POOLE BAY & BOURNEMOUTH
PRIMARY CARE NETWORK

Delivering through SMRs: from identification to review

Steve Williams
Senior Clinical Pharmacist

SPS Webinar
23rd Nov 2022

Plan for session

- Introduction to my views on Overprescribing agenda
- My PCN landscape
- SMR guidance
- SMR variability within ICBs
- SMR identification within a PCN
- SMR Review by Pharmacists
- Gold standard: SMR and holistic LTC one stop reviews
- Questions

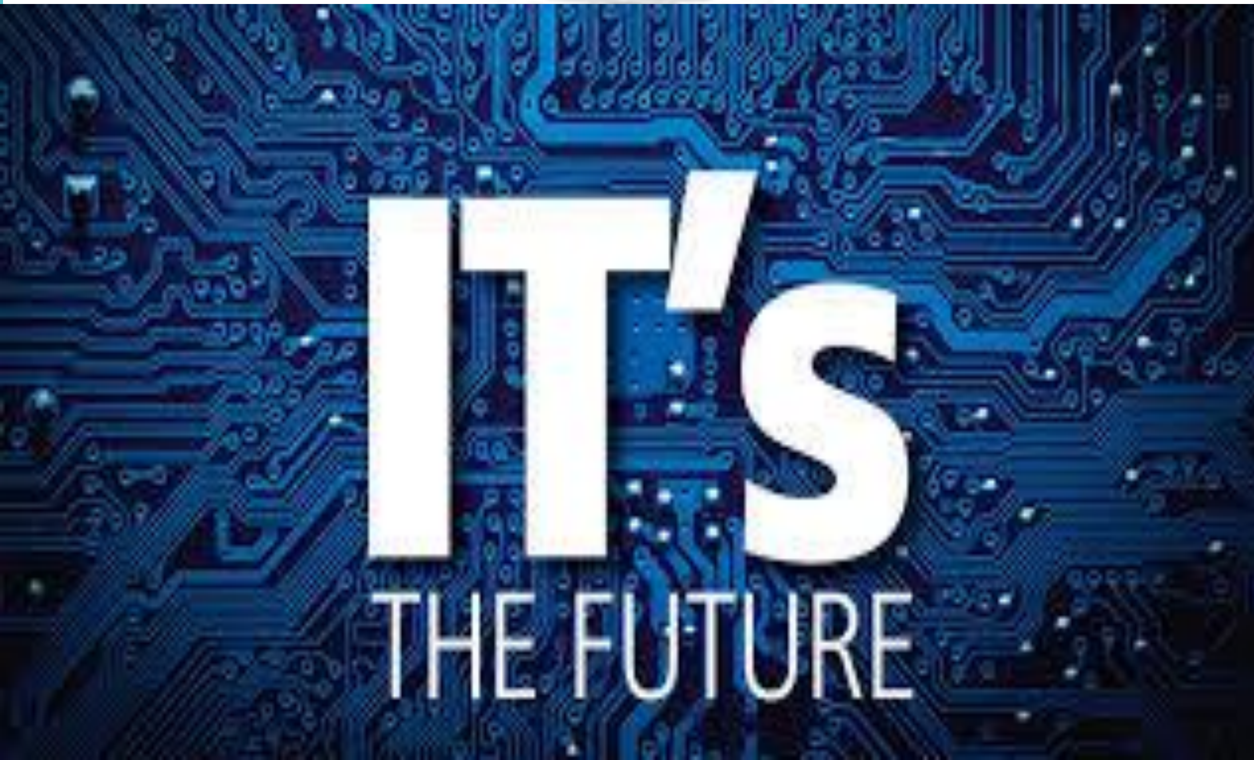
The optimal use of medicines is fundamental to the health and wellbeing of the nation. Clinical pharmacists working in every new primary care net-works multidisciplinary team will deliver this challenge because if we keep adding medicines and never subtracting, we multiply the problems for patients.

Steve Williams

Senior Clinical Pharmacist, Bay PCN, and member of the National Overprescribing Review Short Life Working Group

Declarations of Interest

- Non-Medical Prescribing rep NHS Regional Medicines Optimisation Committee (South)
- Honorary Clinical Lecturer University of Manchester Pharmacy School
- Lead Clinical Pharmacist PrescQIPP Practice Plus
- One Less Pill Ltd consultancy
- Co-host of the Aural Apothecary Podcast
- Pharma - Nil


IT'S
THE FUTURE

Life is a marathon, not a sprint;
pace yourself accordingly.
Amby Burfoot
quotefancy

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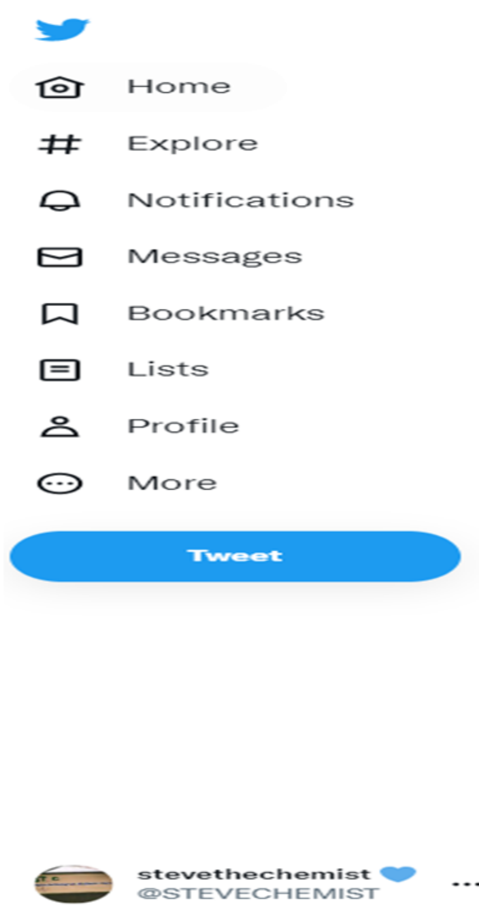
PRIMARY CARE NETWORK

Medicines Expertise in a PCN in 2022 : A Necessity not a Luxury Philosophy

- Subtlety + Complexity
- Holistic v Atomistic
- Proactive v Reactive
- Metrics (Process v Outcome)
- Multi-disciplinary v Uni-disciplinary
- Right people, right jobs
- Learning organisations & Behaviour change
- Medicolegal vulnerability
- Communication within PCN & ICS
- **Clinical Leadership**

Top 3 things to help with overprescribing in Primary Care ?



Poole Bay & Bournemouth
Primary Care Network

Practice	Number of patients		Number of patients with 1 or more repeat med issued in last 6 mths		Number of items issued btw Oct 21 and Mar 22	Number of patients on 10+ medicines		Number of patients aged 65 or over		Number of patients aged 85 or over		Number of patients with moderate / severe		Number of patients in a care home*		Number of patients housebound (not in a care	
Denmark	10,465	26%	3,854	37%	80,909	162	1.5%	1,500	14.3%	190	1.8%	200	1.9%	58	0.6%	77	0.7%
Westbourne	19,848	49%	8,530	43%	155,275	220	1.1%	5,417	27.3%	1,081	5.4%	885	4.5%	290	1.5%	163	0.8%
Winton	10,349	25%	3,244	31%	66,402	127	1.2%	1,601	15.5%	254	2.5%	91	0.9%	62	0.6%	39	0.4%
PCN Total	40,662		15,628	38%	302,586	509	1.3%	8,518	20.9%	1,525	3.8%	1,176	2.9%	410	1.0%	279	0.7%

