The authors discuss the differences between medicines optimisation and medicines management and present the results of a survey that canvassed GP understanding of the medicines optimisation approach.

Medicines optimisation (MO) is proposed as a step change in the way that all healthcare professionals support patients to get the best possible outcomes from their medicines. It is a patient-focused approach to getting the best from investment in and use of medicines, which requires a holistic approach, an enhanced level of patient-centred professionalism and partnership between clinical professionals and a patient.

The four principles of MO relate to understanding the patient’s experience, making an evidence-based choice of medicines, ensuring the use of medicines is as safe as possible and making MO part of routine practice. As such MO is part of a paradigm shift from medicines management (MM), with the former now predominantly focussed on outcomes rather than process, patients rather than systems and is led by, rather than delivered by, pharmacists.

Although there was no widely accepted definition of the much-used term MM, the National Prescribing Centre defined it as: ‘a system of processes and behaviours that determines how medicines are used by patients and by the NHS’. The King’s Fund identified MM as supporting better and more cost-effective prescribing in primary care, as well as helping patients to manage medications better, and recognised that good MM can help to reduce the likelihood of medication errors and hence patient harm. Others have described how MM activities may be aimed at individuals and at populations. To encompass a widening definition, alongside the drive towards more patient-centred care, the focus has changed in the UK towards the concept of MO.

### Table 1. Categorisation of themes identified from GP responses (and number of responses) into MO, MM or other activities

<table>
<thead>
<tr>
<th>Medicines optimisation</th>
<th>Medicines management</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>polypharmacy review, including care home patients (16)</td>
<td>cost-effective prescribing (19)</td>
<td>information sharing/education (9)</td>
</tr>
<tr>
<td>review of repeat prescribing (13)</td>
<td>audit (13)</td>
<td>concerns over unlicensed medication (2)</td>
</tr>
<tr>
<td>check adherence/understanding of medication (8)</td>
<td>appropriate medication – dose, form, quantities (6)</td>
<td>enabling practices to work on prescribing issues (2)</td>
</tr>
<tr>
<td>stopping unnecessary medication (2)</td>
<td>synchronisation/dose rationalisation (5)</td>
<td>being aware of the formulary (1)</td>
</tr>
<tr>
<td>medication review with patient (2)</td>
<td>simplify dose regimens (5)</td>
<td>stop community pharmacy-managed repeat dispensing system (1)</td>
</tr>
<tr>
<td>communicating with pharmacies or with secondary care about medication (2)</td>
<td>avoiding waste (4)</td>
<td>restrict use of new medicines (1)</td>
</tr>
<tr>
<td>reconciliation with discharge summaries (2)</td>
<td>check for interactions (2)</td>
<td>other (7)</td>
</tr>
<tr>
<td>evidence-based choices (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prescribing in accordance with MHRA advice (1)</td>
<td></td>
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</table>
However, there are concerns that there may be a lack of understanding of what MO actually means. An example of such a concern from a pharmacy practice research perspective is that of healthcare professionals thinking that pharmacists optimise medicines because the healthcare professionals’ prescribing is suboptimal without our intervention.7

Likewise a national policy document noted that while hotly debated within pharmacy circles, the terms MO and (the even older term) pharmaceutical care mean very little to even informed health policy and management experts, let alone the wider public.8

We set out to gain an understanding of what GPs understand by the term MO and whether the activities they describe as MO are distinct from MM activities.

**Method**

Across Cornwall locality-based prescribing meetings are held four times a year. These meetings, organised by the Kernow CCG prescribing team, are intended to have a focus on clinical prescribing and (now) MO issues. Each GP practice is asked to nominate a GP prescribing lead who would attend these meetings and disseminate the learning within their own practice.

At each of the three locality meetings late in 2013 the GPs were asked to complete a questionnaire, having been advised that it was anonymous and would take only a few minutes to complete. The questionnaire simply asked the GP to write down up to three activities or tasks that they associate with MO.

