NHS
London Procurement Partnership

A RESOURCE TO SUPPORT THE DEVELOPMENT OF STRUCTURED MEDICATION REVIEW (SMR) TOOLS AND TEMPLATES THAT ARE FIT FOR PURPOSE

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Version 1.0

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Introduction

A Structured Medication Review (SMR) is a NICE approved clinical intervention. It is a critical examination of a person's medicines with the objective of reaching an agreement with the person on:

- their treatment
- options for optimising the impact of the medicines they take
- minimising the number of medicines related problems
- reducing medicines waste

The **PURPOSE** is to ensure that the person's medicines are working for them and this is facilitated by practitioners having **shared decision-making conversations with people** about their medicines.

Through SMRs it is expected that patients and the NHS will get better outcomes and optimum value from medicines use. SMRs are one of the five **Direct Enhanced Services within the GP contract (GP DES)** since October 2020. The SMR specification sets out expectations for enabling **primary care-based clinical pharmacists** to undertake SMRs and lead their implementation by collaborating with specialist hospital, community and CCG pharmacy colleagues, as well as other members of the health and social care multidisciplinary teams.

SMRs should be offered to the identified patients who are most vulnerable to medicines related harm. This will include but is not limited to patients:

a. in care homes
b. with complex and problematic polypharmacy, specifically those on 10 or more medications
c. on medicines commonly associated with medication errors e.g. NHBSA 2019 medication safety indicators
d. with severe frailty (3% of over 65s)[1] who are particularly isolated or housebound or who have had recent hospital admissions and/or falls
e. using one or more potentially addictive medications from the following groups: opioids, gabapentinoids, benzodiazepines and z-drugs.

This resource has been written on behalf of the pan-London Pharmacy Care Homes Group-facilitated by the NHS London Procurement Partnership's Pharmacy team. This resource will highlight principles to consider when designing tools and templates for SMR consultations that are fit for purpose as stated in the NHS England and NHS Improvement SMR and Medicines Optimisation Guidance document (NHSE/I SMR and MO Guidance)

It is a pragmatic document primarily written for primary care-based pharmacists who undertake SMRs and/or seeking to develop tools for use in practice. It is not a standard operating protocol. It incorporates evidence-based practice where available, draws on the author's expertise and makes suggestions based on national guidance or best practice of undertaking medication reviews for older people in primary care, community care and care home settings. This document should be used alongside the NHSE/I SMR and MO Guidance

[1] Severe frailty is defined as a person having an eFI score of >0.36. https://www.england.nhs.uk/ourwork/clinical-policy/olderpeople/frailty/efi/

How to use this document

The resource can be read as a comprehensive resource to provide a basic understanding about the WHY, WHAT and HOW of the SMR process in the context of typical patients who will be offered SMR, as well as useful tools and templates to facilitate the process. Also, individual sections of this resource can be read as a standalone to gain knowledge relating to specific aspects of the SMR or as a 'how to' resource to be worked through when developing or designing various aspects of the SMR process. The resource is divided into 2 main sections:

Section One

- Introduces the case for SMR, as a patient centred intervention to optimise medicines in the context of improving patient outcomes, reducing medicines related harm and overprescribing.
- Gives a broad explanation of what SMRs are, its purpose, who will be offered and prioritised for SMRs as well as the requirements and process of undertaking SMRs, as described in the NICE Medicines Optimisation (NICE NG5) and NHSE/I SMR and MO Guidance.
- Identifies the challenges of managing the risks, uncertainties and complexities identified during SMRs in these vulnerable patients.
- Outlines how to incorporate a patient-centred approach and shared decision making, whilst also considering current evidence during SMRs to address the challenges.
- Section one ends with an outline and brief description of the key processes of an SMR **(Identify 4Ps, 2Cs and Document)** which is illustrated by a flow chart in **Appendix 3.**

