Standardised Medication Reviews

Medicines Optimisations Schemes

1. CCG incentive scheme – Practice Level
    - savings, DOAC and OAB review

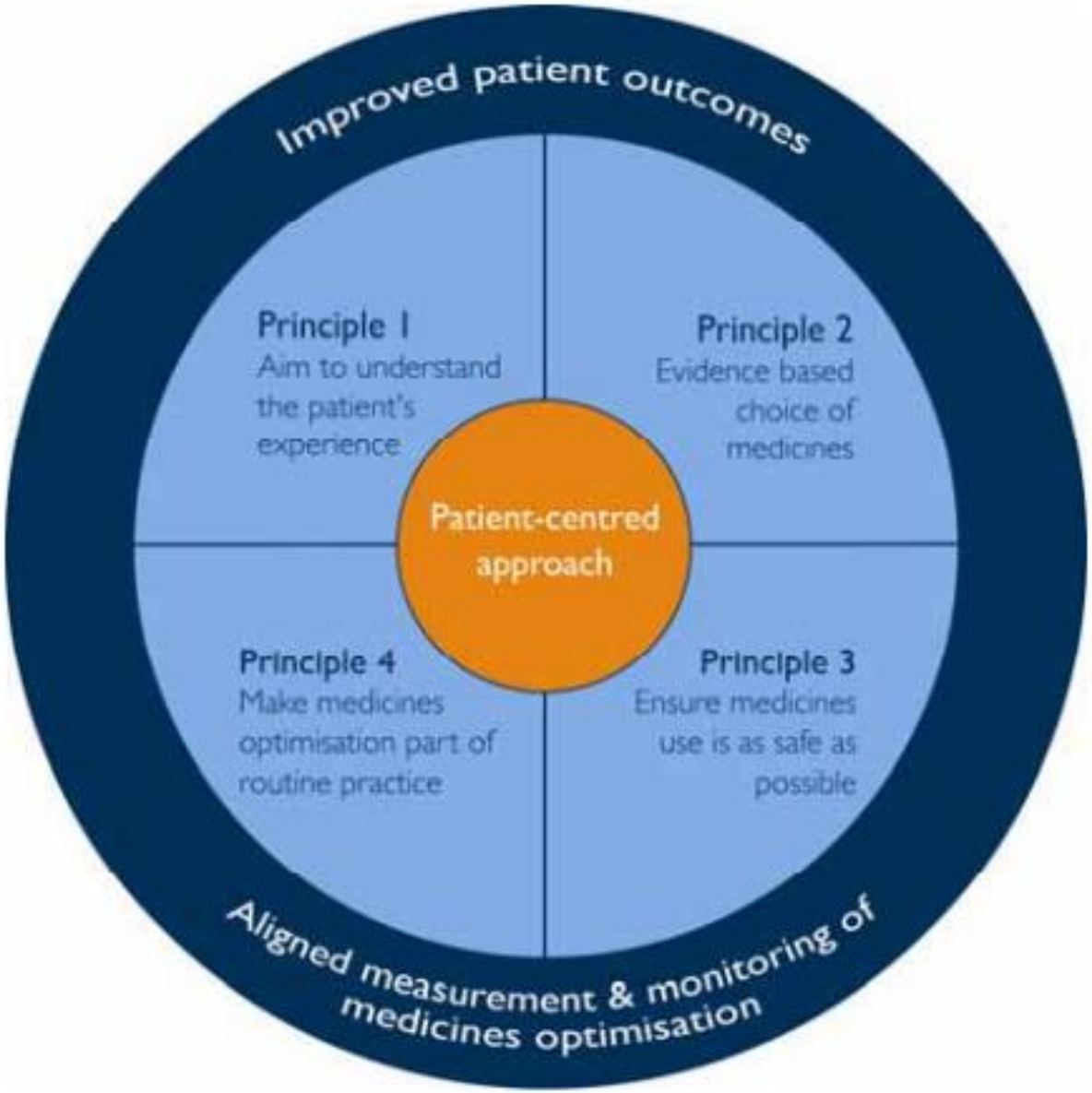
2. NHSE - Investment and Impact Fund (IFF) – Network Contract DES
    - Age 65 and over on NSAID without gastro-protection
    - Age 18 and over on an anticoagulant and antiplatelet without gastro-protection
    - Age 18 and over on aspirin and another antiplatelet without gastro-protection
    - https://www.england.nhs.uk/wp-content/uploads/2020/09/IIF-Implementation-Guidance-2020-21-Final.pdf