PCN patient profile as at 30/06/2022

** Dependent on correct coding*

Poole Bay & Bournemouth Primary Care Network

			Ethnicity**						Deprivation**			
Practice	DiiS patient numbers		White British Ethnicity		Community Minorities		Unknown Ethnicity		Top 20% most deprived		Top 20% least deprived	
Denmark Road	10,471	26%	7,440	71%	2,084	20%	947	9%	502	4.8%	1,222	11.7%
Westbourne	19,866	49%	12,616	64%	4,344	22%	2,906	15%	855	4.3%	3,219	16.2%
Winton	10,348	25%	6,129	59%	3,048	29%	1,171	11%	281	2.7%	644	6.2%
PCN Total	40,685		26,185	64%	9,476	23%	5,024	12%	1,638	4.0%	5,085	12.5%

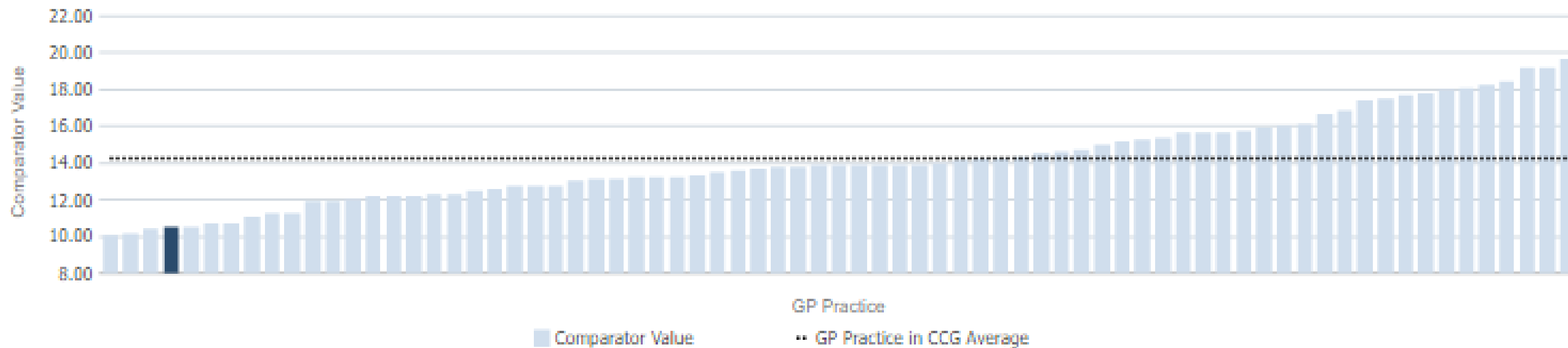
***Figures from DiiS based on different PCN patient total*

Percentage of patients prescribed 8 or more unique medicines - Aged 65 and over

WESTBOURNE MEDICAL CENTRE (J81014) highlighted within results for DORSET CCG during Mar-22

Numerator Definition   Denominator Definition

Display:- Chart



10.50

GP Practice Value

14.22

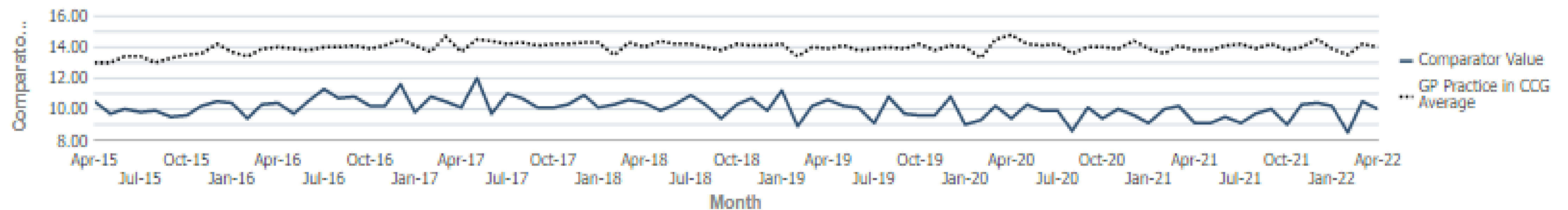
GP Practice in CCG Average

Refresh - Print - Export

Percentage of patients prescribed 8 or more unique medicines - Aged 65 and over

Trend over time for WESTBOURNE MEDICAL CENTRE (J81014)

Display:- Chart



ePACT2: 02Dashboards > Polypharmacy Prescribing Comparators: GP Practice in CCG

Polypharmacy Prescribing Comparators

Home Catalog Favorites Dashboards Create Open

CCG PCN Practice Datasets Supporting Information

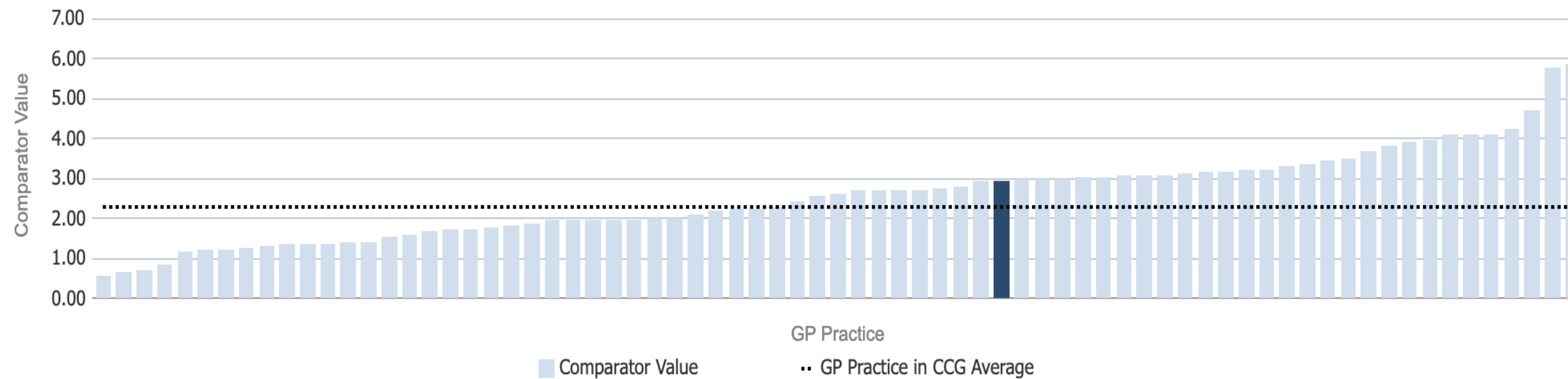
* Practice WESTBOURNE MEDICAL CENTRE (J81014)

Percentage of patients prescribed a NSAID and one or more other unique medicines likely to cause kidney injury (DAMN medicines) - Aged 75 and over

WESTBOURNE MEDICAL CENTRE (J81014) highlighted within results for DORSET CCG during Apr-22

Numerator Definition Denominator Definition

Display:- Chart



2.95

GP Practice Value

2.31

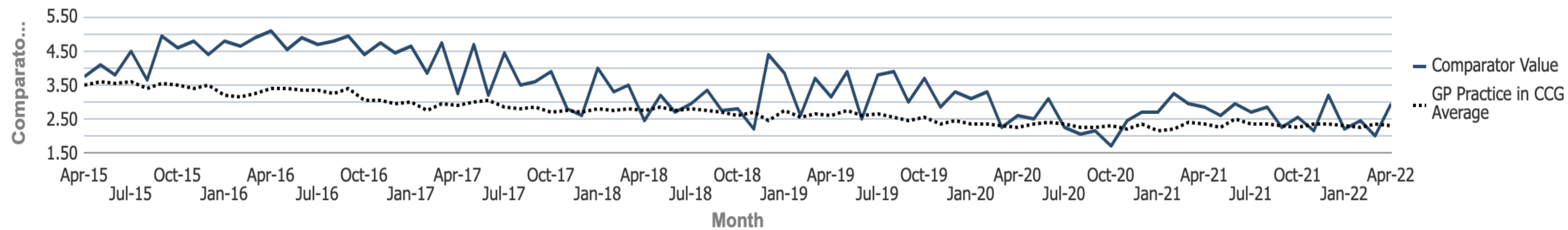
GP Practice in CCG Average

Refresh - Print - Export

Percentage of patients prescribed a NSAID and one or more other unique medicines likely to cause kidney injury (DAMN medicines) - Aged 75 and over

