Bowel

Interest Group

Importance of Adherence Report 2021

The Bowel Interest Group is an independent multi-disciplinary organisation dedicated to improving bowel health.

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Welcome from the **Bowel Interest Group**

That patients will adhere to prescribed therapy is something that many healthcare professionals (HCPs) take for granted. However, a multitude of data covering a range of therapies and a range of clinical contexts have shown that it is easier to give advice than it is to monitor that the advice is being followed. This is especially true for chronic conditions, and possibly for bowel conditions where the symptoms are often intermittent. Bowel symptoms are also somewhat taboo, so it is easy to imagine that once symptoms temporarily abate there is a temptation to ignore their existence and 'return to normal' without adhering to the initial treatment.

This report focuses on adherence to devices and medications in four areas: transanal irrigation for bowel dysfunction; inflammatory bowel disease; pancreatic exocrine insufficiency, and pelvic floor training for treating pelvic floor muscle dysfunctions including lower bowel dysfunctions. Checking that patients adhere with therapy is not something that many HCPs are confident with. It can be regarded as questioning the professional-patient relationship which is at the heart of the clinical process. A theme that emerges from this report is that choosing therapy for a patient should be a joint decision where the patient has a motivation to adhere, rather than being the passive recipient of advice. Having the time to set up that 'ownership' of the treatment is a key component that emerges from this report – it entails the sharing of information about the benefits and adverse effects of available therapies, including the alternatives to the modality that is finally chosen.

"A multitude of data covering a range of therapies and a range of clinical contexts have shown that it is easier to give advice than it is to monitor that the advice is being followed"

Beyond the importance of communication time, another key emerging theme is the need to personalise the advice. How does the disease interfere with quality of life? How will the proposed therapy help (and hinder) that? Additionally, understanding that the therapy and underlying disease will be monitored is essential to optimising adherence with therapy. In some ways, what this report summarises are the essential healthcare values: communication, time and empathy. We hope it also provides some practical tips to apply to your practice.

Professor Anton Emmanuel Professor in Neuro-Gastroenterology at University College London & Consultant Gastroenterologist at University College Hospital and the National Hospital for Neurology and Neurosurgery.

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Introduction

Medication adherence is defined as 'the process by which patients take their medications as prescribed'. Poor adherence to treatment of chronic disease has been described by the World Health Organization (WHO) as 'a worldwide problem of striking magnitude'. A number of rigorous reviews have found that, in developed countries, adherence among patients suffering chronic diseases averages only 50%. In developing countries, the rates are even lower[1].

According to The National Institute for Clinical Excellence (NICE), in the UK between a third and a half of all medicines prescribed for long-term conditions are not taken as recommended[2].

The Third Edition of the Cost of Constipation report, published last year, made it clear that there is an urgent need to improve the management of bowel conditions. The cost, both financial and personal, is huge. Adherence is a factor in this, so The Bowel Interest Group chose to investigate a mixture of medications and devices all related to bowel function to get a broad range of perspectives on non-adherence for this new report.

This report explores the patient journey, includes case studies of adherence/non-adherence to different types of medications, devices and techniques used to treat bowel dysfunction, and also covers studies into adherence and non-adherence in the areas of faecal incontinence and/or constipation; pancreatic exocrine insufficiency; inflammatory bowel disease, microscopic colitis and lower bowel dysfunction.

Adherence to medical treatment can be a challenge, especially when it comes to chronic diseases, which includes certain bowel conditions. For example, in IBD, medications are the cornerstone of treatment, whereas for those patients with bowel dysfunction, such as faecal incontinence and/or constipation, transanal irrigation (TAI) systems are used to treat the condition.

According to the WHO, the consequences of poor adherence to long-term therapies are poor health outcomes and increased healthcare costs. Poor adherence to long-term therapies severely compromises the effectiveness of treatment, making this a critical issue in population health both from the perspective of quality of life and of health economics[1].

The consequences of poor adherence to LONG-TERM THERAPIES are poor health outcomes and increased healthcare costs[1]

1 Sabaté, E., 2003. Adherence to long-term therapies: Evidence for action. World Health Organisation. [online] Available at: https://www.who.int/chp/knowledge/publications/adherence_full_report.pdf?ua=1.
2 National Institute for Health and Care Excellence (NICE) (2009) Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. CG76. Available at: https://www.nice.org.uk/guidance/cg76.

