

## NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

**SCOPE****1 Guideline title**

Medicines concordance: involving adults in decisions about prescribed medicines

**1.1 Short title**

Medicines concordance

**2 Background**

- (a) The National Institute for Health and Clinical Excellence ('NICE' or 'the Institute') has commissioned the National Collaborating Centre for Primary Care to develop a clinical guideline on medicines concordance for use in the NHS in England and Wales. This follows referral of the topic by the Department of Health (see appendix). The guideline will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.
- (b) The Institute's clinical guidelines will support the implementation of national service frameworks (NSFs) in those aspects of care where a framework has been published. The statements in each NSF reflect the evidence that was used at the time the framework was prepared. The clinical guidelines and technology appraisals published by the Institute after an NSF has been issued will have the effect of updating the framework.
- (c) NICE clinical guidelines support the role of healthcare professionals in providing care in partnership with patients, taking account of their individual needs and preferences, and ensuring that patients (and

their carers and families, where appropriate) can make informed decisions about their care and treatment.

### 3 Clinical need for the guideline

- a) The number of prescription items in the NHS increased from 686 million in 2004 to 720 million in 2005, an increase of 34 million, or 5.0%. Between 2004 and 2005, the net ingredient cost of prescription items dispensed fell by £143 million (1.8 per cent) to £7937 million, compared with an increase of 7.6 % in the previous year.
- b) Reviews conducted across disease areas and countries suggest that at least 30–50% of prescribed medication is not taken as recommended, and that non-adherence is often undisclosed by patients and unrecognised by prescribers.
- c) Recent work by Horne (2005)<sup>1</sup> highlighted the complexity surrounding the terminology used when discussing medication-taking behaviours. The three key definitions used in Horne's paper are as follows.
  - Adherence – 'the extent to which the patient's behaviour matches **agreed** recommendations from the prescriber'.
  - Compliance – 'the extent to which the patient's behaviour matches the **prescriber's** recommendations'.
  - Concordance – 'a wider concept which stretches from prescribing communication to patient support in medicine taking'.
- d) Several reasons underpin non-adherence to medical prescriptions, including adverse effects, poor instructions, poor provider–patient

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<sup>1</sup> Horne R (2005) Concepts and terminology. In: Horne R, Weinman J, Barber N et al, *Concordance, Adherence and Compliance in Medicine Taking – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development*. [www.sdo.lshtm.ac.uk](http://www.sdo.lshtm.ac.uk), pp 27-37.

relationship, poor memory, patients' disagreement with the need for treatment or inability to fund it.

- e) Current methods to improve adherence in long-term conditions are quite complex and have little effect, as reported by the latest Cochrane review on interventions for enhancing medication adherence. Similarly, the scoping review commissioned by the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (2005), concluded that the evidence on interventions for adherence was limited. Both the reviews showed that there was little evidence on the effectiveness of interventions to improve adherence to medication for long-term conditions within the clinical setting. Despite this, the SDO report does give some suggestions about how to improve interventions in the future.
- f) There is evidence of significant differences in patterns of prescribing and of variation in adherence to recommended good practice among healthcare practitioners: 'this not only relates to differences in what is prescribed for the same condition but also in the amount and level of information which is provided about prescribed medications'<sup>2</sup>.

## 4 The guideline

- a) The guideline development process is described in detail in two publications that are available from the NICE website (see 'Further information'). 'The guideline development process: an overview for stakeholders, the public and the NHS' describes how organisations

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<sup>2</sup> O' Brien M (1997) Compliance among health professionals. In Baum A, Newman S, Weinman J et al. editors *Cambridge Handbook of Psychology, Health and Medicine*. Cambridge: Cambridge University Press  
cited by Weinman J, Horne R (2005) Patient provider interaction and health care communication In: Horne R, Weinman J, Barber N et al, *Concordance, Adherence and Compliance in Medicine Taking – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development*. [www.sdo.lshtm.ac.uk](http://www.sdo.lshtm.ac.uk), pp 61-8.

can become involved in the development of a guideline. 'The guidelines manual' provides advice on the technical aspects of guideline development.

