Health Innovation Network

Local change, national impact

Polypharmacy: getting the balance right

Improving access to Structured Medication Reviews in seldom-heard communities

Understanding the enablers and barriers to addressing health inequalities

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Background

In England, the NHS primary care system dispenses over 1 billion prescription items every year. As more people live longer with multiple long-term health conditions, the number of medicines they take often increases. This can create a significant burden for the person trying to manage multiple medicine regimes, and, in some cases, it can cause harm.

Evidence shows that people living in areas of higher deprivation are more likely to be taking multiple medicines [1,2], and that Black, Asian and Minority Ethnic communities are also more likely to experience overprescribing.

Structured Medication Reviews (SMRs) are the best tested intervention for reducing problematic polypharmacy[1,3,4,5]. SMRs have been shown to help reduce the number of problematic or unnecessary medicines a patient is taking, with estimates of the reduction between 2.7%[3] and 9.9%[4]. However, studies[1,6] also show that most patients do not understand what an SMR is and receive limited, if any, information to help them understand or prepare for their SMR appointment.

In 2022, the Health Innovation Network's National Polypharmacy Programme, in partnership with patients and Leeds and Bradford Universities, co-designed, tested and evaluated a suite of resources[7] to help patients prepare for their SMR appointment. The resources were later translated into 12 community languages and launched for national testing in September 2023. Local pilots [8,9,10] show that the resources increase engagement with patients who do not speak or read English as their first language and increase attendance rates when these patients are invited to attend an SMR.

Keen to build upon the success of these pilots, the Health Innovation Network opened a call in the summer of 2024, inviting Primary Care Networks (PCNs) in areas of high deprivation to apply for funding to target seldom-heard patient groups, known to be at risk of polypharmacy and not engaging regularly with their GP practice.

£15,000 funding was available from the Polypharmacy Programme for 10 PCNs to receive £1,500 each (one per each Health Innovation Network region HIN participating in the national programme).

The call was advertised via the Health Innovation Network's existing stakeholder networks and NHS England Primary Care Networks, including the NHS England Core20 Ambassadors and Health Inequalities Networks.

This approach successfully engaged PCNs not yet engaged with the Health Innovation Network, resulting in over 100 applications. In addition, five local Health Innovation Networks provided additional local funding for 17 applications that were shortlisted but unsuccessful in securing national funding, resulting in 27 PCNs in total participating in this nationwide initiative.

Funding award criteria for primary care networks

- The PCN needed to have a significant patient population with a high proportion living in areas of high deprivation.
- The PCN received up to £1,500 to deliver a quality improvement (QI) project using the Health Innovation Network's SMR patient resources, write up the results and participate in our evaluation process.
- The Health Innovation Network did not specify how each PCN should allocate the funding, recognising that each PCN is resourced differently and has varying capacity across roles that will contribute to the project, such as administrative staff, pharmacists and GPs.
- The PCN provided baseline and comparative data relating to SMR and Did Not Attend (DNA) rates.

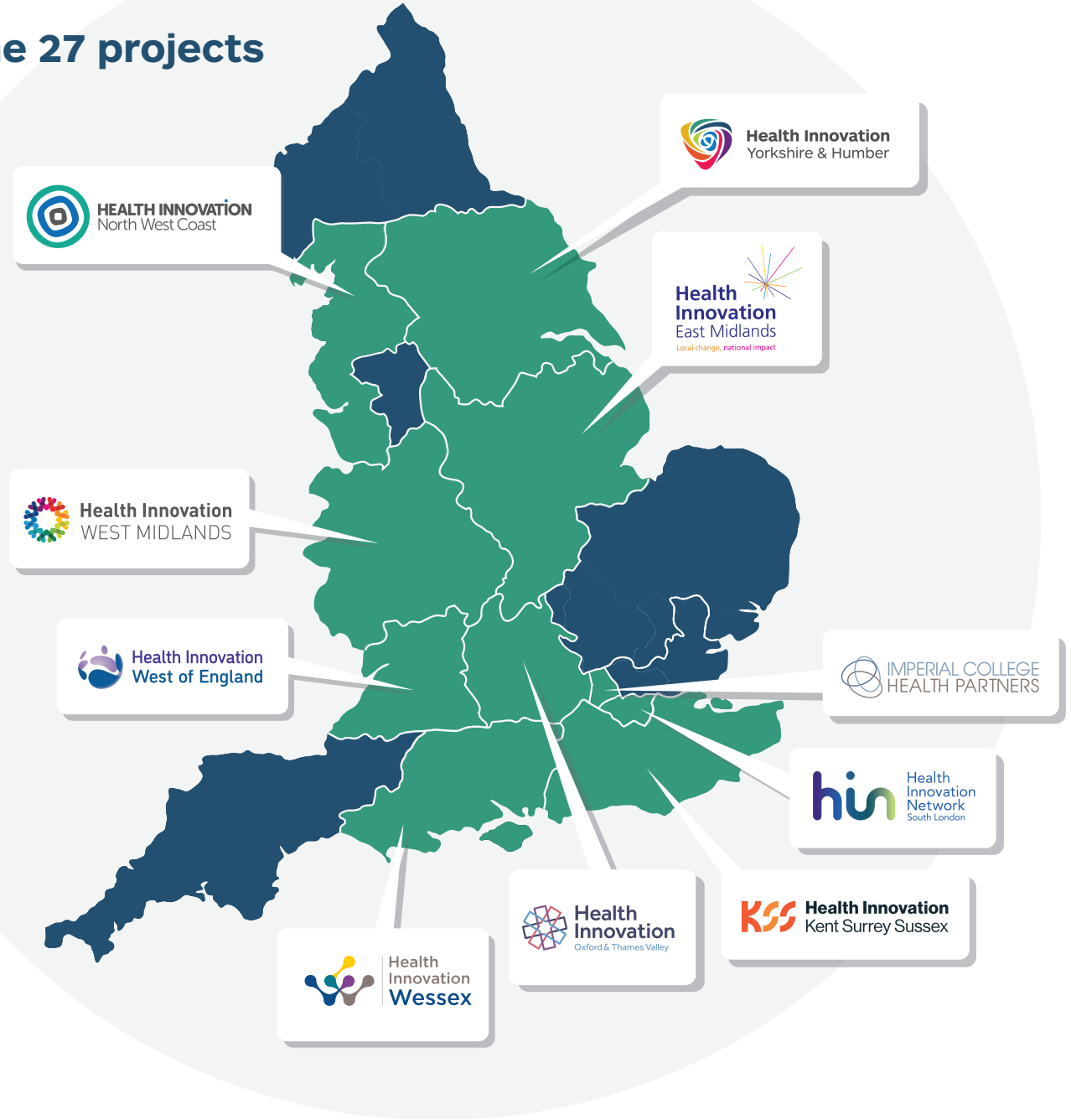
Participating primary care networks

Primary care network	Focus area for project	Health Innovation Network
Victoria Park PCN	Patients with a Clinical Frailty Score of 7 or over and aged 75 or over with polypharmacy (10 or more medications), who live alone or have difficulty accessing the surgery due to physical mobility issues or lack of transport. Patients from an ethnic minority group who do not have English as their primary language and have not attend a medication review in the past 12 months.	East Midlands
Larwood and Bawtry in Bassetlaw PCN	Care home residents, patients with complex polypharmacy prescribed 10 or more medicines who are housebound, frail, recently hospitalised or had a fall in the last three months. Patients prescribed addictive medicines and medicines known to cause harm.	East Midlands
Hammersmith & Fulham, CICC	Patients aged 75 years or over who are prescribed 10 or more medicines.	Imperial College Health Partners
Medway Valley (Reach PCN)	Patients aged 75 or over from an ethnic minority group with polypharmacy (10 or more medications).	Kent Surrey Sussex
South View PCN	Patients from an ethnic minority group and / or have a learning disability / difficulty.	Kent Surrey Sussex
Burnley East PCN	Patients from a Core20 population group, with a focus on the veteran community.	North West Coast
Millman & Kennett PCN	Patients aged 65 years or over with polypharmacy and multiple medicines known to increase the risk of Acute Kidney Injury (one of which is an NSAID).	Oxford and Thames Valley
Modality PCN	Patients aged 75 or over receiving 10 or more medications with additional risks, needs or inequalities, including the need for an interpreter, recent falls or problems with medication.	South London
Gosport Central PCN	Improve SMR attendance rates by using the HIN patient resources.	Wessex
Living Well PCN	Patients with severe frailty in lower 2 deprivation quartiles with preventable admissions and 10 or more medicines, excluding those in care homes or who are housebound.	Wessex
Lordshill Health Centre, Southampton West PCN	Improving access to SMRs in housebound patients.	Wessex
Cheviot Road, Southampton West PCN	Design and implement an SMR pathway for the clinical pharmacists in the practice.	Wessex