Adherence factors

Adherence is 'a multifactorial phenomenon that can be influenced by various factors'[1]:

- social and economic
- therapy-related
- disease-related
- patient-related
- healthcare system-related

Causes of non-adherence fall into two categories which overlap:

- **Intentional** non-adherence occurs when the patient decides not to follow treatment recommendations[2].
- **Unintentional** non-adherence occurs when the patient wants to follow the agreed treatment but is prevented from doing so by barriers that are beyond their control[2].

To understand adherence to treatment we also need to consider the perceptual factors (for example, beliefs and preferences) that influence motivation to start and continue with treatment, as well as the practical factors that influence patients' ability to adhere to the agreed treatment.

Adherence among patients suffering chronic diseases averages only 50%[1].

In the UK between a third and a half of all medicines prescribed for LONG-TERM conditions are not taken as recommended[2].

Why is adherence important?

Adherence to medication as well as other treatments for bowel dysfunction is essential to ensure the best possible outcomes for the patient.

A number of factors affect adherence to treatment, including[3]:

- the therapeutic alliance
- perceived lack of control
- risk of dependence on medications
- stigma associated with medication use
- knowledge, education and support

Meanwhile, non-adherence to treatments for chronic conditions has a number of negative impacts. For example:

- monitoring costs
- work costs (absenteeism/ presenteeism)
- disease recurrence
- increased risk of other conditions
- death

3 Mansoor Malik, M. et al., 2020. Treatment Nonadherence: An Epidemic Hidden in Plain Sight. Psychiatric Times. [online] Available at: https://www.psychiatrictimes.com/view/treatmentnonadherence-epidemic-hidden-plain-sight.

The patient journey: transanal irrigation (TAI)

Transanal irrigation (TAI) of the rectum and colon is designed to assist the evacuation of faeces from the bowel by introducing water into these compartments via the anus. Careful patient selection, directly supervised training by experienced health-care personnel and sustained follow-up are key to optimising outcomes and improving adherence with the technique. The below pathway has been proposed to support adherence to TAI.

THE IMPORTANCE OF SUPPORT THROUGHOUT THE PATIENT PATHWAY

Coloplast has a transanal irrigation (TAI) pathway for new patients consisting of implementable stages within the patient journey, intended to provide the best possible patient outcomes.

Each stage in the journey has corresponding steps based on primary research and secondary evidence. An example of primary research conducted is a survey of 947 patients with bowel dysfunction to learn about their journey to better bowel care with Peristeen®, the only TAI device recommended by NICE for patients with bowel dysfunction[4].

Patient assessment and selection

Factors that influence patient selection include:

- The intrusiveness of the symptoms
- Symptom severity
- Manual dexterity
- Independence from carers
- Patient's body habitus and toilet access

The issue is not whether the patient has symptoms, but rather the impact on their quality of life, for example, if they can't leave the house, if the patient has to change their underwear frequently and so on.

Patients with symptoms of bowel dysfunction will often initially 'self-help' and delay seeing their GP.

Unfortunately, this delay in seeking help can make things worse; the longer patients go without the correct treatment, the more the condition can worsen, leading to extended treatment times. The earlier diagnosis is made, the more recovery/treatment times are accelerated. In addition, if a patient has delayed seeking medical help, it is important to initially exclude red flags for other conditions, such as cancer. Response to TAI depends not only on choosing the correct indications, but also on aspects of the patient's psyche and motivation. In addition to this the patient's bowel function, stool consistency and manual dexterity capabilities should be assessed. There may also be a need to exclude faecal impaction and a need for endoscopy.

HCP tip:

- Assess impact of symptoms on quality of life.
  - Factoring in patient factors (body habitus and social function) helps engage patients with a suggested tailored plan of therapy.
- Consider if the patient is psychologically ready to try a change in treatment.
- The more time the patient has taken to seek help, the more help they will need.
- Identify and exclude red flags first.

Tips for your patients:

- Recovery/treatment times are accelerated by appropriate care. Ensure they seek help from a medical professional instead of relying on self-help to treat symptoms.

4 National Institute for Health and Care Excellence (NICE) (2018) Peristeen transanal irrigation system for managing bowel dysfunction. MTG36. Available at: https://www.nice.org.uk/guidance/mtg36.

