

*The***AHSN***Network*

The AHSN Polypharmacy Programme: Getting the Balance Right

Pillar 1: Population Health Management

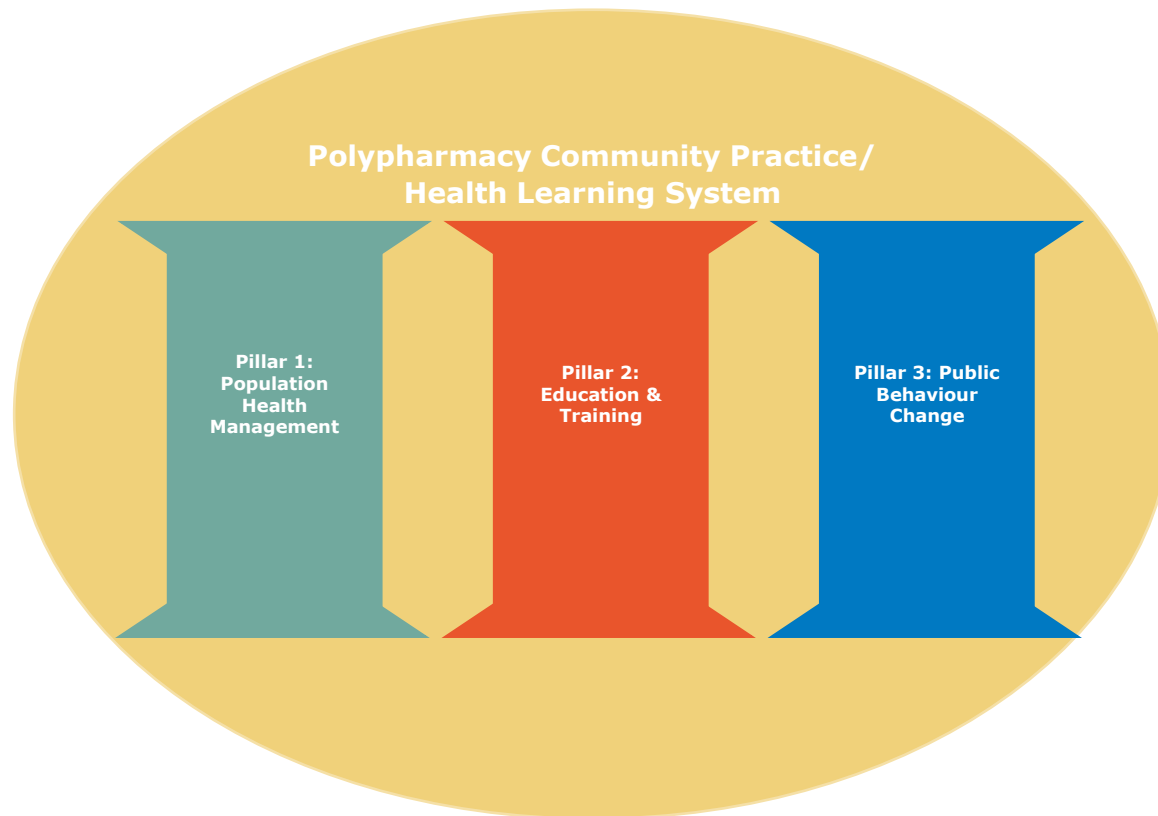
**Clare Howard FFRPS FRPharmS Q
Clinical Lead AHSN Network Polypharmacy Programme**



The AHSN Polypharmacy Programme:

Getting the Balance Right

The core principle of **Polypharmacy** is to support local systems address problematic polypharmacy through:



- **Pillar 1: Population Health Management**
 - Using data (NHS BSA Polypharmacy Comparators) to understand PCN risks and identify patients for prioritisation for a Structured Medication Review
- **Pillar 2: Education & Training**
 - Running local **Polypharmacy** Action Learning Sets (ALSs) to upskill the primary care workforce to be more confident about stopping unnecessary medicines. ALS model originally developed and piloted by Wessex AHSN and supported by Health Education England (HEE)
- **Pillar 3: Public Behaviour Change**
 - A menu of public-facing campaigns to change public perceptions of a “pill for every ill” and encourage patients to open up about medicines. e.g., Me + My Medicines, Are Your Medicines Working For You?

The Size and Scale of Polypharmacy

Medicines are intended to help patients but they can cause harm...



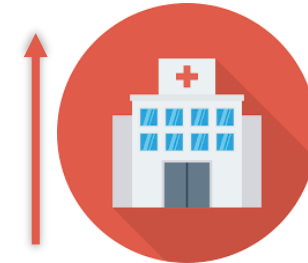
In England in Sept 2022, there were **951,037** people who received 10 or more medicines and **383,354** of them were aged 75 or over.



Over a six-month period, over **three quarters of people** over the age of 70 will have an adverse drug reaction



A person taking 10 or more medicines is **300% more likely** to be admitted to **hospital**



There has been a **53% increase** in the number of emergency hospital admissions caused by adverse drug reactions

Polypharmacy adds preventable cost to the healthcare system and diminishes quality care for the patient

We dispense over 1 billion prescription items per year in Primary care in England

Most of the harm from polypharmacy is **preventable.....**



Better monitoring and drug reviews need to be carried out to ensure patients are only prescribed medicines they really need, says Professor Sir Stephen Powis

GETTY IMAGES

HEALTH

GPs increase side-effect risks with a pill for every ill

England's most senior doctor says unnecessary prescriptions are costing the NHS £1bn a year

costing the NHS £1bn a year. unnecessary prescriptions are England's most senior doctor says for every ill



DR MARK PORTER

Overprescribing is a big problem, but don't just blame it on GPs

Dr Mark Porter

Monday June 20 2022, 5.00pm, The Times

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Dr Mark Porter

blame it on GPs. Overprescribing is a big problem, but don't just



Gout is a form of inflammatory arthritis that affects one person in 40
GETTY IMAGES

HEALTH

Gout sufferers are denied effective pills as cases rise

Kat Lay, Health Editor
Thursday May 26 2022, 12.01am, The Times

Gout sufferers are not getting proper treatment, with only one

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HEALTH

GETTY IMAGES

SUNDAY EXPRESS June 19, 2022

Call for NHS to shift focus 'beyond pills'

By Lucy Johnston HEALTH EDITOR

DOCTORS are over-prescribing drugs and an "NHS revolution" is needed to shift the focus to the root causes of health problems, campaigners claim.

The number of drug prescriptions has doubled in 20 years, while "social prescriptions" such as a lifestyle changes are often overlooked, they said.

A coalition of politicians, NHS chiefs and doctors last week launched the College of Medicine Beyond Pills campaign. It aims to revolutionise healthcare so the social and psychological needs of patients are supported, as well as their physical problems.

It comes in the wake of the Government's National Overprescribing Review, which revealed around one in 10 prescribed drugs - 110 million items - is unnecessary, inappropriate or harmful.

It also found 20 per cent of hospital admissions for over-65s were for an adverse reaction to prescribed drugs.

The Beyond Pills coalition wants family doctors to offer social prescriptions - as well as drugs if necessary - if they think a patient's problems may be linked to their environment, lifestyle or mental health. This includes those who

are lonely, anxious, eating poorly or living in damp, mouldy or poor housing.

College of Medicine chairman Dr Michael Dixon said: "The campaign is demanding a revolution in the NHS."

Some family doctors already offer social prescriptions - taking a more holistic approach to health and wellbeing - but the campaign fears there are "yawning gaps" in provision. It wants the Government to prioritise social prescribing in training and practice.

Bemoaning the "firefighting culture" in the NHS, Dr Bogdan Chiva Giurca, founder of the NHS England National Social Prescribing Student Champion Scheme, said: "For some, the NHS is like a revolving door repair shop. But many patients come in with complex needs far beyond pills and procedures."