Primary care network	Focus area for project	Health Innovation Network
Brunel PCN	Identify and reach housebound patients who are due to receive an SMR.	Wessex
Island City PCN	Design and implement an SMR pathway for the clinical pharmacists in the practice.	Wessex
Portsdown PCN	Improve SMR attendance rates by using the HIN patient resources.	Wessex
Small Heath PCN	Patients aged 75 and over taking 10 or more medicines and who speak one (or more) of the following languages: Arabic, Bengali, Chinese, Gujarati, Polish, Punjabi, Romanian, Urdu or Somali.	West Midlands
Kingstanding Erdington & Nechells PCN	Patients prescribed multiple, addictive medicines with potential problematic polypharmacy in a large Chinese population.	West Midlands
I3 Ladywood PCN	Patients aged 75 and over who are prescribed 10 or more medications.	West Midlands
Health Vision Partnership (HVP) PCN	Frail patients with a Rockwood score of 6 and above and patients who are aged 75 years or over, receiving 10 or more medicines and from an ethnic minority group.	West Midlands
Washwood Heath PCN		West Midlands
Pioneer PCN	10 or more repeat medicines / anticholinergic burden (ACB) score of 9 or more.	West of England
Horfield PCN	Patients exposed to polypharmacy and on dependence forming medications, including patients with a learning disability, red or amber drug alerts, ACB, high risk drugs, dependency, or frailty.	West of England
Severnside PCN	Care home residents receiving 10 or more medications and patients with frailty.	West of England
Hathaway PCN	Move from current ad-hoc SMRs to set up a polypharmacy clinic run by clinical pharmacists.	West of England
Richmond Park PCN	Aged 75 and over receiving 8 or more medications and in the 10th or 20th centile of the national Index of multiple deprivation (IMD) by postcode.	Yorkshire & Humber
Doncaster East PCN	Aged 65 or over with a high ACB score of 4 and above, including polypharmacy.	Yorkshire & Humber
Wharfedale, Airedale & Craven Alliance (WACA) PCN	Patient with more than 10 regular medicines prescribed and no medication review recorded in the previous 18 months.	Yorkshire & Humber

Key groups worked with across the 27 projects

- People aged 65 / 75 or over
- People with a Clinical Frailty Score of 7 or over
- People with polypharmacy (10 or more medications)
- People who are housebound or have accessibility or mobility issues
- People from an ethnic minority group
- People who do not have English as their primary language
- People who have not had a medication review in the last year
- People who live in care homes
- People who are frail, recently hospitalised or had a fall recently
- People prescribed addictive medicines or medicines known to cause harm
- People with a learning disability or difficulty
- Veterans



Findings

Which patient resources were used?

- 85% of PCNs (23/27) used the Patient Invitation Letter to invite patients for a SMR.
- The next most-adopted resources were the Me and My Medicines Patient Charter (67%) and Stopping Medicines Safely Leaflet (48%).
- 37% of PCNs (10/27) shared the patient-facing animation and 26% (7/27) screened the animation in the GP practice waiting room.
- Most PCNs used the standard resources with 30% (eight) PCNs using easy read versions.
- The resources were mainly shared by electronic phone message to patients' phones (55%) or in paper format (52%).
- PCNs used a variety of approaches to share the resources with patients, depending on their preferred method of communication.
- English was the most frequent language version shared (81%). Different PCNs used different languages depending on their patient population, with Urdu, Bengali and Arabic most utilised after English. All 12 languages were utilised across the 27 pilot sites.

Download the resources at www.thehealthinnovationnetwork.co.uk

How many PCNs used the different resources?

Resources

- 23 Patient invitation letter
- 18 Me and My Medicines patient charter
- 7 Patient facing animation (for GP waiting rooms)
- 15 Are the Medicines Working leaflet
- 10 Are the Medicines Working symptom tracker
- 10 Patient facing animation
- 13 Stopping Medicines Safely leaflet

Languages used

- 22 English
- 7 Arabic
- 8 Bengali
- 4 Chinese Traditional
- 4 Chinese Simplified
- 7 Polish
- 5 Gujarati
- 5 Romanian
- 6 Punjabi Gurmukhi
- 5 Punjabi Shanmukhi
- 10 Urdu
- 5 Somali

Versions

- 18 Standard
- 8 Easy read
- 4 Audio
- 3 Animation screened in waiting room

Communication method

- 15 Electronic SMS
- 8 Electronic email
- 9 Practice systems (Accurx)
- 14 Paper

Structured Medication Review (SMR) activity

Number of SMRs

At baseline, 18 PCNs reported **1,241** SMRs were completed during a three-week period. Nine PCNs did not submit data.

During the study period a total of **2,587** SMRs were completed by 27 PCNs.

Many PCNs asked for extensions to the three-week comparative study period due to workload pressures and availability of staff to undertake the SMRs. We cannot therefore directly compare the number of SMRs completed at baseline against the study period, however all areas saw an increase in SMRs and most were able to demonstrate a clear reduction in 'Did Not Attend' rates.

Baseline data – before the pilots

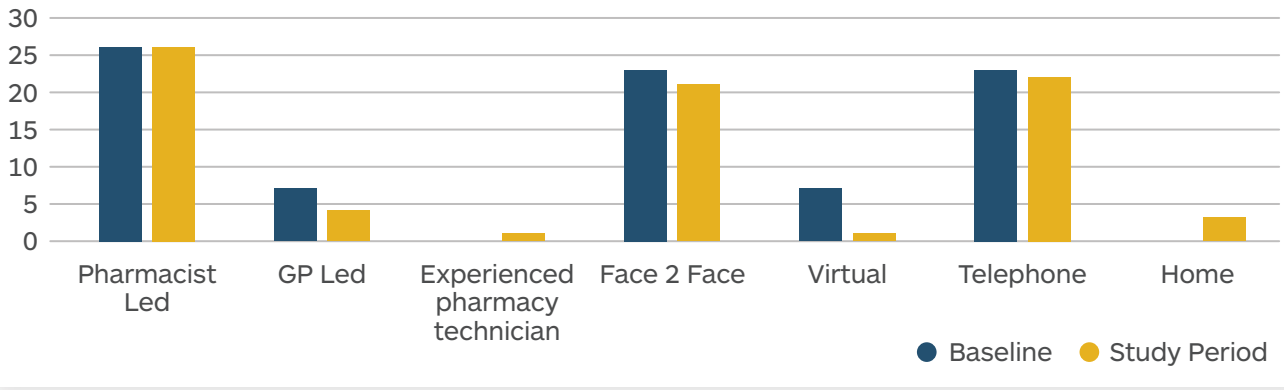
- **Frequency:** 74% of PCNs (20/27) reported that they routinely carried out SMRs within their practice prior to the project starting. Five shared that SMRs were 'reactive', in that they were arranged in response to patient need or happened on an 'ad-hoc' basis.
- **Consultation time:** 51% of PCNs (14/27) allocated 30 minutes or more for an SMR. 18% of PCNs (5/27) did not regularly carry out SMRs or did this on an ad-hoc, reactive basis. The remaining PCNs allocated between 10 and 20 minutes, depending on the number of medicines requiring review.
- **Clinician:** Pharmacists carried out SMRs in all 96% (26/27) PCNs, with GPs also carrying out SMRs in7/27 of the PCNs.
- **Method:** 81% of PCNs (22/27) used a combination of face-to-face and telephone appointments for SMRs. Only three PCNs routinely used only face-to-face appointments. Seven PCNs who used a mixed method approach of face-to-face and telephone also offered virtual appointments.

Comparative data – during the pilots

- **Consultation time:** All, bar one, PCNs allocated 30 minutes or more for the SMRs during the pilots. Seven routinely offered up to one hour during the test period and one PCN allocated 20-minute appointments
- **Clinician:** Pharmacists carried out SMRs in most (26/27) PCNs, with GPs also carrying out SMRs in four of these. Two PCNs used pharmacy technicians to support with less complex patients. One PCN delivered GP led appointments only.

Method: Many PCNs reported that the method for delivering SMRs was similar to methods used before the project testing phase. 85% of PCNs used face-to-face and telephone appointments for SMRs. Four PCNs routinely used face-to-face appointments only and three PCNs offered home visits. One PCN also offered virtual appointments.

PCN SMR activity - baseline and comparative data



Clinician feedback

Participating PCNs were asked to attend a focus group and complete an online survey to share their experiences of using the patient facing materials and carrying our SMRs in their workplace. All participating PCNs either completed the online survey or attended the focus group, with 11 PCNs contributing to both.

I wasn't fully aware of the resources available, and presumed would be time consuming.

