West of England
Academic Health
Science Network

Workshop report

Supporting appropriate polypharmacy in the West of England

13 December 2018, Holiday Inn, Filton, Bristol

Introduction

This report provides an overview of a key polypharmacy event facilitated on 13th December 2018 by the West of England Academic Health Science Network (WEAHSN). The event represents the first step taken by the WEAHSN to focus on polypharmacy, bringing together stakeholders from across the region (i.e. within the footprints of Gloucestershire; Bath & North East Somerset, Swindon and Wiltshire; Bristol, North Somerset and South Gloucestershire).

Polypharmacy is recognised as a complex issue and a topic that affects all levels of society. There is not a clear definition for polypharmacy, but it is generally recognised as concurrent use of many different medicines by a patient, usually in the elderly. Polypharmacy is not necessarily a bad thing; however it needs to be appropriate for the individual patient. The consequences of a patient taking multiple medications may be an increased likelihood of hospital admission due to adverse effects.

NHS England has noted the value of AHSNs in supporting spread of good polypharmacy practice and has incorporated polypharmacy as a work stream into the renewed AHSN license, encouraging freedom in each AHSN to focus on the development of polypharmacy work that is relevant and achievable to their local system.
It is recognised that there is already good work going on across the region in response to the challenges brought on by inappropriate polypharmacy. The specific aims of the workshop were:

- to share and learn from current 'best practice' examples
- to identify opportunities and barriers to appropriate polypharmacy
- to inform polypharmacy priorities for 2019-20 across West of England
- to identify how the West of England AHSN can support

Members of the West of England Medicines Optimisation Steering Group nominated participants to attend the polypharmacy workshop. The event was designed to be small (around 40) to enable practical working and to generate ideas and support networking in a more manageable way.

Our Speakers

The speakers were limited by number and to those that could provide context and examples of good practice, with the intention of feeding this content into facilitated table discussion.

The day's programme is available in Appendix one. Dr Hein Le Roux introduced the workshop, describing the role of AHSNs, particularly in relation to the national Medicines Optimisation programme.

The academic perspective was provided by Dr Rupert Payne, Consultant Senior Lecturer in Primary Health Care at University of Bristol. He informed delegates that one of the gaps in the evidence base on the subject of appropriate polypharmacy was the lack of evidence on the benefits of de-prescribing. However, whilst recognising that even in the frail elderly, there is clearly a strong case for the ongoing prescribing of many drugs, the actual patient stories on the quality of life impact from selective de-prescribing are convincing enough for many of us to actively promote this practice even in the absence of a strong published evidence base at this time.

Tony Jamieson, Director of Transformation at Yorkshire and Humber AHSN reflected Rupert's points, presenting their successful polypharmacy project funded by The Health Foundation (https://s3-eu-west-1.amazonaws.com/yhahsn.org.uk/wp-content/uploads/2015/09/Safer-Prescribing-for-Frailty-on-a-page.pdf).

This included the story of an elderly patient with dementia in a care home that had been on more than 10 different medicines for a number of years for his numerous medical conditions and was showing increasing Behavioural and Psychological Symptoms of Dementia (BPSD) and disturbing behaviour. Following an extended, polypharmacy medication review, it was possible to stop nine of the patient's medicines. The impact was summarised in a quote from his wife – "I cannot remember when we last played dominos together".

The data on polypharmacy prescribing comparators (ePACT2) presented by West of England AHSN Lead Pharmacist Mark Gregory clearly showed positive progress across the West of England healthcare systems, achieving improvements in polypharmacy across the region. Our local challenge therefore is to further build on this to maximise the benefits our patients obtain from their multiple medicine regimes whilst minimising any undesirable impact on their daily lives from their perspectives.

Steve Brown, Regional Pharmacist NHS England / NHS Improvement, South of England provided an overview of the national landscape, initiatives and policy relevant to medicines optimisation. Funding has been made available by NHS England to support the Medicines Optimisation in Care Homes initiative, with 240 pharmacists and technicians working across care homes to support activities reducing errors and waste, optimising treatment that includes de-prescribing.

Nationally there is a drive from NHS England to reduce errors through the Medicines Safety Programme and reduction of the prescribing of multiple medicines inappropriately. There is learning to be utilised from Canada on de-prescribing. Matt Hancock, Secretary of State for Health and Social Care had made a timely announcement just before the workshop regarding an NHS review of over-prescribing, with the aim of ensuring patients are receiving the most appropriate treatment for their needs. It will focus on 'problematic polypharmacy' where patients are taking multiple medicines unnecessarily.

Sharing local practice

It is recognised that there is already work going on to support appropriate polypharmacy across the West of England. Each sector, represented by the STP footprints, was asked to share good practice. Presentations were made from the three areas: Gloucestershire; Bath & North East Somerset, Swindon and Wiltshire; Bristol, North Somerset and South Gloucestershire, not necessarily pan-STP footprint.

Bath and North East Somerset (BaNES)

Work is being done in care homes, where the introduction of a Local Enhanced Service (LES) for nursing and residential homes has been used to support regular medicine reviews and weekly GP 'ward rounds'.

Swindon CCG

A prescribing incentive scheme is in place for polypharmacy reviews. The aim is to ensure patients over 75, on more than 15 repeat drugs, undergo a detailed medication review. A template is used to ensure consistency. In 2017-18, 18 out of 26 practices submitted returns. 885 items were stopped.

Wiltshire CCG

Rational Prescribing Guidance has been developed to support decision making and has been promoted through a series of workshops for GPs, nurses and pharmacist prescribers. The CCG is using Prescription Ordering Direct (POD) telephone line for patients; this aims to reduce waste and encourage appropriate review where identified.

Bristol, North Somerset and South Gloucestershire (BNSSG)

Key work streams have been developed with a polypharmacy focus: the Prescribing Quality Scheme supports practice-based pharmacists carrying out reviews and close-working with prescribing clinicians in practices.

BNSSG STP enables close working across organisations, sharing project ideas and outcomes. There is an agreed focus on proton pump inhibitors (PPIs) and North Bristol Trust specialist pharmacists have developed a de-prescribing algorithm.