Trend over time for WESTBOURNE MEDICAL CENTRE (J81014)

Display:- Chart



Update to the GP contract agreement 2020/21 - 2023/24

6 February 2020

Structured Medication Review and Medicines Optimisation

From 1 April 2020, each PCN will:

1	Use appropriate tools to identify and prioritise patients who would benefit from a Structured Medication Review, which will include those: • in care homes; • with complex and problematic polypharmacy, specifically those on 10 or more medications; • on medicines commonly associated with medication errors[26]; • with severe frailty[27], who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and • using potentially addictive pain management medication.
2	Offer and deliver a volume of SMRs determined and limited by PCN clinical pharmacist capacity, demonstrating all reasonable on-going efforts to maximise that capacity.
3	Ensure invitations to patients explain the benefits and what to expect.
4	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 this qualification and skills.
5	Clearly record all SMRs within GPIT systems.
6	Actively work with their CCG to optimise quality of prescribing of (a) antimicrobial medicines, (b) medicines which can cause dependency, (c) metered dose inhalers, where a low carbon alternative may be appropriate and (d) nationally identified medicines of low priority.
7	Work with community pharmacies to connect patients appropriately to the New Medicines Service which supports adherence to newly prescribed medicines.

In delivering these requirements, PCNs must have due regard to separate guidance.

Classification: Official

Publication approval reference: PR1963_iii

Network Contract Directed Enhanced Service

Investment and Impact Fund 2022/23: Updated Guidance

30 September 2022

Domain	Area	Indicators
	Structured medication reviews and medicines optimisation	**SMR-01A:** Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review
		SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review
		SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review
		SMR-01D: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review
		SMR-02A: Percentage of patients aged 18 years or over prescribed both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant
		SMR-02B: Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID
		SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet

Network Contract Directed Enhanced Service Structured medication reviews and medicines optimisation: guidance 31 March 2021

What is a SMR?

3.10 A SMR is 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. It is not the act of re-authorising repeat prescriptions. A review of **some** specific medicines during a long-term condition review also does not constitute a SMR, which must consider **all** the medicines a patient is taking or using.

3.11 We expect that a SMR would take considerably longer than an average GP appointment, often 30 minutes or more, 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 cases.

3.12 Clinicians should conduct SMRs in line with the principles of shared decision making[15]: consider the health literacy and holistic needs of the patient, provide advice and signpost, and make onward referrals where appropriate, including to services such as healthy living pharmacies[16] that may be able to advise on evidence-based alternatives to medicines.

[15] https://www.england.nhs.uk/shared-decision-making/
[16] From July 2020, changes have been made to the terms of service for all pharmacies providing NHS pharmaceutical services, by revising the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the approvals under them. We expect that pharmacies will be required to, among other things, reflect the criteria/requirements for a Level 1 Healthy Living Pharmacy, as agreed in the five-year deal between PSNC, NHS England and NHS Improvement and the Department of Health and Social Care; this reflects the priority attached to public health

3.13 SMRs should be personalised. They may be undertaken face to face in the patient's home or care home where possible and in line with infection prevention and control in light of COVID-19, or remotely where deemed clinically appropriate. SMRs are not required to take place in any particular location and can be undertaken during extended hours appointments. Above all, clinicians should consider the patient when planning the location and mode of delivery for the SMR, including consideration of equitable access for housebound patients. Practitioners should be cognisant of the different skills required to deliver a remote consultation (see paragraph 3.19).

3.14 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.

Conducting a SMR

3.15 SMRs can be conducted in different ways and should always be tailored to the individual patient. A SMR should follow the high-level principles and evidenced best practice below, resulting from a wide ranging review of guidance with the support of an external expert working group, including NICE guideline 5[17] and the Royal Pharmaceutical Society's polypharmacy guidance,[18] which itself encompasses the Scottish[19] and Welsh[20] polypharmacy models.

PCN Prioritisation

3.6 PCNs should also have, or develop, processes for identifying patients who reactively need to be referred for a SMR. The **reactive triggers for a SMR** could include:

- **Crisis or incident** – such as an admission to hospital to which the patient's medicine regimen could have been a contributing factor or following which their medication regimen might require review.
- **Personal concerns** – when a patient or their carer raises concerns about the growing number of medicines they are being asked to take or requests a review of their medication.
- **Professional referral** – when a health or care professional/worker raises concerns about the growing number of medicines a patient is trying to manage. This individual does not need to be based in or employed by the PCN; they could, for example, be an acute care-based clinician or social care worker.
- **Requests for monitored dosage systems as an aid to managing multiple medicines** – when a patient, carer or healthcare professional seeks the addition of a monitored dosage system as a means to manage multiple medicines.

Service requirement 2: Prioritisation and capacity

3.7 Once patients have been identified, PCNs should create a process for developing SMR caseloads, so that those patients in greatest need of a SMR are seen in a timely manner.

3.8 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.

[14] 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. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61817-5/fulltext

3.9 As set out in the Network Contract DES Specification section 8.2.1.b, the number of SMRs that a PCN is required to offer will be determined and limited by their clinical pharmacist capacity. PCNs and commissioners must discuss and agree a reasonable volume of SMRs on this basis if a PCN has not been able to secure sufficient clinical pharmacist capacity to offer initial, follow-up and reactive SMRs to **all** identified patients in the required cohorts. 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. 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.

My Structured Medication Review definition

- Medication Review (MR)
  - Holistic review of medication allowing annual authorisation of repeat requests assuming Long Term Condition / blood reviews in place (unless individual medication set at < 6 issues)
  - Could be Desk-based OR F2F / Telephone / Videocall
- **Structured Medication Review (SMR)**
  - MR where must have **listened / acted upon WHAT MATTERS to pati**ent (or their advocate) in a SDM process
  - **Cannot** be solely Desk-based

