PCN ROUNDTABLE

STRUCTURED MEDICATION REVIEWS

Clinical directors and PCN pharmacists gave their verdict on structured medication reviews when they joined Pulse PCN editor *Victoria Vaughan* to discuss the service

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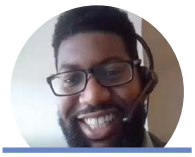

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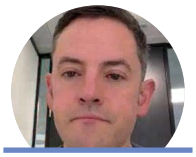

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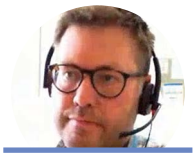

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Chair Victoria Vaughan
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Victoria How has the structured medication review (SMR) and medicines optimisation service specification worked in your PCN and benefited your practices and patients?

Saran I worked in primary care for 30 years as a pharmacist, so I have some issues with this whole idea of an SMR. It's just a new name for something that's been going on for years. I like patients to have their medications reviewed in a meaningful way. That might be a quick update for some patients, and something really complicated for others. If you've got pain patients, you'll probably have a number of encounters through the year. I'm not a big fan of the SMR introduction as part of the DES, but that said, it suits its purpose, doesn't it?

It has helped facilitate the recruitment of pharmacists into the PCN because if you're going to hit your targets and get some points, you need to have staff to do it.

At year-end we have got success in all the SMRs. I would have died of embarrassment if we hadn't as we've got a lot of staff focusing on it.

But it brings its own challenges. Some of them were great. The care home ones should have been really effective. But we took a view locally that we wouldn't do the pain management SMR because it was pointless – there were too many patients. We didn't even bother with it.

Having said that, we've got about 30 to 40% of SMRs on that category. It wasn't that we didn't bother at all – we do what we normally do. We didn't hit the target because it was a stupid target.

Elvis I agree. A real medication review should be thorough. We know that NICE guidance says they should be structured. It said it in 2014. So SMR is really just a term for us to do a piece of work that was assessed in a particular way as part of the investment and impact fund (IIF).

One of the interesting things that did come up is an aspect of standardisation. We cover quite a few practices where historically the medication review quality wasn't up to scratch. [The SMR] really did help and a lot of patients showed appreciation. Also, some patients hadn't had a medication review for absolutely ages. That was quite useful.

Paul I felt it posed a risk of eroding the continuity with the GP. And was it a SMR or a structured condition review? And was it actually more of a holistic review of the greater need?

Because you can review the conditions, but not review the person. It potentially eroded the role of general practice and didn't use the skills and experience of our pharmacy colleagues appropriately. That was partly because it was unclear from the start what the true objective of the SMR was. Was it about safety of medications, which is incredibly important? If it was about safety, focusing on medication was better than focusing on conditions. But it was also about reducing inappropriate referrals. It was aiming to be more proactive and therefore reduce GP demand. It was about upskilling. It was trying to do too many things with a relatively small amount of funding for too many patients.

Bal All general practice agrees you cannot continue your care of your patient without an SMR. It's like the old concept 'refer and forget'. You do the SMR and you forget. I've got some amazing bright pharmacists who are just sitting looking at a computer screen. They could offer so much, it's detrimental to their personal and professional development.

The IIF changes proved the targets were a waste of time
Dr Kieran Gilmartin

The two big areas I would [use] the SMR for are the interfacing of secondary care discharging and intermediate services. If we could start with those, we would make major transformational services. [We could] start with an SMR before the patient is discharged from hospital. If we did that, we'd change the face of general practice.

I think 90% of it is a good idea because it focuses our mind on an important area, but unfortunately it's become habit and rote. It's causing barriers and I'm not sure what the success of it is.

Victoria How did you receive the changes to the Network DES that removed the IIF indicators for the SMRs and what impact will they have?

Kieran The changes proved that the targets and everything they set were a waste of time. We all know that medication errors is a big area. But when you think [there were] 1.04bn prescriptions items 21/22, and there were around 43,000 medication errors that were classed as serious, that's a small percentage of the total – it's ridiculously low. But it's an area to improve.