Gloucestershire CCG

A number of initiatives have been put forward in Gloucestershire. The Prescribing Incentive Scheme, which has a focus on elderly and polypharmacy, requires practices to undertake 'proactive polypharmacy reviews'. These apply principles of de-prescribing to patients over 70 on 6 or more repeat medicines, focusing on 4 medicines groups: bisphosphonate; oral NSAIDs; anticholinergic; statin. A frailty focus has since been added. The county-wide Gloucestershire Frailty Programme features polypharmacy medicines optimisation as a key element.

The polypharmacy experience: Anne's story

Patient stories provide useful insight into what is most important to people and their lives and contributes to our understanding of what is needed to achieve 'appropriate polypharmacy', enriching what is available through published evidence. A video of a local citizen, Anne, who requires a number of medicines, spoke about her experience and provided some focus on the need to keep the patient at the heart of everything we do.

A key message from Anne was around the importance of regular medicines reviews to be undertaken to ensure that people don't remain on medication they don't need.

Group discussion: the challenges, learning, opportunities, and gaps in the evidence

Two table discussions were held during the afternoon. The aims of the sessions were:

- To capture the opportunities in addressing inappropriate polypharmacy
- To capture the challenges/learning of inappropriate polypharmacy as perceived by the group
- Consider gaps in the evidence base/areas for research (build confidence of what works and how)

Discussion session 1
The first session involved delegates sitting in mixed groups of representatives from across the West of England footprint from the CCGs, Acute Trusts, Care Homes, Mental Health Trusts, Community Providers and Primary Care.

They were asked to identify the opportunities that exist in relation to improving the current situation regarding inappropriate polypharmacy and the challenges/learning. These were listed under the headings of: healthcare professionals; patients; system.

Delegates were then asked to align six votes each to the opportunities, to inform priority areas of focus. The five themes that had the most votes were as follows:

- IT integration
- Patient empowerment
- Improved communication across the system
- Incorporating an understanding of the risks of over-medication in training and education programmes of all staff
- Patient communication

Delegates were also asked to identify potential research questions/gaps in the evidence that could feed the research pipeline. One question was identified that highlighted the need for analysis of emergency admissions to identify those that are medicines related and to overlay this information to other data sets.

There was a good level of engagement in this exercise from all delegates and enthusiasm for voting for priority themes. The mixed groups allowed greater opportunity to share from each other's experience, some of which was common but other aspects promoted learning.

Appendix three lists the challenges that were identified. This time delegates were asked to put their name against any of these that they felt they could support/help with. The idea of this was to set up some connections across the system, through collaboration. Offers were made in the following areas:

- Teaching and education
- Which tool to use?
- Interoperability of IT systems community processes and Information Governance
- Poor quality of information at discharge

Discussion session 2
Delegates sat in their STP groupings to discuss:

- What could be the key areas of polypharmacy focus for 2019/20 (including incentive schemes, enhanced services, CQUINS, interface issues, patient engagement etc.)
- How could the AHSN help and support progression and achievement?

Keys areas of focus were predominantly for system-wide ideas including: development of tools and guidelines across systems, education programmes for polypharmacy and improved IT interoperability. Some organisation specific areas of focus related to using a project manager to support improved GP & community pharmacy relationships and linking prescribing schemes to polypharmacy targets. In terms of AHSN support there were suggestions for the funding of education programmes, supporting the establishment of a medicines safety forum across the STP and sharing of and support for polypharmacy projects from other AHSNs including 'Meet Mo' from Wessex AHSN.

All these areas of focus are listed in Appendix four.

Pledges

All delegates were asked to record a pledge that they would wish to take forward outside of the event; these were collected, collated to be returned to delegates and we welcome the opportunity to follow up on these pledges at our next regional event.

I pledge to "develop a systematic approach to identify care home residents that would benefit from a quality medicines review using de-prescribing tools".

I pledge to "develop an educational programme for prescribers and nurses to change their consulting style from a 'fixing' model to a 'facilitative' model in order to empower patients".

All the pledges are listed in Appendix four.

Next steps - our reflection on the day

The West of England AHSN has experience of delivering multi-faceted, regional improvement programmes with a wide range of stakeholders. Our intention is to draw lessons learnt from these programmes and apply them to the polypharmacy agenda. We want to make sure we listen to you, avoid duplication of effort and resource, and add value.

We will be contacting you over the next month to work out how best we can do this at a local level; whether that's by supporting existing networks or creating new local collaborations across STP footprints, providing a virtual workspace for learning and sharing, buddying up successful programmes of work to adopt and spread good ideas for polypharmacy.

We plan to organise another regional event later this year where we can share our progress with this agenda, our methods of collaboration and drive to improve inappropriate polypharmacy in line with the themes identified at this event.

We really appreciate you taking the time to come together to share your practice, your ideas and your experience. This was a great event to set-off this complex but important programme of work.

Appendix 1 - Workshop Programme

Workshop: Supporting appropriate polypharmacy in the West of England

Thursday 13 December 2018

Time	Activity
09:00 - 09:30	Registration, refreshments and networking
09:30 - 09:35	Welcome and Introductions Dr Hein Le Roux, GP Clinical Lead, West of England AHSN
09:35 - 10:05	Setting the scene Dr Rupert Payne, Consultant Senior Lecturer in Primary Health Care, University of Bristol • What is meant by polypharmacy? • Complexities of polypharmacy • Current research and evidence
10:05 - 10:20	RMOC Meds Optimisation Oversight Group and AHSN MO Programme Board update on polypharmacy Steve Brown, Regional Pharmacist, NHS England / NHS Improvement
10:20 - 10.40	Polypharmacy Prescribing Comparators (ePACT2) Mark Gregory, Lead Pharmacist, West of England AHSN
10.40 - 11:00	Refreshments and networking
11:00 - 12:15	West of England polypharmacy initiatives. Sharing learning and best practice • Gloucestershire • BSW • BNSSG
12:15 - 12:45	National polypharmacy initiative - .sharing learning and best practice Tony Jamieson, Director of Transformation and Improvement, Yorkshire & Humber AHSN via Skype
12:45 - 13:30	Lunch - in main restaurant
13:30 - 13:40	Polypharmacy – how does it feel as a patient? Anne's story (video recording)
13:40 - 14:40	Small group discussions: 1. Addressing inappropriate polypharmacy – what are the: a) challenges/learning b) opportunities 2. What are the gaps/unanswered questions that could progress the research/evidence base?
14:40 - 15:00	Interactive review of session 1 – (refreshments available)
15:00 - 15:30	Local 'systems' group discussions: 1. What could be the key areas of polypharmacy focus for 2019/20 (including incentive schemes; enhanced services; CQUINS, interface issues, patient engagement etc.)? 2. How could the AHSN help and support progression and achievement?
15:30 - 15:40	Closing comments and next steps Mark Gregory, West of England AHSN Lead Pharmacist
15:45	Close

