Lundberg D, Fridlund B. A comparison of pain and health-related quality of life between two groups of cancer patients with differing average levels of pain. *J Clin Nurs* (2003) Sep;12(5):726-35.

NHS and Pharmaceutical Industry Working Together for Patients

From Compliance to Concordance



The Issue

Recent studies have produced limited success in understanding the causes of non-compliance, i.e. why patients do not take their medicines. In addition, there has been little success in finding approaches that are consistently effective in overcoming the problem. A number of different factors have been associated with compliance issues including race and social support but no demographic characteristics have yet been found to be predictive for individual patients. According to the Audit Commission in 2001, "one quarter of hospital readmissions are because of non-compliance with medicine regimes".¹

The Challenge

In 1995 the Royal Pharmaceutical Society (RPS) and Merck Sharp & Dohme (MSD) embarked on a collaboration to examine what was known about the barriers to patients taking medicines as they are prescribed. The intention was to review the reasons why patients stopped taking their medicines and to make recommendations about how compliance could be improved. A joint steering group was established to consult a large number of individual healthcare professionals and researchers with a particular interest in this area. Patient groups were also consulted via focus groups that examined the patient perspective on this issue in depth.

Key Actions

1995 - 1997	Working Group enquiry into what was known about the difficulties patients have in taking medicines as they are prescribed.
1997	Publication of influential report "From Compliance to Concordance" and a new term, 'concordance' introduced.
1998 - 2001	Concordance Co-ordinating Group, based at the RPSGB, conducts further research on concordance.
September 2000	The NHS Pharmacy Programme <i>Pharmacy in the Future</i> proposed a national strategy on patient partnership in medicines taking.
2000 - 2003	The Pharmaceutical Industry Competitiveness Task Force (PICTF) considered areas of concordance and patient information, producing an action plan in line with the "Pharmacy in the Future" programme for the final PICTF report.
April 2001	Joint Task Force announced by Lord Hunt.
January 2002	First meeting of the Medicines Partnership Task Force.

Concordance

Concordance

The Outcome

In 1997 the influential report entitled "From Compliance to Concordance" was published.² Conclusions showed that some of the most challenging barriers to overcome regarding compliance are the differences between what the patient believes in terms of understanding diagnosis and proposed treatment – and the beliefs of the health professional. The various benefits of concordance and areas where partnership between patients and prescribers can improve compliance are listed below:

Patient Benefits:

- Provides patients with clear, tailored, accurate and detailed drug information
- Helps ensure patients understand the medicines they are taking and know how to follow their course of treatment
- Addresses practical difficulties and ensures joint actions are agreed with patients

Prescriber Benefits:

- Regular patient reviews keep prescribers up to date on compliance and potential problems
- Helps ensure information is shared effectively between health professionals
- Encourages better compliance, and helps keep prescription costs down

Company Benefits:

- Expands MSD's awareness of medical compliance issues

Current Status

Many of the ideas developed by this Working Group as a result of the partnership between the RPSGB and MSD are now subsumed in the Department of Health's Medicines Partnership initiative. This imaginative and forward thinking initiative brings together NHS and health professional, consumer and industry groups to enable patients to get the most out of medicines by involving them as partners in decisions about treatment and supporting them in medicine taking. Most significant among its achievements has been its involvement in and support for the first UK Ask About Medicines Week. Details of the Medicines Partnership and Ask About Medicines Week can be found at www.concordance.org

References:

1. The Audit Commission (2001): A spoonful of sugar: medicines management in NHS hospitals.
 2. "From Compliance to Concordance: Achieving Shared Goals in Medicine Taking", (March 1997). Available from www.medicines-partnership.org/about-us/history--context.
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