NHS
Nottingham and Nottinghamshire

Structured Medication Review (SMR) – Best Practice Standards

Background

These Best Practice Standards were first published by Nottingham and Nottinghamshire ICB in 2022, following engagement with PCN Pharmacists. They are intended to ensure that SMRs undertaken in Nottingham and Nottinghamshire are of high quality, and in line with national guidance. Implementation of the standards by PCNs will help ensure consistency of how they are undertaken in practice and ensure that patients receive maximum benefit.

Definition & Key Components of a Structured Medication Review

Definition

NICE Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes [NG5] 2015.
https://www.nice.org.uk/guidance/ng5

"A structured medication review is 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 medication-related problems and reducing waste."

Key components of a SMR

NHS England Structured medication reviews and medicines optimisation webpage
https://www.england.nhs.uk/primary-care/pharmacy/smr/

- **Shared decision-making principles** should underpin the conversation.
- **Personalised approach** – tailored to the patient.
- **Safety** – consider the balance of benefit and risk of current treatment and starting new medicines.
- **Effectiveness** – all prescribed medication must be effective for the patient.

Nottinghamshire Defined SMR Best Practice Standards (including areas of focus)

The quality of the conversation with the patient and documentation of this interaction in the clinical record is crucial to be able to obtain the best clinical outcomes for patients.

The words "must" and "should" are used in the following bullet points and should be interpreted as follows:

"Must" = standards which are non-negotiable
"Should" = standards which are ideal, i.e. best practice, but are not mandated.

- SMRs should be undertaken by a pharmacist working within their sphere of competence.
- If SMRs are undertaken by another primary care healthcare professional, i.e. GP or Advanced Nurse Practitioner, then these individuals must also follow these same standards when undertaking SMRs. *(*see below on page 4)*
- The practice must be satisfied that the pharmacist (or other healthcare professional) undertaking the SMR has the necessary skills & training, i.e. patient assessment, history taking & shared decision making. *(*see below on page 4)*
- SMRs must be allocated protected time by the practice to undertake.
    - The minimum amount of time allocated for each SMR must be 30 minutes.
    - Practices must allow for flexibility in appointment length for SMRs, depending on the complexity of individual cases. The actual length of time taken to undertake the SMR will vary in line with the needs of the individual patient.

It is for the patient to choose their preferred method of meeting for their SMR and not for the pharmacist/practice to direct/decide for them.

- The patient must be offered the option of meeting, either:
    - face to face in person *(see boxed text on page 5),*
    - face to face virtually or
    - verbal only via telephone discussion *(see boxed on page 5)*
- The SMR invite to the patient must include an explanation to the patient of the benefits of, and what to expect from the SMR.
- The patient must be provided with sufficient time to reflect and prepare for the SMR, i.e. time between invite and appointment. They should be invited to prepare questions in advance, if they have any, to aid discussion during the review.
- The SMR must take into account ALL of the patient's medicines.
- The SMR must involve the patient in a conversation to understand what their priorities are, i.e. be an all-round holistic review with shared decision making.
- The SMR conversation should provide the patient with an explanation of the "purpose" of each medicine.
- The Seven Steps Review Process should be adopted when undertaking an SMR.
- Key details of the SMR must be recorded in the patient's clinical record. These include, but are not limited to:
    - Any patient outcomes relating to changes made at the previous SMR (for repeat SMRs).
    - Any express wishes/preferences communicated by the patient regarding their medicine treatment.
    - For each current medicine – whether the option to stop or change was discussed with the patient.
    - Whether any new medicines were discussed with the patient.

  - Actual changes made to the patient's medicine therapy, the clinical rationale for the changes & confirmation that the patient has agreed to these.
  - Details of any follow up required to assess the impact of any changes made.
  - Indication of when the next SMR should be undertaken (as opposed to routine follow up).
  - Any point of non-agreement between patient & healthcare professional regarding their medicines. *(**see below on page 4)*
- Patient feedback regarding the SMR should be encouraged.
- SMRs provide an opportunity to link a medicine to its clinical indication.
  - *Linking a medicine to its clinical indication is included in Recommendation 2 of the national overprescribing report*.
- SMRs also provide an opportunity to record whether the patient is using a multi-compartment compliance aid (MCA) and an opportunity to discuss whether this is appropriate.
  - *CQC provides recommendations re appropriate use of MCAs with links to further resources.* *https://www.cqc.org.uk/guidance-providers/adult-social-care/multi-compartment-compliance-aids-mcas-adult-social-care*
- Pharmacists and other healthcare professionals who undertake SMRs are expected to reflect on feedback received and use to improve the quality of experience for future patients.
- The pharmacist/healthcare professional undertaking the SMR should be familiar with the recommendations of NICE NG 5, in particular sections 1.4, 1.5 and 1.6.

