

Structured medication reviews:

origins, implementation, evidence, and prospects

Pharmacists have been employed in UK general practice for many years. Their numbers are now expanding and their roles developing. Clinical pharmacists are expected to alleviate workload pressures on GPs. Notwithstanding the COVID-19 vaccination programme, a new Structured Medication Review (SMR) service has been introduced in Primary Care Networks (PCNs). The long term drivers are clear: addressing problematic polypharmacy in the NHS, reducing avoidable hospitalisations, and delivering better value from medicines spending.¹ SMRs are intended to improve the quality of prescribing, delivering improvements to patient care and outcomes.

RAPID IMPLEMENTATION OF PCNs AND THE SMR

The roll-out of PCNs and the development of the SMR specification were both done at speed. Collaboration between GP practices to form PCNs under the Network Contract Directed Enhanced Service (DES) requires time and goodwill to build the relationships needed to manage clinical, organisational, and business interests collectively.² Short timescales between policy statements, guidance, and expected implementation have jeopardised effective planning, adding to pressures on clinicians and services during the COVID-19 pandemic.

SMRs were one of the first five DES specifications proposed, originally to be delivered to a range of patient priority groups from April 2020. In response to initial consultation, additional new PCN roles were added, including pharmacy technicians. The proposed SMR service was also simplified by reducing the number of target populations and allowing the volume of SMRs to be determined locally.³ COVID-19 planning then took centre stage and has interrupted implementation profoundly. Guidance issued in March 2020 stressed prioritising responses to the pandemic, thus delaying introduction of the SMR. Vaccination was identified as a workforce priority in early 2021.⁴

The full SMR specification, first published shortly before its formal introduction in September 2020, included the wider offer of SMRs to patients who might benefit, subject to clinical pharmacist capacity.⁵ New information (in an annex) expanded the scope of SMRs to include attention to the main public health behavioural risk factors

of smoking, physical activity, diet and weight management, and alcohol, as well as falls prevention.⁵ Further amendments have been made since, including expanding the range of targeted potentially addictive medicines, specifying a minimum consultation duration of 30 minutes, and bringing children into scope.⁶

Important changes with implications for the developing PCN clinical pharmacist role have thus been made at short notice, and a time when much of the NHS workforce has been focused on managing the pandemic. This raises questions about expectations, preparedness, and practice development.⁷ SMR conduct is to be personalised, holistic, and conducted in line with the principles of shared decision making, attentive to health literacy, and likely to be largely delivered remotely for now.⁶ Newly recruited clinical pharmacists conducting SMRs are required to have, or be in training for, a prescribing qualification, and to have advanced assessment and history-taking skills.⁶ Many are coming from the community pharmacy workforce where such skills are not a requirement. Since an initial 18-month training pathway (or equivalent) must first be completed, the SMR is being introduced when few are fully trained, and when training and supervision provision has been impacted by the pandemic.⁷

In socioeconomically deprived areas where polypharmacy is more common and there are underserved populations, the SMR could represent an especially important innovation. Little information is provided in the DES that appreciates the nature of any distinct challenges posed, or how they may be addressed. This is for each PCN to determine. Similarly, content on how to incorporate brief advice for public health purposes in ways underpinned by shared decision-making principles is limited. In the case of alcohol, for example, alongside advice-giving, the annex notes the potential for interactions with medicines and the need for review, neither of which are congruent with the recommended form of brief advice.

There is further work to be done in developing the service and monitoring implementation if SMRs are to make the kinds of contribution that are anticipated. Account must also be taken of what is known about the nature of the person-centred consultation skills possessed by the new clinical pharmacist workforce within primary

care, and the strengths and limitations of the existing evidence.

SMR EVIDENCE

Pharmacist-led medicine reviews have an important role to play in improving prescribing safety.⁸ The original design of the SMR service and the subsequently made amendments have, however, engaged with research evidence in limited ways. National Institute for Health and Care Excellence (NICE) clinical guidelines for medicines optimisation⁹ are cited as the principal source of evidence for SMRs.^{5,6} Closer examination shows weaknesses in this evidence base. Most trials reviewed by NICE were of low to moderate quality and reported mixed findings for diverse outcomes in populations that do not resemble those identified as priorities for the SMR.⁹

There is a growing appreciation of the potential contribution of the expanded pharmacist role in primary care,^{10,11} and established GP practice pharmacists' experience may facilitate SMR implementation in some practices. However, few studies investigate actual practice, such as how pharmacy work is routinely conducted,¹⁰ nor is there evidence to show that pharmacists possess skills in shared decision making as operationalised in general practice. Studies in community pharmacy and primary care identify a substantial gap between patient-centred consultation ideas encouraging patient-generated problem solving and medicines review practice centred on information provision.^{12,13} In general practice, both GPs and pharmacists perceive a trade-off between being time efficient and involving the patient in making decisions about their medicines.¹⁴

Incorporating public health brief advice generates questions about how the targets (for example, obesity) may be implicated in issues raised in medicines-focused work, such as in relation to adherence. Where it exists, available evidence supportive of pharmacists addressing these as standalone issues (for example, as adjuncts) is, at best, highly variable.¹⁵ Alcohol provides another instructive example. The SMR specification highlights the risks to patient safety from interactions with medicines.¹⁶ Recognition of the far reaching nature of the issues with which alcohol is implicated¹⁷ is a welcome first step in advancing thinking about

clinical approaches for both prevention and treatment of multimorbidity.¹⁸ Implicit in the SMR is a more advanced conception of prevention for alcohol than the narrow *NHS Long Term Plan* focus on dependent drinkers and averting their hospitalisation.¹⁹ This could usefully become more explicit. Conceptualising alcohol as a drug²⁰ fits with the core pharmaceutical role, meaning pharmacists may regard the SMR as a legitimate and important venue for addressing alcohol use in routine medicine consultations. Doing so could contribute to a strategic shift in how the NHS thinks about and manages the relationships between such behavioural risk factors, chronic conditions, and care provided. It potentially offers a smarter way forward than promoting widespread dissemination of crude advice, with disappointing uptake.²¹

THE FUTURE OF SMRs

The challenges facing the new clinical pharmacist workforce were already formidable, and have been made more so by the COVID-19 pandemic.² The balance of forces between centralised contractual

implementation and locally tailored innovations will play out in different ways in different places. The active involvement of pharmacists in taking on clearer leadership roles in medicines review practice developments is paramount for the potential of SMRs to be realised. This requires ongoing evaluation of how pharmacists develop their emerging roles in primary care and acquire more advanced person-centred clinical skills in delivering SMRs for diverse and complex needs. General practice and the quality of the service received by patients can benefit, with patients helped to use their medicines in ways that work better for them, improving population health as a result.

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Provenance

Commissioned; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

DOI: <https://doi.org/10.3399/bjgp21X716465>

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