Section Two

- Discusses the practicalities of undertaking SMRs focusing on the use of tools and templates to facilitate SMRs that are safe and fit for purpose.
- Majority of those undertaking SMRs will be generalist pharmacists in primary care-based settings. They will be reviewing the patient 'holistically' using a biopsychosocial approach, which goes beyond managing specific long-term conditions against standard protocols. They will need to have a broad scope of evidence based therapeutic management of multiple long-term conditions and the ability to apply evidence and clinical judgment to what is important to the individual patient to ensure that their medicines are working well for them.
- This section also highlights the role, benefits and limitations of tools and templates to support patient centred consultations and shared decision making during the SMR process. This helps to ensure that practitioners capture all aspects of medicines related care including safety, and helps to ensure that vital aspects are not omitted.
- Categorises tools and templates used in practice according to their intended primary function. It highlights the pros and cons for each category as well as circumstances where they might be useful in practice, depending on the level of competency of the user or the needs of the team or organisational setting
- Provides a checklist of key points to consider when developing or designing an SMR template or tool that is fit for purpose. To illustrate how the checklist could work in practice, Appendix 1 shows how some of the existing templates meet the criteria.

The aim of this document is to provide initial guidance, as SMRs are implemented and become embedded into routine practice. New information, knowledge and experience will emerge over time. Pharmacists and other healthcare professionals that use the principles or checklists from this document, are invited to provide feedback to the author using the form in Appendix 2.

Section ONE: Understanding structured medication reviews (SMR) in the context of frailty, multimorbidity and polypharmacy

1. Background

- Prescribing medicines is the most common intervention in the NHS. There's an increasing population of older people living with frailty and multi-morbidities who often need medicines to manage the symptoms and complications from their long-term conditions (LTCs). This has contributed significantly to the problem of overprescribing inappropriate and problematic polypharmacy [Kings Fund polypharmacy].

- With increasing frailty, multiple LTCs and multiple medicines (polypharmacy) there is a shift in the benefit: harm ratio of medicines compared with existing research evidence which is usually based on studies of younger and more robust people with single LTCs. This shift can increase the risks of medicines related harm or problems and cause uncertainties when making clinical decisions about whether to deprescribe (or prescribe) medicines in this cohort of patients.
- Therefore, a regular review is necessary, to check that the medicines are still working for the patient and to avoid increasing their risks of unwarranted medicines related harm.
- A review of medicines will often lead to **deprescribing:** the complex process of safely discontinuing inappropriate medicines.
- Deprescribing considers the current available research, the patient's perspective and values, as well as the clinician's expertise. Tools and templates can support clinicians to undertake safe, effective and consistent SMRs.

- National guidance such as the NHS Long Term plan, NICE NG5, NICE SC1, and NICE NG56, recommend that patients must be involved in the decision-making process about their care, so that the resulting health care interventions are based on 'what matters most' to them. A review of a patient's medicines should not be an exception and so medication review tools or templates used in routine practice should aim to facilitate this patient centred approach.

- There are existing medicines optimisation frameworks to manage polypharmacy and deprescribing such as NHS Scotland Polypharmacy, NHS SPS approach, RPS Polypharmacy guidance (Appendices) and 3-Step iterative process that utilise a patient centred approach, and could be used as the starting point for designing tools or templates for practice.

2. What is a Structured Medication Review (SMR)?

2.1. Definition and description of SMR

The term structured medication review is not limited to its use in the GP DES contract but was first defined by NICE NG5 2015 as a:

'critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medicines-related problems and reducing waste'

The NHSE/I SMR and MO Guidance describes an SMR in terms of who should receive it, how and why it should be delivered.

***A comprehensive and clinical review of a patient's medicines and detailed aspects of their health that help people who have complex or problematic polypharmacy. SMRs are delivered by facilitating shared decision-making conversations with patients to ensure that their medication is working well for them'*.**

Other recent documents that mention SMRs include the NHSE/I Call to action for Pharmacy response to COVID-19 pandemic in care homes letter 2020 and the EHCH DES specification 2020. They require primary care-based pharmacists* to deliver remote or telephone SMRs where appropriate to care home residents, e.g following a Comprehensive Geriatric Assessment (CGA).

Both the NICE definition and the DES description of SMR imply the necessity for a two-way conversation with the patient (and or their carer) during an SMR consultation. This is to enable practitioners to understand the patient's experience of taking medicines and reach an agreement about what actions to take to ensure that their medicines are working for them. It is not likely then that the clinician undertaking an SMR will be able to make changes to the medicines list without first having a conversation with the person to agree the plan of action. Therefore, to deliver SMRs that are fit for purpose, tools or templates to support the SMR consultation and process must facilitate high quality conversations and shared decision-making.

