NHS
Surrey Heartlands
Clinical Commissioning Group

Surrey Heartlands CCG Guidance to PCNs about implementation of the Structured Medication Review and Medicines Optimisation Network Contract Directed Enhanced Service 2022/23

Date: March 2022

As part of the 2022/2023 national Network specification PCNs are required to implement Medication Reviews and Medicines Optimisation and to have due regard to NHS E & I guidance on Structured Medication Reviews and Medicines Optimisation.

Please find listed below some points of clarity:

a) What is an SMR? SMRs are a National Institute for Health and Care Excellence (NICE) approved clinical intervention that help people who have complex or problematic polypharmacy. SMRs are designed to be a comprehensive and clinical review of a patient's medicines and detailed aspects of their health. SMRs should be a structured, holistic and personalised review of an individual who is at risk of harm or medicines-related problems because of their current medicine regimen. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.

   A SMR is not considered complete until qualified consideration has been given to all the patient's medication; clinicians should be encouraged to collaborate with colleagues across the PCN and elsewhere, including acute care, and take a multidisciplinary approach to managing complex situations. Where prescribing is more complex (perhaps for some people with a learning disability or those at the end of their life), PCN clinicians undertaking SMRs should establish professional relationships and engage proactively with specialist pharmacists, consultants and other healthcare professionals working across the local healthcare system.

   SMRs should be an ongoing process in which an individual appointment or discussion constitutes an episode of care. Regular review and management should be undertaken and SMRs should not be treated as a one-off exercise.

   SMRs are **not:**
   - The act of re-authorising repeat prescriptions
   - A review of **some** specific medicines during a long-term condition review (SMRs must consider **all** the medicines a patient is taking or using)

b) How long will an SMR take? We expect that a SMR would take considerably longer than an average GP appointment, although the exact length should vary in line with the needs of the individual. PCNs should allow for flexibility in appointment length for SMRs, depending on the complexity of individual case.

c) How many SMRs is a PCN required to deliver? The number of SMRs a PCN is required to offer will be determined and limited by their clinical pharmacist capacity. It is not anticipated that any PCN in Surrey Heartlands has the capacity to offer initial, follow-up and reactive SMRs to **all** identified patients in the specified cohorts (see point e). The following will therefore apply:

- SMR is included within the IIF for 2022/23 under SMR-01: *Percentage of patients eligible to receive a Structured Medication Review who received a Structured Medication Review*. There is an **upper threshold of 62% and lower threshold of 44%** with this indicator allocated £12.0m / 53 points.
- The CCG are keen to ensure that the SMRs competed are of high quality and targeted to the patients that will benefit the most and not seen as a tick box exercise.
- It should be noted that the PCN can link with other clinical pharmacists, who meet the requirement to deliver an SMR (see point d) to help work towards their delivery of SMRs (i.e. not just PCN ARRS Clinical Pharmacists)
- PCNs will need to take account of the capability of their PCN ARRS Clinical Pharmacists (CP). Some CPs will be less experienced with SMRs, with some having recently enrolled on the Primary Care Pharmacy Educational Pathway (PCPEP), their competency should be considered when allocating SMRs and ensure process are established to discuss progress and lessons learnt (see point h)
- PCNs are required to demonstrate all reasonable ongoing efforts to reach sufficient capacity to deliver SMRs to **all** identified patients in the specified cohorts

d) Who can do an SMR? PCNs must ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop these, and should be able to take a holistic view of a patient's medication. Although clinical pharmacists primarily are expected to conduct SMRs, suitably qualified advanced nurse practitioners (ANPs) who meet the above criteria, as well as GPs, can also do so.

Specifically, pharmacists must have completed – or at least be enrolled on – the Primary Care Pharmacy Educational Pathway (PCPEP) or a similar training programme that includes independent prescribing (e.g. MOCH / CPGP). NHS E/I are working rapidly with Health Education England credential existing pharmacists who have the experience and skills but have never been through a PCPEP like pathway. It is expected/required that any ANPs who undertake SMRs are experienced in working in a generalist setting and able to take a holistic view of a patient's medication. Currently pharmacy technicians are not able to undertake SMRs.