Key findings

- **84%** of PCN teams agreed that participating in this project had **improved their knowledge and understanding of SMRs**.
- **The focus on seldom heard communities was key to them taking part**. Most participating PCNs shared they had recognised that core groups of more vulnerable patients were not receiving SMRs. Focusing on people with polypharmacy AND an additional issue was seen as an important success criterion, such as taking 10 or more medicines **and** having a high ACB score, or taking 20 or more medicines **and** not being seen for over a year, or people with a learning disability **and** polypharmacy.
- **Increased focus on identifying patients**. PCNs described not previously having a robust process for identifying patients who might benefit from an SMR and that the project had been a catalyst for them to look at this. Some described the searches they had been using as far too broad and that by focussing on a key patient group, they could really think about how they invited those patients to increase uptake of SMRs.
- **The project was a catalyst for designing an SMR pathway**. Some PCNs had not really carried out SMRs before starting the project, so were designing their SMR pathway from scratch. Some were doing them reactively with patients and had used this project to move to a more targeted, proactive approach. All PCNs described the project as providing the catalyst to look at SMRs in their practice more carefully. This included a review of who carried out SMRs in their PCN, the screening process for selecting patients, the pre-SMR work needed to maximise the opportunity of the SMR appointment, and the time needed to carry our an SMR effectively. Some PCNs described the benefits of doing this work as: "we now have a proper process", "we are making the SMR process more consistent across the PCN", and "we have carved out more time for SMRs".

The most helpful part of the patient information leaflets was focussing on what the patient's priorities are. This helped focus the discussion on these priorities. My only anxiety with the symptom tracker was that we would unmask a lot of unmet need that would be difficult to meet! But in practice this actually didn't happen. I would be keen to continue to use the SMR leaflets and will be promoting them with my colleagues.

- **Increased use of patient resources**. Before the pilots, only two PCNs were using the HIN patient resources. Lack of awareness about the materials, SMRs not being a priority and concerns around unmasking unmet needs they would be unable to address were all cited as reasons for not using the materials. **18** PCNs shared they will continue to use the materials and **four** were unsure. (This related to the lack of clarity about SMRs in the future, rather than the materials. Since the project, SMRs have been confirmed as a key component of PCN activity in the PCN Directed Enhanced Services advice from NHS England.

- **Improving engagement with seldom heard communities**. **85%** of PCN teams agreed that the HIN patient-facing resources helped them engage with seldom heard communities. Half of respondents felt that the materials helped patients better understand and prepare for their SMR appointment, that the quality of the SMR improved as a result, and that patients were more likely to ask questions about their medicines. One PCN felt the materials made no difference to the SMR process as the patients had not read the materials before their appointment.

- **Funding was a driver to initiate the project**. The funding, although small (up to £1,500 per PCN), was universally seen as a significant enabler. GPs and pharmacists described that that the money enabled them to create dedicated time to think about how best to deliver SMRs, as well as carving out time to run the project and complete the evaluation. Almost all participants of the focus groups described the beneficial effects of the funding, whilst recognising that it did not cover all the costs of the work.

SMRs were seen as something that was not high on the agenda. As lead pharmacist, I have campaigned and negotiated time to complete successful SMRs and often argued that if done well, will address performance indicators like opioids and gabapentin deprescribing, QoF like lipid optimisation and education as well as reducing net ingredient cost by addressing inappropriate polypharmacy. This project has shown this in the practices that invested into it and has now become a PCN focus.

We stopped doing SMRs when they came out of the IIF funding in 2023.

We were unaware of the resources - we manage a demanding population from deprived backgrounds and often face language barriers. These resources have been very useful.

Clinician teams were asked what went well and what could be improved as a result of participating in the project.

Themes	What went well?	What could be improved?
Patient engagement	• Increased uptake of SMRs. • Reduction in Did Not Attend (DNA) rates. • Patients were better prepared for their SMR. • Improved engagement with seldom heard groups. • Better patient understanding of high-risk medications, side effects and need for regular reviews and monitoring.	• Earlier sharing of the resources with patients. • Attendance at community events to promote SMRs outside of the surgery setting. • Further focus on identifying high risk / underserved patient groups. • Using the resources as 'business as usual'.
Changes in practice	• Clinical pathways for SMRs developed. • Improved confidence and shared decision making. • Quality of SMRs improved / becoming business as usual. • Increased awareness of the value of pharmacist role in the PCN. • Supportive GP lead / practice manager and teamworking by clinical and administrative teams seen as an enabler. • Utilising pharmacy technicians / junior colleagues to undertake pre SMR preparations, for example calling patients to discuss medicine concerns and reviewing current medications.	• Confidence to stop or reduce medicines. • Training for junior team members to better understand problematic polypharmacy / certain medicine risks. • Training / inclusion of administrative teams to support this work. • Protecting time to carry out SMRs as business as usual. • Templates to guide the SMR consultation were considered useful, especially those to measure outcomes.
Health outcomes / clinical impact	• Reduction in medicines stopped, reduced or changed. • Better awareness of health inequalities in specific patient groups. • Increased awareness of polypharmacy within the clinical team and desire to address this.	• Recognition that undertaking a series of complex SMRs can have a significant cognitive load and this needs to be factored into any pathway.

I felt some of our pharmacists could do with further training in discussing reducing opioids, gabapentin and high ACB drugs in frailty/falls and deprescribing inappropriate polypharmacy.

Patients are now more likely to attend the SMR appointment and I feel that patients are receiving a greater benefit from these reviews.

The majority of patients in this cohort had not engaged with the practice (responding to messages, calls, letters) for a long time, so using these resources has clearly helped. We will be using the resources to help to engage patients for more routine medication reviews as well.

Administrative staff training and support for clinical pharmacist to effectively deliver this work is critical, therefore, information and experience sharing opportunities will be sought to embed current work.

Using Pharmacy Technicians picked up issues such as lack of clear indication for the medicine, a lack of up-to-date blood test results, ability to speak to the patient pre SMR to increase engagement with the appointment.

The project highlighted how my team value the role of pharmacist in the MDT, and willing to utilise pharmaceutical knowledge and expertise.

One patient used the SMR information to ask if he could stop solifenacin, as he had heard about ACB and was worried by it - he had been obediently taking the medication for 7 years, and without the SMR information I don't think he would have considered the option of questioning the doctor. He also asked about changing from warfarin to a DOAC, which I think he also wouldn't have mentioned otherwise.

Clinician feedback on the Health Innovation Network patient resources

Overall, the resources were well received. All PCNs, except one, liked the variety of resources, languages and formats available to choose from, so they could share easily digitally via AccuRx, SMS text, or by print and post. Several PCNs had shared with family and carers in addition to patients.

Most highly valued were the leaflets describing what happens at a SMR, the 'questions to ask' prompts and what to do when a medicine is stopped, with the majority of participants highlighting their usefulness. Clinicians also rated highly the SMR animation, although this was not widely shared amongst the test sites. Most PCNs used the patient invitation letter and found it useful, although some practices struggled to get patients to engage with it.

There was a request to expand the Stopping Medicines Safely leaflet. One focus group participant suggested ideas for further new resources, such as a medication prompt sheet which we have since added to the resources in collaboration with Leeds University. One GP had concerns that the symptom tracker would raise expectations that the GP would deal with all symptoms, and suggested instead the symptom tracker could be used just for assessing symptoms after a particular medicine was stopped. For example, a medicine for overactive bladder to see if stopping the medicine had any impact at all on frequency of visits to the toilet.

Great resource. Colourful, easily available, empowers the patient to be in charge of own healthcare. Also gives us confidence as professionals that we have covered all bases and patient can read/ask for further help after the consultation as assessing capacity is not always easy. Also, carers can also review the information.

I can see all the potential benefits (although haven't seen this actually happening) so I will keep sharing them although I believe not many patients read them.

Digital exclusion

While most patients have a mobile phone number, digital exclusion was an issue raised by a significant number of PCNs. Patients may not have a smartphone and therefore may not be able to open web links and in some cases may not be able to read online materials. This meant some PCNs were significantly challenged in getting the SMR resources to their patients. Several PCNs decided to subsequently post the resources but this was not seen as a sustainable process.

A small number of participants expressed having had their eyes opened to the significant challenge they have in communicating with patients and that new methods will need to be developed. Some were thinking about involving community pharmacy to get the materials to patients in the future.

Some were useful but there were almost too many to choose from.

The resources were great to be able to engage patients to take control of their own health. The patient cohort we were contacting are historically challenging to engage and having resources in the patients first language has helped to reduce barriers to access for this group. The patients used this opportunity to ask about other issues impacting their health and were signposted appropriately. Had we not had these resources, I don't think we would have had the same engagement. The majority of patients in this cohort had not engaged with the practice (responding to messages, calls, letters) for a long time, so using these resources has clearly helped. We will be using the resources to help to engage patients for more routine medication reviews as well.

I especially liked the "Stopping medicines" leaflet (although I think it could perhaps be further improved by a section on stopping and a section on reducing, and even potentially a section on "other medication we might think about changing / stopping at a future review") as I think this gave reassurance to patients about what to expect and when follow up would be.

Clinicians were asked whether they planned to build upon this work in their future practice and if so, identify opportunities or barriers.

All focus group participants described having learned a lot about their local SMR process and all described wanting to make this a more improved and permanent arrangement for the future.