Former health secretary Stephen Dorrell said: "The pandemic demonstrated the capacity of science to provide protection when lives are threatened. But the best support for long-term health is to ensure people enjoy the benefits of a home, a friend and a job."

MEDICATION SAFETY

A recent national report outlines the scale of the issue. Key points include;

- A medication error is a preventable event that may lead to inappropriate medication use or patient harm.
- Errors were more likely in older people, or in the presence of co-morbidity and polypharmacy.
- It was estimated that 237 million medication errors/year occur at some point in the medication process in England. This is a large number, but 72% have little/no potential for harm. It is likely that many errors are picked up before they reach the patient, but we do not know how many.
- It was estimated that 66 million potentially clinically significant errors occur per year, **71.0% of these in primary care. This is where most medicines in the NHS are prescribed and dispensed. Prescribing in primary care accounts for 33.9% of all potentially clinically significant errors.**
- Error rates in the UK are similar to those in comparable health settings such as the US and other EU countries.
- There is little evidence about how medication errors lead to patient harm.

The estimated NHS costs of definitely avoidable ADRs are

- £98.5 million per year, consuming 181,626 bed-days, causing 712 deaths, and contributing to 1,708 deaths.

This can be divided into:




- Primary care ADRs leading to a hospital admission (£83.7 million; causing 627 deaths);
- Secondary care ADRs leading to a longer hospital stay (£14.8 million; causing 85 deaths, contributing to 1,081 deaths).

Non-steroidal anti-inflammatory drugs, anticoagulants and antiplatelets cause over a third of admissions due to avoidable ADRs. Gastrointestinal (GI) bleeds are implicated in half of the deaths from primary care ADRs.

Older people are more likely to suffer avoidable ADRs.



BMJ Open Adverse drug reactions, multimorbidity and polypharmacy: a prospective analysis of 1 month of medical admissions

Rostam Osanlou ^{1,2}, Lauren Walker,^{1,2} Dyfrig A Hughes ³, Girvan Burnside,⁴ Munir Pirmohamed ^{1,2}

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► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2021-055551>).

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ABSTRACT

Objective To ascertain the burden and associated cost of adverse drug reactions (ADRs), polypharmacy and multimorbidity through a prospective analysis of all medical admissions to a large university teaching hospital over a 1-month period.

Design Prospective observational study.

Setting Liverpool University Hospital Foundation National Health Service (NHS) Trust, England.

Participants All medical admissions with greater than 24-hour stay over a 1-month period.

Main outcome measures Prevalence of admissions due to an ADR and associated mortality, prevalence and association of multimorbidity and polypharmacy with ADRs, and estimated local financial cost of admissions where an ADR was a contributing or main reason for admission with projected costs for NHS in England.

Results There were 218 identified patient admissions with an ADR giving a prevalence of 18.4%. The majority of these (90.4%) were ADRs that directly resulted in or contributed to admission. ADRs thus accounted for 16.5% of total admissions. Those with an ADR were on average taking more medicines (10.5 vs 7.8, $p<0.01$) and had more comorbidities than those without an ADR (6.1 vs 5.2, $p<0.01$). Drugs most commonly implicated were diuretics, steroid inhalers, anticoagulants and antiplatelets, proton pump inhibitors, chemotherapeutic agents and antihypertensives. 40.4% of ADRs were classified avoidable or possibly avoidable. The mortality rate due to an ADR was 0.34%. The average length of stay for those with an ADR was 6 days. Direct 1-month cost to the Trust from ADR admissions was £490 716. Extrapolated nationally, the projected annual cost to the NHS in England is 2.21 billion.

Conclusion The local prevalence of admission and mortality from ADRs is higher than previously reported. Important factors that could be contributing to this include polypharmacy and multimorbidity. ADRs place a significant burden on patients and healthcare services with associated financial implications. Reducing inappropriate polypharmacy should be a major aim for preventing ADRs.

INTRODUCTION

Improved living conditions and better access to and quality of medical care have led

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Over 1000 medical admissions were individually reviewed by specialists in clinical pharmacology and general internal medicine in this prospective analysis of adverse drug reactions (ADRs).

⇒ Standardised criteria, as listed in methods, were used to identify and classify ADRs. This improves the objectivity and reproducibility of the analysis.

⇒ Extrapolating the cost analysis nationally based on medical admissions locally may be unreliable due to differences including local population and services.

⇒ This study does not take into account how commonly each medicine that caused an ADR is prescribed in the local community.

to increased life expectancy and the associated accumulation of long-term conditions (LTCs).¹ According to a report by the Academy of Medical Sciences, multimorbidity is a growing issue globally, particularly in more economically developed countries where it is now considered the norm not the exception.² Age is the single biggest risk factor for LTCs, such as cancer, cardiovascular disease and neurodegeneration, in developed countries. An ageing population is therefore at increased risk of polypharmacy.³ Care for people with multiple LTCs is often stretched across various single-organ specialists leading to siloed specialty prescribing and increasingly complex medication regimens.

Polypharmacy is the concurrent use of multiple medications by an individual. There is no consensus on the number of medications that defines polypharmacy because of the need to treat complex or multiple comorbidities with combinations of medicines. Thus, numerical definitions vary but perhaps the most common definition is taking five or more regular medications. The Wessex Academic Health Science Network has developed a set of prescribing comparators

<https://bmjopen.bmj.com/content/bmjopen/12/7/e055551.full.pdf>

Over 1,000 medical admissions reviewed.

218 (18.4%) of admissions identified with an ADR
90.4% were ADRs that directly resulted in or contributed to admission
Those with ADRs were on average taking more medicines (10.5vs 7.8
 $p<0/01$)

And had more comorbidities than those without ADRs

Drugs most commonly implicated were

- Diuretics (14.2%)
- Steroids (12.4%)
- PPIs (8.3%)
- Chemotherapy (7.3%)
- Antiplatelets (7.4%)
- ACE/ A2RB (6.4%)
- Opioids (6%)

40.4% of ADRs were considered avoidable

Mortality rate 0.34%

Average LoS was 6 days.

National extrapolated costs £2.21 billion.

The Impact of Medicines in older people

In a recent study in Newcastle

<https://bpspubs.onlinelibrary.wiley.com/doi/10.1111/bcp.15211>



SHORT COMMUNICATION |  Open Access   

Is polypharmacy associated with mortality in the very old:
Findings from the Newcastle 85+ Study

Laurie E. Davies ✉ Andrew Kingston, Adam Todd, Barbara Hanratty

First published: 03 January 2022 | <https://doi.org/10.1111/bcp.15211>

Each additional medication prescribed was associated with a 3% increased risk of mortality (hazard ratio: 1.03, 95% confidence interval: 1.00–1.06). Amongst the very old, the risks and benefits of each additional medication prescribed should be carefully considered.

Not forgetting the many benefits of medication, potential reasons for the association between polypharmacy and mortality in the very old include adverse drug-reactions, non-adherence and inappropriate prescribing –be it through drug-drug interactions; improper doses, indications or durations; high-risk medicines or prescribing omissions. Indeed the very old are likely to be sensitive to medication prescription due to age-related pharmacokinetic and pharmacodynamic changes, coupled with multimorbidity, cognitive impairment and/or frailty. In other words, they have fewer physiological reserves to withstand potential adverse effects of multiple medications.

What are we doing about it?

IT'S GLOBAL

WHO has said “given that medicines are the most common therapeutic intervention, ensuring **safe medication use and having processes** in place to improve medication safety should be of **central importance**”.

IT'S A BIG CHALLENGE AND GROWING

We dispense over a billion prescription items a year in primary care in England each year.