SMRs Overview

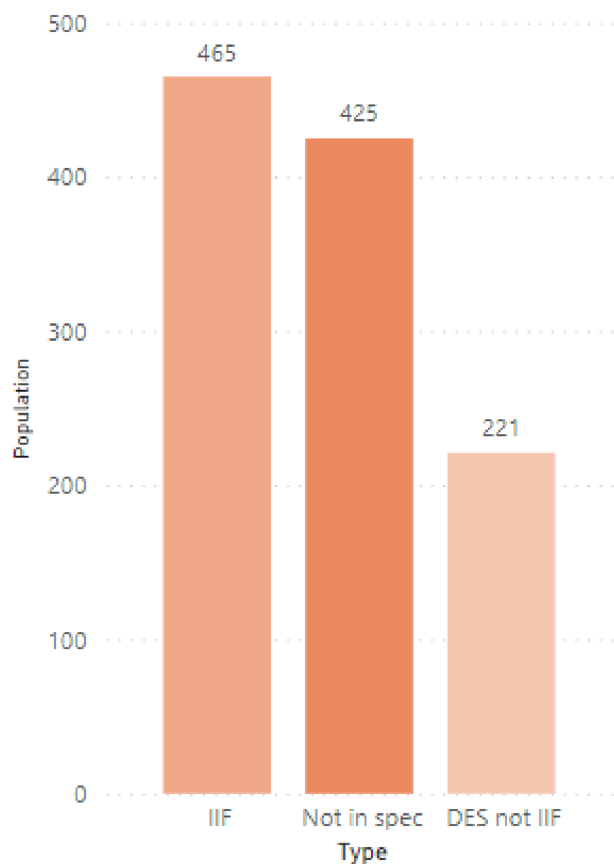
PCN: Poole Bay and Bournemouth PCN

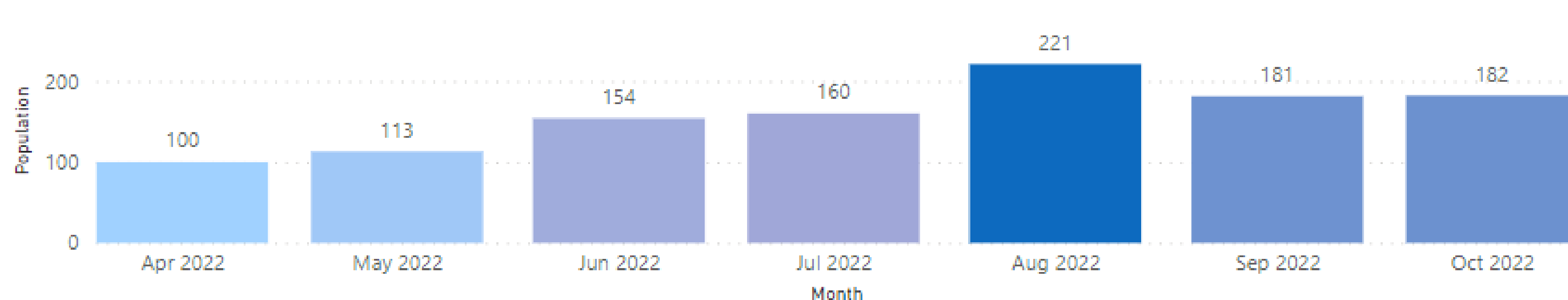
GP Surgery: All

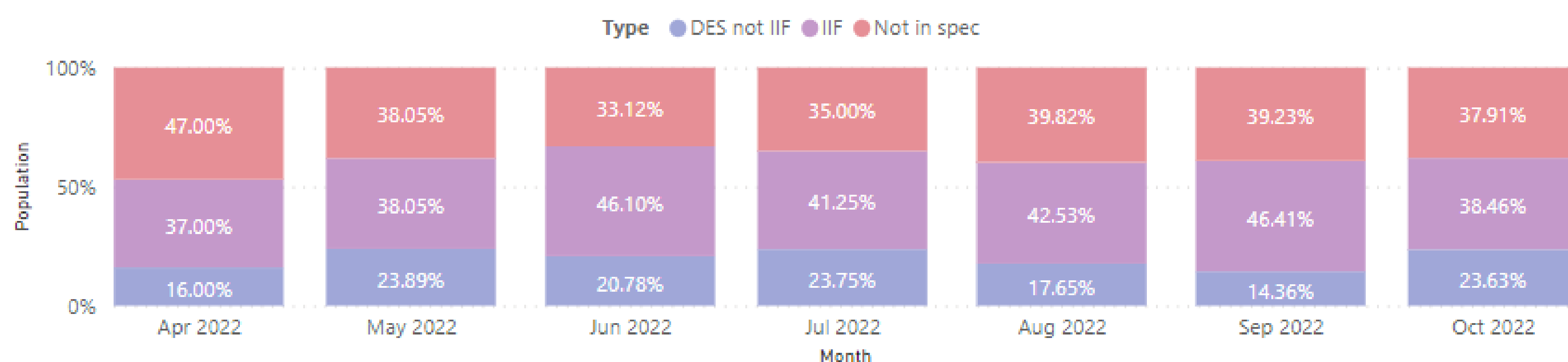
Last Updated: Saturday, October ...

Eligibility (current month):	Eligibility (current month):	SMRs done (previous month):
2,531	1,383	1,111
SMR eligible under DES	SMR eligible under IIF	

Reset Filters







SMRs by Staff Type/Specification

PCN: Poole Bay and Bournemout...

GP Surgery: All

Last Updated: Saturday, Octo...

Reset Filters

Filter by Specification (Ctrl +Click for multiple selections):

Select all	IIF
DES not IIF	Not in spec

Filter by Month (Ctrl +Click for multiple selections):

Select all	Sunday, May 01, 2022	Friday, July 01, 2022
Friday, April 01, 2022	Wednesday, June 01, 2022	Monday, August 01, 2022

Filter by Staff Type(Ctrl +Click for multiple selections):

Select all	GP Registrar	Senior Administrator
Clinical Pharmacists	Nurse Access Role	
General Medical Practitioner	Salaried General Practitioner	

SMRs by Month, Specification and Staff Type:

Staff type
- Clinical Pharmacists
- General Medical Practitioner
- GP Registrar
- Nurse Access Role
- Salaried General Practitioner
- Senior Administrator

DES not IIF

100
50
0
16 27 30 36 25 40

IIF

36 41 50 19 13 73 15 72 58

Not in spec

100
50
0
47 42 51 69 62 61

Apr 2022 Jul 2022 Oct 2022
Month

Apr 2022 Jul 2022 Oct 2022
Month

SMR variability within an ICB

Early Implementation of the Structured Medication Review in England

Mary Madden, Thomas Mills, Karl Atkin, Duncan Stewart and Jim McCambridge

British Journal of General Practice 20 April 2022; BJGP.2022.0014. DOI: https://doi.org/10.3399/BJGP.2022.0014

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Abstract

Background: The National Health Service in England (NHSE) has introduced a new Structured Medication Review (SMR) service within forming Primary Care Networks (PCNs) during the COVID-19 pandemic. Policy drivers are addressing problematic polypharmacy, reducing avoidable hospitalisations and delivering better value from medicines spending. This paper explores early implementation of the SMR from the perspective of the primary care clinical pharmacist workforce. Aim: To identify factors affecting the early implementation of the SMR service. Design and setting: Qualitative interview study in general practice September 2020 to June 2021. Method: Two semi-structured interviews were carried out with 10 newly appointed pharmacists in 10 PCNs in Northern England; and one with 10 pharmacists already established in GP practices in 10 other PCNs across England. Audio-recordings were transcribed verbatim and a modified framework method supported a constructionist thematic analysis. Results: SMRs were not yet a PCN priority and SMR implementation was largely delegated to individual pharmacists, with those already in general practice appearing more ready for this. New pharmacists were on the primary care education pathway and drew on pre-existing practice frames, habits and heuristics. Those lacking in patient-facing expertise sought template driven, institution-centred, practice. Consequently, SMR practices reverted to prior medication review practices, compromising the distinct purposes of the new service. Conclusion: Early SMR implementation did not match the vision for patients presented in policy of an invited, holistic, shared-decision-making opportunity offered by well-trained pharmacists. There is an important opportunity cost of SMR implementation without prior adequate skills development, testing and refining.

Jump to section

Top
Article
Info
eLetters
PDF

Keywords

Primary Health Care, pharmacy, consultation standards, implementation, General Practice, medication review

We recommend

Structured medication reviews: origins, implementation, evidence,

SMR identification within a PCN

- Supply and Demand
- PCN Board level agreement

PCN Prioritisation

- ~80% **Proactive**
  - Primary focus: All 10+ meds / IIF SMR 01 A, B, D
  - Secondary focus: NSAID /DAMN / ACB 6+ / plus Medicines with high risk of harm > 120mg / day morphine equivalents
- ~20% **Reactive**
  - Referral by clinician / patient / carer / agency

Supply : Pharmacist sessions available to perform SMRs

Based on 44 weeks / year

Pharmacist	Sessions a week	Sessions a year
SW	3	132
AB Care Home Pharmacist (2 days via community trust DHC SLA)	3	132
RAM (2.5 days via community trust DHC SLA)	5	220
PCN Total sessions (3 hrs each)	11 sessions	484 sessions

Demand 1: Polypharmacy & high risk medicines patients based on NHSBSA EPACT Feb-March 2022

https://www.nhsbsa.nhs.uk/epact2

(2 month period to give accurate picture. Includes housebound & care home patients)

* Fall within 8+ med group

Practice / PCN	10+ meds	8+ meds	NSAID/ DAMN*	ACB 6+*	Anti thrombotics x3 *
WM	220	538	78(107*)	26 (39*)	0 (2*)
DR	162	318	32 (38*)	15(27*)	0
WHC	127	265	30 (43*)	18 (32*)	0
PCN	**509**	**1121**	**140 (188*)**	**59 (98*)**	**0 (2*)**

Demand 2 : IIF groups agreed as priority by PCN

(S1 GPES extraction)