Most of those errors are in the communication links where things fall between secondary care, primary care and community pharmacy

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We want to deal with everything patients need, especially after hospital discharge because they often aren't told what's happening

Saran Braybrook

because there are too many touch points. Removing it from the IIF completely was about the only good thing that was done. [As was] allowing our teams to get qualified in the areas they need to get qualified in to understand general practice as a whole, to get training they need, to take the workload that is appropriate as they train and qualify.

We started using clinical pharmacists in a very different way even with these crazy SMR targets. We concentrated on the clinical work [even though we missed out on] some of the funding. But in the grand scheme of things, the funding wasn't that much anyway because we've gained in the other areas that were more realistic and more achievable, and stuff that we were used to doing anyway.

We're focusing on the clinical context of doing SMRs on the right population, the highest risk population, those that are discharged from hospital as Bal said. All of those are getting reviews because we know a lot of the failure is there.

A lot of those [people] end up in care homes, so it links in with our home visiting team. That's the big thing we've noticed – having control over the different groups of staff who are in those areas that we've never had before. It's invaluable.

Victoria Does anyone feel that this change destabilised their clinical pharmacy team in any way?

Paul Quite the opposite. The NHS central team doesn't dictate to the Christie Cancer Hospital how a new cancer specialist should work to achieve better outcomes for cancer patients. Yet [it's thought that] the best way of managing general practice in a stressed environment is to dictate who does the work through the additional roles reimbursement (ARRS) scheme, and also how they should do it, and what a meaningful outcome or measure of success of that is.

We're seeing that with other elements in the contract as well including access targets. It's time [to put more] trust in the profession. I know this is said [a lot] through negotiations that the BMA general practitioners committee (GPC) is having at the moment. But [they should] hold us to account on meaningful outcomes that we all agree are reasonable signs of quality and safety.

And [they should} allow us to work with our pharmacy colleagues and other ARRS staff to achieve those outcomes in flexible ways. I'm a single partnership, I've got so much autonomy in terms of the ability to work with all my clinical colleagues and non clinical colleagues across 160 staff. We've got huge potential but [these structures mean] we were held back [from] doing the things we really wanted to do and using people's skills most appropriately.

So yes, I feel freed by the lack of it.

What worries me is that it's still in the letter of the contract. To what extent will they still performance-manage us without those targets? If I cannot prove I am doing an SMR, how can I assure NHS England that I should be paid? I'm sure my pharmacist and GP colleagues aren't twiddling their thumbs, but it is important that we have a way of assuring the centre that we're doing the work.

Dan Our pharmacists help us support the population health management stuff, [for instance] all the patients who haven't had their BP correctly controlled during Covid, and all our COPD patients. They work with the teams to do that first cut after working out that patients are on the correct medication and everything's happening correctly. That's key for us.

It's the thing the NHS doesn't do particularly well – sowing a seed now to have a plant in 10 years' time. We all talk about the prevention agenda, but we are not enabled to do it [against] the backdrop of access at all costs.

Victoria What's been the benefit of having clinical pharmacists in PCNs and more available to practices?

Saran We need to remember all PCNs are at different levels of maturity. Our PCN has only recently got pharmacists within the last 18 months. Some [of our] practices still don't have them or have got remote pharmacists. It's still very new and this will allow us the time to really rethink the priorities.

When patients call, for whatever reason, we [would like to] deal with everything they need in one go. Like Bal says, with discharge patients, often there are lot of issues that haven't been dealt with. We'll be able to deal with that and that will help our access, the phone calls to the practice, [and] the GPs. Most of all it'll help patients because they'll have someone telling them what's going on, and otherwise they probably won't know.

[I don't think we know] the value of pharmacists and pharmacy technicians. When the national data come out for the dashboard, we'll know we've done lots of SMRs and stuff, but we ought to be asking patients and engaging more.

Elvis The SMR aspect of the IIF last year was unclear in terms of the objectives. That may reflect the uncertainty of what is expected from clinical pharmacists in general practice as a whole. You will find in various different places, different pharmacists are doing very different things.

When pharmacists come into general practice it's different from other areas. They need to understand the way teams work. They need to understand the priorities of general practice as well.