3. NHSE- Structured Medication Reviews (SMRs) – Network Contract DES
    - Read service spec
    - https://www.england.nhs.uk/wp-content/uploads/2020/09/SMR-Spec-Guidance-2020-21-FINAL-.pdf

PCPA are also running a more detailed webinar on the network DES from 8-9pm on October 15th which you can sign up for from the following link:

https://pcpa.org.uk/webinar-event-details.html?EventID=43

Four Principles of Medicines Optimisation



About SMRs

- SMRs are a comprehensive and clinical review of **all** of a patient's medicines and detailed aspects of their health.
- Evidence shows they improve patient outcomes, reduce adverse drug reactions and medication related admissions.
- They should also address inappropriate antibiotic prescribing (retrospectively ?), ensure better value for money for the NHS, reduce waste and improve environmental sustainability (low carbon footprint inhalers).
- Clinicians should conduct SMRs in line with the principles of shared decision-making: consider the health literacy and holistic needs of the patient, provide advice and signpost, and make onward referrals where appropriate.
- New responsibilities include signposting to healthy living pharmacies and giving information about possible 'very brief advice' interventions including smoking, falls and frailty, physical activity, weight management, and alcohol.

Identification of patients

- **Patients must include those:**
  - in care homes
  - with complex and problematic polypharmacy, specifically those on 10 or more medications
  - on medicines commonly associated with medication errors (harm) GI bleed, AKI, pain, fractures, respiratory and anticholinergic burden.
  - with severe frailty who are particularly isolated or housebound or who have had recent hospital admissions and/or falls
  - using potentially addictive pain management medication.

There is expectation for NHSE that those patients identified as clinically vulnerable to COVID-19 will be among the groups to be prioritised for a SMR.

- **Reactive triggers for SMR**
  - Crisis or incident eg hospital admission
  - Personal Concerns
  - Professional referral
  - MDS request

How many?

- The number of SMRs will be determined and limited by their clinical pharmacist capacity. PCNs and commissioners must discuss and agree a reasonable volume of SMRs.
- In estimating available capacity, CCGs and PCNs should acknowledge that clinical pharmacists have a variety of responsibilities and not all of their hours should be spent on SMRs.
- 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.
- The commissioner must also be assured that the PCN continues to demonstrate all reasonable ongoing efforts to reach sufficient capacity: for example, by establishing regular **SMR audit meetings** to discuss progress, priorities and lessons learnt.

Who can do them?

- 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.
- It is expected/required that any Advanced Nurse Practitioners who undertake SMRs are experienced in working in a generalist setting and able to take a holistic view of a patient's medication.
- It is expected that a number of GP appointments may be avoided when individuals have a proactive SMR: supporting the alleviation of workload pressures on GPs and reducing the risk of harm to patients.

Collaboration in wider meds opt

- The NHS Long Term Plan sets out the aims for medicines optimisation to reduce inappropriate prescribing of
  - (a) antimicrobials,
  - (b) medicines that can cause dependency,
  - (c) higher-carbon inhalers and
  - (d) nationally identified medicines of low priority.

- To help achieve these outcomes longer-term, PCNs must actively work with their CCG and at ICS/STP level, to share expertise and lessons learned: for example, to integrate national-level programmes, such as the AMR action plan and STOMP (stopping over medication of people with a learning disability, autism or both with psychotropic medicines)

New Medicines Service

- PCNs are required to work with community pharmacies to connect patients appropriately to the New Medicine Service, which supports adherence to newly prescribed medicines. The service currently supports people with the following conditions who have been prescribed a new medicine:

  - asthma
  - chronic obstructive pulmonary disease (COPD)
  - type 2 diabetes
  - high blood pressure (hypertension)
  - who have been given a new blood-thinning medicine.