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Holiday Inn Bristol Filton, Filton Road, Bristol, BS16 1QX

Appendix 2 – Table discussions part 1

POLYPHARMACY WORKSHOP

OPPORTUNITIES

Healthcare professionals	Patient	System
Education from specialist to primary care (2)	Adverse events don't get smaller e.g. PAN "living well with PAN"	Pain nurse/pharmacist from acute into community e.g. GWH project
Education from general practice to specialist (3)	Capture patient early	Influence policy nationally (1)
Social prescribing changing consulting behaviour (2)	1 x up to date meds record	Identify and focus on key priorities across system. E.g. at RUH all staff on 3 priorities (1)
Educational programme for HCPs to facilitate PT's journey (1)	Get patient on board (hearts and minds) (2)	Evidence for PP review. For increase quality of life (3)
Training for community pharmacists "empower educate" (1)	Link into "Help us, to help you" programme	Increase system/join up, between Acute and Primary Care
Upskill community pharmacists (e.g. EOL care)	Don't start drugs in the first place!	Increase Inter-ORR ability between Community and Acute (1)
Fully embed language/Comms training into training for Nurses/Drs	Patient taking responsibility. Be prepared for meds review	Link with charities
Start education early for HCPs/clinicians e.g. first year medical school	Patient benefits that they can relate to (1)	Discharge charter (2)
Patients want to talk about their meds	Patient understanding and expectation of healthcare (5)	Fixed fields on discharge summary
Underpin polypharmacy through teaching (trainees) (4)	Increase quality of info on discharge (4)	Engage all HCPs in system (Nurses, allied HCPs)
BaNES meds OP project • Research op • QI project? • Focus on patients not to take meds	Tools for communicating with PTS (4)	Standardise frameworks/templates (1)
Increase communication between specialisms and Comm/Primary care (3)	Increase healthcare outcomes	Communication between primary and secondary care
Stop/start toolkit	Decrease side effects	To create a national resource to help clinicians to help PTS make informed decisions (1)
Medication reviews primary and secondary care work together (2)	Empower patient self-care to increase confidence (2)	Let's map what we are already doing (2)
Shared education	Hospital admissions	Community pharmacy + general practice = improve relationships

Joint posts across sector (including mental health (1)	Ownership and control (1)	Better collaboration between professionals (1)
Pharma outcomes T of C	Attitudes to medication, both patient and clinicians	Incentive for every appropriate med you take a patient off (4)
Communication of frailty score to community pharmacy (1)	Culture change for patients • Education • Information provision	Primary care – Secondary care – community pharmacy (12)
Outreach/In reach primary care to secondary care (1)	Shared decision making using resources	Better engagement with interoperability programmes (1)
Research Q's • Analysis of emergency admissions • Medicines related • Over lay this to other data sets	How do we give patients permission to say no And what's important to them? Empowering people to ask questions and consider before appointments (1)	Centralised call centre (prescription ordering lines) Kick off the review and then have the conversation regarding meds review, or…build in more time to do this process
Discussion with ward pharmacist about medication	People with frailty more affected by side affects	West of England AHSN to give permission to consider work on polypharmacy (comms strategy)
District/Practice nurse why not include in polypharmacy projects. Patients will appreciate the extra help with their medications and would be a better experience for patients (1)	Respect conversations	Prescribing incentive schemes (CQUIN)
Range of tools to identify patient for review	Wearable tech = Fitbit's can we access data??	Decrease emergency admissions
Promoting de-prescribing guidelines (1)		Community pharmacy Medicines Use Review
Community pharmacists to initiate some discussions about medication taking practices and beliefs with patients – 14 times a year		Shared run charts for focused projects (geography)
Target start/stop and point of medicines reconciliation		Developing multi-disciplinary working and team
Holistic social prescribing		Frailty score to be part of summary care records (2)
NICE Multi-morbidity guidelines Start to change attitudes of clinicians when starting meds		Shared de-prescribing plan (1)
Upskilling in the right questions (the ones used by Yorkshire AHSN)		ICS
Starting you on this…. If this then…..		Better mapping of our clinical pharmacists resources and sessions
		Whole system "de-prescribing plan" in SCR

		Recognised priority across STP (1)
		Local STP focus
		Positive STP shared initiatives – improving communications across interface
		Networking between CCGs to share initiatives (1)
		More pharmacists embedded within the system. NHS pathways
		Empowering patients – care wrapped around them (2)
		IT integration starting to help share medication information (14)
		Pharma outcomes referral from secondary to primary care (2)
		Alivecore in pharmacies instead of GPs
		NMP carers to add de-prescribing knowledge
		Positive risk taking

Appendix 3 – Table discussions part 2

POLYPHARMACY WORKSHOP

CHALLENGES/LEARNINGS

Healthcare professionals	Patient	System
Time	Most vulnerable patients (e.g. mental health/learning difficulties)	Feedback loops breakdown
Recording inter-runs within secondary care	Empowering patients	Communication
Safety netting	Mobility issues (transport etc)	IT from primary to secondary care and visa versa
Prescriber/HCP motivation	Most appropriate HCP. Increase knowledge Decrease admissions	Embedding frailty scores in primary care and making this valuable to secondary care and community pharmacy
Trust among different professionals	Patient Motivation	QoF drives polypharmacy
Positive risk taking may lead to positive consequences	Research ques? Can we influence patient activation measure through de-prescribing initiatives?	CCGs
Directory of pharmacists in primary and secondary care	Capacity for decision making	PIS/CQuin (carrot and stick)
	Fear of symptom returning	Capture financial savings for lower hospital admissions
Which tool to use? (Graham Price)	Pain and polypharmacy. Managing patient expectation	Sustainability (money incentives) Howe can we sustain initiatives?
Where am I going to find the time?	Litigation! Overcome barrier of fear	Increase time needed with patients across the system
Very little contact with community pharmacists and primary care	What do patients want? What is important to the patient? Do we know? Do we ask?	System to monitor adverse effects of drug changes
1 year review	Why are dosette boxes being prescribed. Who is it of benefit for? Doing it themselves?	Pressures on system
Identifying patients at risk of adverse outcomes from polypharmacy Who should deprescribe?		All professionals within system 'on board'
Fear of destabilisation		System wide response to complaints
Teaching and education needs to be earlier (Ana Seoake, Fiona Castle and Kevin Gibbs)		What is our regional outcome measure?
Short acute care stay to		Interoperability of IT systems