Age UK have recently highlighted the issue

RPS published guidance

ACTION IS NEEDED

NHS BSA Polypharmacy Prescribing Comparators tool is available to help GPs and Pharmacists **find the people most at risk**.

Shared Decision Making consultations are helping clinicians and patients to reach agreement about what is important to the patient and what is clinically important.

More harm than good

Why more isn't always better with older people's medicines



Good for you, good for us, good for everybody

A plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions

Published 22 September 2021

Polypharmacy: getting the balance right



Medication Safety in Polypharmacy



MEDICATION WITHOUT HARM
Our Patient Safety Challenge

Technical Report

ROYAL PHARMACEUTICAL SOCIETY

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Polypharmacy: Getting our medicines right



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crop1417x353

Your Feedback

Strategic and Policy Context

NHS Long Term Plan

Commitment to increase the number of Pharmacists working in General Practice. Highlights the importance of Structured Medication review

Primary Care Networks

Funding for PCNs to secure Pharmacists

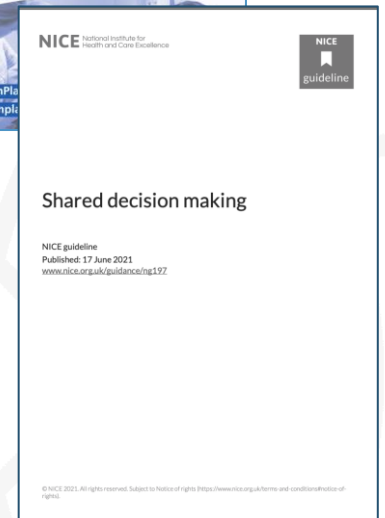
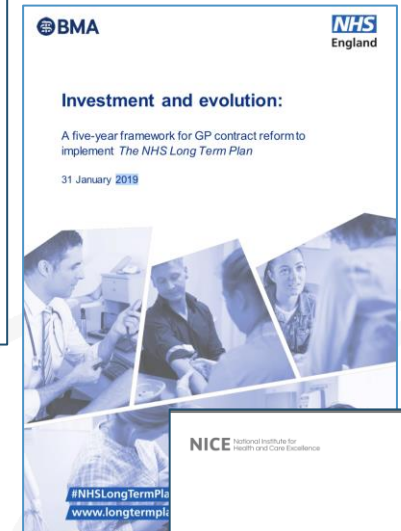
QOF

Update

Overprescribing review published September 2021

NICE guidance on Shared Decision Making (SDM)

published June 2021



THE WORKING GROUP – A collaboration of clinicians, data analysts, statisticians and others developing a practical tool with real patient benefits.



Royal Manor Health Care

Tel: 01305 820422 | Fax: 01305 824143

Talbot Medical Centre



Business Services Authority



The Richmond Group of Charities



Polypharmacy comparators development process

Stage 1 – Wider working group

Wessex AHSN convenes a working group comprising the following members:

- GPs with an interest in the topic or with previous experience in participating in comparator development in the past.
- Pharmacists who will be working with the comparators at GP practice or PCN level. They need to have a working knowledge of ePACT2 but do not need to be data experts.
- Data analysts NHS BSA
- Statisticians NHS BSA
- Clinical Lead Medicines Optimisation (Chair)
- NHS BSA Senior Manager.
- Senior Pharmacist with data experience and expertise. (Simon Cooper)
- Wessex AHSN Programme Management.

Stage 2 - Development

Group convenes to set out objectives and guiding principles.
Agrees broad themes for comparators and highlight limitations.
Starts to develop a wish list of comparators.
NHS BSA work on first iteration of the comparators.
NHS BSA present a prototype to the group for discussion. This stage usually uses data, from the organisations to which wider working group members belong, to enable a sense check.
Group reviews the prototype and discuss amendments and/or improvements.
Smaller working group (Chair, NHS BSA and Senior Pharmacist) hones the comparators and refine the prototype.
Smaller working group begins to draft the specifications. See Annex 1 for headings.
Wider working group reviews the specification and comparators and provide sign off for wider (national) testing.

Stage 3 – Wider testing

Clinicians are selected for a wider (national) testing event. These are pharmacists and GPs who are interested in prescribing data but are not necessarily experts in the topic of the comparators.
At a national testing event (with 2 -3 delegates per AHSN geography) the comparators are presented and then small groups discuss each comparator.
For each comparator, the delegates are asked to discuss.

Is it useful?

Is it valid (are there any health warnings)?

How would you use it?

What other data sources might make it more meaningful?

In or out? i.e., should it be included in the final published measures?

Are there any other measures that the group could suggest?

Positive response?

All responses are pooled and then the smaller working group will review and suggest amendments. Final specification and measures shared with the working group.

**Process for
establishing
NHS BSA prescribing
comparators**

Stage 4 – Publication

Specification is signed off by the smaller working group.
Communications plan and launch date agreed.
Stakeholder list is shared with the wider working group prior to launch to ensure everyone is included
Comms teams from BSA, Wessex AHSN and NHS will be key leads.



The role of the NHS BSA Polypharmacy Prescribing Comparators

1. Benchmarking polypharmacy prescribing

Use the data tool **see how GP practices' prescribing** (both volume and risky combinations of medicines) **compares to others' in England.**

2. Prioritise and identify those at risk from harm

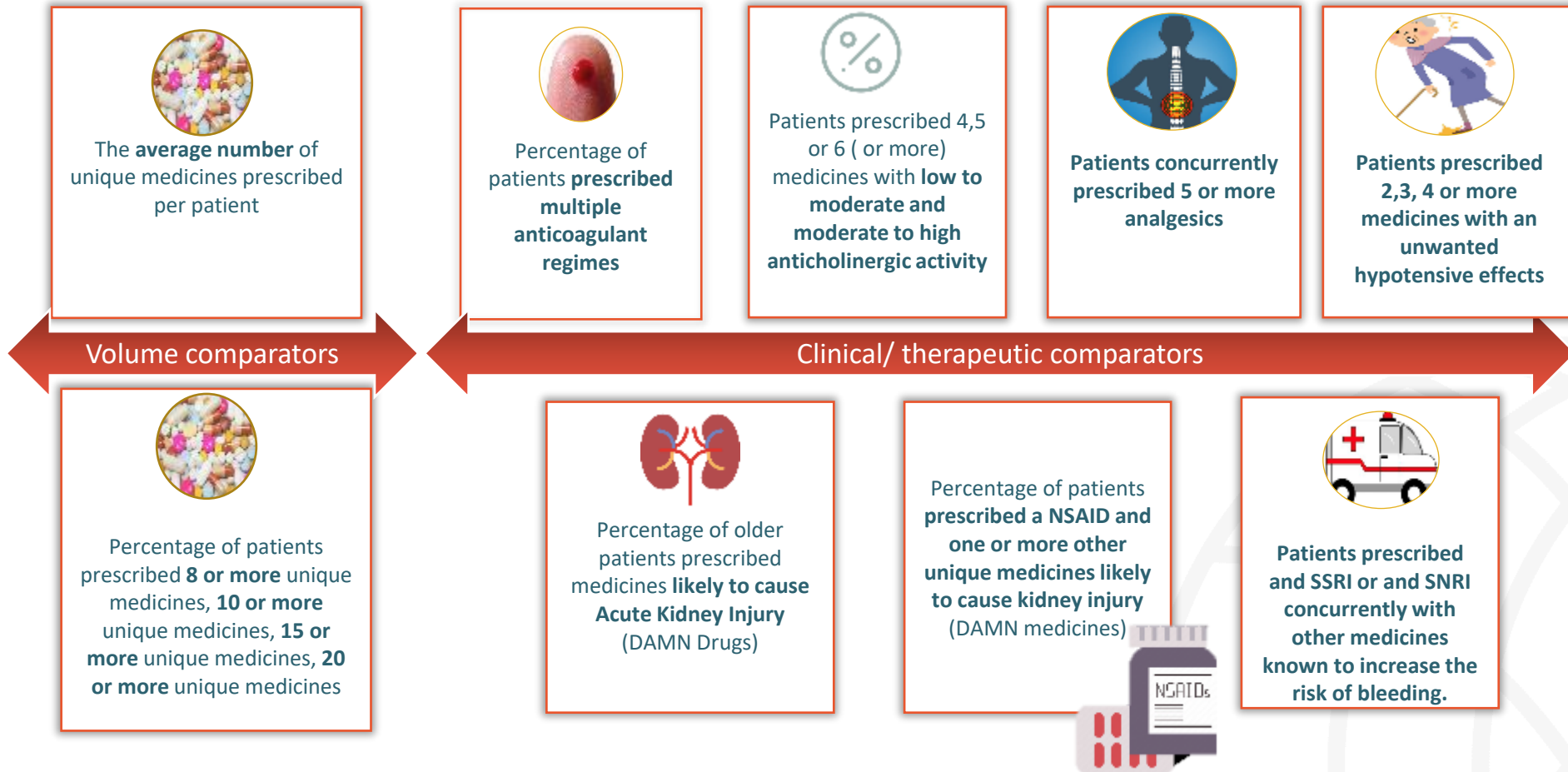
The tool **helps GP practices to quickly and reliably prioritise** the areas where practices have the most risk (because you can't review everyone)
Then, **without any additional technology or kit**, the GP practice can identify which of their patients most require a medication review.