2.2. What is the purpose of SMR?

An SMR is a clinical intervention to optimise medicines. Medicines Optimisation is a **patient-centred, outcome-focused approach** to care that takes into account the **patient's values, perception** and **experience** of taking their medicines. The Royal Pharmaceutical Society's four Principles of medicines optimisation should underpin the approach to SMRs and keep the patient at the centre of care:

- Aim to understand the patient experience
- Evidence based choice of medicines
- Ensure medicines use is as safe as possible
- Make medicines optimisation part of routine practice

* The term Primary care-based pharmacists here refers to General Practice (GP), Primary care networks (PCN), Medicines optimisation in care homes (MOCH) pharmacists

Medicines Optimisation aligns with evidence-based practice, which is about integrating the patient experience, available research evidence and the clinician's judgement into care (*Sackett et al 1996)*. Table 1 summarises key elements in the process of medicines optimisation for people living with frailty and multi-morbidities *(NICE NG56, NICE NG5, NICE SC1, BGS Fit For Frailty1, NHSE GP managing Frailty toolkit 2017, NHSE/I SMR Guidance 2021)*

Table 1: Key elements of medicines optimisation in frailty and multi-morbidities

- **Identify** patients most vulnerable to adverse medicines problems
- Use a **structured and evidence-based approach** to conduct medication reviews e.g SMR (DES 2020/21)
- Use **clinical judgment** and personalised goals to apply disease-based clinical guidelines to the individual's therapeutic management
- Generate a **personalised shared care & support plan** with clear treatment goals, interventions, monitoring and follow up as well as a crisis plan
- **Patient engagement (including shared decision making), care co-ordination** and **sustained support** through intervening crises or adverse events.

3. Which patients should be prioritised to offer an SMR?

Table 2 summarises the groups of patients to prioritise for SMRs described in different national documents. Primary care based clinical pharmacists are expected to lead on delivering SMRs.

Table 2. Patients to prioritise for SMRs

National document	NICE 2015 SMR	GP DES 2021-22 SMR	NHSE/I COVID-19 response 2020 SMR	Enhanced health in Care Homes (EHCH) 2020 SMR
Offer to	○ Adults, children and young people taking multiple medicines (polypharmacy) ○ Adults, children and young people with chronic or long-term conditions ○ Older people	People ○ in care homes ○ with complex and problematic polypharmacy, specifically those on 10 or more medications ○ on medicines commonly associated with medication errors ○ with severe frailty (3% of over 65s)[2] ○ using one or more potentially addictive medications from the following groups: opioids, gabapentinoids, benzodiazepines and z-drugs.	○ Care homes residents via remote or telephone conversation ○ Patients with COVID-19 symptoms ○ Acute illness that may need changes to medicines ○ Optimising medicines at the end of life ○ Discharge from hospital	○ Care homes residents identified from Comprehensive Geriatric Assessment (CGA) or by multidisciplinary teams (MDT)

[2] Severe frailty is defined as a person having an eFI score of >0.36. https://www.england.nhs.uk/ourwork/clinical-policy/olderpeople/frailty/efi/

3.1. DES SMR and EHCH patient cohort

Typical SMR patients will be older people, living with frailty and multi-morbidities (mainly cardiovascular or respiratory conditions, dementia), care home residents, as well as patients who are clinically vulnerable to COVID -19 (e.g. BAME). Therefore, practitioners should be competent to deliver person-centred SMRs in the context of these vulnerabilities and manage the identified risks and associated complexities. Table 3 below shows some compelling reasons for this.

Table 3: The case for practitioners to develop competencies to undertake SMRs in the context of frailty, multi-morbidities and polypharmacy

- A significant number of patients on the SMR caseload will have frailty, multi-morbidity and polypharmacy due to an increasing ageing population and prevalence of multi-morbidities
- Person-centred care, including shared decision making (SDM) is now 'business as usual' (NHS Long Term Plan)
- Managing complexities is the norm in these patients
- Recognising that clinical decisions are not based solely on explicit therapeutic knowledge but also require tacit knowledge and contextual interpretation
- Pressing need to address overprescribing by managing polypharmacy, deprescribing and shared decisions.