monitor deprescribing		community processes and IG (Nikki Shaw)
Empowerment of clinicians to deprescribe		IT Interoperability
Multi-speciality prescribing from secondary care		Current interoperability barriers
Type of range of resources. Whittle down to what is practical as we promote on two or three resources of preference.		Poor quality of information at discharge (Richard Brown)
Empowering everyone to have the conversation		Technology/Interoperability
Non-medical care-coordinators not trained to pass on information (e.g. side effects)		Conflict of interest with systems
TIME		Not lacking good ideas. How do we scale?
Communication		How do we build thrust into the system? Between different professional groups?
		IT and IG. Doesn't encourage sharing access to records
		Different system have different templates
		Embedding sustainable processes
		Not easy to flag patients to GPs if they need deprescribing or a review
		GPs are worried about ethical barriers – am I doing more harm by stopping? Put into QoF
		Not good evidence based on deprescribing and who's best to do it. Need to be better at real world data to link to outcome and decisions
		Repeat dispensary makes it harder to stop
		Are we getting more outcomes if we prescribe less? Research question!
		Review incentives in system to align to the behaviour that is desired
		Pharmacist are paid by volume prescribing (review incentives)

Appendix 4 - Table discussions part 3

AREAS OF FOCUS & PROGRESSION

	BaNES, Swindon and Wiltshire STP	BNSSG STP	Gloucestershire STP
System	PharmOutcomes - AWP → Acutes → Community Pharmacy	Develop/agree tools to consistently use across system.	Tools to support decision making
	System wide polypharmacy chart template	Tools for GPs/Patient/Clinicians to support evidence base for de-prescribing.	Fit for purpose guidelines
	Integration of IT: using nhs.net with primary care, secondary care, care homes and carers	Links with specialist in polypharmacy review to upskill all in primary care	Primary care offer?
	Convert to Summary Care Record - system wide	Frailty networks	For pre and registered pharmacy trainees and GP trainees - develop polypharmacy programme/audit/competency
	Patient education across STP	Cross system education programme - with support from AHSN	
	System focus - single "aim/measure" for STP system	Fund education programme across system.	
	Pharmacist/Technician team for care agencies for de-prescribing/appropriate use of monitored dosage system	Link community pharmacy across wider networks: - social services - mental health - acute trusts	
	Any care agencies that are good examples of shared worked with patients and pharmacies		

	BaNES, Swindon and Wiltshire STP	BNSSG STP	Gloucestershire STP
AHSN	Educational events with support from RPS and CEPN	Cross system education programme - with support from AHSN	Link in with Social Care providers
	Spread "Meet Mo" from Wessex	National research funding in reducing polypharmacy	Mapping - what is currently working in our region? - share and learn
	Create Medicines Safety forum to share and learn across the STP	Fund training within prescribers/trainers to change consultation models.	Me and My Medicines - share info across the West of England region
	FOI request to ascertain percentage of patients on an automatic dosette box? Implement completion of form prior to start patients on dosette box	Help nationally to avoid duplication of work.	
	Clinical Pharmacist - contact App.	DWAC model - local champion	
		Help support having local champions team made up of different health care professionals to enable this across BNSSG.	
		Website/database needed to assist clinicians to gain information to make robust informed decision making to empower patients.	
		Support to accelerate interoperability of systems to allow better communications across interfaces.	

Appendix 5 - Pledges

Pledge
Hold the AHSN to account to deliver on the key projects. Avon LPC will provide support and access to 230 community pharmacies when required
Develop a systematic approach to identify care home residents that would benefit from a quality medicines review using de-prescribing tools.
I will include a slide in my team session for anaesthetists and surgeons about polypharmacy and the need to be clear on discharge - How long meds should be taken for, how to reduce etc., review date.
Improve the quality of medicines on discharges from secondary to primary care (elderly patients): -Education - pharmacists/prescriber. -Rationale -Justification? -Plan for polypharmacy, review if appropriate/necessary - push back to primary care. -How to identify those frail patients?
To manage MURS for discharge practices through CCG. Explore with GWH the potential to add de-prescribing plan to discharge outpatients letter.
1. Facilitate agenda and discussion on polypharmacy de-prescribing - senior team @ AWP. 2. Explore a pilot with LPC on a discharge info pilot AWP wards; - Community pharmacy - Clinical pharmacist in GP 3. Look at MSO BSW Networks? (+CPPE?)
1. Look at a share G-care resources/Wiltshire MMT monographs 2. Pursue sharing information through nhs.net plus access to TPP for care homes
1. Learn more about scoring of frailty and the Yorkshire Project and applying it to reviewing prescriptions for older adults on my wards and identify opportunities for de-prescribing. 2. Better pharmacist medication R/V @ admission for rationality of Rx - increase discussions with patients, prompting doctors to have discussion about de-prescribing medications.
Support pharmacy professionals from different sectors to come together for educational events. To explore collaboration with CEPN for multi-disciplinary learning.
To promote sharing of clinically relevant information to community pharmacies through Pharmoutcomes and nhs mail and support action on this information
To promote medicines safety within SCHS, focussing on polypharmacy as a key area. Raise quality of discharge at pharmacy board through MSO. Explore ↓dosette box use/review of patients for appropriateness before starting a new dosette.
We will try to develop polypharmacy indicators in secondary care to: i) Help prioritise our patient reviews ii) Inform primary care @ discharge
I pledge to improve communication between secondary care to primary care within NBT. ↑ communication with pharmacists & Drs.
Email DN & CM team leads and raise awareness of de-prescribing and polypharmacy and to refer patient and pharmacist for a review if they suspect patients.
Support AHSN & system to progress further a consistent approach to polypharmacy across BNSSG

