MLCSU Clinical
Medicines Management and Optimisation

NHS
Midlands and Lancashire
Commissioning Support Unit

PCN Pharmacy Teams: What does good look like?

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NHS Midlands and Lancashire CSU

Background

The NHS Long Term Plan sets out the aims for Medicines Optimisation teams to reduce inappropriate prescribing of:

- antimicrobials
- medicines that can cause dependency
- higher-carbon inhalers; and
- nationally identified medicines of low priority.

Despite still being in their infancy, Primary Care Networks (PCNs) have played a leading role in the national response to COVID-19. Just two years on from their creation, PCNs have risen to the challenges presented by the pandemic, administered the majority of COVID-19 vaccinations, reached out to deprived communities and made significant progress in tackling health inequalities.

PCNs are crucial to the success of Integrated Care Systems (ICSs). Population health management takes centre stage in the transition to ICSs. The proximity of PCNs to patients renders them indispensable to the success of ICSs. ICS priorities must reflect total population need, yet they will also need to take heed of population diversity at a local level and PCN engagement will be a deciding factor in this. Establishing place-based partnerships and provider collaboratives that both include and are informed by PCNs will be instrumental in achieving this, enhancing local population health management and creating a much-needed golden thread between neighbourhood and system levels to ensure ICS objectives are evidence-based.

PCNs are required to work collaboratively and share expertise and lessons learned: for example, to integrate national-level programmes, such as STOMP (Stopping over medication of people with learning disabilities), into their local approach around Structured Medication Reviews (SMRs).

This document has been developed to support PCN pharmacy teams with practical tips to help them achieve the priorities of the NHS Long Term Plan and the PCN Directed Enhanced Services (DES), whilst delivering safe, effective, practice prescribing systems and medicines use in primary care.

What does good look like?

PCNs are key to the development of primary care. However, in many cases PCNs are seen as a vehicle for adding a little more capacity into the system; essentially reinforcing the current model.

Under the Primary Care Network DES, PCNs can recruit new roles through the Additional Roles Reimbursement Scheme (ARRS); for example, clinical pharmacists to expand their care teams in general practice. The aim of the ARRS scheme is to build and utilise the additional roles to solve the workforce shortage in general practice. Whereas the funding will be for new roles to be introduced within PCNs, each network will have the flexibility to determine which roles form a core list they require based on their patient population requirements.

New service specifications have caused confusion over the role and responsibilities of PCNs and there is a need for a better shared understanding of the individual additional roles and what these professionals can offer. Many of the recruited professionals are not being given tasks appropriate to their competencies and there are often disagreements around whether these roles should be used only to deliver the PCN's specifications, or

whether they are there to provide extra capacity to ‘core’ general practice work. There is often a lack of understanding or agreement about what pharmacists and technicians could, or should, contribute to and how they would best be deployed across the network. This is further complicated where staff such as pharmacists have previously been employed directly by practices for example as part of early NHSE Clinical Pharmacists in GP Practice programme pilots. Often the preferences of individual practices are given priority over the PCN’s decision-making, potentially because the PCN strategy is not felt to take precedence over individual practice needs or wants.

Pharmacists often complain of feeling isolated working in PCNs, especially if they have moved from roles where more established team structures were in place. Frequently, they describe how their Primary care pharmacy education pathway (PCPEP) training time is not necessarily seen as part of their ARRS role or whether it adds any value to the practice.

There is strong consensus that leadership support is crucial to get the best from pharmacy teams. Establishing a pharmacy team with a defined structure, regular protected team meetings and development time, enables a more focused approach. Mentoring and coaching sessions with experienced senior pharmacists are recommended, with regular opportunities for protected professional discussions in a safe environment.

Workplan

Formation of a PCN workplan can support the most effective use of a PCN pharmacy teams skills and can improve delivery of patient care in line with the current Investment and Impact Fund (IIF) incentive scheme. PCNs should work towards having a clear shared vision and strategy to enable standardised best practice across the network.

Following a local review of the PCN IIF targets and considering local demographics and health inequalities, we suggest practices or PCN teams focus SMRs on the following five areas:

Respiratory:

- Reviewing patients on the QOF Asthma Register who received six or more Short-Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months.
- Considering switches to low carbon inhalers

Cardiovascular Prevention & Diagnosis

- Reviewing patients with undiagnosed hypertension, at high risk of cardiovascular disease and patients on direct-acting oral anticoagulants (DOACs).

Care homes and frailty patients

Patients at risk of harm

- Reviewing patients at increased risk from medication errors e.g., after hospital discharge or after a hospital outpatient appointment, patients using potentially addictive medicines and patients on high dose opioids for pain management

Safety audits for patients on valproate

For a thorough SMR, we recommend a 30 minute appointment slot with review sessions running over 3.5 to 4 hours. To allow PCNs to achieve the required outputs related to medicines use, we recommend that pharmacy professionals provide a minimum of 50% time allocation or five patient facing (or remote) review sessions per day per full time

employee. This is to ensure delivery of the required clinical improvements and patient-focused outcomes. Whilst medicines query support and administration will be required, this should not be the focus of these additional roles. Other members of the practice team may be able to deal with repeat prescription prescribing and administrative tasks that can be managed within the whole GP practice and not just by the pharmacy team.