3.2. Challenges with optimising medicines in frailty, multi-morbidity and polypharmacy

- Frailty, multimorbidity and polypharmacy often coexist (Fried et al).
- *Herr et al 2015* showed that frailty and polypharmacy have an independent and combined effect to increase the risks of mortality and adverse outcomes. Patients on polypharmacy are more likely to be frail. Also, people living with frailty are more likely to be prescribed 10+ drugs, and drugs with a high burden index such as anticholinergic, sedatives[3]
- Transfer between care settings also increases the risk of medicines related problems (Parekh et al) especially in the first 30 days post discharge. These factors should be taken into account when prioritising patients for and undertaking SMRs.
- There are other factors (Table 4 below) that add varying degrees of uncertainty and complexity to the decision-making process about the risks and benefits of taking medicines for these patients. These can be managed by having better conversations and utilising a biopsychosocial approach during the SMR consultation.

[3] Gnjidic et al. High-Risk Prescribing and Incidence of Frailty Among Older Community-Dwelling Men. *Clinical Pharmacology & Therapeutics* (2012); **91** 3, 521–528. doi:**10.1038/clpt.2011.258**

Table 4. Some factors that add complexities to optimising medicines in this cohort of patients during SMRs

- The heterogeneity of older people in relation to their health, function, resilience to stressors necessitates an individualised versus a one size fits all approach
- Limitations of current research evidence when applied to frailty and multimorbidity
- Shift in care goals from preventative to mainly palliation in later years. Primary end goals or outcomes in clinical trials for younger people often differ from those important to older people.
- Limited life expectancy in frailty alters the risk: benefit ratio for patient outcomes.
- Increased risks of adverse drug events (ADEs) due to age-related physiological (pharmacokinetic and pharmacodynamic) changes that alter drug handling
- Presence of frailty syndromes and functional impairments that increase vulnerability to ADEs and impact on patient's willingness and capability to use medicines as prescribed
- Therapeutic competition, drug: drug interactions in the presence of multi-morbidities and polypharmacy
- Added challenges of remote vs face to face consultations during COVID-19 pandemic in this vulnerable group. *See Optimising Remote consultations for older people during COVID-19*
- Varied, multiple and constantly changing, interdependent factors that make it difficult to pin-point the causative factor and therefore require sequential trialling of multiple interventions or solutions
- Maintaining the balance between treatment burden and the patient's ability to adhere to prescribed treatments
- Maintaining a balance between managing acute or chronic conditions and declining quality of life and function, particularly from a perspective of what matters most to the patient

3.3. Managing risk, uncertainties and complexities during SMR consultations

- In order to manage these issues during the consultation, practitioners should be able to identify and assess medicines related risks in the context of the patient's circumstances, experience and priorities.
- This requires good consultation and communication skills to enable patient centred medicines reconciliation, history taking, and shared decision making with patients.
- Better conversations allow the patient and clinician to consider competing and conflicting values, negotiate a shared agenda and goals as well as jointly agree an action plan. Tools and templates developed should facilitate better conversations during the SMR.

4. SMR processes and consultations that get the desired outcomes

The NHSE guidance sets out the requirements and process for delivering safe and effective SMRs. Table 5 below outlines the main stages of the SMR process.

Table 5. Key stages of the SMR process

1. **Identify** and **Prioritise** patient for review
2. **Prepare** for the consultation
3. Undertake safe and effective **Patient-centered Consultation** with shared decision making
4. Agree a **Plan** for monitoring, referral/signposting and follow up
5. **Co-ordinate** care and **Collaborate** with relevant others
6. **Document**

*(Easy to remember **'Identify** 4Ps 2Cs and **Document'**)*

4.1. Identify, Prioritise and invite for SMR

- PCNs can use various tools (examples in *NHSE/I SMR Guidance 2021*) to identify patients who are most likely to benefit from SMRs.
- Once identified, these patients should be invited for a review which could take place by face to face or remote consultation.
- The invitation (written or verbal) should explain what the SMR is about and who it will involve. It should emphasise that it will be a shared decision-making conversation about all their medications to ensure they are working well for them.
- It is important that letters are written in plain, jargon-free and patient centred language.
- Patients should be encouraged to come prepared to ask or discuss what matters to them about their medicines.
- They should be advised to bring all their medicines to the appointment and other people to support them if needed.
- The Healthwatch Top Tips guide was developed for patients and practitioners to get the best out of remote consultations and this can be adapted to be used for SMRs.

