Royal College of General Practitioners
Coleg Brenhinol Meddygon Teulu
CYMRU WALES

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RCGP Wales Response to the Public Accounts Committee: Medicines Management in Primary and Secondary Care

RCGP Wales is a member organisation representing GPs and GPs in training in Wales. We welcome the opportunity to respond to the Public Accounts Committee on the Auditor General's Report published in December 2016 on Medicines Management in Primary and Secondary Care and in particular to comment on the recommendations. The Committee advised they were keen to hear our views on the issues highlighted in its report and, in particular, on the Auditor General's four underpinning conclusions:

- **Corporate arrangements: Health bodies are collaborating well but there is scope to raise the profile of medicines issues, improve local planning and strengthen scrutiny of performa**

We would agree that there is scope to improve local planning. Although some local formularies are being developed these are not universally followed. This can cause problems when secondary care advises medication outside of the LHB formulary, which GPs are encouraged to follow. The plans need to be strengthened.

Local plans need to include out of hours GP services, community pharmacy and A&E departments to ensure that messages about antibiotic prescription and over the counter medications are consistent. Pharmacies are in some areas being paid to treat minor illnesses and can prescribe medication which GPs would advise were purchased.

- **Primary Care: NHS Wales is taking positive steps to improve medicines management in primary care although there is scope to make prescribing safer and more cost effective**

We are aware that generally GPs are trying to improve medicines management in primary care and acknowledge that there is still room for improvement particularly in relation to those on multiple therapy. GPs regularly do medication reviews, but there is potentially a need to increase the patient involvement in the decision making around medication. We need to discuss with patients the full implications of preventative medication and discuss the pros and cons of their continuation. This is even more important as patients get older and the benefits of treatment are over shadowed by the risks. This takes time and standard 10-minute appointments are not long enough. With the restrictions on GP time due to increasing workload and problems with GP recruitment this may not always be a priority.

Community pharmacists do medication reviews and are paid for these. The purpose of these are not the same as GP medication reviews. There is however some duplication which could be reduced. Patients may in fact get conflicting advice from the two professionals and this makes for poor medicines management. This may be compounded, when patients do attend more than one pharmacy, or their carers or family collect scripts from different pharmacies.

In some clusters and GP practices pharmacists are employed with medicine management as their

primary role. Training for these pharmacists to move into primary care is essential as the working environment is different from hospitals or community pharmacy.

Clinical staff in practices have good access to drug information with new BNF and univadis apps. The All Wales Prescribing Advisory Group (AWPAG) produces guidance for GPs and other prescribers around appropriate, safe and cost effective prescribing

- **Interface between primary and secondary care: There are medicines-related safety risks and inefficiencies when people move in and out of hospital**

The interface between primary and secondary care accounts for a high number of significant clinical errors. These occur in both directions and can be reduced by timely transfer of information electronically and it is imperative that these systems are developed in a robust fashion. It needs to be clear which medication is acute short-term therapy and which is ongoing. Recently changed medication and the reasons for the changes need to be clear. If medication has been stopped this should be explicit as sometimes there is a confusion about whether this has just been left off the list.

There are often delays in transferring information and advised changes in medication both following discharge but also after outpatient and A&E attendances. It is helpful if this information is in a format to be transferred electronically into a patient's notes to prevent typing errors or pick list errors of similar drugs or varied doses. A universal system needs to be developed as a priority for Wales.

Delay in outpatient appointments or time intervals between follow up appointments mean that in some cases medication has been altered by the GP or another health professional either in primary or secondary care. Patients' records should be checked at the time of the appointment and further enquiries made about acute medication or hospital only medication, which are not on the repeat medication lists issued to patients or in the Individual Patient Record. This is an issue that needs to be highlighted to those seeing patients in secondary care or in out of hours general practice, A&E and for acute admission.

Areas with electronic discharges have helped this and their consistent rollout throughout Wales. Junior doctors who tend to complete discharge letters need to be trained in the importance of their timely correct completion. The letter writing must be factored into job planning. In some areas the production of the numbers of letters is monitored, but this does not include monitoring their quality which can be poor. The quality needs to be improved and the task not left to the most junior or least experienced member of the clinical team. In some areas letters are delayed as the medication has to be checked by clinical pharmacists, which is potentially good for clinical care and reducing errors but may lead to additional delays if those members of staff are not available at the time of discharge such as weekends. In some areas, the discharge medication is sent to a community pharmacist and this can cause problems and delays if the patient attends a different community pharmacist and the GP is not sent a list. This can often happen if the patient changes carers or is being supported by family members. Similar problems occur when discharge is not to the patient's own home and the patient is discharged to a care home or relatives' home and registered with a temporary or new GP. There should be any easy mechanism to ensure that the patient has the information available on discharge as well as the electronic or paper letter going to their original GP.

Increasingly, LHBs are developing medication formularies and encourage GPs to use these but often hospital doctors advise or start medication outside the recommended formulary, which can cause problems for GPs, anxiety for patients and increase cost without any obvious benefit for the patient. Formularies should be applied across the LHB and ideally should be the same for all of Wales. If different drugs are recommended there should be clear instructions for the reasons and the doctor making the recommendation should be prepared to prescribe and monitor the patient.

Shared care protocols are available to ensure patients get the best care nearest to home. GPs may

not feel they have the competencies to take on the care of a patient under a shared care protocol even with support for specialists. It would help if the shared care protocols were unified across Wales as patients may move LHB or be seen by a GP in a different LHB and this can cause problems and delays. Sometimes these patients are advised following hospital appointments to get medication from their GP without the GP being asked if they will accept the patient on the shared care agreement or before the patient has been stabled. This should never happen as it causes delays and anxiety for the patient.

Some medication is hospital only and patients may either be advised or they should get a script from their GP. This may be due to a lack of understanding of some staff particularly junior doctors or due to delays in outpatient pharmacies. This can cause delays in patients getting medication or even gaps in treatment if medication has already been started. This should be improved.

We welcome the fact that the NHS Delivery Unit is looking at safe transfers of information around discharges and anticipate that this will have robust benefit for the system's improvement.

- **Acute hospitals: Pharmacy services are rated highly by medical and nursing staff but there are problems with medicines storage, gaps in medicines information and there is frustration at delays in implementing electronic prescribing**

  As GPs we have little contact with hospital pharmacies. We are however concerned that sometimes when patients are seen and given hospital scripts in outpatient clinics, there are long delays and the hospital pharmacy advises the patient to go to the GP surgery and ask for a script. This is duplication of work, disruptive of GP work schedule and not always appropriate if the patient has been given hospital only medication or shared care drugs.