As stated in point c PCNs will need to take into account the capability of their PCN ARRS Clinical Pharmacists (CP) in conducting SMRs as some will be less experienced with SMRs and only recently enrolled on the PCPEP. More complex patients should be prioritised for an SMR by a more experienced Clinical Pharmacist.

e) Which patients should be prioritised to receive an SMR? PCNs should **proactively** prioritise patients who would benefit from an SMR from the following groups:

1. Care home residents
2. Patients with complex and problematic polypharmacy, specifically those on 10 or more medications
3. Patients on medicines commonly associated with medication errors
4. Patients with severe frailty who are particularly isolated or housebound or who have had recent hospital admissions and/or falls

5. Patients using potentially addictive pain management medication

Surrey Heartlands CCG have produced searches to support PCNs in proactively identifying patients from the cohorts outlined above.

Where PCN clinical pharmacist capacity allows, and where patients are not covered by the criteria above, PCNs should also consider offering a SMR to any other patients they think would benefit from a SMR, including those prescribed multiple but fewer than 10 medications, and other potentially addictive medication.

PCNs should also have a process for identifying patients who **reactively** need to be referred for a SMR in cases such as:

1. Crisis or incident e.g. admission to hospital
2. Personal concerns about their medication
3. Professional referral about a patients medication
4. Request for a monitored dosage system as an aid to managing multiple medicines

f) <u>What should a PCN do if the proactively identified list of patients exceeds the capacity of the PCN Clinical Pharmacists?</u> Once the patients from the 5 priority cohorts have been identified PCNs should create a process for developing SMR caseloads so that the patients in greatest need of a SMR are seen in a timely manner, linked with PCN population health management data where possible. It is important that this work is linked with the available workforce to conduct the SMRs taking into account their capabilities (see point c)

PCNs should offer a range of appointment slots to cater for new SMRs and follow-up consultations as well as for those patients identified reactively.

Invitations for SMRs should be sent to patients explaining the benefits and what to expect from SMRs. Surrey Heartlands CCG have provided PCNs with a template letter.

g) <u>How should SMRs be coded?</u> **All** SMRs conducted must be coded using the structured medication review Snomed code: 2800911000000115

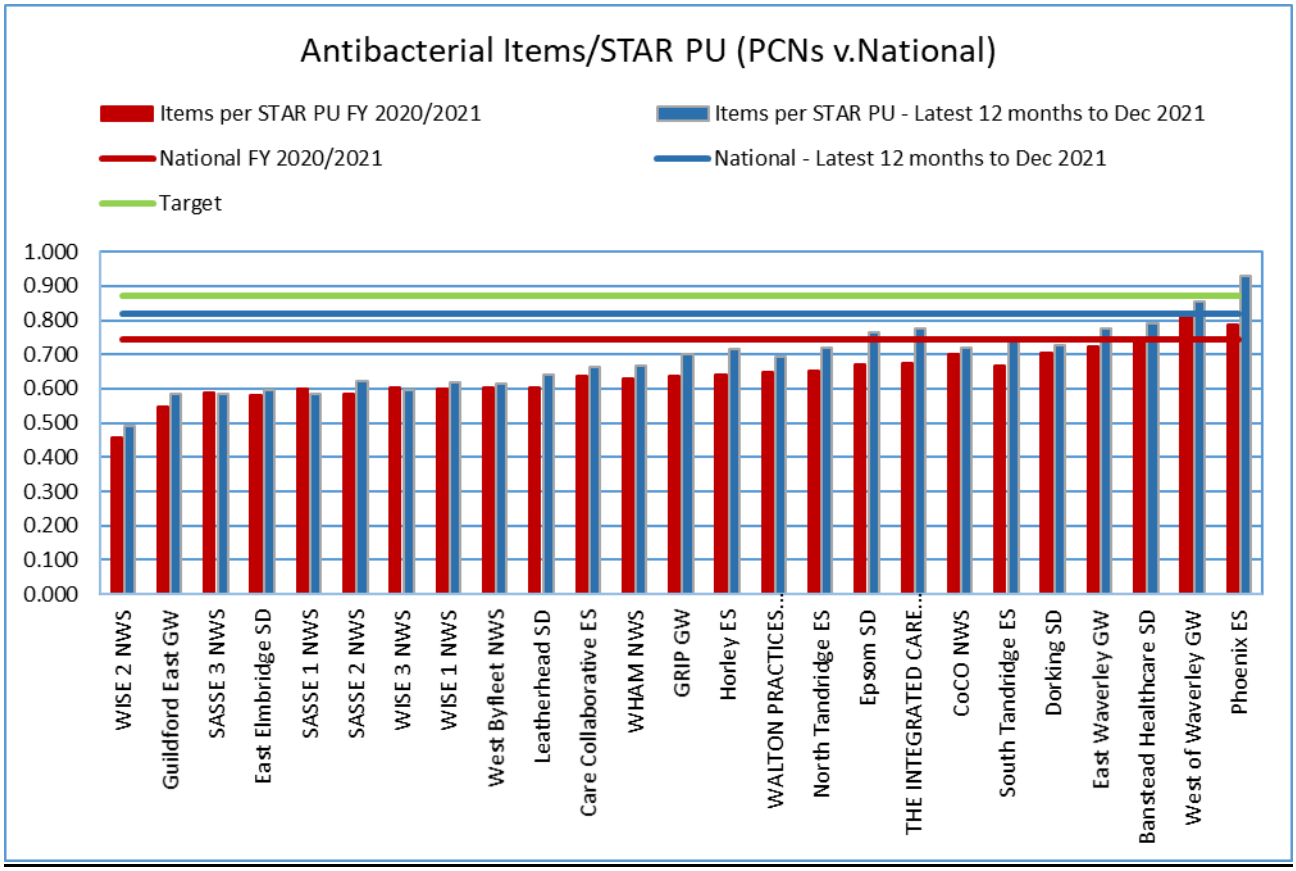
h) <u>Education and support for SMRs:</u> as the SMR DES is new it is particularly important to share learnings in order to drive up the quality of the SMRs being conducted and to mitigate against any concerns at an early stage. PCNs are will need to ensure processes are established to discuss progress made and lessons learnt. Alongside this the Surrey Heartland CCG ICP pharmacy networks moving forward will include time for wider discussions and support.