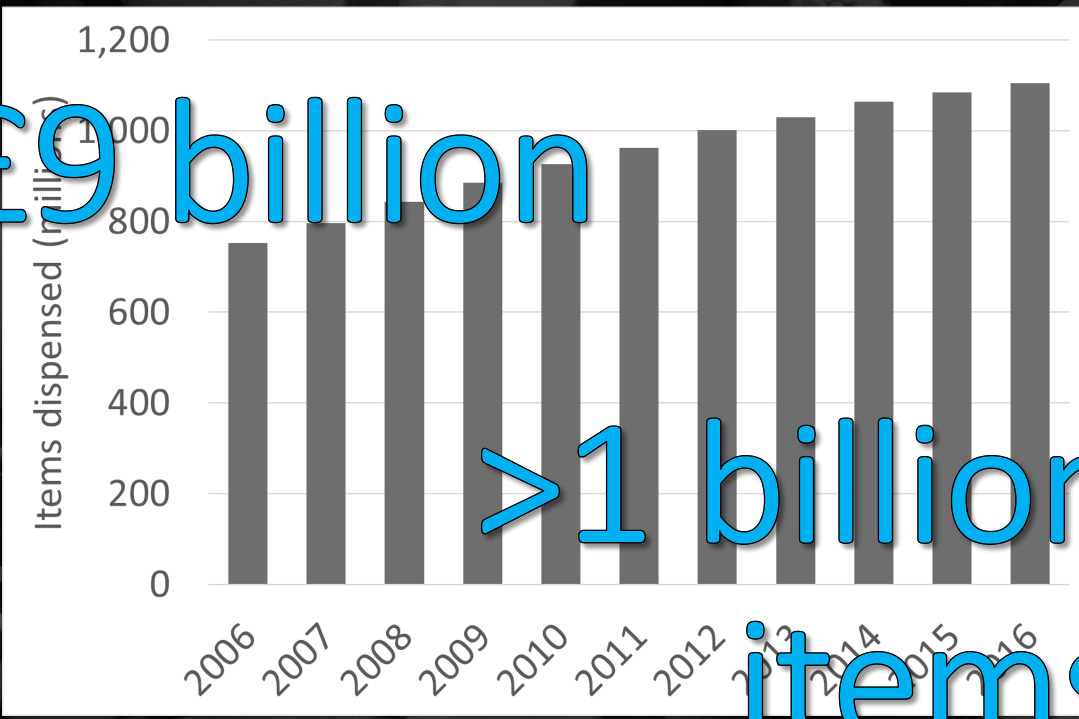
Incorporate polypharmacy reviews into the 2019/2020 prescribing quality scheme focussing on specific patient groups using agreed best 'tools' to structure the review.
To develop an educational programme for prescribers and nurses to change their consulting style from a 'fixing' model to a 'facilitative' model in order to empower patients. Also to develop a resource/catalogue of information for informed decision making.
To work to enable development of good communication across interfaces as part of the MOCH programme concerning medication review of polypharmacy and de-prescribing.
Improve communication about medicines at discharge to avoid medications being inappropriately continued
1. To work with GP pharmacists and community pharmacists to develop training for our pre-reg pharmacists on polypharmacy, local objectives, targets & work streams. 2. To work with Cheltenham locality to evaluate the communications policy then work with the CCG to see if we can adopt across the STP footprint.
1. Develop more robust communicated medicines reconciliation on discharge from primary care to secondary care interface. 2. Plan to enhance clinical pharmacy mental health support at primary care to secondary care interface.
Currently review medicines management training - will include section on polypharmacy.
Ask your clinician? - Ask your pharmacist. - PPG - Nurses CIC's, - +ve risks
Review GP use of email communication with community pharmacy.
1. Understand our practice variation on polypharmacy comparators both within and across practices Leaflet for patients/carers to empower/prompt them to ask their prescribers re potential for de-prescribing in their cases. 2. Support positive risk taking in patients and by prescribers for de-prescribing or not prescribing Education of providers re addressing inappropriate polypharmacy - holistic patient care approach 3. Downstream education to include GP-trainees & pre-reg pharmacists re MDT approach to polypharmacy reviews

Appendix 6 - Links to slides

Slides are accessible via this link:
https://www.slideshare.net/secret/AePTL8wXzlmFvZ

Please see the slides from Rupert Payne's presentation below:

£9 billion



>1 billion items

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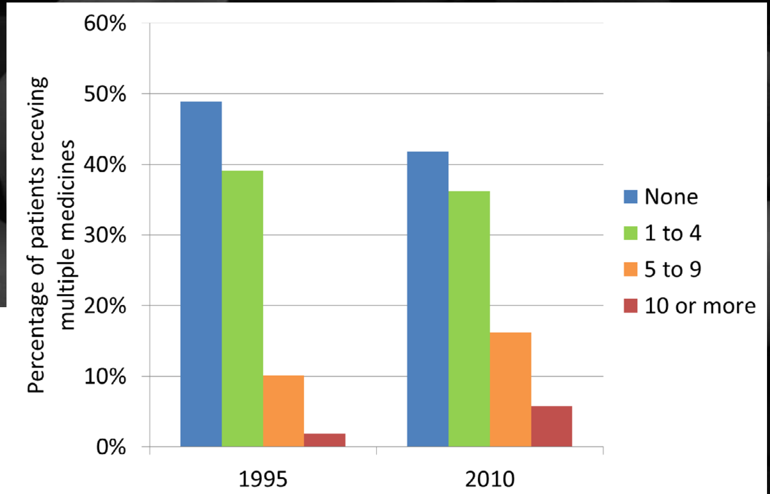