4.2. Prepare for the Consultation

- In order to maximise the contact time with the patient during the SMR consultation, it is important for the practitioner undertaking the review to prepare ahead of time.
- Depending on the set up, familiarity and experience of the practitioner with undertaking SMRs, gathering some basic information pre consultation may be useful. Table 6 below is an example of a pre-consultation SMR checklist.

Table 6: Pre-Consultation checklist*

Basic information	Medicines information
☐ Reason for referral/risk or problem identified ☐ Frailty score ☐ Relevant MHx – LTCs, acute/major, COVID status/isolation ☐ Relevant previous consultations ☐ Recent hospital admission ☐ Latest investigations and test results ☐ Additional useful info e.g social care package, learning disabilities, dementia, dexterity, housebound, safety issues ☐ Patient's capacity to be involved with decision making or Person with power of attorney (POA) ☐ Advance care plan (CMC) ☐ Face to face, phone, video consultation	☐ Acute medicines ☐ Repeat medicines ☐ Recently stopped/started ☐ Non prescribed medicines and supplements ☐ Allergies ☐ Multiple compartment aids ☐ Potentially inappropriate/high risk drugs

* Ravi Sharma and Lelly Oboh February 2020

4.3. Undertake safe and effective Patient-centred consultation

Several well-established consultation models used by doctors are available, each with pros and cons. The CPPE Consultation skills resource (login required) is a 'good read' for pharmacists undertaking SMRs. Table 7 below is an adaptation of the Calgary Cambridge model[4] for SMRs or other medicines related consultations.

Table 7. Applying key elements of the Calgary Cambridge model to SMR consultations[**]

1. **Initiating the session**
   - Introduction
   - Build relationship and rapport, negotiate a shared agenda, check/state reason for consultation, explain the purpose and structure of the consultation
2. **Gathering information** and explore medicines related problem
   - History taking, medicine reconciliation and eliciting the patient's perspective (ideas, concerns, expectations, what matters most)
   - Questioning: open, closed, probing (tell, explain, describe)
3. **Explanation and planning**
   - Discuss potentially inappropriate, problematic and high-risk medicines
   - Educate and give information in the context of what patient wants to know
   - Agree actions (shared decisions) and interventions
4. **Closure**
   - Safety netting (specific)
   - Follow up plans e.g referrals, monitoring, sign posting for support (why, what, who, how, when)
   - Summarise and close
   - Document

Underpinned by the practitioner **maintaining a good rapport and providing the structure** needed to ensure flow, manage time and keep discussions relevant to agreed goals. Allowing the patient to share their ideas, experience about their medicines.

Section TWO: The Role of tools and templates for SMR consultations

5. Why do we need SMR consultation tools and templates?

- A tool is anything that helps to accomplish a given task and a template is a type of tool. In the context of SMRs, a template is pre-formatted document used as a guide or prompt to speed up, document and ensure standardisation of a frequently repeated process.
- An SMR template helps to save time and streamline the consultation. It provides structure and direction for both the practitioner and patient. Predefined prompts or questions can act as a safety net so that vital information, tasks or checks are not overlook or omitted.
- Templates can provide the assurance that trained and competent pharmacists within a team or organisation are working to a consistent and appropriate standard.
- However, over reliance on a template without giving due attention to the patient can reduce the consultation to a 'question and answer' session or tick box exercise. Also, when followed

[4] Kurtz SM and Silverman JD. The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organising teaching in communication training programmes. Med Educ 1996; 30: 83-9.

[**] Adapted by Lelly Oboh 2020

rigidly, it may impede rather than facilitate patient centred and shared decision-making conversations, making it difficult for the practitioner to adapt in response to the patient's needs or evolving situations arising during the consultation.

