Advisory note to members regarding Structured Medication Review

October 2024

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Introduction

The term 'structured medication review' was first noted in NICE guidance and went on to be included in the 2019 guidance accompanying the introduction of Primary Care Networks (PCN) and the Designated Enhanced Service (DES) which runs alongside the existing GMS contract. There were clear instructions on which healthcare professionals could undertake Structured Medication Reviews (SMRs) and what they should include.

Despite this, the PDA is receiving an increasing number of calls from members who are being pressurised to undertake SMRs when they lack the required training and skills, or to reduce the time taken to a level which renders the review ineffectual and possibly pointless.

What the PCN DES states about SMRs

Structured Medication Reviews (SMRs) are a NICE approved clinical intervention that help people who have complex or problematic polypharmacy[1]. SMRs are designed to be a comprehensive and clinical review of a patient's medicines and detailed aspects of their health and are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.

Evidence shows that people with long-term conditions using multiple medicines have better clinical and personal outcomes following an SMR[2]. Timely application of SMRs to individuals most at risk from problematic polypharmacy will support a reduction in hospital admissions caused by medicines-related harm in primary care. It is estimated that £400 million is wasted in unnecessary medicines-related harm admissions to hospital annually.[3]

It is evident from these two paragraphs that the type of patients suitable for and most likely to benefit from a SMR are not individuals whose medication regime can generally be reviewed in as little as 10-20 minutes. Indeed, tackling problematic polypharmacy to improve patient quality of life and reduce unnecessary hospital admissions was deemed important enough for NHS England to commission the Health Innovation Network to provide a series of Polypharmacy Action Learning Sets for GPs, pharmacists and other healthcare professionals (HCPs) with a minimum of one year's prescribing experience to help them get the most from polypharmacy medication review.

The patient groups recommended for SMR in the original DES document were as follows:

- All patients in care homes as per the Enhanced Health in Care Home specification
- Patients with complex and problematic polypharmacy, specifically those on 10 or more medications

[1] https://www.england.nhs.uk/wp-content/uploads/2020/09/SMR-Spec-Guidance-2020-21-FINAL-.pdf
[2] NICE Guideline 5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015
[3] Parekh N, Ali K, Stevenson J, et al. Incidence and cost of medication harm in older adults following hospital discharge: a multicentre prospective study in the UK. Br J Clin Pharmacol 2018. https://bpspubs.onlinelibrary.wiley.com/doi/10.1111/bcp.13613

- Patients who are being prescribed medicines that are commonly and consistently associated with medication errors
- Patients with multiple long-term conditions and/or multiple comorbidities – in particular respiratory disease and cardiovascular disease
- Housebound, isolated patients and those with frailty – particularly patients who have had recent admissions to hospital and/or falls
- Patients who have received a comprehensive geriatric assessment as per the anticipatory care requirements
- Patients with severe frailty
- Patients prescribed high numbers of addictive pain management medication.

What the PCN DES document says about HCPs suitable to carry out SMRs

PCNs must ensure that only appropriately trained clinicians working within their sphere of competence should 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 skills – and must be able to take a holistic view of a patient's medication. This could include:

- *Clinical Pharmacists*
- *General Practitioners*
- *Advanced Nurse Practitioners*

Despite the guidance above, direct reports from our members and published research[4] have shown that pharmacists new to working in general practice have been expected to undertake SMRs very soon after commencing work in general practice and before they have received sufficient training and support to ensure that their reviews will provide the improvements in patient safety and quality of life possible. When one considers the frailty and medical vulnerability of the types of patients recommended for SMR, this approach appears counterproductive, and it is regrettable that the wording "*or be enrolled in a current training pathway to develop these skills*" was ever included in PCN DES documentation. The selection of clinicians to undertake SMR should always have been based on experience, skills and competence, not on enrolment on an 18-month programme.

Supportive approaches where newer pharmacists receive initial instruction and then are provided with supervision and support when they start carrying out their own reviews can help pharmacists to build up their knowledge and skills safely and effectively. It should be borne in mind that patients on multiple medicines may well require several appointments, particularly if changes and deprescribing are taking place, as these actions are best done in a stepwise fashion rather that making several changes simultaneously.