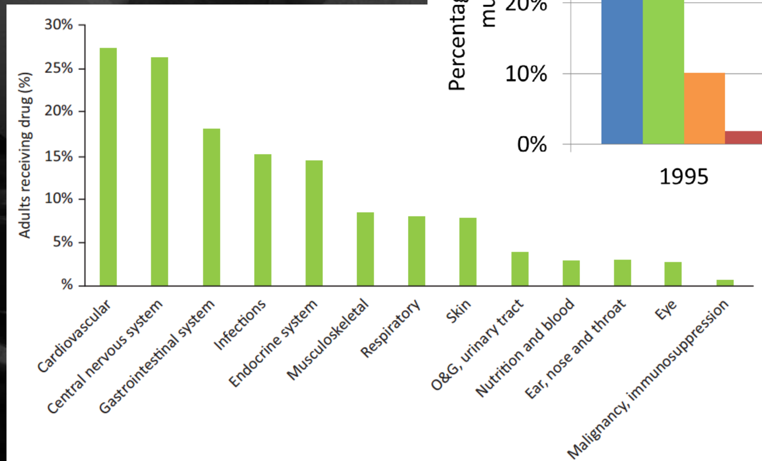

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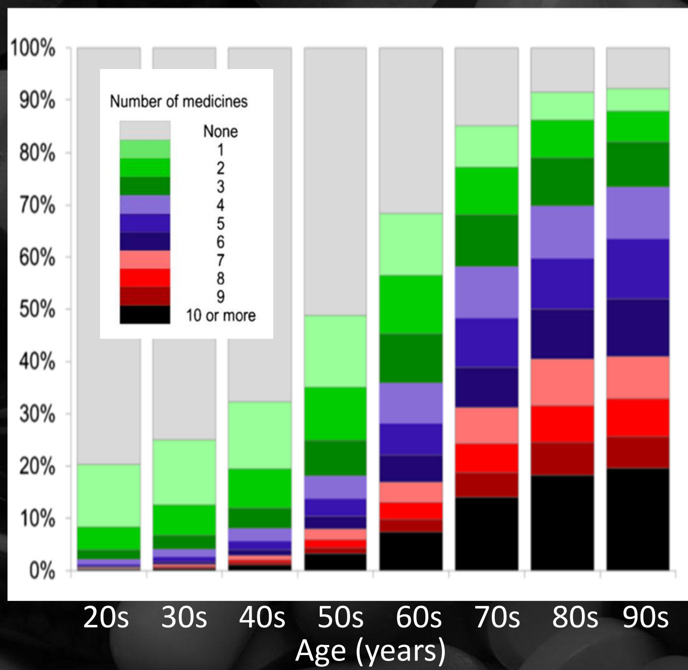
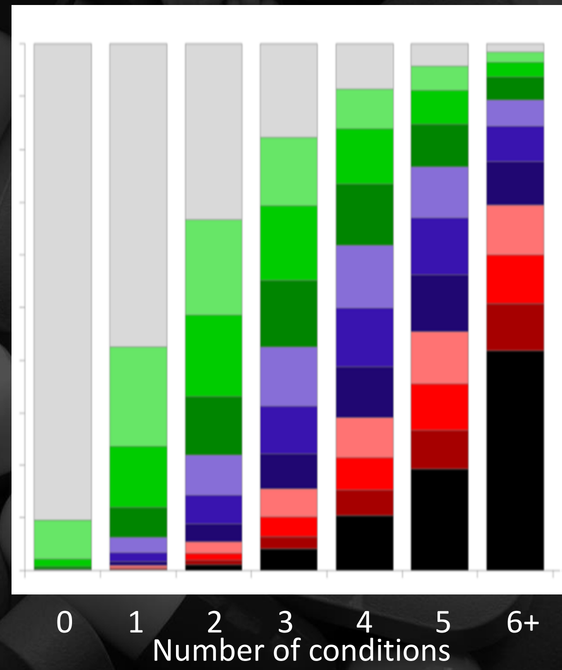
Guthrie B. 2015

Payne RA, Eur J Clin Pharmacol 2014





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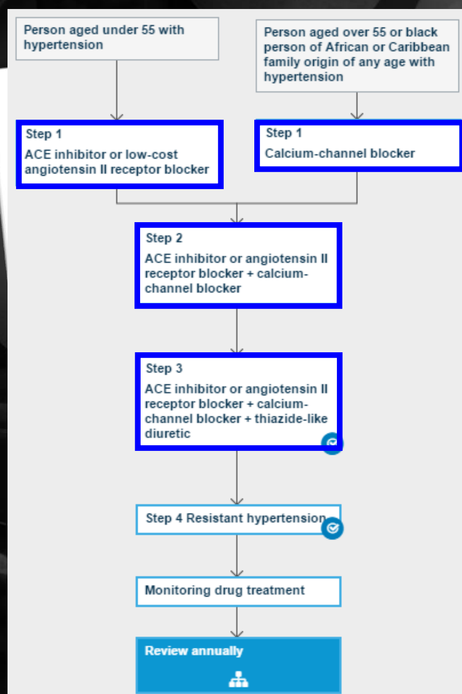

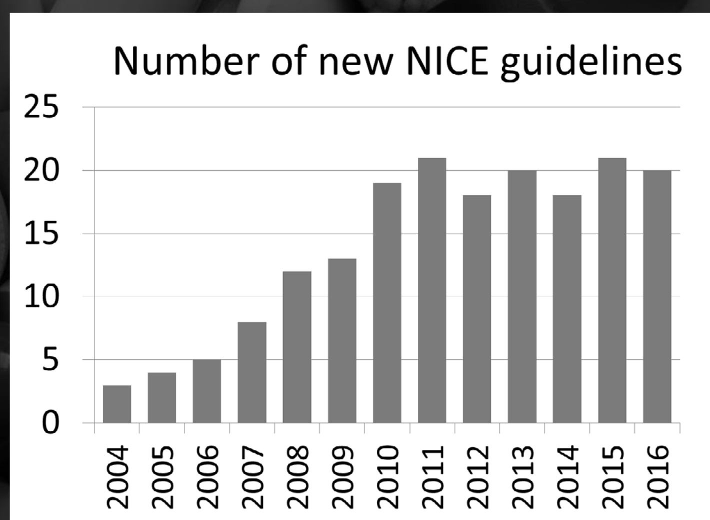

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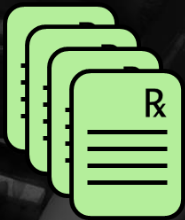
Systems & Processes



