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**Addressing inequalities: improving access to Structured Medication Reviews in seldom heard communities.**

**Please submit your completed application form before 4pm Friday 12th July via email to** [**healthinnowest.polypharmacyprogramme@nhs.net**](mailto:healthinnowest.polypharmacyprogramme@nhs.net)

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| --- | --- | --- |
| **Applicant Details** | | |
| Lead Applicant Name |  | |
| Lead Applicant Job Title |  | |
| Lead Applicant Organisation |  | |
| Lead Applicant email address |  | |
| Health Innovation Network Region |  | |
| If known, please provide details of the wider project team involved in this work (name, job title, organisation) |  | |
| **Please provide an overview of your proposed project.** | | |
| Proposed test site (s) |  | |
| Proposed patient community group(s) |  | |
| Who will lead on the SMR consultation e.g. GP, Pharmacists, other? |  | |
| Which data sources will you use to identify patients? |  | |
| How to you propose to use the HIN SMR patient resources e.g. electronically/paper based / sent via SMS / animation shared with patients / animation screened in waiting rooms etc. |  | |
| Please tell us how you will ensure sufficient time is allocated for a comprehensive shared decision-making structured medication review? |  | |
| **Please provide below potential challenges and or risks to the completion of this project and how you will mitigate against them?** | | |
|  | | |
| **Please confirm your application meets our eligibility criteria** *(insert yes or an electronic signature)* | | |
| I confirm that one or more of our test sites will be a CORE20 PCN/GP Practice | |  |
| I confirm that the HIN SMR patient resources will be shared with each patient involved in our project prior to their SMR | |  |
| I confirm that sufficient time will be made available to the nominated health professionals to carry out a minimum of 20 SMRs | |  |
| I confirm that the HIN Polypharmacy Programme Team will receive a comprehensive case study/written report by the deadline of 20th January 2025. | |  |
| I confirm that the case study will include patient feedback via quotes or filmed feedback. | |  |
| I confirm that a representative from the project team will be available to participate in a short phone call as part of the wider Health Innovation Network Polypharmacy Programme Evaluation | |  |
| **Date of declaration:** | |  |
| **Name of signatory :** | |  |
| **Signature:** | |  |