Obviously, one of the key things is to broaden their knowledge in general practice, [over] a whole breadth of conditions, and to a fairly deep level as well. And so that does take time. There is a Centre for Postgraduate Pharmacy Education (CPPE) pathway that allows pharmacists to improve their skills and gain clinical examination skills as well, over a period 18 months. But that can feel like eternity for practices that are in dire need of pharmacists. It could probably be quicker.

Paul We've now adopted a personalised list approach, so our pharmacists and our pharmacy techs work alongside us to proactively review medications in a virtual way, in advance of a patient's annual review, before we see or speak to them. That works very well.

That's nothing about working at scale. If anything it's the opposite of working at scale. It's a colleague who's skilled and knowledgeable about the medications sitting with me and upskilling me, [while I] look at the conditions side of things. It's got huge potential. The national thing is about working at scale, [but] working at scale is not always the most efficient use of our team.

Our pharmacists have said they're lucky, because they work alongside one group of GPs in the same practice, with the same policies, the same

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procedures, the same clinical record. I recognise we're relatively lucky from that point of view.

Saran I love Paul's example because you work at these targets and things develop as you go along. I found one of the best ways of doing care home reviews was to put a summary in the notes ready for whoever is going out [to visit]. We are moving towards a more holistic approach.

The SMR was almost a red herring because sometimes we're at our best when we're all doing bits and pieces [that are] then put together. We're feeling our way because there isn't any defined way.

And following on from Elvis, the national pathway is shocking. It's appalling. It's a waste of time from my perspective. From what I've seen, pharmacists that don't have much experience [are] trained to be little doctors, which is not what we need. And speaking as an experienced clinical pharmacist who's just done the pathway, it's a slog and a waste of time. So we don't have a pathway or training that helps pharmacists learn how to work in a general practice, which is interesting for me at this stage in the fifth year of the DES.

Victoria Has anyone figured out a better way of supporting pharmacists in their PCN?

Saran It's about networking. I'm working across a massive geographical area and we're recruiting when a lot of places can't, because people want to come as they can see we've got a big team. We have a monthly networking meeting. We work together, we put support in. Everyone's different.

I did think when I started this, 'any pharmacist and any technician could fit into these roles'. But after a couple of years, we've just had one pharmacist leave for a hospital job where they will be better supported. It's quite an isolated, vulnerable role for pharmacists at this stage while our training doesn't support it.

To pick up Bal's point, I'd like to see pharmacist roles where the hospital pharmacists also work in a GP practice, because then they can see the trauma they cause by writing something stupid on the prescription. Equally, if a primary care pharmacist had to work in hospital, they'd understand why it's so hard and why discharges sometimes come out with nothing helpful.

"Working at scale is not always the best use of our team

Dr Paul Bowen

We need a more integrated approach, for instance, at our community hospitals. Nurses put patients on a dosette or monitored dosage system (MDS), with no pharmaceutical assessment. The patient medicines supply comes under the care of the practice and any willing local community pharmacy. MDS is difficult to stop once started and It sucks up so many resources that should be reserved for patients that need it to keep them independently living at home. Often all that's needed is a medicines review and deprescribing. MDS is not what the patient needs long term but is a quick way of getting them out of hospital into primary care, but it eats up a lot of resources in the wrong way.

Bal We're into the fourth year of the DES. ARRS roles are in place. We're hearing that ARRS funding will continue [in 2024 and beyond]. And yet, we still have a central diktat of what a clinical pharmacist should do – the national pathway. I didn't even recognise the job description for a clinical pharmacist in the DES. I don't know who wrote that. We're talking as if they're transitory things that we'll do this year because next year the real stuff's going to happen. We need to move on from that.

My challenge back to you, Saran and Elvis, is to ask what is your own profession doing about it? It's not for me to tell your colleagues what the support structure for a clinical pharmacist is. The profession needs to recognise that you're not transitory. That conversation [doesn't seem to be] going on in the pharmacy world either.