3. Measure the impact of interventions

The data is updated every month so clinicians can quickly see the impact of their interventions.

The NHS BSA Polypharmacy prescribing comparators are available at **Practice, PCN and ICB level** in England

What do the comparators measure?



Classification: Official



Network Contract Directed Enhanced Service

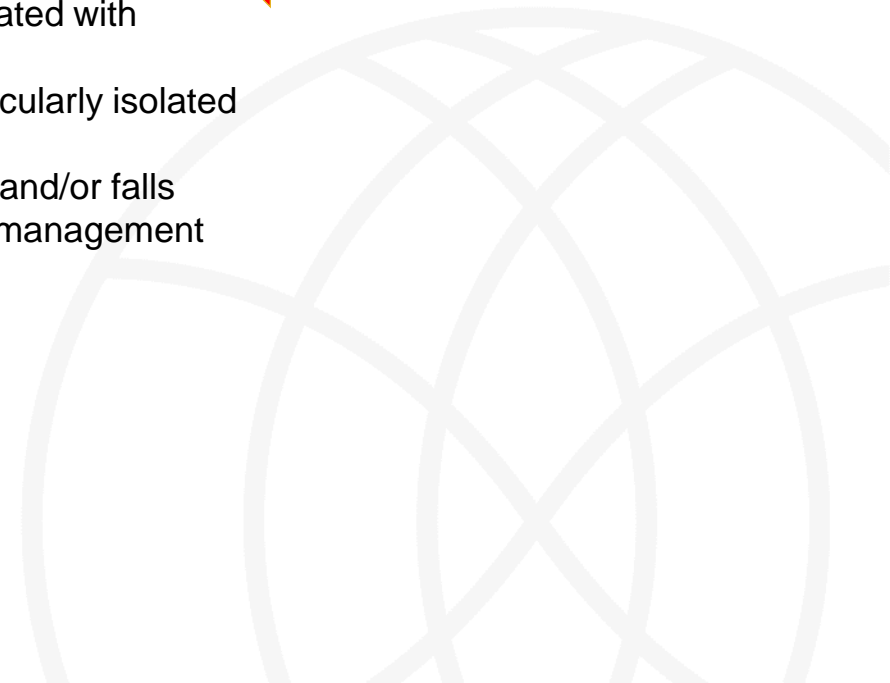
Structured medication reviews and
medicines optimisation: guidance

31 March 2021

Service requirement 1: Identification of patients

3.1 From 1 October 2020, each PCN must use appropriate tools to identify and prioritise patients who would benefit from a SMR, which must include those:

- 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, who are particularly isolated or housebound or who have
- had recent hospital admissions and/or falls
- using potentially addictive pain management medication.



Polypharmacy prescribing comparators in action:

See <https://youtu.be/iqKf1Lz0eq4> for “live” demonstration



Wessex
Academic Health
Science Network

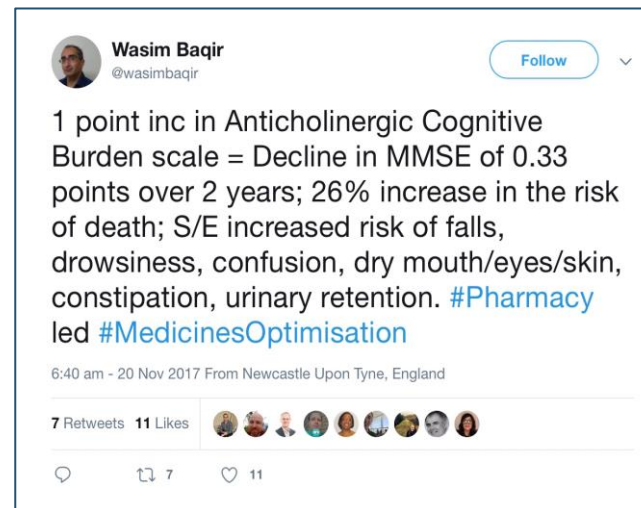


Business Services Authority

Polypharmacy Prescribing Comparators

On publication, it was very well received...

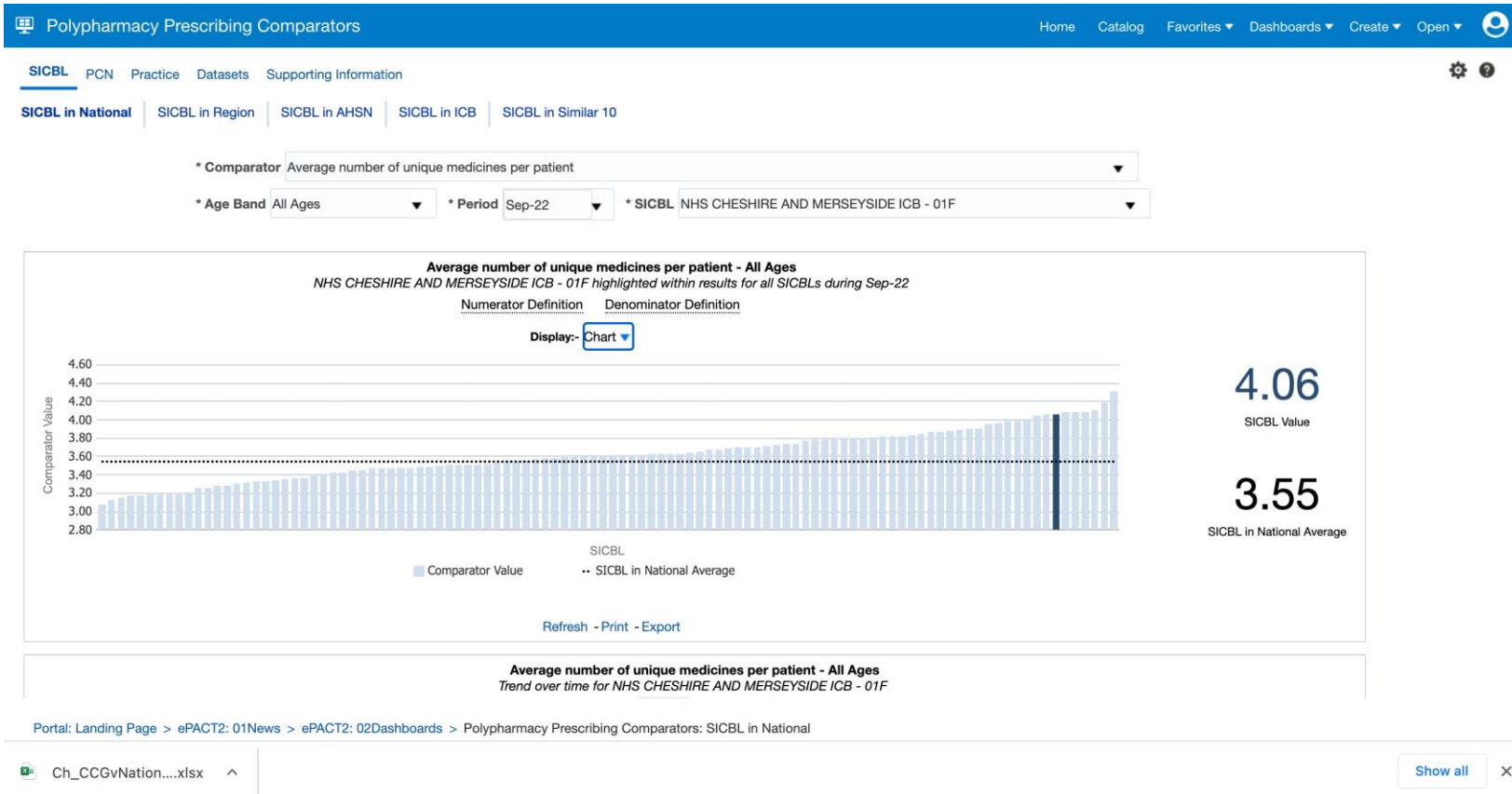
First published in Summer 2017
This work filled a very significant gap in the data resources in England. GPs and Pharmacists working in primary care had no idea if their prescribing was worse, better or more risky than others.