A recommended PCN pharmacist's work schedule can be seen in the table below. In summary:

- 50% of time is spent working on SMRs as a core requirement of the DES (considering the IIF indicators and the funding associated with them).
- 25% of time is spent working on audits/admin, where IIF cohort patients are reviewed in line with a workplan based on achieving upper threshold targets for indicators. In this admin time, pharmacists and technicians can support with other priorities including ICB-related activities such as safety audits for high risk drugs, AMR stewardship, for example reducing antibacterial items per STAR- PU to below national targets and reviewing UTI prescribing based on national guidance.
- At the beginning and end of the day, the workplan also recommends supporting practices with Docman tasks and medicines-related queries and tasks. This may be significantly less time than practices are used to having. Individual practices will have their own wants and needs, and therefore the workplan should be flexible and taken as a guide to aid discussions, bearing in mind the wider PCN strategy and priorities.

Weekday	8.30 to 9am	9-10am	10-11am	11-12pm	12-1pm	1-2pm (30min)	2-3pm	3-4pm	4-5pm
Monday	Docman	SMR clinic 20min slots	SMR clinic 20min slots	SMR clinic 20min slots	Other	Lunch/ catch up	admin/audit	admin/audit	Med enquires / Tasks 10min slots
Tuesday	Docman	SMR clinic 20min slots	SMR clinic 20min slots	SMR clinic 20min slots	Other	Lunch/ catch up	admin/audit	admin/audit	Med enquires / Tasks 10min slots
Wednesday	Docman	SMR clinic 20min slots	SMR clinic 20min slots	SMR clinic 20min slots	Other	Lunch/ catch up	admin/audit	admin/audit	Med enquires / Tasks 10min slots
Thursday	Docman	SMR clinic 20min slots	SMR clinic 20min slots	SMR clinic 20min slots	Other	Lunch/ catch up	admin/audit	admin/audit	Med enquires / Tasks 10min slots
Friday	Docman	SMR clinic 20min slots	SMR clinic 20min slots	SMR clinic 20min slots	Other	Lunch/ catch up	admin/audit	admin/audit	Med enquires / Tasks 10min slots

When pharmacists are qualified as non-medical prescribers it is important to ensure they are only working within areas of their clinical competencies. Accountability is a key element of non-medical prescribing, and all registered non-medical prescribers are personally accountable for their practice and when prescribing medicines must work to the same standard or competence that applies to all other prescribers. Non-medical prescribers should adhere to and regularly review the Royal Pharmaceutical Society Prescribing framework competencies:

https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf

Areas of focus for ARRS pharmacy technicians

Close working with ICS medicines teams will also support development and avoid duplication of any historic work that may have been completed by these teams. The agenda for medicines teams is wide- ranging, covering a broad focus on multiple clinical areas,

local priorities and/or incentive schemes, national workstreams and repeat prescribing systems. PCN pharmacy technicians can support:

- Cardiovascular Prevention and Diagnosis
- Identification of patients with previous elevated blood pressure (BP) readings to help confirm or exclude hypertension diagnosis and undertake activity to improve coverage of BP checks
- Identification of patients at risk of familial hypercholesterolaemia by running GP clinical system searches for patients with high cholesterol levels
- Safety of DOAC doses by ensuring renal function tests, recording of actual body weight and Creatinine Clearance rates are up to date and recorded
- Care Homes: gathering information to support pharmacists to undertake SMRs and helping to identify patients requiring Personalised Care and Support Plans.
- Respiratory Care and Environmental Sustainability: technicians are ideally placed to help support the green inhaler agenda.
- Safety Audits and Antimicrobial Stewardship.

Supporting resources

Data analysis

- EPACT https://www.nhsbsa.nhs.uk/access-our-data-products/epact2
- Open prescribing https://openprescribing.net/
- NHSBSA dashboards https://www.nhsbsa.nhs.uk/access-our-data-products/epact2/dashboards-and-specifications

Clinical support

- NHSE&I https://www.england.nhs.uk/primary-care/pharmacy/smr/
- National Overprescribing review https://www.gov.uk/government/publications/national-overprescribing-review-report
- AMR strategy https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024
- NICE https://www.nice.org.uk/guidance/qs120/chapter/quality-statement-6-structured-medication-review
- NICE Clinical Knowledge Summaries https://www.nice.org.uk/
- Specialist Pharmacy Services (SPS) resources https://www.sps.nhs.uk/articles/using-tools-to-support-medication-review/