A SMR is not:

- **A routine annual medication review** (see below).
- **Held only for the purpose of reauthorising repeat medications.**
- **A "tick box" exercise and must not be treated as such.**

An SMR is not the same as a routine medication review:

- The two must be coded differently.
- The practice should ensure a consistent application of SNOMED codes that differentiates between SMR and routine medication review.
- All staff should be familiar with the difference between them and the correct application of the SNOMED codes.

There are a range of codes available for medication review, available from https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof/quality-and-outcome-framework-qof-business-rules/primary-care-domain-reference-set-portal

Only three of these relate specifically to structured medication reviews. These are as follows:

Description - abbreviated	Description Full	SNOMED Code	SystmOne CTV3 Code
SMR	Structured medication review (procedure)	1239511000000100	Y282b
Invite for SMR	Invitation for structured medication review (procedure)	1363201000000103	Y35e3
SMR Declined	Invitation for structured medication review declined (situation)	1363191000000100	Y35da

The first code above must only be used when a full SMR has been undertaken according to these standards, i.e. it must not be used for any other type of medicine review.

Note re clinicians able to undertake SMRs & level skills/training

NHSE Structured medication reviews and medicines optimisation guidance
https://www.england.nhs.uk/publication/structured-medication-reviews-and-medicines-optimisation-2021-22/

Further detail relating to which clinicians & their qualifications are permitted to undertake SMRs is outlined in paragraphs 3.18 – 3.21 of the above NHSE guidance; particularly 3.18:

3.18 PCNs must ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop these, and should be able to take a holistic view of a patient's medication. Although primarily it is clinical pharmacists that are expected to conduct SMRs, suitably qualified advanced nurse practitioners (ANPs) who meet the above criteria, as well as GPs, can also do so.

Note re patient non-agreement with healthcare professional

GMC Good practice in prescribing and managing medicines and devices (updated Mar 2022)
https://www.gmc-uk.org/-/media/documents/prescribing-guidance-updated-english-20210405_pdf-85260533.pdf

Sometimes a patient may not wish to make a change to their medicine despite the healthcare professional believing it is in that patient's best interests to do so, e.g. reducing dose of opioids. For such circumstances all healthcare professionals who undertake SMRs are advised to follow the GMC Prescribing Guidance (see link above) as follows:

"Handling patient requests for medicine you don't think will benefit them

50. Sometimes, patients will ask for treatment or care that you don't think is in their clinical interests. In these situations, you should explore the reasons for their request, their understanding of what it would involve and their expectations about the likely outcome. This discussion will help you take account of the factors that are significant to the patient and assess whether providing the treatment or care could serve the patient's needs.
51. If, after discussion, you still think the treatment or care would not serve the patient's needs, you should not provide it. You should explain your reasons to the patient and explore other options that might be available, including their right to seek a second opinion."

Face to Face v Verbal SMRs

The patient must be allowed to choose their preferred method for the meeting.
If the patient seeks the advice of the practice/healthcare professional in trying to decide what is best for them, the following should be taken into consideration:

Face to face meetings (either in person or virtual) offer the opportunity of providing more information to the healthcare professional than verbal only discussion. They allow for assessment of body language, & demeanour, i.e. (non-verbal communication), which is not available via telephone. This is the same for the patient as they will be able to obtain the same non-verbal communication from the healthcare professional. This can provide more insight for the healthcare professional into the patient's situation/circumstances and vice versa, promote greater understanding and allow for more effective dialogue.

Face to Face in Person SMRs

These can be undertaken in the patient's own home or at the practice. Although not an expectation it is ideal to undertake the review in the patient's own home where possible for the following reasons:

- The patient will be more relaxed in their own home compared with a clinical environment; this is more conducive to a constructive discussion.
- The patient will have physical access to ALL of their medicines - The packaging/labelling of the individual medicines provide a good visual aid for the patient to assist the conversation.
- Patients may bring only some or none of their medicines if invited for a review in practice – this can then compromise the quality & effectiveness of the review if the patient does not know the names of their medicines.