Introducing & initiating TAI treatment for the first time

Professor Anton Emmanuel advises that when introducing TAI treatment for bowel dysfunction such as faecal incontinence and/or constipation for the first time, the two most important considerations for successful treatment adherence are:

- The quality of training provided to the patient.
- The quality of the follow-up provided to the patient.

In addition to these factors, the HCP/patient dialogue must be of high quality. 'Shared care' means that both the HCP and the patient understand the treatment. TAI technology is complex and requires HCP experience and understanding with the patient needing to understand how the features have a clear benefit.

Unlike adherence to medication such as a tablet, TAI is something that the patient 'does to themselves' – it is a dynamic relationship between patient and device. Successful treatment adherence requires the patient to take responsibility; once they become familiar with the treatment, they learn more about it and can give feedback on their experience. Prof Emmanuel says that this is "incredibly motivating" for patients and their adherence to the treatment.

HCP tip:

- Both training and follow-up must be excellent; you cannot have one without the other.
- You must have excellent knowledge of the technology and be clear on its features and benefits.
- High quality patient/HCP dialogue creates the ideal environment for successful adherence.

Tips for your patients:

- Ensure they take responsibility for the treatment – it is a dynamic relationship.
- Encourage them to enable a dialogue with you – successful adherence is all about shared care.

Establishing a routine

Prof Emmanuel advises the following steps for establishing a successful TAI routine for treatment of bowel dysfunction:

1. Training – HCP understanding of the technology.
2. Discuss product options with the patient presenting a range of equipment and considering relevant NICE guidance to encourage the feeling of choice and ownership on the part of the patient.
3. Patient training – show the patient a model of the equipment so that they feel comfortable with using it.
4. Give and record specific instructions on equipment use.
5. Provide a diary to the patient to record their treatment and anything else they experience.
6. Discuss the option of structured support calls to help the patient develop a personalised routine.
7. Be adaptable – troubleshoot if problems arise.

HCP tip:

Recognise the importance of a personalised approach to treatment:

- Patient's relationship with the equipment
- Change if not working for the patient
- Be flexible in your approach

Advise the patient to:

- Ask questions to ensure they are comfortable using the equipment
- Follow specific instructions
- Keep a treatment diary
- Feed back on any problems they experience with treatment

"Those patients who 'get it' early on will be more likely to stick to the treatment and stay on board"

Maintaining a routine

Longer term adherence with TAI has a number of factors, according to Prof Emmanuel. These include:

- Regular reviews
- Remote consultations on the telephone or over a video call. These are becoming the norm in COVID-19 times
- A safety net provided for the patient by the HCP to give a sense of security including emergency contacts
- The HCP remains up-to-date on therapy developments and provides updates to patients on alternative therapy options
- Patient groups – this creates a sense of camaraderie amongst patients undergoing the same treatments.

All of the above is beneficial to the patient, helping them to feel more engaged and involved in their treatment. This is particularly important when treating long-term patients, e.g., neuro patients. In addition, those patients who 'get it' early on will be more likely to stick to the treatment and stay on board, according to Prof Emmanuel.

CASE STUDY

Despite high expectations of using Peristeen for transanal irrigation, this patient with progressive Multiple Sclerosis found getting used to the therapy took a little while. Firstly, training and moral support, initially in person from a Peristeen nurse and then from a Coloplast Charter Telehealth Specialist who provided ongoing support, was required to enable the patient to gradually fine-tune their treatment. For instance, with guidance during the early months, the patient experimented with different water volumes to establish the optimum for effective bowel emptying with treatment intervals every three days settled on in the end. 'Special routines' were also established to maximise comfort and peace of mind before, for example, going on holiday or taking a flight. All of this training and support helped the patient's confidence as routines were optimised and ensured long-term adherence. The patient emphasised the critical need for such support during this early period and described the therapy as 'utterly life changing'.

Patients commenced on Peristeen and registered to Coloplast Charter for their product deliveries and enrolled onto the Best Start programme receive expert initial training, and a follow up programme tailored to their support needs. If they require further face to face support, a Peristeen nurse can also visit them at home or hold a virtual consultation. As NICE points out, patients need this level of high quality support for long-term adherence to TAI.

