# Regional Medicines Optimisation Committees

## DISCUSSION SUMMARY

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<th>Meeting date:</th>
<th>28th June 2017</th>
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<td>RMOC Region:</td>
<td>North</td>
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<tr>
<td>Subject:</td>
<td>Poly Pharmacy</td>
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| Documents Distributed Prior to Meeting: | Poly Pharmacy Draft Briefing pack (SPS)  
Poly Pharmacy data pack |

### Key Discussion Points:

- Not a UK problem but global. WHO campaign underway; this is going to be issuing statements many of which are based on the Scottish model that is highlighted in the SPS document.

- Concerns around looking at this as a cost saving issue as its more than just cost however conversely cost savings should be mentioned as it will allow CCGs to put in the business case for extra resources to tackle this. i.e. an invest to save model. Acknowledged however that it is more about quality and holistic patient review rather than a purely cost saving exercise.

- This is also a key theme for AHSNS so need to engage to ensure there is no duplication.

- Data will be available in EPACT 2.

- Needs to be about patient centred care – e.g. ‘you can only really take 5 medicines effectively’

- So many tools available because it’s a difficult area to tackle

- Clinical pharmacists in GP practices – a good resource to use to help organisations tackle polypharmacy and ensuring medication review in elderly patients on >10 meds. There is no standard programme of work. Reported good practice in GM where LPN ensures links across. Also good practice with targeted interventions in Sheffield.
- Support clinicians in stopping medicines – clinicians ‘risk averse’. i.e. statins, bisphosphonates etc.
- Need to link to other pieces of guidance and tools e.g. [NICE guidance on frailty](http://www.nice.org.uk)
- Link to medicines waste agenda should be encouraged and used
- Use other pieces of guidance e.g. low clinical value medicines, de-prescribing to support.
- Workforce pressures exist in primary care across GPs and GP practice pharmacists. Technician roles should be encouraged to do ‘stops, swaps and switches’ so pharmacists can concentrate on clinical review work.
- Electronic dispensing – evidence that patients are not being asked the required 4 questions and as delivery by driver they frequently don’t see a pharmacist. Some examples of how this can be addressed exist and should be shared.
- Take ‘PRNs’ off repeat - will help with waste.
- Numbers of patients at practice level aren’t huge so percentages could change relatively easily. Tackling this at practice level is more manageable.
- Admission to hospital is an opportunity to review meds and monitor effect however this doesn’t happen very often. And if changes are made these are often not continued in primary care. Need better communication across interfaces and system wide approach. Look to Transfer of Care work
- Barriers around stopping meds others have started when indication and other info is not available.
- Secondary care should be required / encouraged to review meds however reported massive increases in pressures on clinical teams.
- More case studies to support others.

### Actions:

1. Share Good Practice Case studies and work done to date.
2. GP Practice Pharmacists - can we ask HEE about directing pharmacists towards this, as additional resource in practices is required for review?
3. Monitor BSA data once available and use locally to encourage discussion and action.
4. Promote NICE Morbidity guidance and frailty tools for deprescribing.