Structured Medication Reviews and Optimisation Specification

Consultation response from the Chartered Society of Physiotherapy 15/01/20

NHS England has consulted on 5 new service specifications which contain important changes to how primary and community services will be expected to deliver from April 2020, and implications for physiotherapy.

This is how the CSP replied to questions on the *Structured Medication Reviews and Optimisation* specification.

1. Is there anything else that we should consider for inclusion as a requirement in this service? For example, are there approaches that have delivered benefits in your area that you think we should consider for inclusion?

1.1 Independent Prescriber Physiotherapists meet the definition used (paragraph 2.10) and should be added to this list, and their expertise fully utilised for SMRs for certain patients.

1.2 The last published figure of Independent Prescriber Physiotherapists from the Health and Care Professions Council was over 750, and this number will be growing rapidly with the roll out of first contact physiotherapy roles and demand for advanced practice physiotherapy more generally.

1.3 Independent Prescriber physiotherapists can currently prescribe all licensed medicines including a list of 7 controlled drugs. Work is ongoing that may result in this controlled drug list expanding in the future. Evidence of the impact of prescribing physiotherapists and non-prescribing physiotherapists shows they both play an important role in medicines optimisation (particularly de-prescribing opioid drugs), and achieve an overall reduction in prescribing levels. This was evidenced most recently in the national evaluation (due to be published very soon) of musculoskeletal (MSK) first contact physiotherapist (FCP) roles.

1.4 The patient groups identified as being most likely to benefit from an SMR (paragraph 2.7) include most patients who physiotherapists are working with. This includes physiotherapists in First Contact Physiotherapist roles (delivering personalised care), in Pain Clinics, Community Teams, Frailty Practitioners, those in interface roles with Home First and Early Support Discharge and Emergency Departments. It should be noted also that every patient admitted to hospital with a hip fracture will have a comprehensive geriatric assessment as this is part of the tariff. Bullet points 5, 6 and 7 all relate to patients who physiotherapists will be closely working with.

1.5 It is essential therefore that physiotherapists are able to directly refer into a SMR service as required, that pharmacists delivering services liaise directly with physiotherapists looking after patients with long-term conditions, and that both have access to the same shared records.

2. Are there any aspects of the service requirement that are confusing or could be better clarifies?

2.1 The specification needs to clarify that registered physiotherapists also meet the criteria and should therefore be included in the list of appropriate practitioners (2.10, page 11).

2.2 In paragraph 2.7, bullet point 3 which relates to patients prescribed medicines commonly and consistently associated with medicine errors – the CSP supports this but suggest that the definition needs to be tightened up to give greater clarity.

2.3 The reference to 0.5 WTE physiotherapist per PCN within Additional Roles in paragraph 1.12 is confusing.

2.4 The CSP supports NHS England's ambition for full roll out of FCP roles by 2023. FCP staffing of 1 WTE for every 10 thousand population is required for the FCP to manage 50% of a GPs MSK caseload and appointments, rather than the GP. This would free up GP time considerably, including to enable GPs to deliver key elements of the specifications.

2.3 We ask that the indicative illustration in 1.12 is removed. Local areas will have different starting points, rending the illustration meaningless. Further, it confuses the specific intention to deploy additional roles (including FCP) within practice teams (with the purpose of freeing up GP time), with the significant opportunity offered by these five specifications that requires work from a range of clinicians, requiring other specific workforce consideration.

3. What other practical implementation support could CCGs and Integrated Care Systems provide to help support delivery of the service requirements?

3.1 The key role of physiotherapists and physiotherapy support workers across all 5 PCN specifications needs to be within ICS's workforce growth and development plans.

3.2 There is strong growth in numbers of registered physiotherapists with physiotherapy pre registration courses continuing to be over subscribed with high quality candidates and strong completion rates. This growth needs to be supported, and furthermore, translated into staffing to meet needs.

3.3 In relation to developing the existing physiotherapy workforce the priorities for local workforce plans are:

- increasing numbers of physiotherapists with advanced practice capabilities (including prescribing and FCP specific modules)
- supporting development of and access to tailored advanced practice modules within multi-professional ACP programmes/ apprenticeship

4. To what extent do you think that the proposed approach to phasing service requirements is manageable in your area?

4.1 The contribution of the physiotherapy workforce to deliver across the 5 specifications, both from primary care and community services in line with the schedules set out is dependent on continued workforce growth, translation of workforce growth into staffing and the training and development of the physiotherapy workforce. This includes full roll out of FCPs that is critical to freeing up GP time (see answer to Q3).

4.2 In paragraph 1.21 it states that where PCNs are struggling to recruit, CCGs and systems should take action to support them.

4.3 The current NHS England and NHS Improvement suggestion is for PCNs who have not spent all of the Additional Roles Reimbursement Scheme (ARRS) funding should be redistributed to neighbouring PCNs.

4.4 The CSP believes that the funding should ideally be used for the population that it is intended for. The CSP therefore suggests that the DES contract specify that CCGs' supporting activity expected here (including workforce training and development) can in part be financed by ARRS underspend. This would support the scheduling as set out.

5. Do you have any examples of good practice that you can share with other sites to assist with delivering the suggested service requirements?

5.1 The CSP contributed to anti-microbial stewardship competencies developed by Cardiff University. This has since been endorsed by NICE as good practice in anti-microbial prescribing training for health care professionals.[1]

6. Referring to the 'proposed metrics' section of each of the services described in this document, which measures do you feel are the most important in monitoring the delivery of the specification?

6.1 The CSP believes the local prescribing formulary metrics are key to this. In addition to what is there, we recommend that the number of prescriptions for controlled drugs is also collected.

6.2 The partnership working between PCNs and community services highlights the importance of multi-professional access to systems and the development, improvement and procurement of any new primary care electronic systems, across all of the service specifications.

6.3 Access to the prescribing sections of EMIS in particular continues to be a challenge for those without a GMC/NMC number. In places, physiotherapy independent prescribers are having to use inappropriate workarounds to prescribe medication in primary care. This is logged as an issue with EMIS but there has been no solution so far.

References:

1. National Institute for Health and Care Excellence. Consensus based national antimicrobial stewardship competencies for UK undergraduate healthcare professional education. London: National Institute for Health and Care Excellence; 2019.

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For further information on anything contained in this response or any aspect of the CSP's work, please contact: Rachel Newton, Head of Policy, newtonr@csp.org.uk