"The patient emphasised the critical need for such support during this early period and described the therapy as 'utterly life changing'"

Pancreatin for the treatment of pancreatic exocrine insufficiency (PEI)

Pancreatin is a prescription medicine used to treat people who cannot digest food normally because their pancreas does not make enough enzymes due to cystic fibrosis, swelling of the pancreas that lasts a long time (chronic pancreatitis), removal of some or all of the pancreas (pancreatectomy), or other conditions[5] The following demonstrates the importance of setting expectations for patients taking pancreatin to ensure long term adherence.

"It is important to explain the rationale for treatment"

Dr Ben Disney, Consultant Gastroenterologist, University Hospital Coventry and Warwickshire

Patient assessment and selection

Patients are most commonly selected for treatment if they have symptoms in addition to abnormalities found (e.g. chronic pancreatitis on imaging, low faecal elastase) or have pancreatic cancer.

Initiating the treatment

Adherence is related to a number of factors – it is important to explain the rationale for treatment (improve symptoms, weight gain, etc) and the need for long-term treatment.

HCP tip: Explain possible side effects and what to expect.

Introducing the treatment

Explain the need to titrate the dosage as 'not one size fits all'; some patients will require a higher dose to help their symptoms.

HCP tip: Explain the dosage and possible adjustments at the onset – patients will think that the treatment does not work and therefore adherence is likely to be poor.

Tips for your patients: Advise them to be prepared for changes in dosage; if the initial dose needs to be modified, it doesn't mean that the treatment is not working.

CASE STUDY – Pancreatin

60-year-old lady presented with longstanding diarrhoea (bowels open six to seven times daily for the past 12 months) with frequent episodes of faecal incontinence resulting in her wearing incontinence pads. This led to significantly impaired QoL and anxiety at leaving the house.

She has a history of type 2 diabetes.

She had been seen by one specialist beforehand who had arranged a colonoscopy which had not revealed a cause for her symptoms.

Given her history of diabetes I checked her faecal elastase which was 144, indicating moderate PEI.

She was started on pancreatin 50000 units with meals and 25000 with snacks.

At follow up her bowels are open once every two days with no further episodes of incontinence and she is now more comfortable with leaving the house.

Dr Ben Disney, Consultant Gastroenterologist, University Hospitals Coventry & Warwickshire.

5 Keller, J. and Layer, P., 2005. Human pancreatic exocrine response to nutrients in health and disease. Gut, 54(suppl_6), pp.1-28.

Adherence in inflammatory bowel disease (IBD)

The following is a summary of a review which recognises how nurses can provide practical assistance along with advice on behavioural change to tackle the challenges of adherence in a chronic condition such as IBD.

STUDY: Self-management through social support among emerging adults with inflammatory bowel disease[6]

This 2019 study examined individuals' 'self-management behaviours, social support, and the relationship between these two constructs' in emerging adults (age 18–29 years) who have inflammatory bowel disease (IBD).

The results showed: 'Emerging adults with high received informational support reported greater medication adherence compared to those with low received informational support when controlling for biological medications, time since diagnosis, symptom frequency, and feeling in-between adolescence and adulthood'.

STUDY: Adherence in inflammatory bowel disease[7]

Inflammatory bowel disease (IBD) describes conditions characterised by chronic inflammation of the gastrointestinal tract. The most common inflammatory bowel diseases are ulcerative colitis and Crohn's disease. Microscopic colitis is a less common IBD.

As with any chronic disease, adherence to medication for IBD is a challenge.

In 2019, Adherence in inflammatory bowel disease (IBD): a clinical review, was published in Gastrointestinal Nursing. The review found that:

- Adherence to treatment can be challenging, especially in chronic diseases.
- In IBD, maintenance therapy is common to prevent a disease relapse, and adherence becomes more of a challenge during remission.
- Practical problems with taking topical treatment can increase the likelihood of non-adherence.
- In IBD, the definition of adherence can be expanded beyond taking medication to factors like leaving blood or stool samples, keeping appointments or adjusting behaviour regarding smoking or diet.

The review also describes how IBD nurses can open up conversations with patients that could lead to an improvement in their adherence.

6 Kamp, K. et al., Self-Management Through Social Support Among Emerging Adults With Inflammatory Bowel Disease. Nursing Research, 68(4), pp.285-295.
7 Bager, P. and Jäghult, S., 2019. Adherence in inflammatory bowel disease (IBD): a clinical review. Gastrointestinal Nursing, 17(6), pp.24-27.

Ulcerative colitis can develop at any age but is most often diagnosed in people from 15 to 25 years old[8].