i) <u>Collaboration on wider medicines optimisation:</u> the NHS Long Term Plan sets out the aims for medicines optimisation to reduce inappropriate prescribing of:

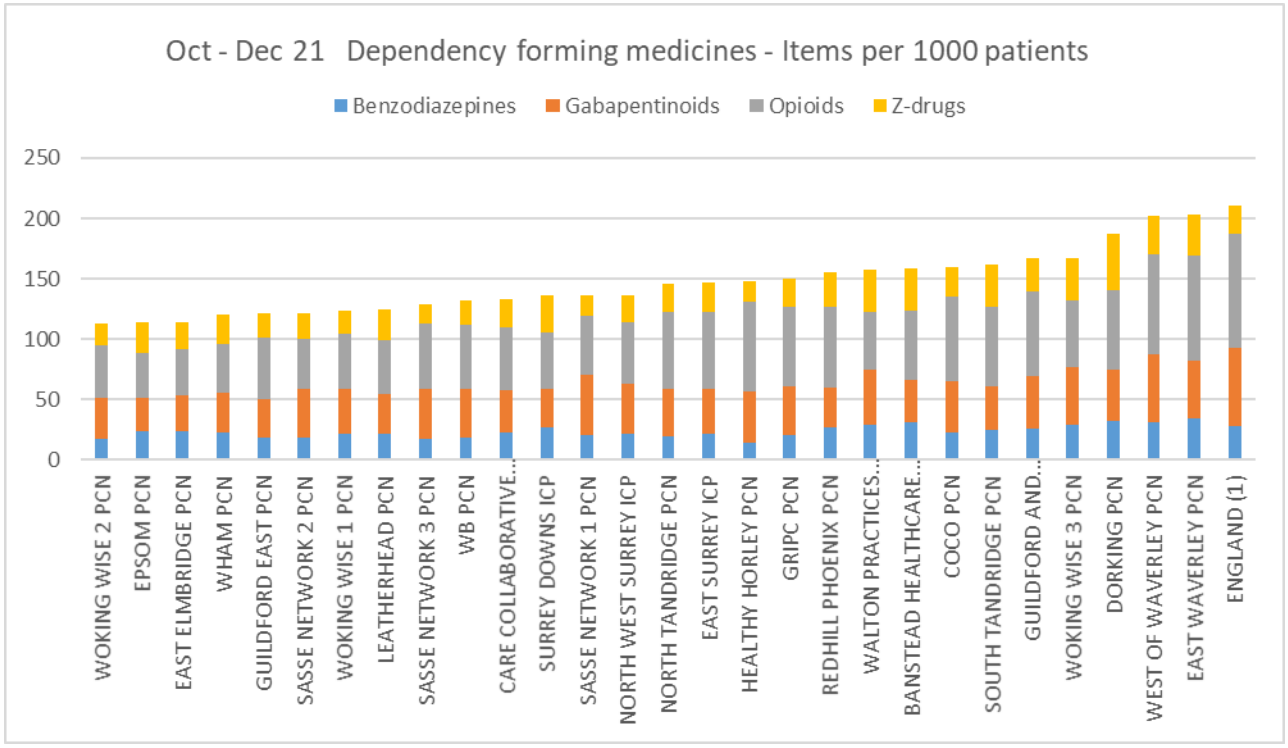
- Antimicrobials
- Medicines that can cause dependency
- Higher-carbon inhalers
- Nationally identified medicines of low priority