Some PCNs shared that this work had been so successful in increasing engagement with their target patient population, such as veterans or people with a learning disability, that they were now moving on to other groups recognised as not having been particularly well engaged with SMRs previously, such as those with severe mental ill health.

Our pharmacy team has really shone. Their value is there for all to see now. I'm glad our lead pharmacist took the initiative on this. We now have a way as a PCN to better support our patients for good outcomes and empower them to help us support safe prescribing practices.

Great project. Having a medical student with me on the project was also really great as it streamlined the process of the SMR, I think a health care assistant might also be able to do this work in preparation for a SMR.

Many PCNs described a desire to continue this work but highlighted some significant infrastructure barriers to this:

1. Additional Roles Reimbursement Scheme (ARRS) money is coming to an end, which means that the person doing the work would not be in post.
2. Lack of capacity in the pharmacy team to conduct SMRs at this level and maintain all the other work.
3. Lack of a properly funded incentive to carry out proactive SMRs with patients from seldom heard groups. Many described how SMRs had dropped down the 'priority list' after the national Investment and Impact Fund targets were changed.

Ideas and suggestions shared by PCNs:

- Some PCNs wanted to link this work to other PCN initiatives such as focusing on frailty, or initiatives to engage ethnic groups more with their healthcare or trying to increase utilisation of electronic repeat dispensing (eRD).
- Some felt that more practical tools were needed to make SMRs easier to carry out, such as a list of easier medications to stop.
- It was thought that with vulnerable groups of patients, making sure there is a few weeks in between the invitation and the materials being sent out and the SMR appointment date means that patients get enough time to think about issues they want to discuss.
- Several PCNs shared they valued the support available from the Health Innovation Network.

This was a great project to be involved in. We will try to continue the good work started in this project by expanding the cohort and contacting more patients over the next 6 months. The HIN team have been wonderful in providing support for the project.

The HIN team were supportive and introduced me to pharmacists working on similar projects. I believe there were opportunities for joined up working between various PCN teams, which will hopefully continue. The education / training sessions were also helpful in highlighting how SMRs are not embedded in routine work for good outcomes and empower them to help us support safe prescribing practices.

I think it has been very worthwhile to participate in this project. It has certainly worked well as part of our INT work and provoked some good discussions with other clinicians around the value of SMRs preparation for a SMR.

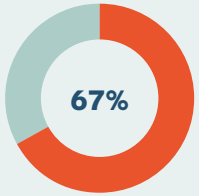
Patient feedback

PCNs were asked to collect patient feedback as part of the pilot, either by using a patient feedback survey from the Health Innovation Network, their own feedback form or by collecting quotes from patients with permission to share them at the end of the consultation.

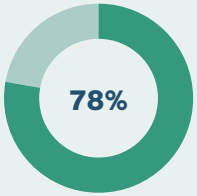
112 patients responded to the patient survey and 85 individual patient quotes were received from PCNs. Patient feedback has been generally very positive with common themes covering patient empowerment, what matters to them, wider economic benefit, improved quality of life, valuing time for preparation and receiving resources in their own language.

Several challenges were highlighted regarding resources. These included: accessibility, whether resources were actually received, and if they were, whether they were received in a timely manner to allow enough time for preparation before the SMR appointment. Communication has also been identified as a challenge through this feedback with lack of understanding about the function of an SMR and a lack of understanding about the role of the pharmacist, which may need further consideration.

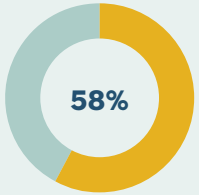
Headline findings from the patient surveys



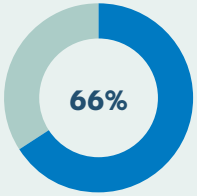
67% said the materials helped them **understand the reason for the SMR appointment**.



78% said they were **happy with what was achieved** from the SMR appointment.



58% said the resources **helped them prepare for the SMR appointment and the issues they wanted to discuss**. 12% felt they didn't, and the remainder didn't comment.



66% said the resources **helped them share what was important to them with their doctor/pharmacist** during the SMR appointment.

Increased understanding and preparation for the appointment

I feel this is our best review because my mum had chance to read the information about why we need to review the medicines in Bengali and she was happy. She was also happy to reduce the pregabalin and because she has no more pain she agreed with the pharmacist to help to stop completely and she will use her co-codamol when she needs it.

Yes, receiving the resources beforehand definitely helped me understand the purpose of the appointment. It made me feel more prepared and confident going into the review, I knew what exactly what we needed to discuss.

Satisfaction with the service

I did not realise how much knowledge pharmacist had. I haven't stopped any medicines today but I have information to take with me and the door was left open for me to come back. I have a better understanding now of my medication.

It was good to speak to someone who spoke in a way that I can understand take in and do the right thing with my medicines.

Stopping medication

I wasn't aware of this service. This is very important in looking at patients fully. I did not realise that some of my medicines could safely be stopped. I thought they were all for life.

They help me today. I have 2 less medicine now and I will manage with my 6 medicine now. I want to reduce more please.

Shared decision making

Very thorough. Finally, someone is taking an interest in what matters to ME!

Finally I can be part of decisions about my medicines and make decisions that I can stick with. Thank you for listening and explaining things to me.

Before the review, I was unsure why I was taking so many medications. Now, after the pharmacist's clear explanation and adjustments, I feel more confident and reassured with a simpler, more manageable treatment plan.

Improved health

I didn't receive any materials prior to the review, but I think it was really good. Somebody explained all about my medicines, I've learned some useful tips on managing pain too.

I was not sure if my gabapentin was working or causing me to be unsteady. We tried reducing it and I can go out again with no extra pain. I thought reducing this will cause me pain but understanding that a lot of pain medicines can actually worsen pain, well this proved it over just 4 weeks. I know my problems are not over but at least I get some of my life back. thank you. I am grateful for that chance encounter at the veterans event.

I learnt a lot and now has good information to support me. I was referred to social prescribers to help me with other things that needed addressing. I can see a way out now and I am hopeful for the future.

I didn't realise some of my issues were medicine related. My colleagues have noticed such an improvement in me since stopping these medications.

I had been on multiple medications for years, but during the polypharmacy review, the pharmacist identified some unsafe combinations.

Concerns about the resources

Found resources 'too much reading' so opted not to take.

I got it in text message so looked but could not print as I don't have a printer.

Didn't get sent in time prior to appointment.

Several patients spoke to one of the Pharmacy and said they were worried about opening links due to crime.

I was worried that the pharmacist wanted to change all my medicines, I didn't really know what to expect.

Conclusion

Our findings show that it is possible to increase the number of Structured Medication Review appointments and reduce 'Did Not Attend' rates in priority communities, including typically underserved patient groups, such as people with a learning disability or housebound patients. Using patient engagement resources can be instrumental in encouraging more targeted uptake in this way.

The relatively small amount of funding was appreciated by PCNs and was seen as a key enabler to run the project well, providing an important catalyst to the improvement work. It gave PCN teams protected time to review existing processes, identify patients and carry out the SMR appointments. Clinicians reported that screening and preparation in advance of an SMR is time consuming, but it can make a positive difference to the quality of SMRs.

This work has enabled PCNs to look at their existing SMR processes and, in most cases, has resulted in refining or establishing new pathways within the practice. For some PCNs these projects highlighted the value of SMRs, both to the practice and patients, and they are working towards implementing SMRs as 'business as usual', particularly in the PCNs who stopped SMRs once the national Investment and Impact Fund incentives were withdrawn.

This work has greatest impact where it is part of a review of the PCN pathway for SMRs.

The Health Innovation Network SMR resources were appreciated and valued by patients, helping them to understand and prepare for the SMR appointment and, in several cases, discuss their concerns with the family and carers.

Most clinicians could also see the benefits of using the materials, citing improved quality of conversations with patients and greater shared decision making. The translations and easy read versions were considered very helpful in engaging patients. Patients said they appreciated receiving information in their own language.

Some PCNs found the reliance on sharing resources digitally created challenges, with fear around opening links on phones and lack of access to smart phones a much bigger issue than some PCNs had previously thought. Although the resources significantly improved engagement with some more seldom heard patients, it was acknowledged by many PCNs that there remains a large cohort of patients at risk of health inequalities who do not engage with the GP practice.

Case studies

Holistic reviews of a Core20 population with a focus on the veteran community

HEALTH INNOVATION North West Coast

Opportunity for change

This PCN is based in a deprived area, and according to the Office for National Statistics, 85.3% of our population lives in areas classified among the most deprived.

There is a strong correlation between polypharmacy from cascade prescribing, anticholinergic drug prescribing, high opioid and gabapentin in deprived communities. This increases health inequalities, leading to poorer patient outcomes and increased mortality.

Holistic patient care with shared decision making empowers patients. It also improves the patient-clinician relationship. Structured Medication Reviews (SMRs) are a good way to engage and educate patients and provide holistic care to address issues that may be part of wider health determinants for these patients.