Centre for Academic Primary Care

>50% Black dot interactions 10+ drugs

16% Medication errors increase per drug

half Medication adherence 5+ drugs

Quality of Life

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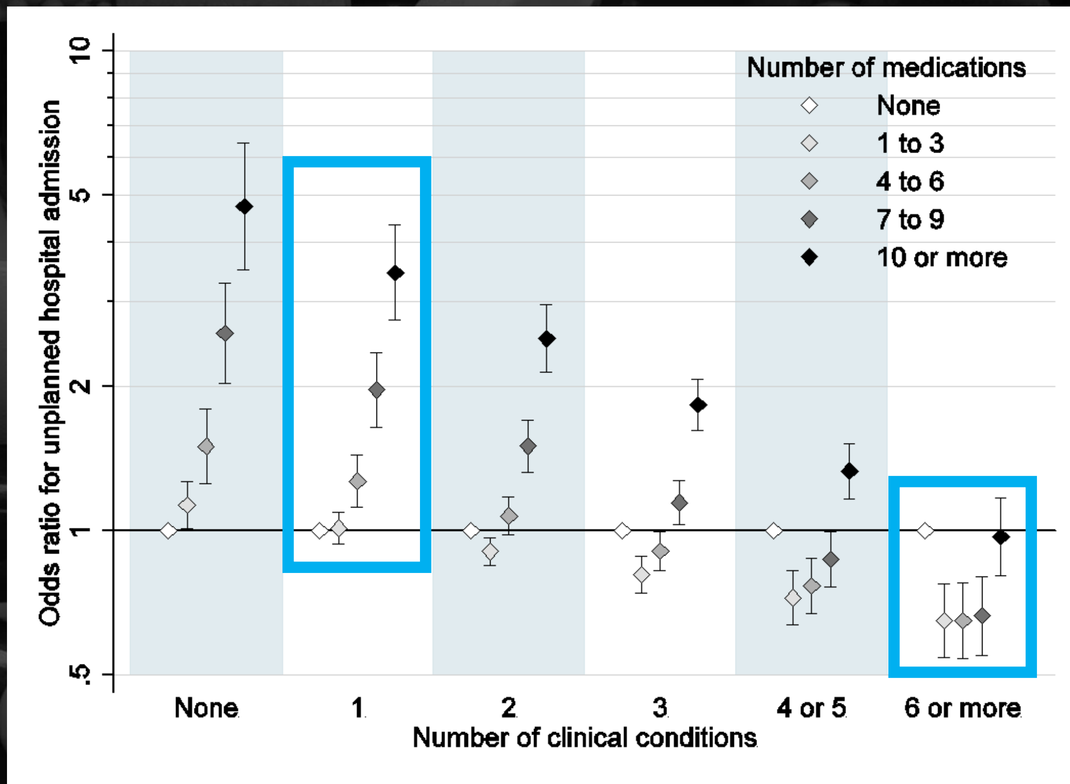
Payne RA, Br J Clin Pharmacol 2014



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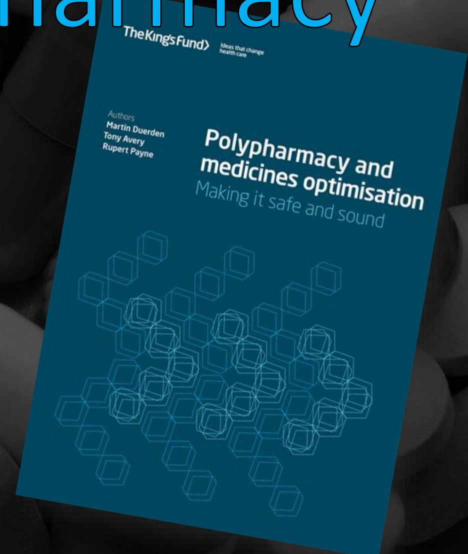
Appropriate polypharmacy

"…medicines use has been optimised and … prescribed according to best evidence. The overall intent … to maintain good quality of life, improve longevity and minimise harm…"



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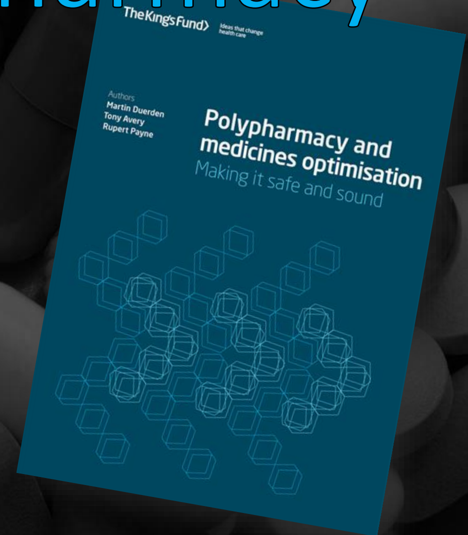
King's Fund, 2013

Problematic polypharmacy

"...prescribe inappropriately ... or where intended benefit ... not realised

... not evidence-based ... risk of harm from treatment is likely to outweigh benefit ... one or more [other issues]"



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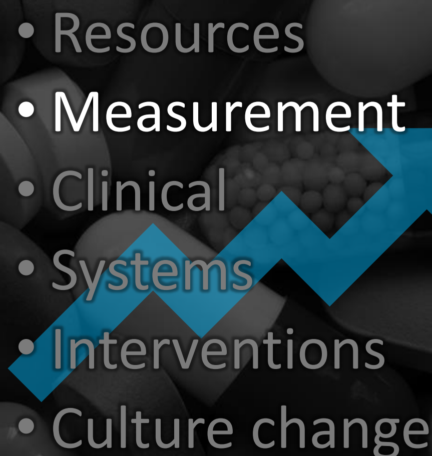
King's Fund, 2013

Improving polypharmacy



- Resources
- Measurement
- Clinical
- Systems
- Interventions
- Culture change

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Business Services Authority

ePACT2
Polypharmacy Prescribing Comparators

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Developing a new measure of polypharmacy appropriateness

The University of
Nottingham

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Explicit vs. Implicit

Inappropriate prescribing criteria

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Identifying polypharmacy?