	SMR 01A PINCER	SMR 01B Severe Frailty	SMR 01D Care Homes	Total
PCN	**177**	**130**	**290**	**597**

Demand 3: Total proactive SMRs to complete for PCN

Based on 60 mins / SMR including pre and post follow up 15 min appt

	10+ meds	SMR 01 ABD	NSAID/DAMN / ACB / Anti-thrombotics	Total
PCN	**509**	**597**	**199**	**1305 hours** **= 435 x 3 hour sessions**

Demand 3a: Primary focus proactive SMRs to complete for PCN

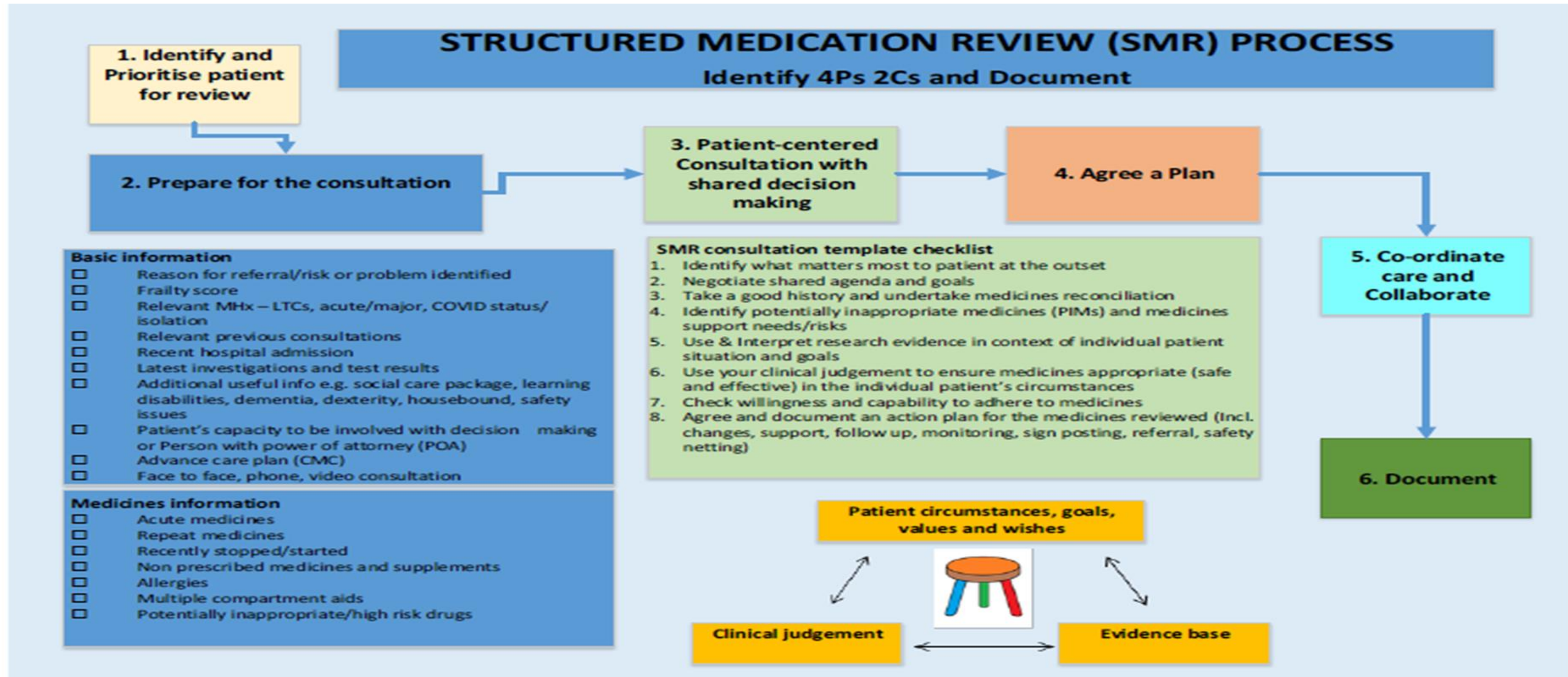
Based on 60 mins / SMR including pre and post follow up 15 min appt

	10+ meds	SMR 01 ABD	Total
PCN	**509**	**597**	**1106 hours** **= 368 x 3 hour sessions**

PCN Prioritisation

- ~80% **Proactive** 368/484 sessions
  - Primary focus: All 10+ meds / IIF SMR 01 A, B, D
  - Secondary focus: NSAID /DAMN / ACB 6+ / plus Medicines with high risk of harm > 120mg / day morphine equivalents
- ~20% **Reactive** 116/484 sessions
  - Referral by clinician / patient / carer / agency

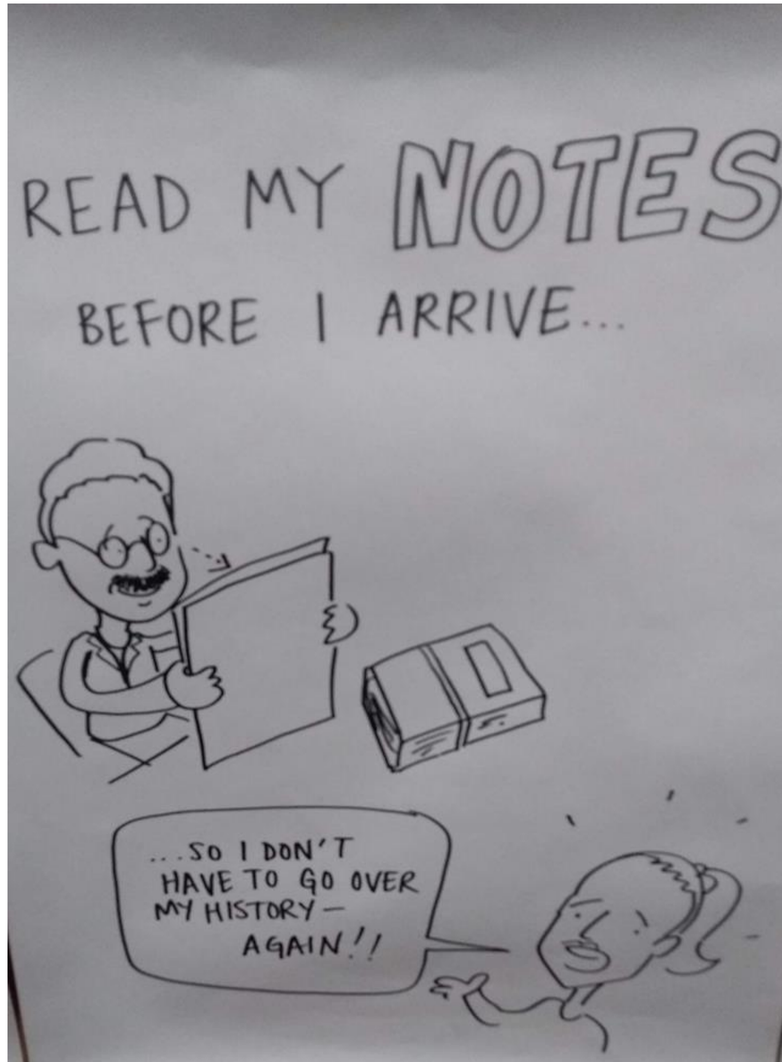
SMR Review by Pharmacists



Author: Lelly Oboh, Consultant Pharmacist, Care of Older People
31/3/21, Version 1.0

Preparation and Listen

It's OK to ask...
me + my medicines



SystmOne GP: WILLIAMS, Steven (Mr) (Pharmacist) at Westbourne Medical Centre - Patient Record

Patient Appointments Reporting Audit Setup Links Dispensing Clinical Tools Workflow User System Help

Search Task Save Note Teleph... Details Next Acute Discard eCons... Teleph... Home Appts Visits Panic Free Slot

TESTPATIENT-TESTPATIENT, Male (Mr) 01 Jan 1960 (61 y) M
...lburn Road, Bournemouth BH4 9HJ
Mobile (preferred): ... Test Patient

