

Time and pharmacist support in general practice are needed to improve medicines optimisation

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Many doctors are aware that medication errors pose a serious threat to their patients and that this needs to be addressed. Many are aware that it is a growing, complex, overwhelming, and stressful problem. Some striking statistics [published earlier this year](#), and widely shared by the mainstream media, shed light on the scale of the problem:

- An estimated 237 million medication errors occur in England every year.
- An estimated 712 deaths in England occur every year from medication errors.
- One in 20 prescriptions has an error.
- One in 550 is a serious error.
- Errors are more likely to occur in medications for older people and patients with multiple conditions who are using many drugs (polypharmacy).

Given this, the management of polypharmacy could be seen as a new type of specialism that has to be embraced in an already overloaded work schedule.

Exacerbating the problem is that while life expectancy has grown steadily since the 1980s (the projected life expectancy in 2039 is 96 for women and 93 for men), healthy life expectancy is not increasing as steadily. This means more people living longer, but with a growing proportion of that time in poor health. This increase in the number of patients with long term conditions increases the amount of polypharmacy.

Also relevant is that the ageing body becomes less able to metabolise medicines safely. Prescribers need much greater awareness of the importance of a patient's weight and liver function, and to take more detailed assessments of renal function than is standard practice in consultations.

The Royal College of General Practitioners (RCGP) has called for older patients to have support to manage their medication. [One recommendation](#) is to prioritise

the care of patients living with multiple long term conditions by adopting face-to-face dedicated medicines reviews, which incorporate the skills of GPs and practice based pharmacists. There's already a growing inclusion and acceptance of practice based pharmacists. And [from our experience](#), a practice based pharmacist has improved our confidence to raise the quality of our prescribing and manage day to day problems that arise in the practice. In addition, the new [ePACT2 polypharmacy prescribing comparator datasets](#) allow much easier ways for practices to benchmark and identify patients most at risk.

It now seems sensible to propose that the routine management of polypharmacy should be "owned" in primary care. This is where the holistic overview of patients in their own environment (which is key) can best take place. It cannot be managed in hospital silos.

Ongoing professional development for all clinicians in primary care needs to place greater emphasis on developing capability for this task. Generating new knowledge, coping with change, and improving efficiency are all essential requirements for the effective management of polypharmacy and reducing medication errors.

While many practices are already striving to achieve this, we think that giving practices support so they become medicines optimisation "aware" would help develop understanding of key prescribing issues and the implementation of improved medicines optimisation processes. This model is already proven for dementia friendly practices; for example, in Wessex.

A medicines optimisation "aware" practice would, for example:

- Show awareness of—and implement a prescribing guidance policy for the practice that takes account of—polypharmacy and "red flag" high risk medications. In particular, those that contribute to preventable hospital admissions (NSAIDs, anticoagulants, antiplatelets, diuretics); those that should be prescribed with extreme caution in older people; and those that risk prescribed drug dependency. The guidance should also have clear processes for managing national medication alerts, eg from the Medicines and Healthcare Products Regulatory Agency.
- Show awareness of—and pragmatically deploy—stratification tools, such as PINCER, PRIMIS, and ePACT2, to identify patients at the greatest risk of harm from medicines.

- Record body weight and renal function as a minimum requirement in all reviews of patients with a long term condition.
- Provide an annual learning update for all clinicians about the risks of inappropriate polypharmacy and practical de-prescribing tips and techniques.
- Have a clear process for reconciling medication changes for hospital discharges.
- Demonstrate a working relationship with their local community pharmacies using electronic repeat dispensing. They would report and learn from medication errors together.

Medicines optimisation is a time consuming process that does not appear to have been given adequate assessment by health economists. By investing in better systems at the primary care level, potential cost savings could be made to the greater healthcare economy. It is not currently financially possible, practical, or sustainable to expect individual practices to resource this work.

Northern Ireland has secured unconditional pharmacist support in general practice. Now is the time to insist that NHS England provide ongoing support for pharmacists in general practice, as well as educational support and protected time for the whole practice team to be able to work towards improving medicines optimisation.



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