Both men and women seem to be equally affected by ulcerative colitis[8].

STUDY: Medication non-adherence in inflammatory bowel diseases associated with disability[9]

A total of 173 subjects on inflammatory bowel diseases (IBD) maintenance medications were recruited for this 2018 study into medication non-adherence in IBD. The study set out to find if identifying negative outcomes, such as disability, would encourage adherence.

The results showed that 'disability correlated significantly with medication non-adherence'. Non-adherence was independently associated with difficulty managing bowel movements, rectal bleeding, and arthralgia/arthritis.

The study concluded that 'medication non-adherence was associated with significantly increased disability in IBD. Female gender, higher disease severity and medication concerns were additional predictors of disability'.

CASE STUDY – Adherence to treatment with mesalazine in ulcerative colitis

Rachel Campbell IBD Advanced Nurse Practitioner at Stockport NHS Trust

Mesalazine medications are used in ulcerative colitis, by either oral or rectal route, to help reduce the immune response that causes the patient's bowel symptoms. The importance of adherence to these medications is paramount as non-adherence increases the risk of disease flare five-fold and can significantly increase the risk of the patient developing colorectal cancer[10].

The risk of flares due to non-adherence also has an impact on NHS resources. It has been found that if a patient has a flare that does not require hospitalisation, this increases the associated patient cost two to three-fold, however if the patient is hospitalised this cost increases 20-fold[10].

To improve adherence, a number of techniques can be used. Lessening the pill burden by using higher strength mesalazine tablets; utilising once daily dosing regimens; involving patients in the medication decision-making process and providing the necessary and appropriate information will all support patient medication adherence.

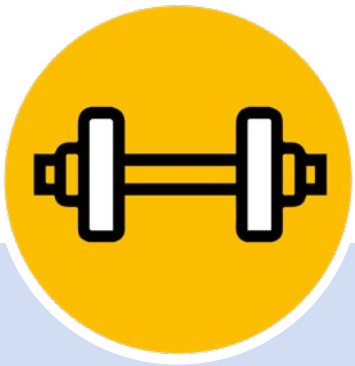
An example of this was when one of my patients was given an ulcerative colitis diagnosis by a surgeon and supplied with a one-month mesalazine prescription. The patient did not receive any guidance around why he was on it, how to take it, or the importance of continuing. The patient believed this was a 'one off' prescription and subsequently flared. Following this, I took over his care.

I spoke with him directly and involved him in the decision-making process to ensure that the medication fit within his lifestyle as well as being tailored to his colitis needs. It was decided to reduce his pill burden through using a higher strength, once daily, mesalazine product. These factors resulted in the patient having greater adherence to his mesalazine and has ultimately helped keep the patient in remission for the last 18 months.

8 Nhsinform.scot. 2021. Ulcerative colitis symptoms and treatments. [online] Available at: https://www.nhsinform.scot/illnesses-and-conditions/stomach-liver-and-gastrointestinal-tract.
9 Perry, J. et al., 2018. Medication non-adherence in inflammatory bowel diseases is associated with disability. Intestinal Research, 16(4), pp.571-578.
10 Testa, A. et al., 2017. Adherence in ulcerative colitis: an overview. Patient Preference and Adherence, Volume 11, pp.297-303.

Adherence to pelvic floor muscle training (PFMT)

The following explores the factors involved in long and short term adherence to pelvic floor muscle training. Patients with faecal incontinence or bowel leakage may be helped by specific exercises for the sphincter and pelvic floor muscles.



Professor Doreen McClurg, Professor of Pelvic Floor Physiotherapy, reviews current studies on pelvic floor muscle training adherence.

Level 1 evidence indicates pelvic floor muscle (PFM) training (PFMT) is effective in treating PFM dysfunctions:

- stress, urgency or mixed urinary incontinence (UI)
- pelvic organ prolapse (POP)
- lower bowel dysfunctions [11,12].

Continued adherence is key to maintaining PFMT effectiveness[13]; poor adherence results in a longer-term decline in effect[14]. PFMT adherence is complex and necessitates behavioural change and active patient participation[15]; over 200 variables correlate with exercise adherence alone[15,16]. Differences exist between short-term adherence (e.g., during supervised PFMT) and long-term adherence (e.g., patient training alone after supervised therapy). Clinicians estimate that 64% of patients adhere to short-term, but only 23% long-term[17]. Thus, planning and implementing PFMT programmes informed by adherence theory and evidence is potentially critical to achieving and maintaining treatment effect.