Saran I agree Bal. It's a problem for our profession because primary care pharmacists are a very small percentage. We're never going to be the

I want to create a hub so pharmacists in each PCN can work together, share knowledge and cross-pollinate

Dr Dan Bunstone

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priority and we're the ones that are sucking the life out of the other two areas where pharmacists work. I'm not sure we're ready to do that yet. I'd like to see our NHS workforce be planned and thought through. [I'd like us to] do integrated training together, pharmacists and GPs. That's how it worked in hospital clinical pharmacy.

I trained in hospital 30 years ago, and clinical pharmacist means something different to me from what the DES says. It means someone's that's got an accredited clinical diploma or extensive experience working in the hospital or maybe supervising primary care.

I think it's coming, it's not there yet, it's just a matter of time. I love your idea about thinking long term and that this is not transitory. We need to get that into NHS England.

Victoria How do you fit in with the wider NHS, with the medicines optimisation teams at integrated care boards (ICBs), hospital pharmacy and community pharmacy teams?

Kieran We've had a pharmacy team for the last four years and it is building up those links, especially with community pharmacies, and between pharmacists and pharmacy techs in the PCN and community teams.

Obviously there are fewer pharmacies because they're closing in droves. We've got three pharmacies closing in our PCN area.

Hospital [pharmacy] is trickier because they are still siloed. They're still located in one area in most hospitals as part of the churn of discharges. The medicines optimisation teams in the old clinical commissioning groups (CCGs) are now in the ICBs. Some of that work is being pushed in our direction, and every time I kindly push it back. Because at the end of the day, that's what they're there for. They're not doing clinical work, they're just reducing the budget for the prescribing budget. That's the only thing I've ever seen in 20 years of being a doctor.

Dan The PCN team link with the place-based medicines management team. They have regular monthly meetings because there's a theoretical overlap. They work around that to create common goals. Some of the SMR stuff and care home work that the local medicines management team want to do is wrapped into a realistic piece and pulled together.

Victoria What's the possibility, the capacity and the potential for this service? What could you achieve with what you've got now for the future health of your patients?

Dan I'd want to create a hub so that pharmacists in each PCN will work together, cross-pollinate and share their knowledge. They will have targets to meet. They'll support through triage, [and] some of the forward-facing patient activity – dealing with minor ailments, dealing with more complex problems, and of course, dealing with specialty areas too, [perhaps] menopause or hypertension. And ultimately [they will] help us to manage long-term conditions more proactively, and better. At the moment, if you look at hypertension, it's not being managed perfectly, and that's because we're having to deal with other areas first.

Elvis Following on from Dan, we actually have an e-hub. We're still bringing it together but there will be a pharmacist doing triage and acute stuff. It will take work away from practices, but also [it creates] job satisfaction for the pharmacists as well. There's career progression and variety. That's important as we're thinking about pharmacists coming into general practice and we've got to keep them there, otherwise we [will] have the same issue we've got with GPs. We need to think about retention.

Paul My concern is this: while we need to focus on increasing and improving the offer of general practice in medications and pharmacy services, we can't do it in isolation. It's no good having fantastic SMRs for some of our most frail, complex patients, yet not have enough nurses simply to take their blood pressure. We have to look at the bigger picture. Alongside those pharmacists, we also need all the other clinical staff that can make a just-about-managing service into an excellent and fully optimised service.

Saran I want to work in more personalised and focused [patient] care. The NHS keeps telling us to sign up to shared decision-making. It's time the NHS management signed up for shared decision-making learning, because it needs to stop giving us targets to put people on statins that they don't want. We need to listen [to patients]. And the NHS management needs to listen.

We need more focus on systems, too. We've plonked pharmacists into primary care. We need to make sure we enable pharmacists to work at the top of their licence and change our workflows. We could do things more effectively in primary care if we work around the patient, and around what they really need and want, instead of what the NHS target is.

I'd like to see more integrated roles across community services, across hospitals and community pharmacy. [Then] we'll all see, and we'll stop offloading our problem patients to each other, and we'll start managing them in a different way. And I'd like to see a workforce plan. One that will actually take us all together and, particularly for the pharmacists, take them from their early years into training. They'll get supervision in lots of different areas. They'll have career development.