The 2024 PCN DES document is clear that supervisors are responsible for ensuring that individuals are competent to undertake the duties delegated to them – this echoes Care Quality Commission expectations.

[4] British Journal of General Practice 2022; 72 (722): e641-e648. DOI: https://doi.org/10.3399/BJGP.2022.0014

Length of time for an SMR

The PCN DES document contained the following guidance:

We expect that undertaking a SMR would take considerably longer than an average GP appointment, although the exact length should vary. PCNs should allow for flexibility in appointment length for SMRs depending on the level of complexity presenting with individual cases. Clinicians should conduct SMRs in line with the principles of shared decision-making, and consider the holistic needs of the patient, providing advice, signposting and making onward referrals where relevant…

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.

Whilst as noted above there can be no 'set time' for undertaking an SMR, the level of supporting work and time required to have meaningful discussions with patients means that any patient on more complex medications or taking significant numbers of medicines will require a consultation which is longer than 10-20 minutes. The guidance also makes it clear that an SMR process can rarely be completed within a single consultation, but will require a series of meetings, particularly when changes to medications are being implemented and monitored. Professor Tony Avery, National Clinical Director for Prescribing at NHS England, speaking at a conference in 2022 made it clear that the minimum time allocated for SMR should be 30 minutes[5]. Professor Avery's presentation included a slide with the following statements:

"For example, there is currently no fixed length for a SMR, though they are expected to last at least 30 minutes,"

"It is important that SMRs are maintained in terms of their quality, including the time allocated for each one and the experiences of patients taking part."

What the PDA is hearing from members

- The PDA has received multiple reports of pharmacists who are very new to general practice, and who may only just have started the Centre for Postgraduate Pharmacy Education's Primary Care Pharmacy Education Pathway, being expected to deliver SMRs. This is not appropriate unless the patients involved are significantly less complex than suggested by NHS England – in which case they would potentially seem less of a priority for SMRs and the appropriateness of coding any such review as an SMR could reasonably be called into question.
- The PDA has received reports of pharmacists being criticised, subjected to 'time-trials' and accused of 'incompetence' because they are not completing SMRs in 15-20 minutes.

[5] *The Pharmaceutical Journal*, PJ, June 2022, Vol 308, No 7962;308(7962)::DOI:10.1211/PJ.2022.1.145918: Structured medication reviews should last at least 30 minutes, confirms NHS lead - The Pharmaceutical Journal (pharmaceutical-journal.com)

The PDA's view

The PDA finds it deeply disappointing that an intervention which has been given the level of importance it has by NHS England, and some of the pharmacists who provide that intervention, are being treated so dismissively. The evidence of patient morbidity and economic damage caused by iatrogenic disease resulting in hospital admissions has been apparent for years. The failure to provide patients with an *effective* review of their medicines and opportunity to discuss therapy and agree ongoing care has real consequences.

Whilst 30 minutes is suggested as a minimum in the quote above, some schools of thought believe that appointments lasting more than 30 minutes may result in patients being given more information than they can effectively absorb. If this is the case, a series of appointments should be provided to ensure patients receive the optimal support.

If practices are concerned about the time which SMRs can take, then they could make the whole process more streamlined by ensuring that their in-house processes for ordering and recording of blood tests, coding of diagnoses, problem-linking of medicines, measurement of blood pressure, weight, etc are up-to-date, completed and recorded in a timely fashion – and that test results are acted upon where they indicate that action is required. This would remove a significant additional time commitment which pharmacists need to spend gathering this information before they can undertake the SMR. Those practices which have used skill mix to ensure that appropriate staff are keeping all of these administrative house-keeping elements up to date have pharmacists who can complete some SMRs and medication reviews more rapidly. Those practices with pharmacy technicians could consider utilising their skills to support SMRs by undertaking these preparatory tasks before handing patients over to their pharmacist colleagues to undertake the SMR.

PCNs and practices need to ensure that they are delegating the delivery of SMRs and medication reviews to staff members who are competent to carry out these duties effectively and therefore realise the safety, improved outcomes, and patient satisfaction benefits which follow.

If members are experiencing any of the concerns outlined in this article, we would like to hear from you. Contact us via policy@the-pda.org.