Responses were tallied and grouped into major themes. These themes were then categorised by the authors as MO activities, MM activities, or other. Any response that could be described as both MO and MM was categorised under MO. This categorisation was informed by a variety of resources developed to explain and describe these terms.1,3,5,9

It should be noted that a ‘good practice in prescribing’ meeting was included as part of the prescribing incentive scheme during 2013/14 that was delivered to interested surgeries, typically 60–90 minutes’ duration. Topics discussed during these meetings included MO, prescribing of licensed and unlicensed medicines, and the GMC document Good Practice in Prescribing and Managing Medicines and Devices. Hence a number of our respondents would have attended one of these meetings.

**Results**

The three meetings were attended by a total of 58 GPs, with completed questionnaires returned from 43 (74 per cent). No GP characteristics were recorded, although it is known that approximately 70 per cent were male and about half of the GPs belonged to a dispensing practice. There were 125 responses and these were categorised into the themes in Table 1. We recorded 48 responses as MO tasks, 54 as MM and 23 as other.

**Discussion**

We found a mixed response from GPs as to the type of activities that could fall under the MO agenda. For instance, a response of ‘cost-effective prescribing’ was deemed to be MM. Perhaps if the GP had indicated clearly that this was to take into account the patient’s perspective on cost-effective prescribing, this would then have been MO. Likewise, simplification of dose regimens that alluded to patient involvement would have been an MO activity. NICE, acknowledging that MO has not been formally defined in the published literature, uses a definition of ‘a person-centered approach to safe and effective medicines use, enabling people to obtain the best possible outcomes from their medicines’, and recognises that MO requires greater patient engagement than MM.9 Others have argued that MO and pharmaceutical care will be what turns MM, which is primarily focused on the medicines, into roles that are focused on the nuances, individual therapeutic challenges and confounding factors that we come across in patients taking the medicines. Hence such roles make pharmacists an essential part of the healthcare team.10

This integration of the pharmacist into the team was rarely explicitly mentioned in any of our GP responses. However, there has been a recent focus by the prescribing team on joint GP-pharmacist reviews of care home patients and it can be reasonably assumed that many of the 16 respondents identifying review of polypharmacy/care home patients had pharmacist input in mind.

Although there has been substantial promotion of MO in the pharmaceutical press, it is unclear how MO has been promoted in the medical press. Certainly the MO good practice guidance for healthcare professionals1 was endorsed by the RCGP and it is understood that the RCGP would signpost this document to their members. Likewise the same MO guidance document has been mentioned in an NHS England press briefing,11 though these press releases may currently not be a key piece of GP reading material.

A larger earlier survey of healthcare professionals indicated a lack of clarity in understanding the difference between MM and MO.12 It may therefore have been unfair to ask our GPs to describe an approach that is still very much in a pharmacy mindset and that has not yet penetrated the GP mindset.

Limitations of our study relate to the authors’ own interpretation of the responses and the resulting categorisation, acknowledged concerns with questionnaire surveys and the relatively small number of GPs who were surveyed. Although our question, which required a free-text response, has the advantage of allowing the GP to freely express themselves, it also has the disadvantage of requiring more thought and time on the part of the respondent.

A common problem in questionnaire surveys is the tendency of people to give perceived desirable answers. Attempts to minimise this tendency were made by emphasising that the responses would be processed anonymously and that it would not be possible to link responses to demographic details of the respondent.

We also recognise those limitations associated with delivering a questionnaire that was brief and hence could be
completed quickly (with the aim of achieving a high response rate), as well gauging the views of GPs who attended meetings held specifically for other purposes and who, in their role of practice prescribing lead, could be described as a self-selected group.

Conclusion

The foreword to the Royal Pharmaceutical Society document notes that there is much to be done to help patients, public and society more broadly get best outcomes from medicines. We would argue that there is still much to be done to ensure that GPs fully understand the principles of MO and the actions required to adopt this new approach.

References


Declaration of interests

No interests to declare.

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