Start Consultation Next Event Event Details Pathology Drawing Auto-Consultation Settings

Clinical | Administrative

- Patient Home
- WMC
- Quick Glance
- Home Visit Summary WMC v2
- Home Visit Summary WMC v2 with
- Tasks
- Problems and Summary
- Major Active Problems (4)
- Minor Active Problems
- Inactive Problems
- Summary & Family History (10)
- Safeguarding Information (2)
- Safeguarding PCN
- Summary Care Record
- Journals
- Read Code Journal (89)
- Tabbed Journal
- Death Admin WMC
- Death Admin WHC
- Medication
- Medication (2)
- Repeat Templates (9)
- Prescription History (15)
- Sensitivities & Allergies
- Prescription Requests (4)
- Action Group Timeline
- Vaccinations
- Vaccinations (2)
- Communications

Repeat Templates

View: Current repeats

Last medication review recorded on 11 Oct 2021 by WILLIAMS, Steven (Mr) (Pharmacist) . Next due on 11 Oct 2022. Record medication review Read code (XaF8d)

Authorised	Drug	Last Issued	Review	Issues	Compl.	Flags
	100 ml - 5ml for extreme pain at night					
11 Nov 2019	**Temazepam 10mg tablets** 28 tablet - take one at night if needed for sleep *Additional Script Notes: not for regular use*	Reauthorised		0 / 1 (0)		CD
15 Oct 2021	**Cetirizine 10mg tablets** 30 tablet - take one daily if needed for hayfever in summer Requested by patient 15 Oct 2021	Reauthorised		0 / 12 (0)		
15 Oct 2021	**Pregabalin 100mg capsules** 28 capsule - ONE to betaken at NIGHT *Generalised anxiety disorder (E2002)*	Reauthorised		0 / 12 (0)		CD
15 Oct 2021	**Pregabalin 25mg capsules** 28 capsule - ONE to be taken at NIGHT *Generalised anxiety disorder (E2002)*	Reauthorised		0 / 12 (0)		CD
15 Oct 2021	**Bisoprolol 5mg tablets** 28 tablet - take one daily Requested by patient 15 Oct 2021 *Atrial fibrillation (G5730)*	12 Mar 2020, Issue from previous template, Reauthorised		0 / 12 (1)		
11 Nov 2019	**Sertraline 100mg tablets** 28 tablet - 1 om *Moderate cognitive impairment (Xaagi)*	Reauthorised		0 / 3 (0)		
15 Mar 2021	**Furosemide 40mg tablets** 28 tablet - Take ONE tablet each MORNING Requested by patient 27 Sep 2021 *Atrial fibrillation (G5730)* *Serum creatinine level 118 umol/L 09 May 2018*	Never		0 / 6 (0)		
11 Nov 2019	**Dabigatran etexilate 110mg capsules** 60 capsule - take one twice a day until Jan 2020 Requested by patient 19 Jul 2021 *Atrial fibrillation (G5730)* *Serum creatinine level 118 umol/L 09 May 2018, Weight 52 Kg (8 st 3 lb) 30 Jul 2018*	20 Feb 2019, Amended, Issue from previous template and Reauthorised		0 / 6 (3)		

9 Repeat templates

Click here to view 1 'other' medication

Search features

17:54

Gold standard: SMR and holistic LTC one stop reviews

- **If** Clinical Pharmacist has required clinical competencies then can perform LTC QOF reviews at the same time as an SMR
- e.g. Diabetes / Asthma / COPD / CVD **ie one-stop shop GOLD Standard**
- Invitation letters reflect this and explain clinical pharmacist's role
- Benefits to Patients , GPs and practice

Gold standard: SMR and holistic LTC one stop reviews

Impact of practice based clinical pharmacist led medication reviews on ambulatory patients with hyper polypharmacy

Steven D Williams Senior Clinical Pharmacist, Lawrence D Brad GP Partner Westbourne Medical Centre, Bournemouth, Dorset

Background

- Problematic polypharmacy is a 'wicked problem' at the heart of medicines usage in patients with multi-morbidity, and review by medicines experts in primary care is essential[1]
- RCGP has called for older patients to have support to manage their medication and the need recognised with health and social care services to ensure that appropriate plans are in place[2]

Aim

To assess the impact of medication reviews by a clinical pharmacist in ambulatory patients with hyper polypharmacy (≥ 10 medicines)[3]

Findings

- 85 out of 17000 (0.5 %) patients were receiving ≥ 10 medicines
- 37/85 (44%) patients were excluded (17 were house bound or in a care home, 20 had dementia, were palliative or had died)
- 34/48 patients (71%) patients replied to the letter and were seen by the clinical pharmacist, 2 were excluded as they were taking < 10 medicines
- The median age of the 32 eligible patients was 83.5 (range 75 – 95), male to female ratio 47:53% with a median Rockwood clinical frailty score of 4 (range 3 – 6)
- 30/32 (94%) patients had their medication regimens optimised *See table 1 for details*
- 28/32 (88%) patients completed the satisfaction survey, and all rated the overall consultation as very good to outstanding (median score 6 = excellent). All elements of the survey had a median score of 6

Table 1: Medicines Optimisation issues identified during consultation

Table 1: Medicines Optimisation issues identified during consultation

Metric	Frequency	Range
Number of medicines pre-consultation	11 (median)	10-19
Number of medicines post-consultation	10 (median)	8-18
Number of patients with medicines stopped	20/32 (63%) at least 1 medicine 7/20 (35%) a high risk medicine*	1-4
Number of patients with high risk medicines* stopped	7/32 (22%) NSAID = 2 Antiplatelet = 3 Diuretic = 2	1
Number of patients with at least 1 medication dose changed	24/32 (75 %)	1-2
Number of patients with at least 1 new medication started	4/32 (12.5 %)	1-2
Number of patients with at least 1 medication ADR identified	15/32 (47%)	1-3
Number of patients with at least 1 medication adherence issue identified	12/32 (38%)	1

* High risk medicines associated with preventable drug-related admissions to hospital: NSAIDS, Anti-thrombotics, Anti-platelets, Diuretics

Discussion

- The true value of clinical pharmacists conducting medication review needs further examination on a larger scale across multiple sites, and should include follow up data regarding subsequent consultations and hospital admissions
- A limitation of this work was that the pharmacist was susceptible to the Hawthorne effect
- There is an opportunity for practices to adjust their team skill mix and prioritise patients with multiple QOF recalls being reviewed by clinical pharmacists. This should allow practice nurses to focus on patients with single long-term conditions in addition to their provision of acute care

Conclusion

- All patients highly rated medication reviews with a clinical pharmacist, nearly all had their medication regimens optimised and a fifth had a high-risk medicine associated with preventable drug-related admissions stopped
- This model of care supports the RCGP recommendation to prioritise the care of patients living with multiple long-term conditions by adopting face to face dedicated medicine reviews incorporating the skills of GPs and practice-based pharmacists

Thanks for listening
Any questions ?

