Letters

All letters are subject to editing and may be shortened. General letters can be sent to **bjgpdisc@rcgp.org.uk** (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication.
For submission instructions visit: **bjgp.org/letters**

Clinical pharmacists in general practice

The recent article by Williams *et al* estimated that one clinical pharmacist post in Westbourne Medical Centre saves a GP 80 hours a month.[1] Researchers in Dudley determined that 769.6 GP hours were saved by 5.4 full-time equivalent pharmacists over 4 months between September and December 2015.[2] This equates to one post saving a GP 35.6 hours per month.[2] We estimated the potential time saved for GPs by tasks being undertaken by part-time pharmacists in three general practices in Canberra, Australia, at 23% from May to December 2017. Assuming that a full-time pharmacist works 37.5 hours per week, our data suggest that 37.4 hours per month of GP time may be saved by one full-time pharmacist.

This comparison suggests that differences in GP hours saved may depend on the different activities undertaken by the pharmacists, their clinical experience, or the different methods of coding activities as a GP task.

Making a cost-effectiveness case for pharmacists in general practice is complex. Using GP hours saved alone underestimates the health economic value of pharmacists in general practice. Other contributions that can be considered include hospital admission avoidance due to safer prescribing,[1,3] reduced drug costs,[2] involvement in government payments for quality or specific services,[1,4] and improved clinical outcome measures.[5]

We agree that using GP hours saved implies that pharmacists are *'cheap doctors or expensive nurses'*[1] but feel that using GP hours saved will be a necessary component of cost-effectiveness calculations until pharmacists are universally accepted as essential to the general practice team.

Louise S Deeks,

Pharmacist Researcher, University of Canberra, Canberra.
Email: louise.deeks@canberra.edu.au

Sam Kosari,

Pharmacist Lecturer, University of Canberra, Canberra.

Mark Naunton,

Head of Discipline of Pharmacy, University of Canberra, Canberra.

REFERENCES

1. Williams S, Hayes J, Brad L. Clinical pharmacists in general practice: a necessity not a luxury? *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X694697.
2. Bush J, Langley CA, Jenkins D, *et al*. Clinical pharmacists in general practice: an initial evaluation of activity in one English primary care organisation. *Int J Pharm Pract* 2017; DOI: 10.1111/ijpp.12426.
3. Avery AJ, Rodgers S, Cantrill JA, *et al*. A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. *Lancet* 2012; **379(9823):** 1310–1319.
4. Deeks LS, Naunton M, Tay GH, *et al*. What can pharmacists do in general practice? Activities of pharmacists within general practice: a pilot. *Aust J Gen Pract* 2018; in press.
5. Tan EC, Stewart K, Elliott RA, *et al*. Pharmacist services provided in general practice clinics: a systematic review and meta-analysis. *Res Social Adm Pharm* 2014; **10(4):** 608–622.

DOI: https://doi.org/10.3399/bjgp18X697625

Long-term conditions and the National Diabetes Audit

The management of long-term conditions[1] in primary care has hit the headlines thanks to a report from the Academy of Medical Sciences,[2] which highlighted the clustering of different physical and mental health conditions in a single patient, and estimated that millions of Britons suffer from multimorbidity.

Diabetes is acknowledged as a condition where primary care clinicians should be well used to managing multimorbidity, and lessons may be learnt from this area. The National Diabetes Audit data[3] provide practice-level measures of diabetes outcomes including the numbers achieving target HbA1c and those at elevated risk of complications. We have recently published[4] multivariate analysis linking variation in these outcomes to the organisation of diabetes care.

There was a univariate relation between a higher percentage of 'No' responses to *'satisfaction with level of support for all LTC'* and a lower proportion of T2DM patients hitting target glycaemic control (TGC). Practices in the highest decile of patient rating with 3.0% 'No' response to this question had 68% TGC versus the lowest decile of ratings with 27.3% 'No' response associated with only 64% TGC. Interpolation gave a 1% increase in the TGC proportion at GP practice level associated with a 5.9% decrease in 'No' response.

We have shown how ensuring that patients with LTC feel listened to, involved, and cared for is a key way to make a difference to their clinical outcomes. Patients' perception of clinical care may be a significant determinant of clinical outcomes.

Adrian Heald,

School of Medicine and Manchester Academic Health Sciences Centre, University of Manchester, Manchester; Department of Diabetes and Endocrinology, Salford Royal Hospital, Salford.
Email: adrian.heald@manchester.ac.uk

Mike Stedman,

RES Consortium, Andover, Hampshire.

Sanam Farman,

Mersey Deanery Psychiatry Rotation, Liverpool.

Anthony Fryer,

Department of Clinical Biochemistry, University Hospitals of the North Midlands.

Sue Bailey,

Warwick Medical School, Warwick.

Roger Gadsby,

Chair, Choosing Wisely steering group of the Academy of Medical Royal Colleges, London.

REFERENCES

1. Mann C, Shaw A, Wye L, *et al*. A computer template to enhance patient-centredness in multimorbidity reviews: a qualitative evaluation in primary care. *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X696353.
2. The Academy of Medical Sciences. Global burden of multiple serious illnesses must be urgently addressed. https://acmedsci.ac.uk/more/news/global-burden-of-multiple-serious-illnesses-must-be-urgently-addressed (accessed 5 Jun 2018).
3. Heald AH, Livingston M, Fryer A, *et al*. Route to improving Type 1 diabetes mellitus glycaemic outcomes: real-world evidence taken from the National Diabetes Audit. *Diabet Med* 2018; **35(1):** 63–71.
4. Heald A, Livingston M, Malipatil N, *et al*. Improving type 2 diabetes mellitus glycaemic outcomes is possible without spending more on medication: lessons from the UK National Diabetes Audit. *Diabetes Obes Metab* 2017; **20(1):** 185–194.

DOI: https://doi.org/10.3399/bjgp18X697637