At Burnley East PCN, we reviewed our Core20 population with a focus on the veteran community, many of whom have polypharmacy and frailty and are often on medication like gabapentinoids and opioids, sometimes in combination with anticholinergic drugs. SMRs honour our armed forces' covenant: "Caring for them before, during and after service to us all".

Intervention

We used NHS Digital Pathways Eclipse data to prioritise our patients. Eclipse prioritises scores based on frailty, polypharmacy, dependence-forming medicines, high ACB burden, learning disability, housebound and care home patients. We also organised an outreach programme for our veteran community as our targeted audience.

The focus was for patients with SMR scores above 10. This score was agreed with our Integrated Care Board (ICB) and encompasses the requirements of the Directed Enhanced Service (DES) contract for priority SMRs.

The patient resources used included the medication review animation, Me and my Medicines charter, and the Stopping Medicines Safely leaflet in both printed as well as electronic format as appropriate. The main languages used were Urdu, Punjabi and English.

"I wasn't aware of this service. This is very important in looking at patients fully. I did not realise that some of my medicines could safely be stopped. I thought they were all for life.

Four GPs and six pharmacists delivered this project across our 56,000 population in six practices within our PCN. 476 SMRs were face-to-face, with 272 telephone SMRs. Voluntary patient feedback was collected after SMRs in two practices by two pharmacy technicians.

Impact / outcomes

Practice	3-week Baseline SMR numbers	Number of SMRs in the 6-week project period*	% change in opioid prescribing within the project period**	% Change in Gabapentinoid prescribing within the project period**
A	51	91	↓ 0.8	↓ 2.0
B	27	82	↑ 0.2	↑ 1.1
C	34	114	↓ 2	↓ 3.4
D	21	95	↓ 0.4	↓ 2.2
E	41	103	↓ 4.2	↓ 2.7
F	5	267	↓ 13.4	↓ 9.4

*** Eclipse data results 10 February 2025**
**** ICB data within the project period from 21 October 2024 to 30 November 2024**

- CVD risk reduction: As part of social history taking, patients had a diet, exercise, smoking status and alcohol consumption assessment. This led to questions around CVD risk reduction within our patient cohort. Patients were willing to explore lipid lowering therapies, particularly lipid optimisation within our secondary prevention patients. The pharmacy team led an ICB initiated workshop on lipid management because of this.

- Increased social prescriber referrals and increased involvement of the pharmacy team in PCN outreach programmes.

Finally, I can be part of decisions about my medicines and make decisions that I can stick with. Thank you for listening and explaining things to me.

I learnt a lot and now have good information to support me. I was referred to social prescribers to help me with other things that needed addressing. I can see a way out now and I am hopeful for the future.

Future work

Our aim is to bring about institutional change where SMRs are aligned to medicines optimisation enhanced services and form a part of our ICB GP contract framework with wider use of Health Innovation Network resources for better patient engagement.

More information

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Enhancing Structured Medication Reviews at four West Midlands PCNs to tackle problematic polypharmacy in areas of high deprivation

Health Innovation WEST MIDLANDS

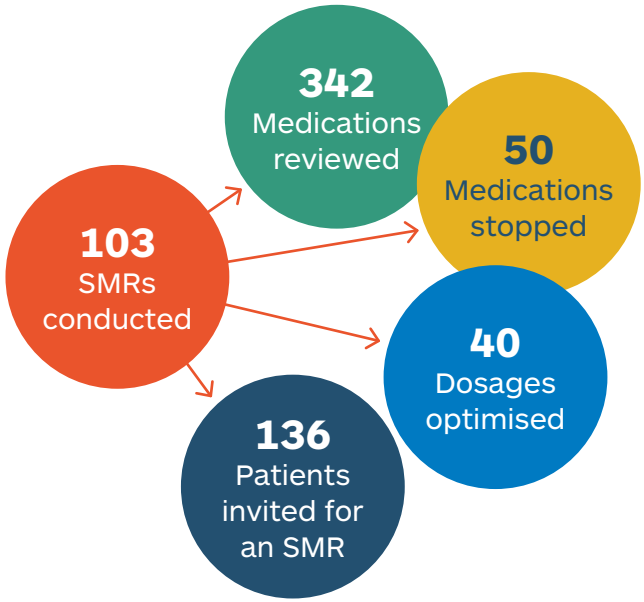
Background

In July 2024 the National Polypharmacy Programme issued a funding call looking to award £1,500 to 10 PCNs in the most deprived areas of the UK. Following this funding call, the West Midlands had an overwhelming response from local primary care networks (PCNs) with over 30 applying for the funding.

Many districts in our region fall under the most deprived 20% of the population. West Midlands is also home to the Black Country Integrated Care System, which is reported to be the second most deprived ICS region in the country[1].

With several excellent applications from highly deprived areas, the local Polypharmacy delivery team at Health Innovation West Midlands decided to fund an additional four applications. The team selected those who shared detail on their local population, such as patients on 10+ medicines and their age groups, and patients who do not speak English as their first language. Plans for how they would conduct their QI projects were also assessed. The team checked the IMD scores within each of the applicants' practices to determine the final shortlist.

Project statistics



Intervention approach

As a part of this funding, the PCNs needed to undertake a QI project targeting their SMR service. SMRs are the best tested intervention for problematic polypharmacy[2]. The medication review can help to identify any medicines that are no longer appropriate or any that may need a change in dose.

To improve their SMRs, the pharmacy teams at the four PCNs had to incorporate patient facing SMR resources developed by the National Polypharmacy Programme and its partners. These are designed to aid shared decision making between both patient and clinician, allowing clarity throughout the whole process.

The patient group who would be trialing the new SMR approach would be over the age of 75 and on 10+ medicines. All the PCNs taking part have practices in areas where elderly residents do not speak English as their main language. Having patient materials available in several languages helped reach out to those patients.

The teams had to conduct a minimum of 20 SMRs identifying patients using their appropriate systems. The local team also shared their 'practice bespoke' data pack, which identified the number of patients registered at their practice who are within the specified group. Patients would be invited using the patient resources in the appropriate language. The 20 SMR appointments had to be a minimum of 30 minutes and to be completed within a six to eight-week period.

Outcomes and impact

Among the four PCNs, a total of 103 SMRs were conducted and 342 medicines reviewed. The pharmacists were able to stop 50 medicines and optimise 40 dosages across the 103 SMRs. The patient resource packs were utilised effectively and allowed the teams to reach out to patients who did not speak English as their first language.

15 pharmacists took part in the project across the four PCNs. Their confidence levels were captured both before and after the project. Overwhelmingly all 15 pharmacists reported an increase in confidence in deprescribing once completing the project and will be implementing the processes into their future SMRs.

I prefer my children to talk on my behalf but it is nice to know I understand what you're talking about.

I knew what to expect from the appointment so had a chance to think about my medicines.

Patients who had their SMR using the patient resources at Kingstanding, Erdington and Nechells PCN

Conclusions

With this project there has been an overwhelmingly positive response from both patients and clinicians. The improvements to the SMRs processes have allowed pharmacists to reach out to seldom heard communities and help them optimise their medicine dosages. This is in turn allowing patients to live a healthier life with lower risk of hospital admissions due to adverse drug side-effects. It has also greatly benefitted four PCNs in a region where there are some of the highest levels of healthcare inequalities in England.

Working with HIWM was a genuinely positive experience – the team was well-organised, supportive, and always approachable. The project ran seamlessly, and the materials provided played a key role in supporting our patients and enhancing our consultations, leading to improved outcomes and better shared care decision making. We especially valued that the resources were user-friendly, easily accessible, and available in multiple formats and languages. Given the success of the project, these resources are something we will continue to use moving forward.

Mr Javed Iqbal – Lead Pharmacist at I3 Ladywood PCN

Meet the primary care networks who took part:

Kingstanding, Erdington & Nechells PCN
Based across North and Central Birmingham with seven practices. Covering areas with high levels of deprivation among its population. They are also a part of the wider West Midlands based Our Health Partnership group.

Washwood Heath PCN
Based in the Washwood Heath area of Birmingham, the PCN has nine practices and delivers primary care services to around 55,000 individuals in the area.

I3 Ladywood PCN
Based in the Ladywood area of West Birmingham, the PCN has nine practices taking care of 74,000 residents across the district.

Health Vision Partnership PCN
Covering the Black Country, the PCN has seven practices serving the diverse population in the region of Sandwell.

References

1. https://blackcountry.icb.nhs.uk/about-us/people-we-serve
2. https://www.england.nhs.uk/primary-care/pharmacy/smr/

Created by Sabeel Sajid
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Medway Valley Primary Care Network (PCN): Supporting patients from ethnic minority populations to participate in Structured Medication Reviews (SMRs)

Health Innovation Kent Surrey Sussex

Opportunity for change

Our SMR project in Medway Valley PCN targeted people from ethnic minority groups with polypharmacy, who were over 75 years old and taking 10+ medications.