Limitations

- Historically, prescribing information was derived from the reimbursement processes for dispensed medicines. However, the BSA is now able to capture extra information that undoubtedly adds value to prescribing measures.
- The NHS number can now be linked to prescription items. In this way, we are able to demonstrate much better the quality of prescribing in key areas.
- The polypharmacy prescribing comparators were the first suite of measures to take advantage of this development.
- Between January and December 2020 an NHS Number was captured for 97.15% of sampled prescription forms. The accuracy rate for NHS Number was found to be 99.99%.
- Age was available for 94.88% of sampled forms with an accuracy rate of 99.95%.
- **ICBS are encouraged to drive up the uptake of EPS.**

Health Inequalities



Top 5

Cheshire and Merseyside 99A (Liverpool)
Lancashire and South Cumbria
Stafford and Stoke on Trent
Cheshire and Merseyside 01T (South
Sefton)
South Yorkshire

Lowest 5

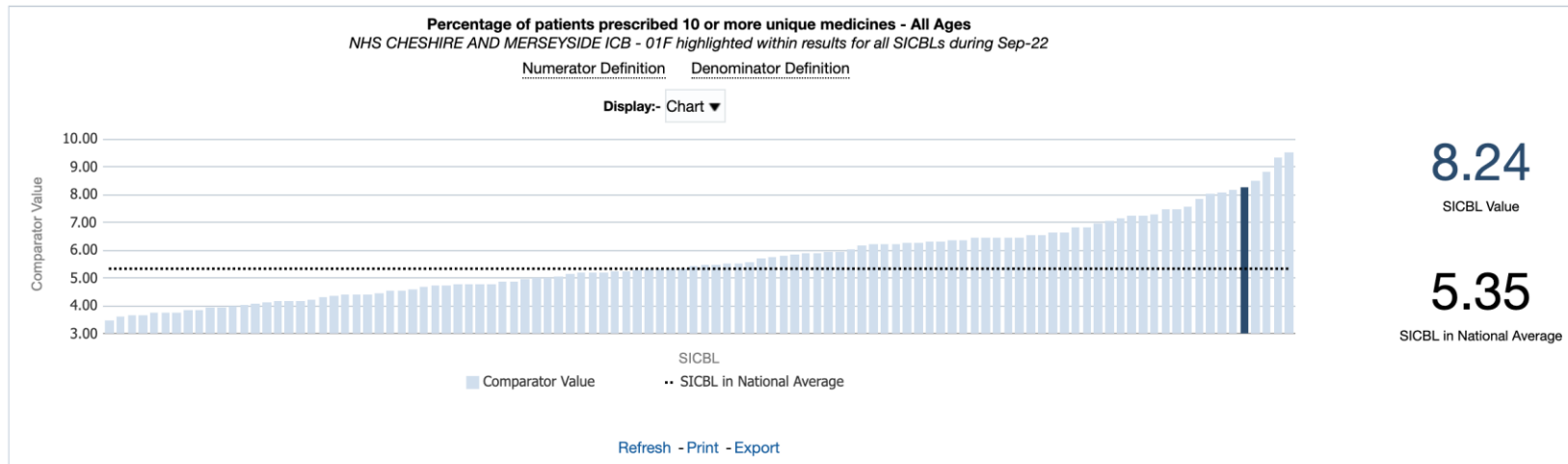
Bristol, North Somerset and South Glos
Frimley
NHS Sussex
Hertfordshire and West Essex
Surrey Heartlands

Health Inequalities

SICBL PCN Practice Datasets Supporting Information

SICBL in National | SICBL in Region | SICBL in AHSN | SICBL in ICB | SICBL in Similar 10

* Comparator
* Age Band * Period * SICBL



Top 5

- Cheshire and Merseyside 01J (Knowsley)
- Cheshire and Merseyside 99A (Liverpool)
- Greater Manchester 14L (Manchester CCG)
- Greater Manchester 01Y (Tameside and Glossop)
- Cheshire and Merseyside 01F (Halton)

Lowest 5

- Mid and South Essex
- BOB 10Q (Oxfordshire)
- BOB 15A (Berkshire West)
- BOB14Y (Buckinghamshire)
- Surrey Heartlands



* Comparator Percentage of patients prescribed 10 or more unique medicines

* Age Band Aged 75 and over

Period Sep-22

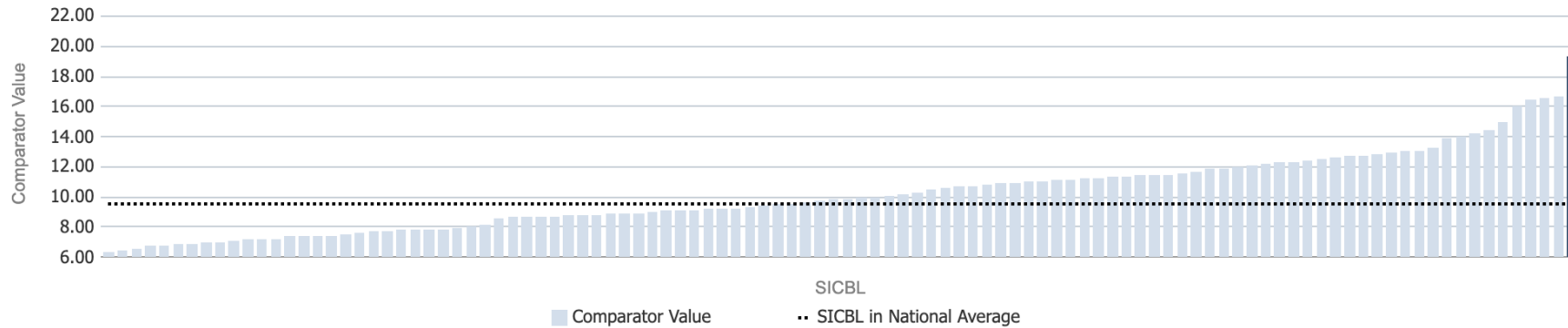
* SICBL NHS GREATER MANCHESTER ICB - 14L