It is unlikely that there will be access to the clinical record in a patient's own home. If this will be the case, then it is crucial to review the clinical record prior to the visit. Making notes of potential items for change prior to the visit will help facilitate the discussion. If there are questions from the patient that are unable to be resolved during the visit, these can be addressed in a follow up telephone call. Some patients will need a follow up call regardless of where they are seen if confirmation of the change is required by the patient's GP.

Areas of focus for Structured Medication Reviews

The information below is copied from national documents – it is for individual practices/PCNs to determine the priority of patient cohorts who they consider would most benefit from an SMR. Ideally these should align with National and Nottingham and Nottinghamshire Integrated Care Board Priorities.

Department of Health & Social Care - National overprescribing review report
https://www.gov.uk/government/publications/national-overprescribing-review-report

Alongside SMRs, deprescribing & medicines reconciliation are responses to overprescribing listed in this report. An SMR can be used to achieve both of these.

NHSE 2026/27 Network Contract DES Specification
https://www.england.nhs.uk/publication/network-contract-des-contract-specification-2025-26-pcn-requirements-and-entitlements-26-27/

Targeting resource and efforts

8.4.2. Other key requirements of a PCN are to:

a) detail the measures a PCN will take to improve medicines optimisation and implement those measures, including ensuring medicines management and use of Structured Medication Reviews for high-risk cohorts, as specified in the Guidance. This should include medicines optimisation strategies for reducing polypharmacy, minimising risk of prescribing harm, reducing over-prescribing and managing the risk of dependency on prescription drugs;

NHSE 2026/27 Network Contract DES Guidance
https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-guidance-for-2026-27-in-england-part-a-clinical-and-support-services-section-8/

Identify patients suitable for an SMR

2.2.6 PCNs should use appropriate tools to identify and prioritise patients who would benefit from a SMR, which is expected to include those people where there is evidence of benefit such as those:

- in care homes;
- with learning disabilities;
- with complex and problematic polypharmacy, specifically those on 10 or more medications;
- on medicines commonly associated with medication errors and risk of harm;
- with severe frailty who are particularly isolated or housebound or who have had recent hospital admissions and/or falls;
- using one or more potentially addictive medications from the following groups: opioids; gabapentinoids; benzodiazepines; and Z-drugs.

2.2.7 PCNs should also be alert to the needs of communities and individuals at particular risk of health inequalities (e.g. CORE-20PLUS5 population, BAME, those with learning disabilities), including by considering how complex prescribing regimens may be rationalised to improve their safety.

2.2.8 PCNs should consider NICE guidelines NG5 and the Royal Pharmaceutical Society's polypharmacy guidance, as well as the findings of the National Overprescribing Review, in identifying patients and determining their approach.

2.2.9 Once patients have been identified, PCNs should create a process for developing SMR caseloads so that those patients in greatest need of a SMR are seen in a timely manner.

2.2.10 The patient's invitation to the SMR – whether oral or written – should explain what the SMR will involve, and that they will be coming in for a shared decision making conversation to review all their medications and make sure they are working well for them.

Version Control **Structured Medication Review – Best Practice Standards**			
Version	Author(s)	Date	Changes
1.0	R Wise (NNICB MO Team) & J Thomas (Crown House Surgery, Retford)	Dec 2022	
2.0	R Wise (NNCIB MO Team)	May 2023	• Background section reworded • Added statement from PCN DES concerning prescribing qualification requirements for individuals undertaking SMR • Investment and Impact Fund (IIF) indicators removed as no longer current • Webpage reference hyperlinks checked/updated • Version Control Added
3.0	R Wise (NNCIB MO Team)	Jul 2024	• Updated hyperlinks & minor formatting changes • The term "Read code" has been changed to CTV3 code (as appears in SystmOne) • Removed reference to 2023-24 Network DES and amended detail on page 6 to reflect 2024-25 Network DES
4.0	R Wise (NNCIB MO Team)	Sep 2025	• Updated hyperlinks & minor formatting changes • Removed reference to 2024-25 Network DES and amended detail on page 6 to reflect 2025-26 Network DES • Made accessible for screen readers
5.0	R Wise (NNCIB MO Team)	Jun 2026	• Updated hyperlinks & minor formatting changes • Updated table on page 3 with additional SNOMED Code • Removed references to 2025-26 Network DES and amended detail on page 6 to reflect 2026-27 Network DES