- ≥10 medicines
- 4 to 9 medicines and
  - Inappropriate criterion
  - Non-adherence
  - Single major diagnosis
  - End-of-life care

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Burt J, BMC Med 20

Systematic review of inappropriate prescribing indicators

20879 abstracts
273 full text screening
22 papers included
160 implicit indicators
18 categories

10 experts (GP, hospital, pharmacy)
160 indicators reviewed
134 agreed clinically important
Re-categorised, highest scoring retained
Overlapping indicators removed
12 final indicators

RAND Appropriateness consensus process

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12

indicators of polypharmacy appropriateness

- The **indication** for the drug is recorded in the medical record
- There are no **non-pharmacological** alternatives
- Drug selection is consistent with **established clinical practice**
- There are no clinically significant **drug-drug interactions** (including duplication of therapy)
- If the drug is **contraindicated**, the prescriber gives a valid reason
- The drug is **effective** in this patient for this indication
- The drug as currently given is not likely to be **sub-therapeutic or toxic**, based on the dose, route and dosing interval for the age and rena status of the patient
- The drug regimen cannot be **simplified**
- The patient/caregiver is **clear** about the drug regimen
- The patient **adheres** to the drug schedule
- The drug treatment is **reviewed** by an appropriate clinician at leas once per year in accordance with best clinical practice
- If an **adverse drug reaction** occurs, there are details given of the reaction and recommended future monitoring in the medical recor

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Automate indicators for targeting and monitoring interventions

Operationalise
Validate
Evaluate

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Improving polypharmacy

- Resources
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- Culture change

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Cochrane systematic review

(Patterson 2014)

- 12 studies, older patients
- Multi-faceted complex interventions
- Questionable evidence of benefit

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Patient

Profession

Setting

Timing

Method

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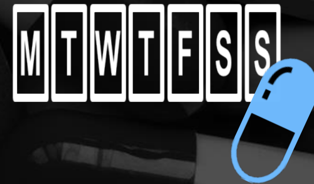
Patient

Profession

Setting

Timing

Method



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Patient

Profession

Setting

Timing

Method

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GP and pharmacist interactions

GPs views on pharmacist skills

- Lack of clinical decision-making skills
- Inflexibility of pharmacists
- Reluctance to relinquish control of decision-making

55% of pharmacist recommendations not actioned

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The 3D Study: Improving whole person care

Patient

Profession

Setting

Timing

Method

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Patient
Profession
Setting
Timing
Method

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Barnett N, 20

What does a good medication review look like?

- Systematic review of 32 papers
  - Facilitators for review (e.g. time, training)
  - The review process (e.g. which HCP/setting, nature of information gathering, patient-centred, nature of communication, face-to-face)
  - Specific treatment issues (e.g. ADRs, interactions, effectiveness, complexity, adherence)
  - Specific tools (e.g. STOPP/START, Beers)
  - Supporting resources (e.g. IT, templates)
  - How are the recommendations actioned?

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Deprescribing

"The process of withdrawal of an inappropriate medication, supervised by a health care professional with the goal of managing polypharmacy and improving outcomes"

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Reeve E, Br J Clin Pharmacol 20

- Immature evidence base
- Rhetoric underpinned by assumptions of benefit
- Paradox – higher risk populations who benefit most from drugs may also benefit most from deprescribing

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Improving Medicines use in People with Polypharmacy in Primary Care

The IMPPP study

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Keele UNIVERSITY

University of Dundee

NHS
National Institute for Health Research

to develop, implement and evaluate an intervention to optimise medication use for patients with polypharmacy in a general practice setting

Aim

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Structured review process

1. Identification of patients (case finding)
2. Technical prescription review
3. Collaborative discussion between GP and pharmacist
4. Face-to-face review with patient
5. Follow-up

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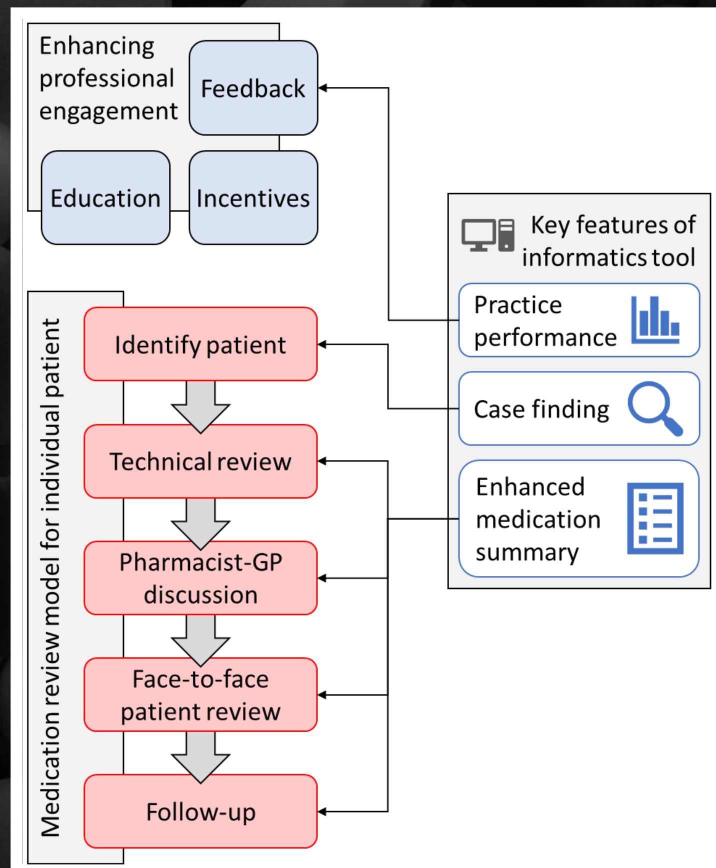

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Development phase (1 year)

- Define/refine intervention components

Pilot/feasibility study (1 year)

- Optimise intervention

Multicentre cluster randomised trial (2 years)

- Intervention vs. usual care
- 54 practices, 2700 patients
- Primary outcome: prescribing safety

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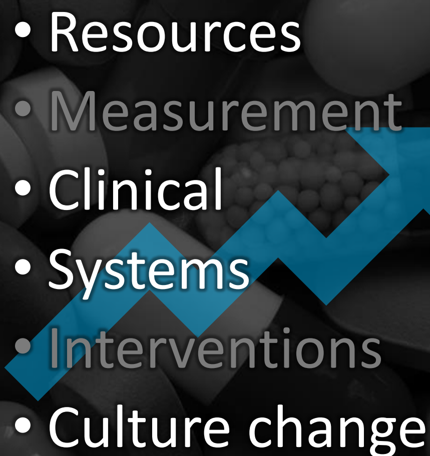
Improving polypharmacy



- Resources
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Improving polypharmacy

- More Resources
  - Time, expertise
- Clinical
  - Training, guidance (e.g. RPS polypharmacy guidance)
- Improved systems
  - better continuity, coordination of care, repeat prescribing
- Culture shift
  - Will take time!
  - Needs education/training, incentivising more holistic care

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Dealing with polypharmacy in the real world

- Policy and practice moves fast, but research moves slowly
  - Coordinated approach
  - Building evaluation into new policies
  - Informed by evidence

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