Exercise adherence has been identified as an important predictor of overall PFMT effectiveness[13], and cost-effectiveness is dependent upon whether short-term outcomes can be maintained long-term[15]. Adherence and its determinants, from initial uptake to longer-term maintenance, needs to be understood, measured, and harnessed to maximise PFMT effectiveness.

HCP Tips:

At all levels (guidelines, patient/clinician), clinicians should adopt an approach to the design and implementation of PFMT interventions (prevention and treatment) that incorporates appropriate behaviour change techniques to promote exercise adherence. Specifically:

- Develop accurate and sufficient patient 'knowledge' through judicious selection of content and delivery of information.
- Teach skills, then enhance performance in the correct 'physical skill' of a PFM contraction and develop patient confidence in correct performance.
- Promote positive and decrease negative feelings about PFMT and counter negative with positive role models for PFMT.
- Enable constructive 'cognitive analysis, planning, and attention' to problem-solve common PFMT barriers, and enhance PFMT facilitators, in daily life.
- Boost the 'prioritisation' of PFMT in patients' lives.

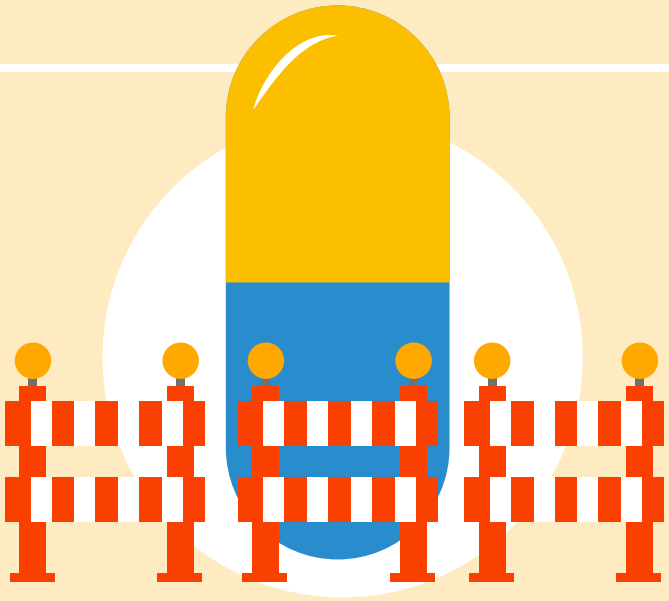
11 Boyle, R. et al., 2012. Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women. Cochrane Database of Systematic Reviews.
12 Hagen, S. and Stark, D., 2011. Conservative prevention and management of pelvic organ prolapse in women. Cochrane Database of Systematic Reviews.
13 BO, K. and TALSETH, T., 1996. Long-term effect of pelvic floor muscle exercise 5 years after cessation of organized training. Obstetrics & Gynecology, 87(2), pp.261-265.
14 Chen, H., 1999. Efficacy of pelvic floor rehabilitation for treatment of genuine stress incontinence. Journal of the Formosan Medical Association, 98(4), pp.271-276.
15 Borello-France, D. et al., 2010. Adherence to behavioral interventions for urge incontinence when combined with drug therapy: adherence rates, barriers, and predictors. Phys. Ther. 90(10), pp1493–505.
16 Imamura, M. et al., 2010. Systematic review and economic modelling of the effectiveness and cost-effectiveness of non-surgical treatments for women with stress urinary incontinence. Health Technol Assess. 14(40), pp1-188.
17 Dumoulin, C. et al., 2014. Consensus statement on improving pelvic floor muscle training adherence: International Continence Society 2011 State-of-the-Science Seminar. Neurourol Urodyn. 34(7), pp600-5.

Barriers to adherence

There are multiple factors at play in barriers to medication adherence. These include:

- the healthcare team/system
- social and economic factors
- disease characteristics
- therapies for the disease
- patient-related factors[18]

Each of these factors has related problems that must be resolved if therapy adherence is to improve.