With funding and support from the Health Innovation Network, we focussed on Gillingham, which is a low economic area (Core20PLUS5). The PCN is new and had not previously focused on SMRs in this cohort or fully engaged with people from ethnic minorities. SMR slots were not historically coded separately from general appointments, limiting data on past SMR activity.

Appointments were made as accessible as possible. Most medication reviews had been conducted via telephone, but face-to-face (F2F) reviews were the optimal option. The practice has multiple sites. For each appointment, we selected the most suitable site for both patient and clinician.

Intervention

The project was run between October and December 2024 by the clinical pharmacist with support from care-coordinators who invited the patients. 30 minutes were allocated for each appointment.

An EMIS search was conducted and 23 patients from the chosen criteria were invited for an SMR. Invites were sent via text message where we had a mobile number. We informed the patient of the purpose of an SMR. The booking link was in English or their preferred language if clearly recorded in the patient records. Family members/carers were also able to support.

Identifying patients from ethnic minorities was challenging as ethnicity data did not match the census searches, making the process very time consuming for care coordinators. This also made knowing which language to provide difficult. As a result, we added the patient video and all the resources to the practice website and sent the link with the invite allowing patients to self select.

We did not have Did Not Attend (DNA) figures when the project began as the PCN approach is to continue contacting patients until the consultation is booked.

We contacted 11,000 patients to confirm ethnicity, approx. 4,000 responded so our data is much more accurate for future engagement.

Luke Tate,
Pharmacy Technician

Impact / outcomes

The PCN team found the SMR materials resources useful and are now utilising them for all patients who are invited for an SMR.

18 of 23 patients attended an SMR, nine F2F and nine via telephone. DNAs occurred because some patients were on extended holiday and others were unreachable.

This intervention led to 17 medicines being changed, reduced or stopped. The impacts include reducing the anticholinergic burden score, changes to opioids and antidepressants, changes to improve kidney safety and stopping statins.

Patients provided mixed feedback on the resources; some patients came prepared with their medication concerns, whilst others had not utilised the materials.

Many patients didn't understand the SMR is for medicines discussion only and were expecting to see a GP. This led to some disappointment and consequently increasing pressure on the clinical pharmacist. As a result, other health concerns were also discussed and eight referrals were made to other medical colleagues, such as for overdue blood tests and asthma/COPD or diabetes appointments. One patient had to be referred to secondary care, to a rapid access chest pain clinic.

The review agenda strongly depended on the patient's accompanying advocate (and translator).

Future work

People from ethnic minorities in our local community experience variation in care. This work helped identify this and supported improved data management (for example, recording of correct ethnicity and coding of SMRs).

This cohort need particular attention as many may not be aware of their own health needs and are overdue various health checks. Future work is needed to ensure that people from ethnic minorities are well engaged and well educated about their health. Advocates for this population are needed.

Supporting spread: we will continue to use the links to the resources when booking SMRs –to improve SMR outcomes for all patients.

More information

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Increasing the uptake of Structured Medication Reviews (SMRs) in Hammersmith and Fulham North PCN

IMPERIAL COLLEGE HEALTH PARTNERS

Opportunity for change

Hammersmith and Fulham North HFN PCN comprises nine GP practices serving a population of 58,766 and is one of the Core20 PCNs within London. There is a correlation between increased risk of polypharmacy and deprivation. The PCN Network contract DES 24/25 specifies PCNS should utilise SMRs to optimise medication for high-risk cohorts, as they have been shown to be the best tested intervention for reducing problematic polypharmacy.

The Health Innovation Network Polypharmacy Programme have co-designed a suite of resources to help patients understand and prepare for a SMR.

Clinical pharmacists within HFN PCN undertake SMRs, and as part of a pilot they tested the use of these resources to increase the uptake of SMRs in patients over 75 years of age who were prescribed 10 or more medicines.

Intervention

Practice A serves a population of 6,658 and was identified as the pilot site. Patients aged 75 and over, prescribed 10 or more medicines and who had not had an SMR in the preceding 12 months were identified using the GP clinical system. Patients identified were sent a patient invitation letter and then contacted by the practice by telephone and text message offering either a 30-minute face-to-face or telephone appointment with the clinical pharmacist for a SMR. An SMR clinic was set up once a week for three weeks to review patients.

Resources utilised included:

- Patient invitation letter
- Me and my Medicines patient charter
- Stopping Medicines Safely leaflet
- Patient facing animation played in the GP waiting room

I was kind of waiting for this type of appointment as there was a specific query which I wanted clarification on but did not want to impose on the surgery.

Patient

Impact / outcomes

All patients (N=20) invited for a SMR attended their appointment. There was an increase in utilisation of SMR appointments from 31% to 57% as a result of the pilot and engagement with patients.

Table 1: Top 10 interventions conducted during SMRs

Intervention	Percentage
Allergy status confirmed	100%
Drug interactions checked	100%
Drug monitoring checked	100%
Drug side effect checked	100%
Advice about drug treatment	75%
Synchronisation of repeat medication	75%
Dose of medication changed	30%
Drug treatment started	25%
Drug treatment stopped	25%
Lifestyle advice about diet and exercise	25%

Patient feedback on Health Innovation Network resources

100% of patient feedback surveys were returned following the pilot of using HIN resources to increase uptake of SMRs.

All patients were sent the patient invitation letter but only 75% reported receiving these materials. Patients felt the materials helped them to:

- understand the reason for the appointment (81%)
- prepare them to think about the issues for discussion (67%)
- share what was important to them during their appointment (73%)

> **The resources are useful as a supporting tool for engaging patients in. They are extremely useful in explaining what a SMR is, why it can benefit the patient and what they should prepare to get the most out of it.**
>
> **PCN Pharmacist**

Future work

The pilot identified the need to standardise processes for identifying and inviting patients for SMRs across the PCN. The pharmacy team will review how to implement successful strategies from the pilot, including driving patient engagement using Health Innovation Network resources and practice staff to communicate with patients.

High risk patient cohorts will be prioritised to optimise outcomes.

Collaboratively working with practice staff, such as admin and pharmacy technicians, was key to setting up of SMR clinics to ensure appropriate patients were invited and offered an SMR.

More information

For more information visit the ICHP Polypharmacy webpage.

Improving safety and reduce prescribing burden in high-risk patients on multiple medications where English is a second language

Health Innovation
Oxford & Thames Valley

Opportunity for change

A cohort of patients was identified for this project focusing on patients with polypharmacy, aged over the age of 65 years, where English has been documented as a second language, on medications that are deemed 'high risk', including controlled dugs and medications that increase the patient's risk of an Acute Kidney Injury (AKI).

The cohort was later refined to include the Frimley Insights Patient Segmentation data to focus on those patients in the highest risk groups.

This cohort of patients is historically challenging to engage and frequently Did Not Attend (DNA) their appointments. The aim was to change this and improve access for this cohort by utilising the Health Innovation Network polypharmacy resources, particularly the SMR invitation letter available in multiple languages.

Intervention

Over 70 patients were contacted by a care coordinator via various means, including:

- Telephone call (with the aid of an interpreter if needed)
- Text message, with link to an attachment containing a patient invitation letter in the patient's first language
- Posted invitation letter, with copies of all resources included.

Patients were invited to attend an SMR, ideally face-to-face in the practice. However, some patients preferred a telephone appointment due to travel costs and family or carer availability (approximately 50%).

From these points of contact, 52 appointments for SMRs were scheduled with the pharmacy team.

The HIN resources in multiple languages, allowed a cohort of patients, that was historically challenging to engage, to share what was important to them in a review, leading to improved patient safety and reduction in polypharmacy.

Clinical Pharmacist 1

Impact / outcomes

Over the course of the audit period for this project, 23 SMRs were completed by the clinical pharmacy team.

The resources were well received, with the patient invitation letter, written in the patients first language, being the most well received by patients. This allowed patients to prepare for their appointment in advance and have a clear understanding of what the appointment entailed. Other resources such as videos were also utilised during and after the review.

Successes:

- **Improved access**: 23 patients we had not previously been able to engage with texts, calls, letters attended for this review with the support of the HIN polypharmacy materials.
- **Reduction in polypharmacy**: proton pump inhibitors and over the counter medications being the most commonly deprescribed medication in the cohort.
- **Reduction in side effects**: side effects of medications reduced, including medication that increase the risk of falls.
- **Engaging and empowering** an underserved cohort.

Barriers:

- **Digital exclusion**.
- **High DNA rates** (35%), of these, 22 patients have had an appointment rescheduled.
- SMRs over the phone can be challenging with an interpreter.
- **Access difficulties, such as frailty**.

Future work

We will continue to use the Health Innovation Network resources to encourage engagement and improve access for patients where English is a second language.

These resources will be shared in waiting rooms and on our website, and paper copies will be held in reception to proactively look at opportunities to provide these to patients.

Learnings from this project will be shared with the clinical team at the next Medicines Management meeting.