Steve Williams

@stevechemist

One less pill

Additional Slides if needed for questions NOT for circulation

Over prescribing

"All prescribing decisions should come with an indication (that might change), a time period (as short as possible), a dose (as small as possible), side-effects/complications (that might multiply with time) and cost (as low as possible if generic is effective)"

Susan Bewley MA MD FRCOG

Professor (emeritus) of Obstetrics and Women's Health

King's College London

PrescQIPP Practice +

Steve Williams
Lead Clinical Pharmacist -
PrescQIPP Practice Plus
February 2022

Clinicians

- GPs, advanced nurse practitioners, practice nurses, pharmacists, paramedics, physios
- Pharmacy technicians, healthcare technicians, physician associates, district nurses
- Specialist roles - GP prescribing lead, frailty team, mental health team, long term condition lead GPs, patient safety clinical lead , social prescribers
- Students (multi-professional)

Non-clinical teams

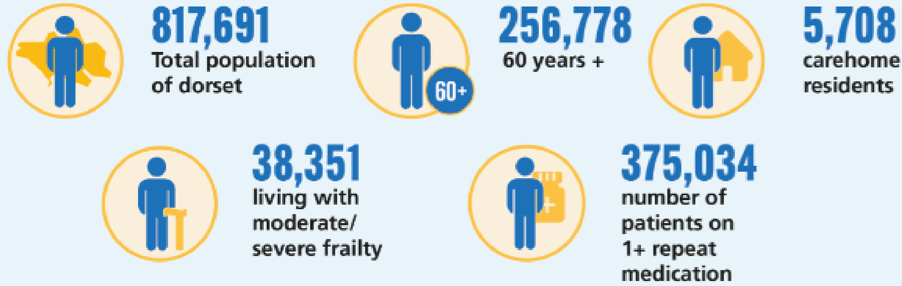
- Prescription team
- IT team
- Data analysis team
- Quality improvement team
- Reception/call handling teams

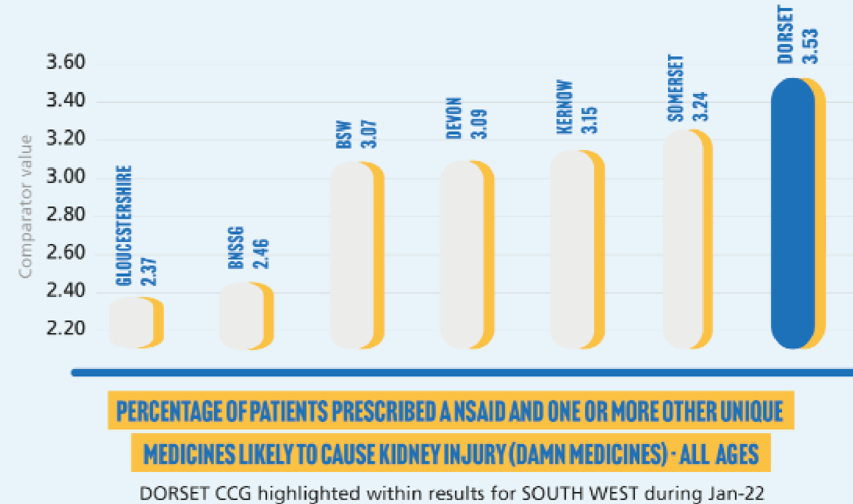
THE SIZE OF THE POLYPHARMACY PROBLEM 2022

The World Health Organisation has highlighted the suboptimal use of medicines as a major problem worldwide. It estimates that more than half of all medicines are prescribed, dispensed or sold inappropriately, and that half of all patients fail to take them correctly. Risks of not addressing polypharmacy include:

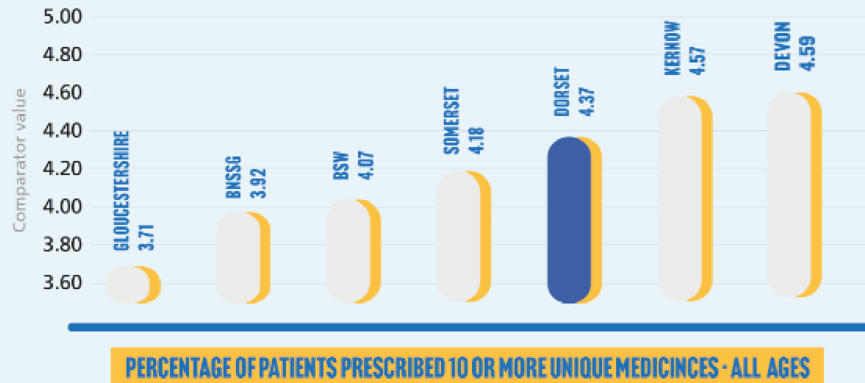
- INCREASED RISK OF HARM
- INCREASED RISK OF NON-ADHERANCE/MEDICINE ERROR
- INCREASED RISK OF HOSPITAL ADMISSION

THE DORSET STATISTICS

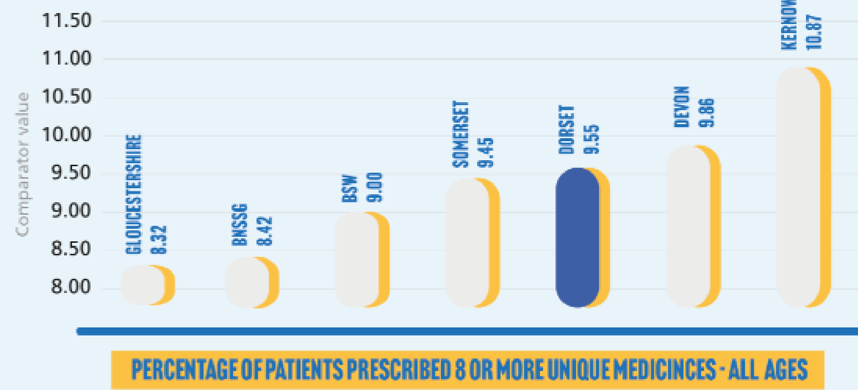




DORSET CCG highlighted within results for SOUTH WEST during Jan-22



DORSET CCG highlighted within results for SOUTH WEST during Jan-22



DORSET CCG highlighted within results for SOUTH WEST during Jan-22

BNSSG: Bristol, North Somerset and South Gloucestershire. BSW: Bath and North East Somerset, Swindon and Wiltshire.

Source: NHS BSA EPACT2

Top 5 Polypharmacy actions for clinicians

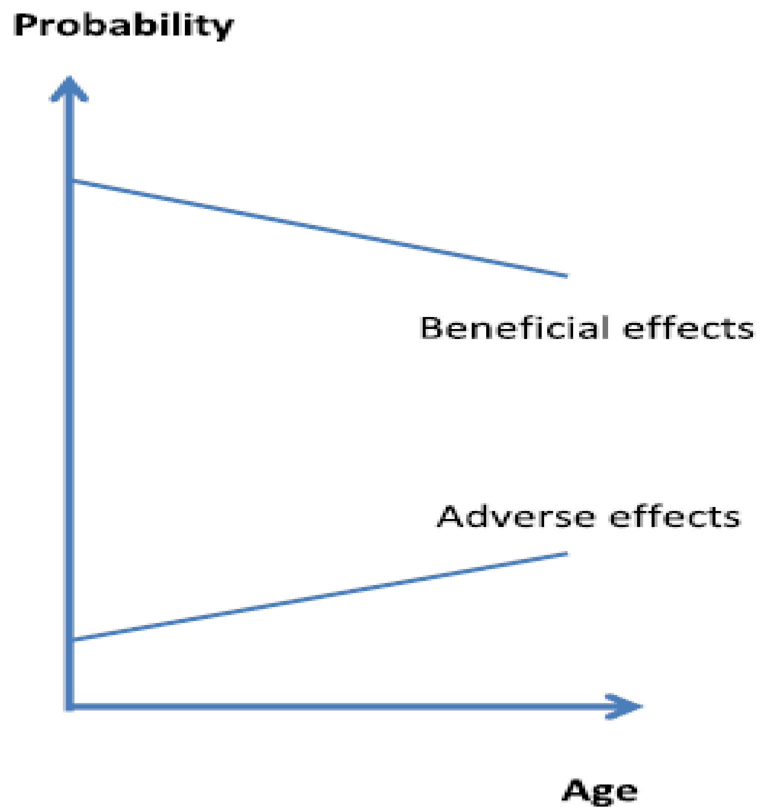
Always consider current indication/contraindication & dose for every patient on these top 5 medicine groups

Anticoagulants
Opioids
NSAIDs
Diuretics
ACB* drugs

*ACB =Anticholinergic Burden
http://www.acbcalc.com/

New horizons in deprescribing for older people

Henry J.Woodford, James Fisher *Age and Ageing* 2019; **48:** 768–775
doi: 10.1093/ageing/afz109