- b) This document is the scope. It defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health (see appendix).
- c) The areas that will be addressed by the guideline are described in the following sections.

## **4.1      *Population***

### **4.1.1    Groups that will be covered**

- a) Adults (18 years and older) with long-term medical conditions seen commonly in primary and secondary care, including people with comorbidities.

### **4.1.2    Groups that will not be covered**

- a) Children and young adults (younger than 18 years).
- b) Patients being treated in specialist or tertiary centres, or undergoing specialist treatment regimes not normally delivered in a generalist primary or secondary care setting.

## **4.2      *Healthcare setting***

- a) Primary care, including community care.
- b) Outpatient settings in secondary care, excluding tertiary care.

### 4.3 *Areas that will be covered*

- a) Concordance in prescribing decisions and medicine taking as reported by the patient. The guideline will focus on the barriers (such as communication difficulties or cultural issues), facilitators (including structural or procedural factors), beliefs and health behaviours that influence concordance. This will be structured according to the stage in the care pathway: before, during and after the consultation with a healthcare professional.
- b) Concordance in prescribing decisions and medicine taking as reported by the healthcare professional. The guideline will focus on the barriers (such as communication difficulties or cultural issues), facilitators (including structural or procedural factors), beliefs and health behaviours that influence concordance. This will be structured according to the stage in the care pathway: before, during and after the consultation with a healthcare professional.
- c) The effectiveness and cost effectiveness of interventions to promote concordance in prescribing decisions and medicines taking (looking at time of intervention – before, during, or after the consultation with the healthcare professional; mode of delivery). The target of the intervention may be the patient, the prescriber, a healthcare professional providing ongoing support or a combination of these.
- d) The effectiveness and cost effectiveness of interventions to promote adherence in medicines taking (looking at time of intervention – before, during, or after the consultation with the healthcare professional; mode of delivery). The target of the intervention may be the patient, the prescriber, a healthcare professional providing ongoing support or a combination of these.

Interventions to increase adherence, **without** achieving concordance, will be included only if they address barriers, beliefs or behaviours identified in the reviews above. For example,

interventions using pill reminder tools (such as dosset boxes) will be included only if the evidence shows that people find a complex medication regime a barrier to appropriate medicine taking.

- e) The guideline development group will take reasonable steps to identify ineffective interventions and approaches to care. When robust and credible recommendations for re-positioning the intervention for optimal use, or changing the approach to care to make more efficient use of resources, can be made, they will be clearly stated. When the resources released are substantial, consideration will be given to listing such recommendations in the 'Key priorities for implementation' section of the guideline.

### ***Areas that will not be covered***

- a) Emergency treatment.
- b) Medicines prescribed for acute (short-term) conditions (such as a single course of antibiotics).

## **4.4 Status**

### **4.4.1 Scope**

This is the consultation draft of the scope. The consultation period is from 30 October 2006 to 27 November.

### **4.4.2 Guideline**

The development of the guideline recommendations will begin in January 2007.

## **5 Further information**

Information on the guideline development process is provided in:

- 'The guideline development process: an overview for stakeholders, the public and the NHS'
- 'The guidelines manual'.

These booklets are available as PDF files from the NICE website ([www.nice.org.uk/guidelinesprocess](http://www.nice.org.uk/guidelinesprocess)). Information on the progress of the guideline will also be available from the website.

## Appendix: Referral from the Department of Health

The Department of Health asked the Institute to develop a guideline:

‘... on involving patients in decisions about prescribed medicines. The guidelines should cover:

- Approaches to achieving informed agreement between the prescriber and the patient on medicines to be taken
- Communication with patients around medicine-taking, including the provision and use of medicines information
- Dealing with poly-pharmacy and co-morbidity
- The skills and competencies required by prescribers
- Medication Review.’