The teams will be looking at identifying medications suitable for deprescribing and will proactively looking at inviting patients for reviews using the Health Innovation Network resources.

More information

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Pioneer medical practice: reviewing patients with hyperpolypharmacy and anticholinergic burden

Health Innovation West of England

Opportunity for change

Data from ePACT2 showed the Northern Arc PCN in Bristol, which includes the Pioneer Medical Group to be the highest scoring PCN for percentage of patients prescribed 10 or more unique medicines or with an anticholinergic burden (ACB) score of nine or more in April 2024.

We recognised that our practice area is a socio-economically deprived area and, as polypharmacy is not restricted to older patients, we chose to focus more broadly on problematic polypharmacy. Most of the patients were 75 years old or older but not exclusively.

Intervention

The ePACT2 data was accessed and NHS numbers were requested for the target patient groups. Selected patients were then invited to SMRs with Health Innovation Network patient resources, explaining what the reasons for the review and what would be included.

Information resources were shared via text message but if unable to open these, printed copies were given. The PCN pharmacists were healthcare professionals involved in the project along with reception staff if patients wanted to change/ cancel appointments.

The PCN pharmacists also ran an education session for clinicians at a clinical meeting on polypharmacy and ACB.

263 patients were invited to SMRs from September to December 2024 and 200 SMRs were completed.

Impact / outcomes

- Using the Bristol, North Somerset and South Gloucestershire SMR template we recorded evidence-based components for an effective medication review[1] as outcomes for all 200 SMRs.

- **Notable outcomes:**
  - Non-compliance issues were identified (18%)
  - Side effects discussed (60%)
  - ACB score discussed (40%)
  - Inappropriate medications stopped - overtreatment (11%)
  - New medicines started - undertreated (22%)

- 97% of patients didn't know why they were taking at least one of their medications and we were able to optimise drug dosages in 23% of SMRs.

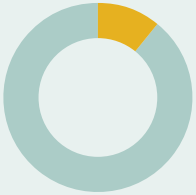
- One surprising outcome was how easily we were able to impact ePACT2 data for polypharmacy-related parameters due to the focus from the project.

200

Number of patients who had an SMR completed

18%

Non-compliance of medication identified in patients seen



11%

Patients seen having inappropriate medications stopped

16%

Patients seen having medicine quantities synchronised

23%

Patients seen having drug doses optimised

- From April to October 2024: Hyperpolypharmacy (patients on 10 or more unique medicines) ePACT2 data reduced from 5.76 to 5.64 and patients with ACB 9 or more reduced from 0.10 to 0.07.
- Resources from the Health Innovation Network were shared with all patients and in particular leaflets explaining the review process (patient invitation letter), especially the large print version for certain patients, along with a leaflet explaining ACB.

Future work

We will discuss these results at a meeting with our clinical leads and decide using EPACT 2 what our next focus will be.

We aim to share best practice with other practices in our PCN and across the ICB.

More information

Graham Price, Clinical Pharmacist, Northern Arc PCN: graham.price1@nhs.net

References

1. McCahon, D., Denholm, R., Huntley, A., Dawson, S., Duncan, P and Payne, R. (2020) Development of a Model of Medication Review For Use in Clinical Practice

Improving access to Structured Medication Reviews (SMRs) in Wessex

Health Innovation Wessex

Background

Seven primary care networks (PCNs) in Wessex applied for national funding (awarded to one PCN per regional health innovation network) to deploy the Health Innovation Network resources to improve the uptake of SMRs in seldom heard patient groups.

Due to such a positive local response, Health Innovation Wessex funded five additional PCNs to use the materials locally.

Wessex projects fell into three categories outlined below. Practices collected three weeks of baseline data and then started to use the Health Innovation Network SMR resources.

Wessex projects by category

1. Design and implement a sustainable pathway for the clinical pharmacist within the practice to offer SMRs

- Cheviot Road Surgery, Southampton West PCN
- Island City PCN

2. Identify and reach housebound patients due an SMR

- Lordshill Medical Practice, Southampton West PCN
- Brunel PCN

3. Pilot using Health Innovation Network SMR resources

- Gosport Central PCN
- Portsdown PCN
- Living Well Partnership (nationally funded)

Wessex results

Over the three-week testing phase:

- 77 SMRs were carried out across five PCNs compared to 24 SMRs before the project started (an increase of 220%).
- Use of the Health Innovation Network SMR resources reduced 'Did not attend' rates and increased the uptake of SMRs compared to baseline.
- The SMR process helped reach patients in more deprived areas, supporting them with taking their medicines. The SMR materials worked especially well for patients who were housebound.
- PCNs who were not previously doing any SMRs developed an SMR pathway with robust arrangements for selecting patients, inviting them to their appointment and following up.
- Patients and pharmacists felt that the SMR process led to a better understanding around medicines for long term conditions.

Next steps

Hampshire and Isle of Wight Integrated Care Board and Health Innovation Wessex are working together to increase the uptake of SMRs across Hampshire and Isle of Wight, using the learning from this work.

Find out more about our work on SMRs on the Health Innovation Wessex website.

The patient information leaflets helped patients prepare for their SMR. Some patients came with questions about their over-the-counter medications, others thought in advance about each medication and why they would like to continue, stop or reduce a dose. Prior to the resources, patients were unsure who was calling and why... a bit like cold calling.

Practice pharmacist

Thank you for explaining my medications. It's helpful to know which ones are essential and which ones I can take when needed.

Patient

Thank you for everything you have done for my Mum and Dad. We have managed to return old medicines to the pharmacy.

Patient's son

Larwood and Bawtry PCN: seldom heard communities polypharmacy project

Health Innovation East Midlands
Local change, national impact

Opportunity for change

Westwood Surgery is a practice in the Larwood and Bawtry PCN in Nottinghamshire with 3,500 registered patients.

Residents in the local community fall within the second most deprived decile in England, with NHS data showing a direct correlation between deprived communities and obesity, serious mental illness, diabetes or other long-term condition and learning disability.

The intervention

22 patients from the Westwood Surgery were invited for a SMR with a clinical pharmacist after meeting three or more criteria following searches. The categories used included care home residents, complex polypharmacy (10 or more medicines), frailty, being prescribed to medicines known to cause harm or addictive, housebound, recent hospitalisation or a fall in the last three months.

The Health Innovation Network resources used were the patient invitation letter, Me and My Medicines patient charter shared via SMS and paper letters in English.

Impact / outcomes

At the practice, SMRs were previously completed by GPs, with an allocated time frame of 6-10 mins. For this study, SMRs were completed by a clinical pharmacist with 30 minutes allocated, allowing for a more comprehensive intervention.

Patients advised they had time to plan for the discussion helped with outcomes, leading to productive shared decisions and deprescribing.

SMR uptake increased by over 10% due to the targeted approach and materials provided. Outcomes included:

- The prescription and administration of inclisiran for familial hypercholesterolemia.
- The development of a deprescribing plan with the aim of reducing ACB score and opioid / gabapentinoids reduction.
- Opioid reduction for non-palliative pain, with a fully agreed opioid reduction plan.
- Addictive medicines review and mitigation of risk secondary to safeguarding concerns.

Data

- Baseline number of SMRs scheduled: **20**
- Baseline number of SMRs completed: **16 (80%)**
- Study number of SMRs scheduled: **22**
- Study number of SMRs completed: **20 (91%)**

Future work

We will be identifying and prioritising high risk patient groups for SMRs – care home residents, housebound, complex polypharmacy, frail, and those prescribed addictive medicines or medicines known to cause harm.

More information

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Health Innovation East Midlands: Richard.mcbain@nottingham.ac.uk

I think this work highlights the value of a SMR. Patients felt heard and every decision made was a shared one. It gave me a real sense of job gratification. I recall a patient telling me that they would never have considered reducing their opiates if we had not engaged with them.

Clinician

Prioritising the patient's perspective in Sheffield

Health Innovation Yorkshire & Humber

Opportunity for change

At Richmond Park PCN in Sheffield, SMRs were prioritised for care home patients, largely due to time constraints. This meant opportunities were being missed for patient-centred SMRs for large numbers of patients with polypharmacy. Medication reviews are also usually carried out by a clinician reviewing the notes, rather than as an SMR conversation with a patient.

Intervention

20 patients aged over 75, on eight or more medications were identified in the 10th or 20th centile of the Index of Multiple Deprivation (IMD). Patients were texted links to SMR leaflets, or these were posted for the digital excluded.

A medical student rang patients to gather information prior to the review and updated SystmOne with indications for medicines, drug interactions, calculated anticholinergic burden (ACB) and monitoring requirements. The student rang the patient to discuss and record reported concordance, understanding of medication, feelings about medication and verbally assessed frailty.

The clinician undertook a home visit to conduct a patient-centred medication review, as well as identify any stockpiling.

Impact / outcomes

The mean number of medications was 12 (range 8-19). Significant digital exclusion was identified, with many patients not receiving or being able to open messages on their phones. One patient was completely illiterate, making it impossible to convey the leaflets by any means.