To help achieve these outcomes longer-term, PCNs must actively work with their CCG and at ICS level. For 22/23 PCNs within Surrey Heartlands should target this work based on the data sets below noting where they are an outlier either within Surrey Heartlands or nationally. Each PCN should work with their CCG medicines optimisation team member to agree a minimum of 2 priority areas for collaborative working.

Antimicrobials



Medicines which can cause dependency



Agreed by PCCC November 2020. Updated March 2022

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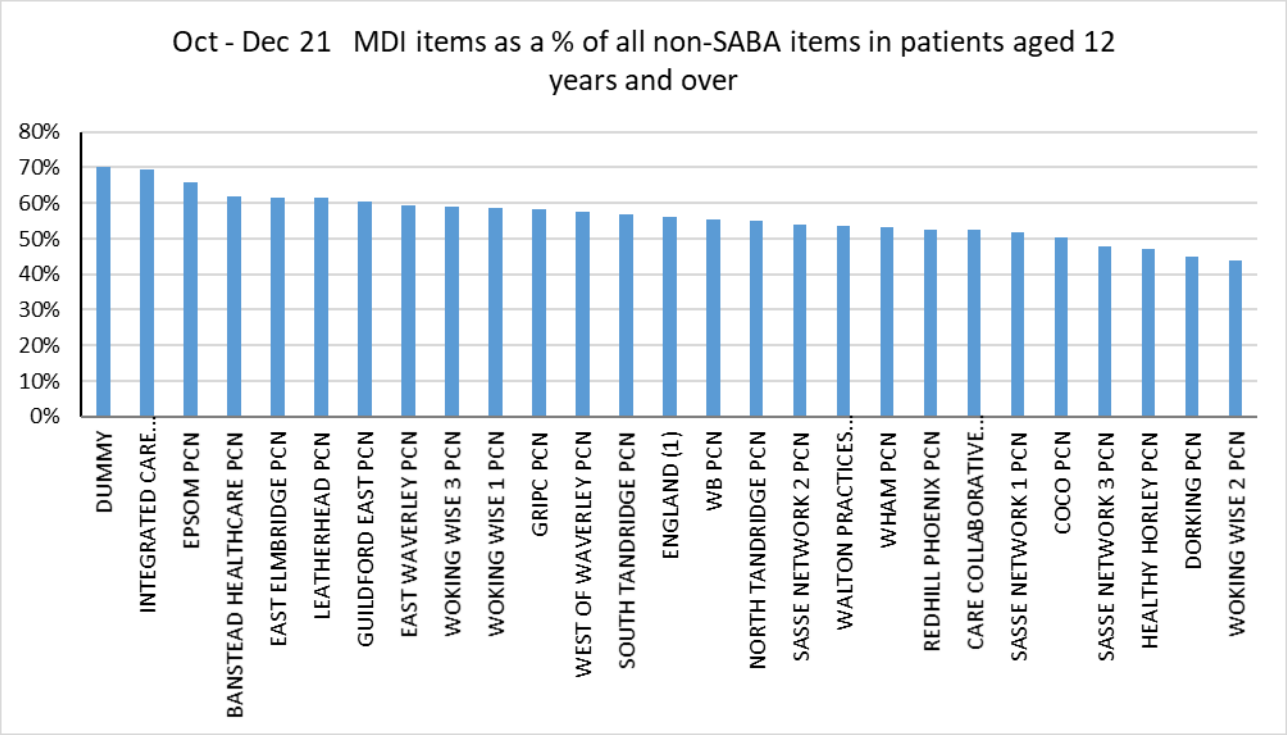
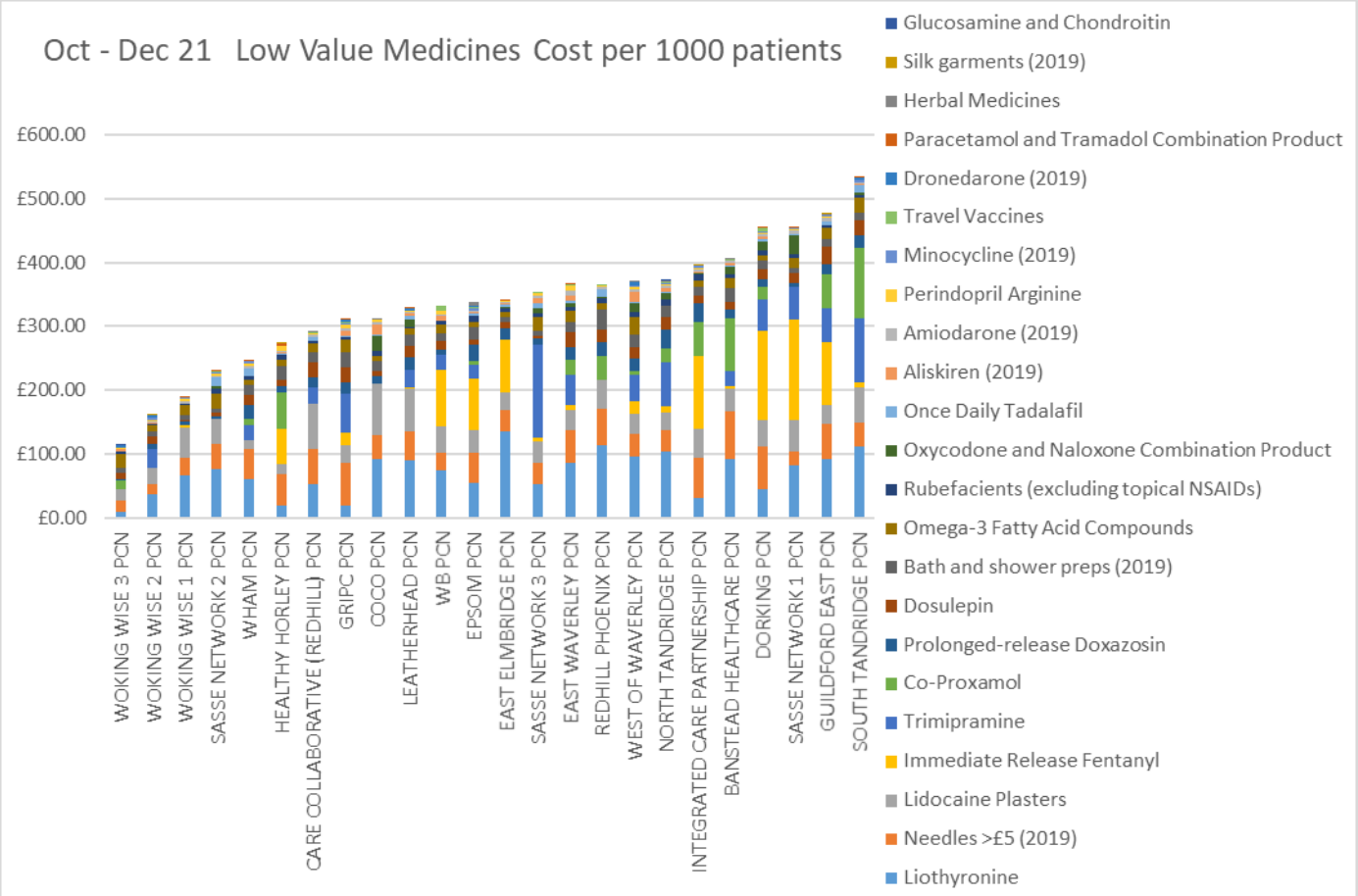
Metered dose inhalers where a low carbon alternative may be appropriate



Note: DUMMY represents the data of any GP Practices that are not aligned to a PCN (currently this only applies to a single practice in GW)

Nationally identified medicines of low priority



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