Manchester CCG

Percentage of patients prescribed 10 or more unique medicines - Aged 75 and over
NHS GREATER MANCHESTER ICB - 14L highlighted within results for all SICBLs during Sep-22

Numerator Definition Denominator Definition

Display:- Chart



19.22

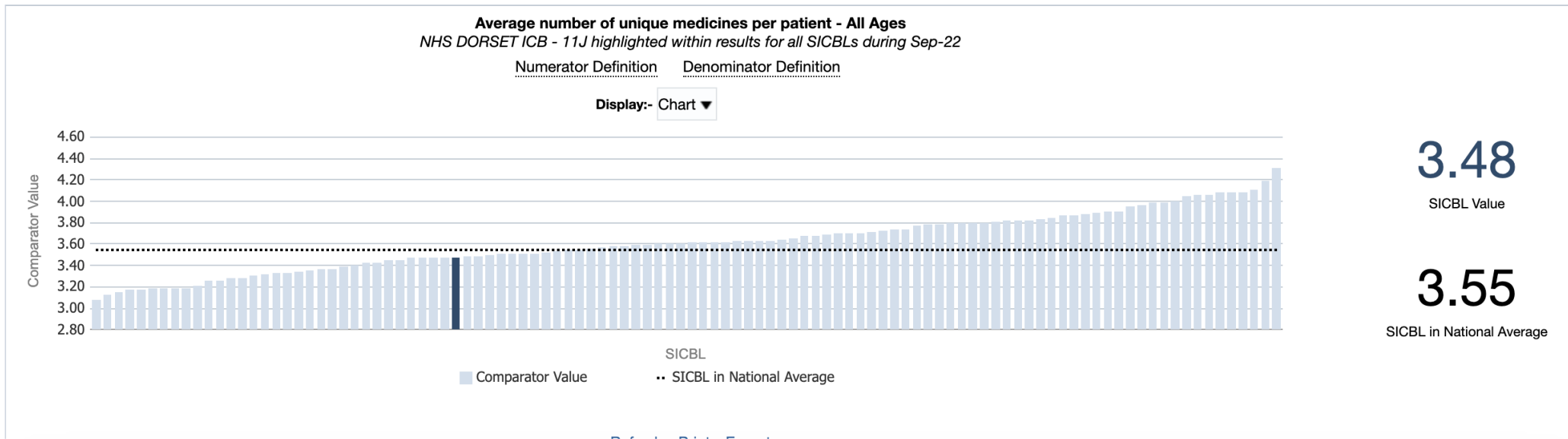
SICBL Value

9.51

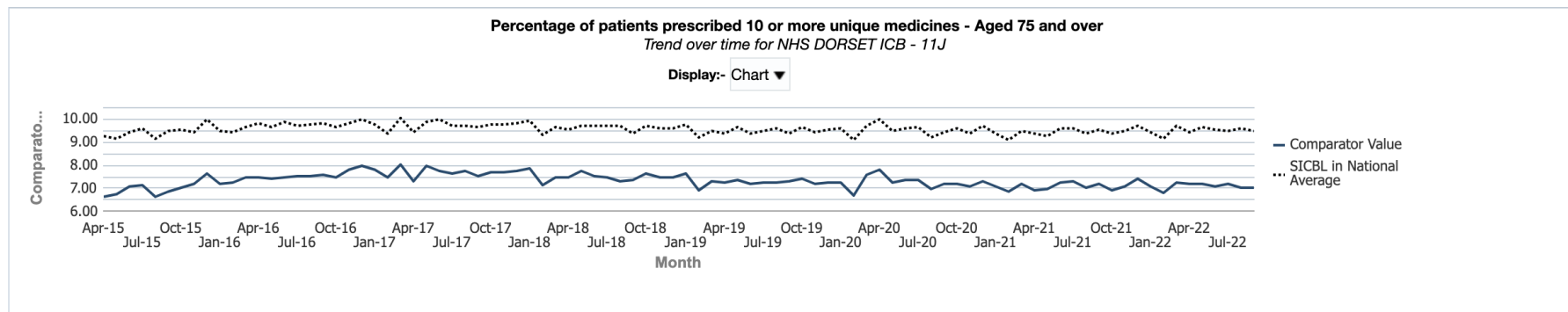
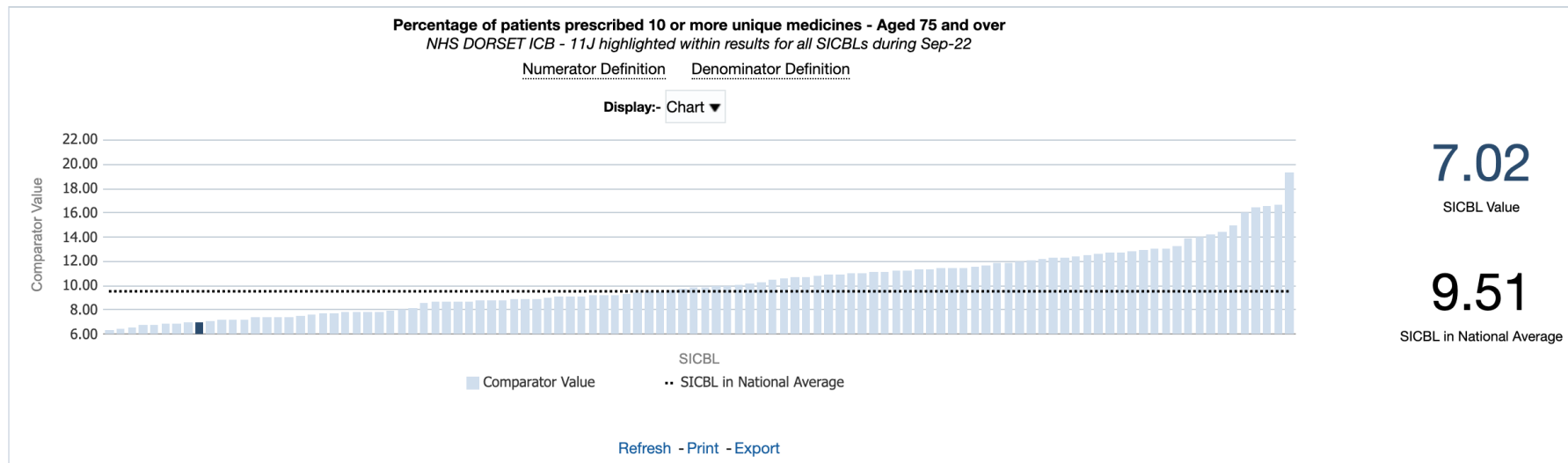
SICBL in National Average



* Comparator Average number of unique medicines per patient
* Age Band All Ages * Period Sep-22 * SICBL NHS DORSET ICB - 11J