The interview with the medical student was useful in identifying the patient's priorities, highlighting drug interactions and preliminary frailty scoring.

The clinician home visit was crucial in identifying significant stockpiling in three patients. One patient had 20 glyceryl trinitrate (GTN) and many duplicate prescriptions of metformin sachets and liquids (the latter costing £55 / bottle).

Frailty scoring was essential to identify inappropriate ongoing prescriptions. Mean ACB score was 2.55 (0-6).

The most useful leaflet was the Stopping My Medicines leaflet, which helped with follow-up arrangements.

28 medications were stopped, eight were started, 27 were reduced and one cost effective switch was undertaken.

Future work

We will continue to use the patient information leaflets and formalise a template for a less qualified clinician to do a pre-SMR discussion or, if possible, home visit, to streamline the process and optimise the time spent with a qualified clinician.

More information

Richmond Park PCN: Dr Honey Smith
honey.smith1@nhs.net

I've been taking this medication for many years, but the leaflets made me think about how I felt about taking them. I'm glad to have this opportunity to talk about them because these tablets aren't working, and I heard they could cause memory problems and falls.

Sheffield patient

Improving access to Structured Medication Reviews (SMRs) in Lewisham

Health Innovation Network South London

Opportunity for change

Modality Lewisham is a PCN with 3,600 patients across three practices. Our PCN includes some of the most deprived communities in Lewisham.

Lewisham is one of the 10% most deprived local authorities in England and the 10th most deprived London borough. More than 40% of the population are from Black and ethnic minority groups.

Although only around 10% of the population are over the age of 65, 14.5% of the adult population are living with a long-term disability. This partially reflects the multi-ethnic composition of the population and deprivation.

The main cause of death in Lewisham is cancer, followed by circulatory and respiratory disease.

Due to the cost-of-living crisis and high rates of poverty, there have been concerns raised about the risk of prescribed medication not being taken or over the counter medication being used inappropriately. It is possible that those experiencing long term conditions or polypharmacy may be more at risk.

Intervention

By developing a search within the PCN clinical software EMIS, we identified patients that were 75 or older and taking 10 or more medications. This search identified 138 patients across the PCN of which 58 were male and 80 were female.

We then reviewed this list to identify those who may have been more at risk of difficulties with their medication or increased likelihood of not having a SMR. Our Lead Pharmacist and a GP partner took responsibility for reviewing the patients.

Patients were invited for an SMR either by telephone call, text or letter. We set up a text template that included the Health Innovation Network invitation letter and the video. In some cases, we provided printed invitations.

The reviews were carried out either by telephone or in person in the practices, and afterwards we asked for feedback. We set up a further AccuRx template with this information but also shared paper copies.

Impact / outcomes

All 20 patients who were invited to a SMR attended their appointment.

In almost all cases, medications were stopped or changed, monitoring was arranged, or coding of records took place. In some situations, a clinical issue was noted that required further follow up or investigation.

A number of interventions were required in each SMR. This included blood monitoring, medication changes, and identification of compliance issues. Medication reviews completed by GPs allowed investigation of other symptoms that were detected in the time. This highlighted the benefits of having a more multidisciplinary approach to the project.

Patient and professional feedback

One patient watched the video with her son on his phone. She reported finding the video helpful.

Several patients spoke to one of the pharmacy administrators and said that they were worried about opening links due to the risk of crime. Further patients reported having problems opening links or understanding how to do it.

There were clear challenges in patients receiving text messages with links or attachments and also in sending printed materials due to the cost of postage.

We found the Health Innovation Network resources helpful but need to ensure that they are selected and provided to patients appropriately. Many documents or pieces of information are rarely read.

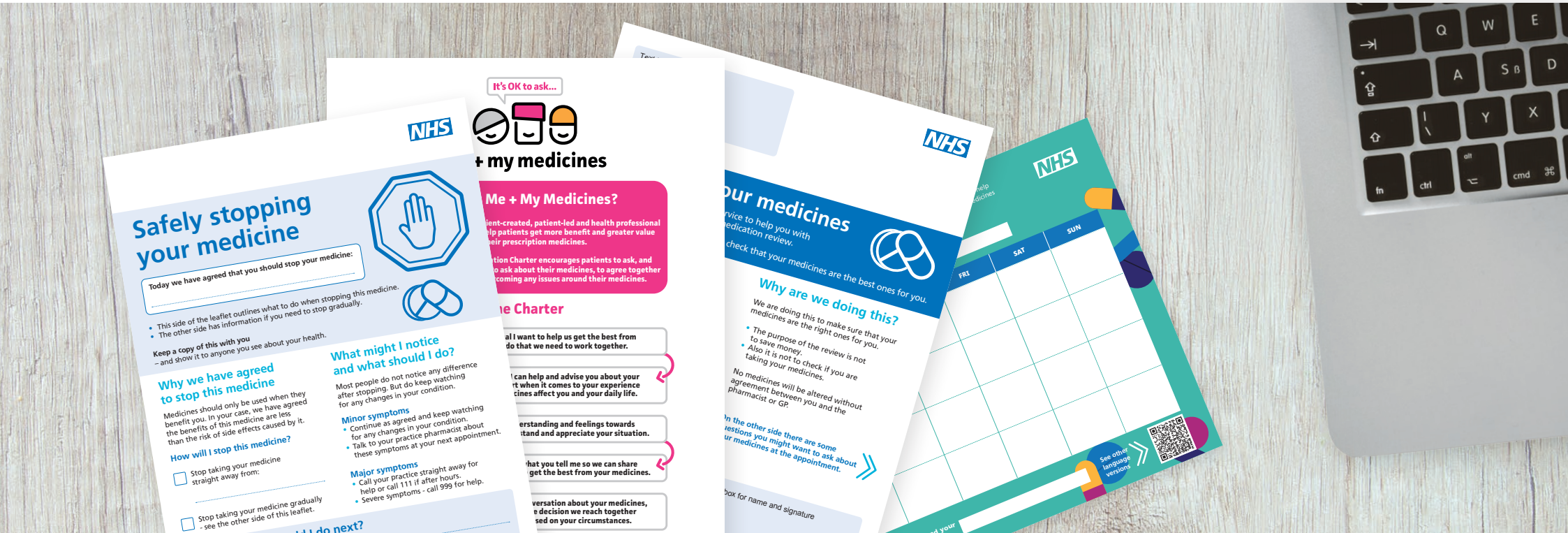
Future work

We are encouraged in our local Medicines Optimisation Scheme to complete SMRs for patients on more than 10 medications. This age cohort is particularly vulnerable to the effects of polypharmacy.

As an outcome of this work, we will continue to make this group a priority. Where possible, we will also continue to use the multidisciplinary team approach to develop the skills of the wider team and ensure patients have a holistic review.

More information

HIN South London: Dr Esther Appleby
estherappleby@nhs.net



Resources

Patient resources

- The suite of patient resources 'Preparing for your Structured Medication Review' can be downloaded from the Health Innovation Network website.
- Health Innovation Yorkshire and Humber have worked with local healthcare professionals and patients to produce an example video of Structured Medication Reviews. The video supports patients to prepare for an SMR with their healthcare professional and encourages shared decision-making. The full video is available here on YouTube and the shorter video for social media is here.
- Health Innovation Wessex have also produced a patient animation called Meet Mo patient available here.

Evidence to support Structured Medication Reviews

Health Education Scotland 'Economic evidence to support polypharmacy reviews' available at https://rightdecisions.scot.nhs.uk/polypharmacy-guidance/help-more-info/appendices/appendix-d-health-economics-analysis-of-polypharmacy-reviews/#:~:text=The%20analysis%20follows%20a%20top,of%20any%20potential%20review%20charge

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iSIMPATHY Study available at https://www.isimpathy.eu/uploads/iSIMPATHY_Evaluation_report_ver8_online.pdf

Structured Medication Reviews resources for healthcare professionals

- Health Innovation Yorkshire and Humber have worked with local healthcare professionals and patients to produce an example video of a 'good' SMR, focusing on shared decision-making. The video is aimed at primary care teams who are involved in SMRs. Here is the full healthcare professional video and here is a shorter version for social media.
- Health Innovation Network animations to be screed in GP waiting rooms 'Preparing for your SMR' with sound and subtitles or without sound and with subtitles.
- GP evidence: summaries of the evidence on the benefits and harms of treatments for long term conditions available here.
- Supporting patients to get the most out of their SMR – watch a recording of the Health Innovation Network masterclass: Polypharmacy lunchtime masterclass: supporting patients to get the most out of their structured medication review (July 2024).

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7. Resources to support patients having a Structured Medication Review - The Health Innovation Network

8. A campaign to help patients discuss their medicines nearly doubled our medication reviews - The Pharmaceutical Journal (pharmaceutical-journal.com)

9. Me and my medicines on Vimeo (Nottingham PCN pilot)

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www.thehealthinnovationnetwork.co.uk