- It is important that the SMR consultation is an iterative process that follows the patient's interest within the framework of the template. Allowing the clinician flexibility to identify and address what aspects of medicines use or medicines related issues matter most to them and then adjusting the consultation accordingly. For this reason, it may be that templates have limited benefits for complex SMRs associated with frailty, multi-morbidity and polypharmacy compared to straightforward reviews of single LTCs

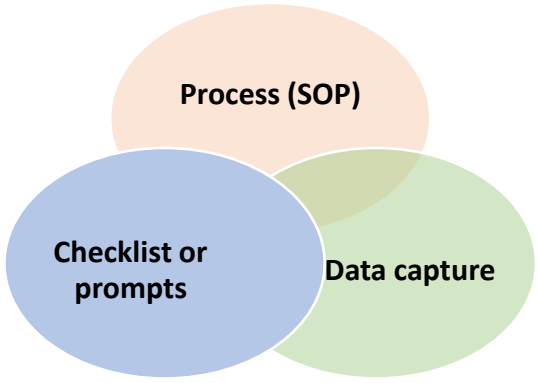
6. What tools and templates are available for undertaking SMR consultations?

- There are several tools and templates available to support SMR consultations but there is no validated or national template.
- There are tools to facilitate both the consultation conversations and consultation process. Some are designed to incorporate the patient's perspective, shared decision making, as well as translate research evidence into clinical practice (e.g. identify potentially inappropriate medicines (PIMs) in older people).
- For simplicity and pragmatism, I have broadly categorised templates according to the primary purpose/function it serves during the SMR consultation. It is worth noting that this is an arbitrary categorisation as there are significant overlaps in practice and each template can serve two or more purposes.

Diagram 8 highlights the features of the three broad categories

- **Process** templates to direct and structure the SMR consultation or process
- **Checklist or prompt** templates to remind of specific actions to take during the SMR
- **Data capture** template to document key aspects of the SMR consultation

Diagram 8. 3 Categories of SMR templates



6.1. Process templates

- A step-by-step guide to undertake a SMRs from start to finish. Ideally, they should cover the main aspects of the SMR process outlined in Table 5.
- Usually included within a broader medication review or polypharmacy guidance that contains other useful information about SMRs (e.g background, context, SMR process including case finding, evidence-based tools).
- They are ideal for **novice practitioners*** and can be used as a training and development resource until the practitioners become more competent and SMRs become embedded in their routine practice.

* Dreyfus and Dreyfus 1986. Five Stages of Acquiring Expertise - Novice to Expert

- They help practitioners to understand the role of SMRs in the wider context of medicines optimisation and managing polypharmacy rather than as an isolated activity or intervention.
- Process templates are useful for ensuring consistency and assuring quality of SMRs within teams and organisations.

6.2. Checklist or prompt templates

- They are used during the SMR consultation to allow the practitioner to check against a list of important tasks as a reminder to avoid omissions.
- The prompts can be a combination of generic tasks such as medicines reconciliation, checking indications, ADEs, adherence and specific tasks relating to particular drugs or conditions e.g checking renal function with ACEIs or in diabetes.
- Depending on the number of prompts, these templates can become overwhelming and time consuming for a novice practitioner and may therefore limit the quality of conversation with the patient.
- They are useful for **advanced beginners (consciously competent practitioners)** to build their confidence. Also, **competent and proficient practitioners** can use as a quick checklist during the SMR e.g for less common safety checks that are easily forgotten.
- Some templates may also have space to capture data such as read codes.

6.3. Data capture template

- They give structure and allow direct capture of activity during the SMR consultation. They may or may not be integrated within general practice IT systems.
- The templates set out a range of pre-defined medicines related aspects to the practitioner to cover during the SMR consultation.
- The scope and number of aspects covered vary ranging from a few to many e.g adherence, use of MCA, cardiovascular risk assessments, drug monitoring, synchronisation of repeat medicines.
- Data is often captured by a mixture of tick boxes, drop-down menus and free text. The data captured can be used to monitor a range of SMR related activities and outputs including read codes, types of interventions, referrals, signposting, monitoring and follow up.
- It is worth noting that for reporting purposes, the DES SMR guidance only requires documentation of the SMR read code to show that the SMR took place.
- In an attempt address and capture a broad range of medicines related issues in one consultation, these templates can become lengthy, and time consuming. A **novice practitioner** may be unable to adapt the structure or flow to prioritise what matters to the patient during the consultation.
- They are useful as a guide for **advanced beginners**, and as a double check for **competent and proficient practitioners**.