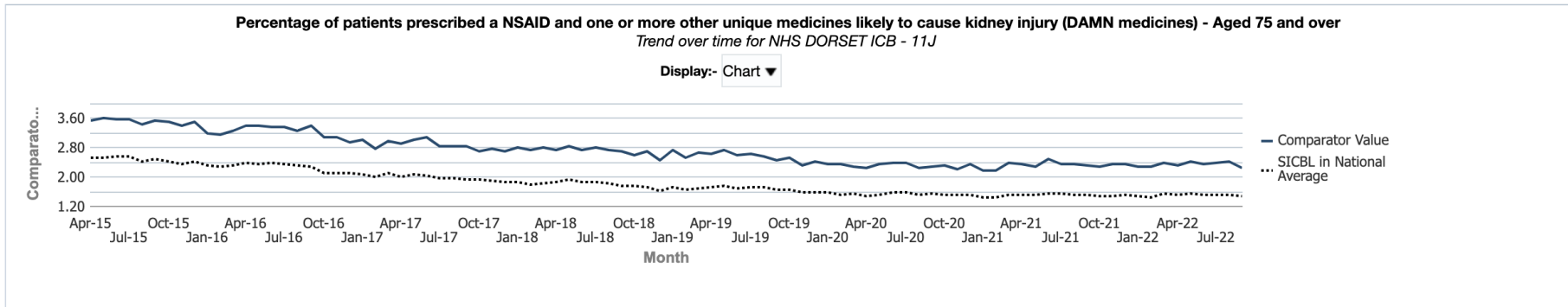
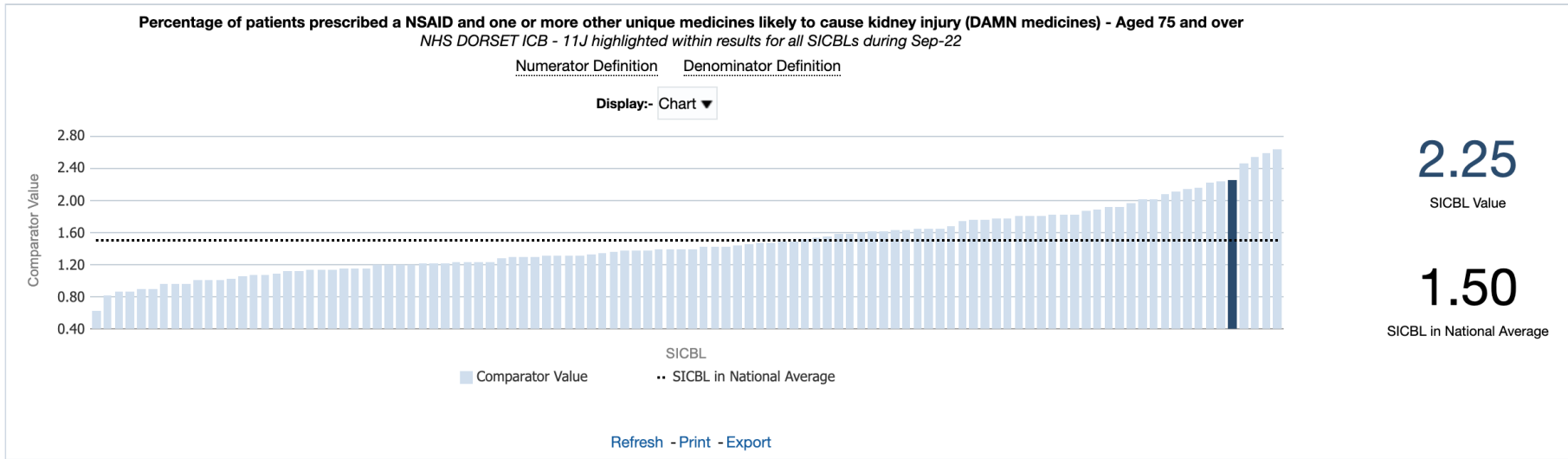
* Comparator ▼
 * Age Band ▼ * Period ▼ * SICBL ▼



SICBL PCN Practice Datasets Supporting Information

SICBL in National | SICBL in Region | SICBL in AHSN | SICBL in ICB | SICBL in Similar 10

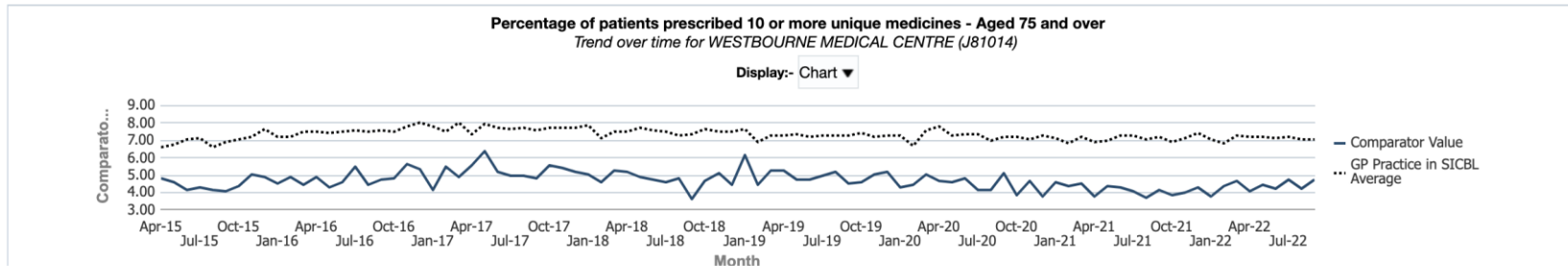
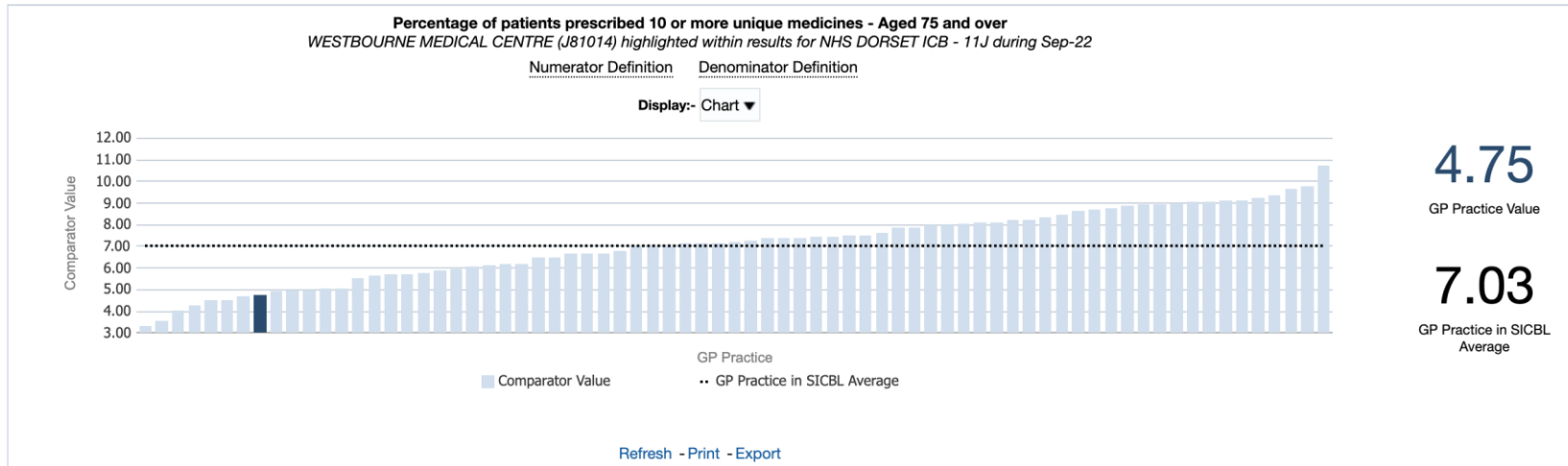
* Comparator
 * Age Band * Period * SICBL