The problem with non-adherence

According to 'Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence' (NICE Clinical guideline [CG76])[2]:

- It is thought that between a third and a half of all medicines prescribed for long-term conditions are not taken as recommended.
- Non-adherence may limit the benefits of medicines, resulting in lack of improvement, or deterioration, in health.
- The economic costs of non-adherence are not limited to wasted medicines but also include the knock-on costs arising from increased demands for healthcare if health deteriorates.
- Addressing non-adherence is not about getting patients to take more medicines.
- Non-adherence should not be seen as the patient's problem.
- Addressing non-adherence is not about getting patients to take more medicines per se. HCPs have a duty to help patients make informed decisions about treatment and use appropriately prescribed medicines to best effect.

HCP tip:

- An open, no-blame approach encourages patient engagement, enabling them to discuss their concerns about treatment.
- Involving patients in prescribing decisions and adapting consultation style to the individual can help you to establish how involved they would like to be involved in decision making.
- Ensure that all information is accessible and understandable to the individual patient.
- Any interventions must be tailored to the patient and their specific difficulties.

Tips for your patients:

- Encourage your patient to be open with you and share concerns about their treatment, this will enable you to understand any factors which could stop them taking their medicine.

18 Gast, A. and Mathes, T., 2019. Medication adherence influencing factors—an (updated) overview of systematic reviews. Systematic Reviews, 8(112).

Intervention and follow-up must be tailored to each patient and condition

Solutions

A multidisciplinary approach

- Patients need to be supported, not blamed: 'Provider and health system-related determinants have a major effect on adherence[1]', not patient-related factors alone.
- Adherence is multi-factorial: Solving the problems related to factors including 'social and economic factors, the healthcare team/system, the characteristics of the disease, disease therapies and patient-related factors[1]' is essential to improving patient adherence.
- Intervention and follow-up must be tailored to each patient and condition: 'There is no single intervention strategy, or package of strategies that has been shown to be effective across all patients, conditions and settings[1].'
- Open up conversations: Adherence must be a partnership between patient and HCP.
- Good bowel management and support is essential to improving adherence.
- Different interventions are needed for different types of non-adherence.
- The quality of instructions and training (depending on the treatment) and follow-up must both be excellent.
- Community and patient groups: Support in the community from other patients with similar chronic conditions are a key factor for adherence success.
- Signposting to online support.

Conclusions

On reviewing this Importance of Adherence report, what strikes me is the sheer scale of non-adherence, which NICE places at 33–50% in the UK for long term conditions[2]. However, what also becomes clear is that there are solutions, and the most basic yet most important of these is the need for we as clinicians to spend a good amount of time talking to the patient. Education is key! I appreciate that this level of communication can be difficult in our busy clinics BUT it is so important to get patient buy-in to the treatment from the start.

Patients need to know – why have I been prescribed this medication? What can I expect? What do I do if there is no improvement? In addition, with treatment for bowel conditions highlighting the need for long term treatment (for example mesalazine reduces cancer risk, pancreatin will improve symptoms and so on), involving the patient in decision-making and promoting patient control/responsibility for their treatment is crucial.

This report also demonstrates the need for ongoing support and follow up to ensure long-term adherence. As Professor Emmanuel points out, 'choosing therapy for a patient should be a joint decision where the patient has a motivation to adhere, rather than being the passive recipient of advice'. Being aware of patient and non-patient factors is vitally important, because it is this personalised approach which increases the chances of a patient adhering to their treatment.

"Involving the patient in decision-making and promoting patient control/responsibility for their treatment is crucial"

On the horizon there are some intriguing advances in technology which may help with adherence, for example, 'smart' TAI, and mobile phone apps that help patients to self-manage their condition.

As an organisation, the Bowel Interest Group exists to support you in achieving the best management and outcomes for your patients. The aims of this report are to educate on the reality of the current rates of adherence, and to present positive and actionable change for healthcare professionals, to raise awareness of what you can do to promote medication adherence.

Dr Ben Disney, Consultant Gastroenterologist, University Hospital Coventry and Warwickshire.

Bowel Interest Group

The Bowel Interest Group (BIG) is a multi-disciplinary group dedicated to raising the profile of bowel management. The group provides evidence driven educational resources to support healthcare professionals treating patients with bowel conditions.

The Bowel Interest Group is owned by E4H Ltd. The Bowel Interest Group receives funding from commercial partners. This allows E4H to provide secretariat support to the group. Please find out more about our supporters on our website www.bowelinterestgroup.co.uk/about.

The Bowel Interest Group has developed this report with contribution from external partners including Coloplast and Tillotts Pharma UK Ltd.

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