Table 8. Three categories of SMR consultation templates based on main function			
Type	**1. Process (SoP)**	**2. Checklist or Prompts**	**3. Data capture**
Purpose	Ensure structured and consistent process for the SMR consultation from start to finish.	Ensure that important aspects of the SMR consultation are not omitted or overlooked	Ensure a consistent and structured approach to certain aspects of the SMR consultation and robust documentation of the activities undertaken
Covers	The consultation and sometimes pre- and post-consultation as well as other useful relevant information	The consultation	The consultation and post consultation
Pros	• Structure allows incorporation of evidence-based tools and patient engagement • Broader context is useful for teaching, laying good foundation, evaluating clinical competences • Recognises that the SMR is more than the consultation (includes preparation and follow up)	• Short and easy to use, usually one side of A4	• Searchable (codes) • Real time link to various tool and resources at the point of care • Real time documentation in the patients records when integrated in GP IT • Links with other reviews in the practice
Cons	• Larger document of which the actual template is only a part	• Focus on consultation only • Brief information, so practitioner must be competent and familiar with undertaking SMRs • Can easily become a tick box exercise especially for novice practitioners	• Scope can be overwhelming if less experienced • Redefined aspects may not be that relevant to what matters most to patients • Can distract from patient's goals to focus on completing the template
Who may find useful	• **Novice** practitioners e.g. redeployed pharmacists • Clinical leads for teaching, competency checks, consistency and quality assurance	• **Advanced beginners** to build confidence • A quick reminder for **competent and proficient practitioners**	• Pharmacists who have access to GP systems • **Advanced beginners** to structure the consultation and build confidence • A quick reminder for **competent and proficient practitioners or those** experienced in undertaking SMR in other care settings but need help to document in GP system

Table 8. Three categories of SMR consultation templates based on main function			
Type	**1. Process (SoP)**	**2. Checklist or Prompts**	**3. Data capture**
Examples *Links and references to follow*	• *NHS SPS patient centred approach* • *NHS Scotland Polypharmacy 7 step process* • *3-Step Iterative process* • *Wales Polypharmacy Guidance (Medication review process Page 9)*	• *No TEARS tool BMJ* • *CONSULT tool (remote consultations) (Login required)* • *4Es Consultation tool*	• *Ardens SMR template (Subscription needed)*

7. What to consider when designing your SMR template?

This will depend on the main purpose it is intended to serve, the end user of the SMR template and local setting. Nevertheless, each consultation template should be designed to deliver the overall aim of SMRs as defined in the NHSE guidance i.e *to ensure that the patient's medication is working well for them by facilitating shared decision-making conversations with them*. Therefore, SMR templates should enable the practitioner to have conversations with their patients that incorporate evidence-based practice and medicines optimisation principles i.e a 3-pronged approach that integrates:

- Patient's perspective
- Available research evidence for the medicines being reviewed (using relevant guidance that translate research into practice and tools that identify potentially inappropriate medicines e.g STOPP/START tool, STOPPFrail Criteria, Anticholinergic burden risk scales like the AEC scale)
- Practitioner's clinical judgement

Evidence-based practice approach (Sackett et al[5]) to medicines optimisation

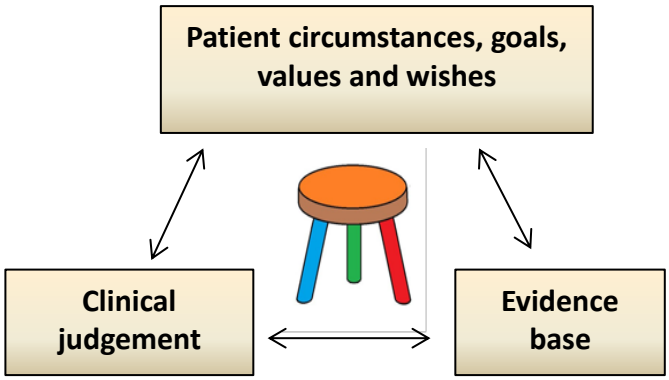


Table 9 below is a checklist to be used when designing a new or evaluating an existing SMR template for its fitness for purpose. Appendix 1 gives examples of existing templates that meet the different criteria in Table 9.