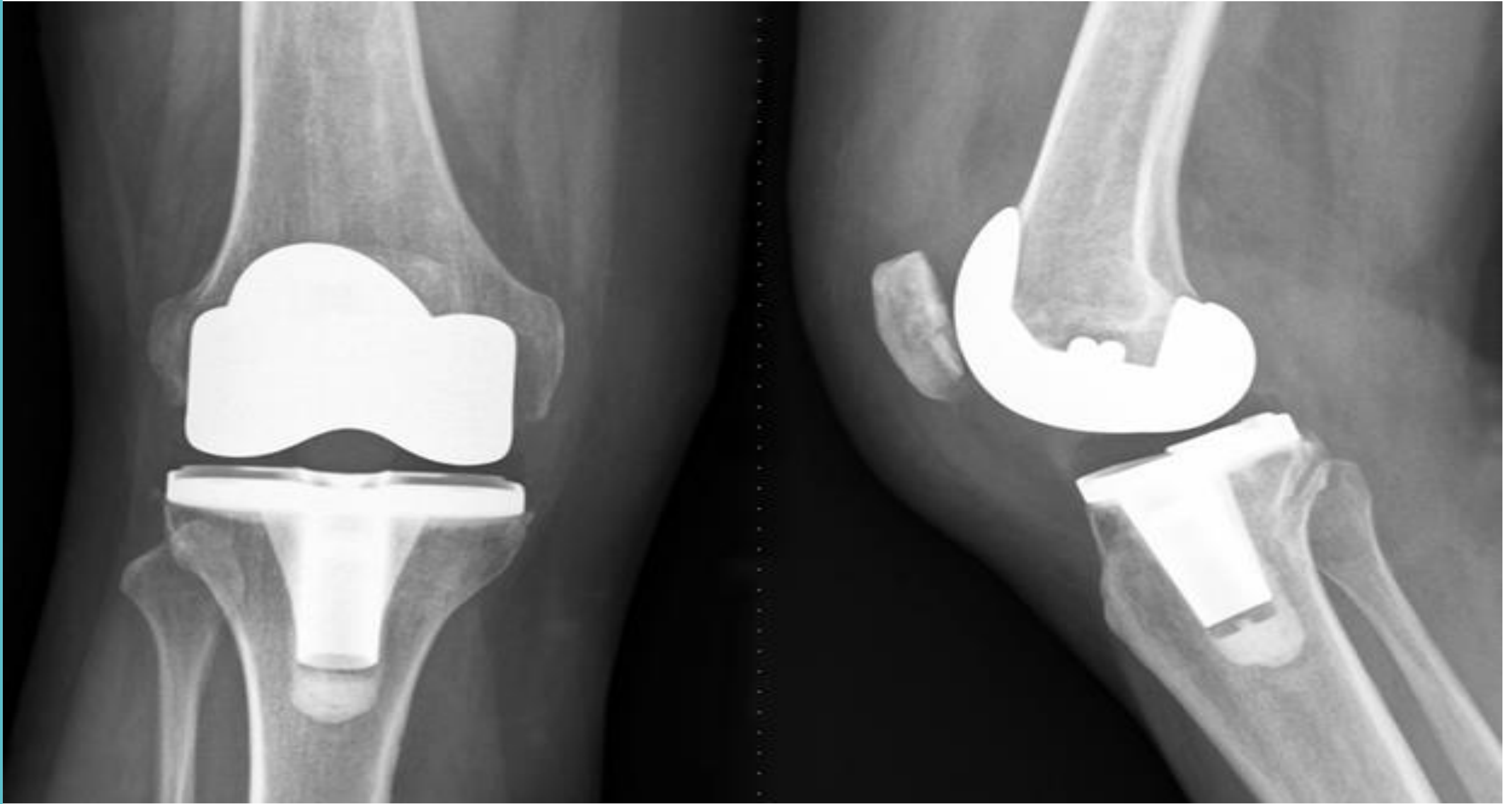
Reduced efficacy (increased number needed to treat)

- Frailty – impaired function of the physiological systems that are the target of medications
- Competing causes of death
- Death before therapeutic benefit occurs (e.g. statins)
- Co-morbidity (e.g. cerebrovascular and neurodegenerative pathologies)
- Reduced adherence

Increased adverse effects (reduced number needed to harm)

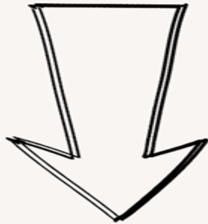
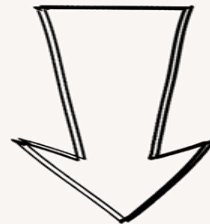
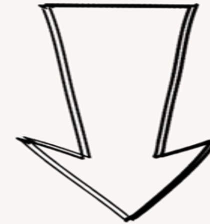
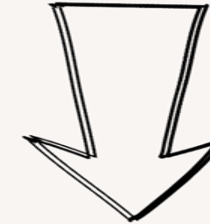
- Drug-drug interactions (polypharmacy)
- Drug-disease interactions (multimorbidity)
- Drug-frailty interactions (pharmacokinetic and pharmacodynamics changes)
- Atypical presentations of adverse drug reactions (misrecognition may lead to prescription cascades)
- Therapeutic burden (including care fragmentation)

Figure 1. The drug-ageing paradox.



Triggers for a structured medication review

Proactive	Reactive	Reactive	Reactive
Polypharmacy data tool or similar identifies person as being potentially 'at risk' or as being 'at risk from harm' from multiple medicines.	Crisis or incident such as admission to hospital should be explored to see if polypharmacy is a contributory factor. Consider also if carer becomes poorly then medication issues may become acute for the person they care for.	Person highlights concern about the growing number of medicines they are being asked to take.	Healthcare professional or healthcare worker highlights concern about the growing number of medicines a person is trying to manage.

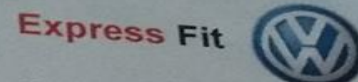
Holistic, structured medication review should aim to:

- Identify and discuss the person's goals
- Identify and discuss any adherence issues
- Identify and assess medicines with potential risks to cause harm
- Identify and assess the use of any unnecessary medicines
- Agree with the person the actions to be taken regarding medicines, including stopping
- Share any decisions with the person, their carers, healthcare professionals, pharmacist
- Review and adjust as needed or refer if required.

Healthcare professionals to ensure they are skilled in good consultations and shared decision making

Date of Next Service	06/12/2011
Date of Next MOT	04/12/2017
Date of Next Brake Fluid	
Date of Next Cambelt	04/12/2018

Service Book? [Y] (Location)
Locking Wheel Nuts? [Y] (Location)

Express Fit 

Follow-Up J F M A M J J A S O N D
Customer Tel No. Home: 07840 739327
Visit Type
WIP NO: 35033 **JOB NO: 224319**

	OK	Advisory Report	Price Inc. VAT	Completed Y/N	Immediate Attention Report	Price Inc. VAT	Completed Y/N
wipers and ...eration.	N	air con service due	0.00	N			
...per blades	Y						
...ngine oil ...level. • Min	N	Brake fluid change due No history of cambelt change	0.00 0.00	N N	Engine oil level	0.00	N
	N	Service light on.	0.00	N			
...t,	Y						
	N	Check OSF tyre Check NSR tyre Check OSR tyre	0.00 0.00 0.00	N N N	nail in tread Check Spare tyre	124.00 0.00	Y N

Immediate Attention

...m) Inner | Pressure | Tyre Size/Comments

Premium Tyre Price £ Please Tick ☐

Wheels Alignment: Price £ Please Tick ☐

Service Advisor
Kristopher Pemberton

Technician

To stop or not to stop medicines in hospital: That is the question ?

- **Yes** - If critical / life threatening to patient whether the reason for the admission or not
- **Consider-** If not critical but related to reason for hospital admission and can make a complete & shared decision with the patient / advocate
- **No -** For everything else BUT document advisory notices on the discharge letter BUT don't state the bleedin obvious….