[5] Sackett David L et al. Evidence based medicine: what it is and what it isn't *BMJ* 1996; 312 :71

Table 9. SMR consultation template checklist (answer Yes or No) Does the format and structure enable the practitioner to:
1. Identify what matters most to patient at the outset
2. Negotiate shared agenda and goals
3. Take a good history and undertake medicines reconciliation
4. Identify potentially inappropriate medicines (PIMs) and medicines support needs/risks
5. Use & Interpret research evidence in context of individual patient situation and goals
6. Use your clinical judgement to ensure medicines appropriate (safe and effective) in the individual patient's circumstances
7. Check willingness and capability to adhere to medicines
8. Agree and document an action plan for the medicines reviewed (Incl. changes, support, follow up, monitoring, sign posting, referral, safety netting)

8. Summary

- It is expected that implementing the SMR DES will optimise medicines by ensuring patients medicines are working for them, reducing medicines related risks and inappropriate polypharmacy.
- Majority of the patients who be prioritised and offered SMRs will be older people, those living with frailty and multi-morbidities and taking 10 or more medicines.
- Optimising medicines in this cohort of patients is complex and requires patient centred conversations with shared decision making in other to manage the uncertainties about medication benefits and harms.
- Research evidence is limited in this group of patients and the practitioner should use their clinical judgement to interpret the evidence in the context of the patient's perspective and experience to ensure that patients get the best outcomes and do not suffer unduly from taking their medicines.
- There are a number of tools to support the SMR process and consultation. Templates can provide practitioners at different levels of competences with a framework or structure to undertake safe and effective patient-centred SMR consultations.
- However, unless practitioners are trained, competent and confident with undertaking SMRs, the template may become a barrier to realising the intended patient outcomes.
- This document highlights the benefits and challenges with 3 types of templates (categorised by their main function) and recommends a checklist to consider when designing the SMR consultation template that is fit for purpose.

9. Feedback to the author

As teams and organisations develop local templates over the next 6-12 months, it is anticipated that this document will be reviewed and updated accordingly to reflect progress. So if you use the information or principles from this document to guide the design of your template, please complete the feedback form in Appendix 2 and send to Lelly.oboh@nhs.net

10. Appendices

10.1. Appendix 1 examples of existing templates or tools that meet the criteria

CRITERIA	EXAMPLES (references/link to be added)
1. Identify what matters most to patient at the outset	*NHS Scotland tool, NHS SPS tool, adapted Calgary Cambridge model, AGROW, 4Es*
2. Negotiate shared agenda and goals	*NHS Scotland tool, NHS SPS tool, 3-step guide, Adapted Calgary Cambridge*
3. Take a good history and undertake medicines reconciliation	*NHS Scotland tool, NHS SPS tool, 3-step guide, Adapted Calgary Cambridge*
4. Identify potentially inappropriate medicines (PIMs) and medicines support needs/risks	*Ardens template, NHS Brent polypharmacy template, NHS Scotland tool, NHS SPS tool, MedStopper*
5. Use & Interpret research evidence in context of individual patient situation and goals	*NHS Scotland tool, NHS SPS tool, 3-step guide, Adapted Calgary Cambridge, www.MedStopper.org*
6. Use your clinical judgement to ensure medicines appropriate (safe and effective) in the individual patient's circumstances (SDM)	*NHS Scotland tool, NHS SPS tool, 3-step guide, Adapted Calgary Cambridge*
7. Check willingness and capability to adhere to medicines	*NHS Scotland tool, NHS SPS tool, Ardens SMR template (subscription needed)*
8. Agree and document an action plan for the medicines reviewed (Incl. changes, support, follow up, monitoring, sign posting, referral, safety netting)	*NHS Scotland tool, NHS SPS tool, 3-step guide, Adapted Calgary Cambridge*

10.2. Appendix 2: Feedback form

Name:	**Role:**
Contact email: **Contact telephone:**	**Organisation**
• What section of the document did you find useful? Please explain why	
• What section of the document did you find least useful? Please explain why?	
• Which aspect of the checklist in Table 9 was lacking in your current template?	
• Please suggest any other criteria you think we should consider adding to the checklist in Table 9.	
• Indicate if you would like to share a copy of your template	**Yes or No** If yes, please send to lelly.oboh@nhs.net
• Indicate if you don't mind being contacted about your template	**Yes or No**
• Please write any other comments you have.	
Thank you.	

10.3. Appendix 3: Flow Chart: Summary of the SMR process