* Comparator

* Age Band * Period * SICBL

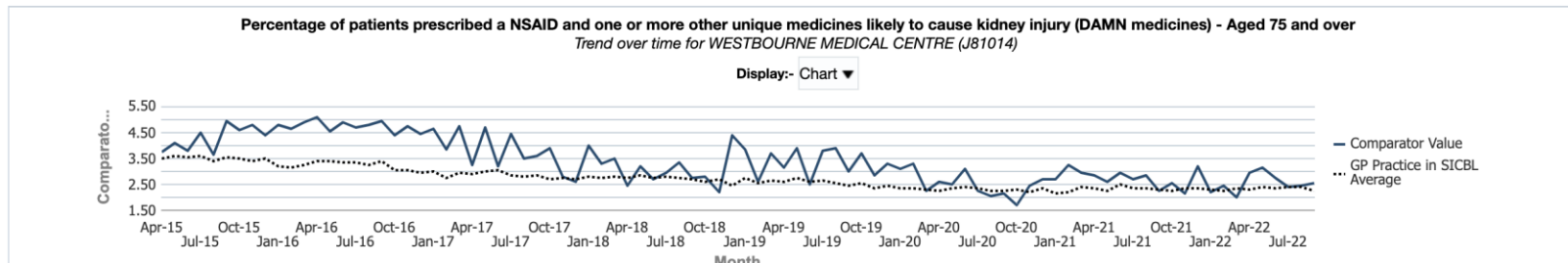
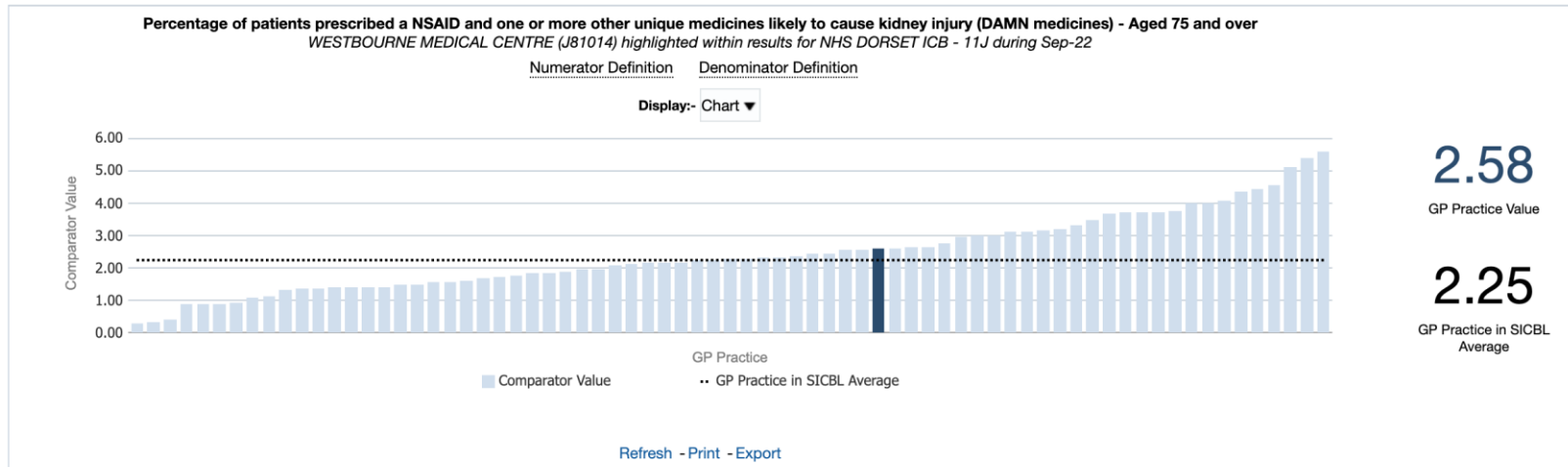
* Practice



* Comparator

* Age Band * Period * SICBL

* Practice

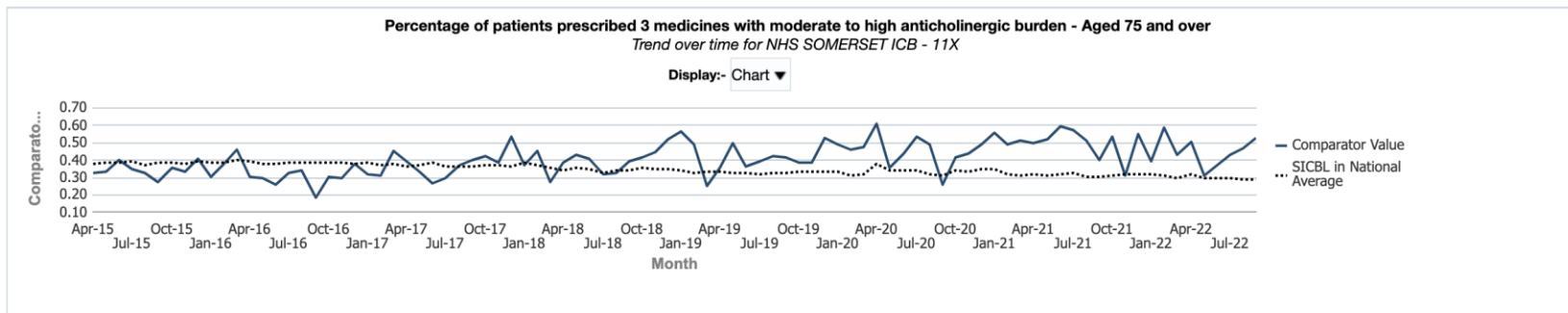
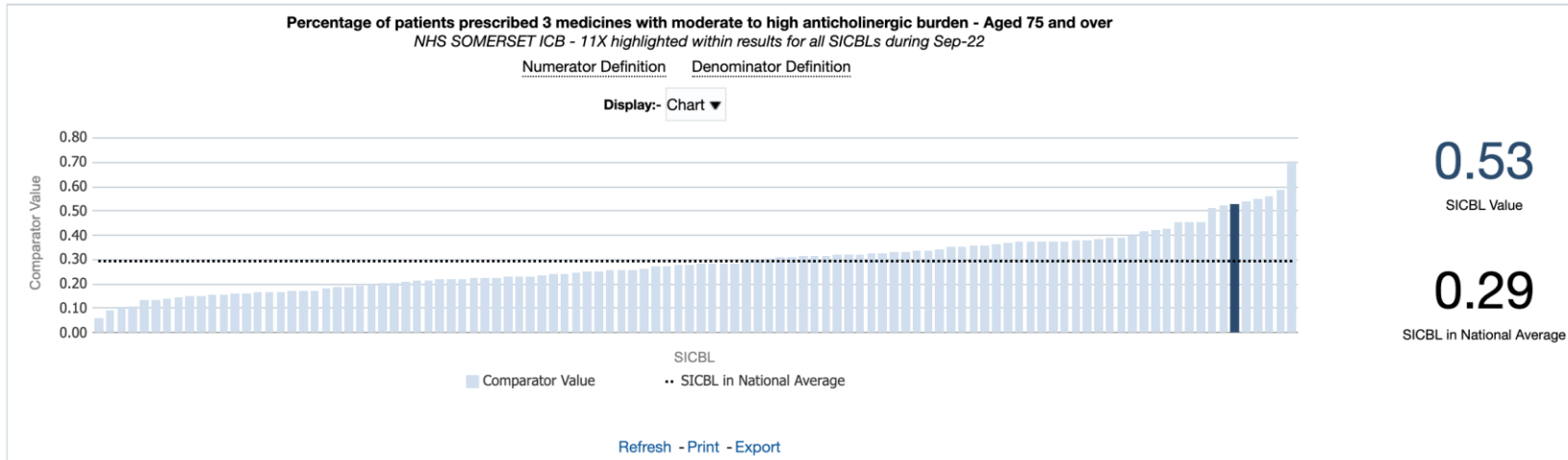


[SICBL](#) [PCN](#) [Practice](#) [Datasets](#) [Supporting Information](#)

[SICBL in National](#) | [SICBL in Region](#) | [SICBL in AHSN](#) | [SICBL in ICB](#) | [SICBL in Similar 10](#)

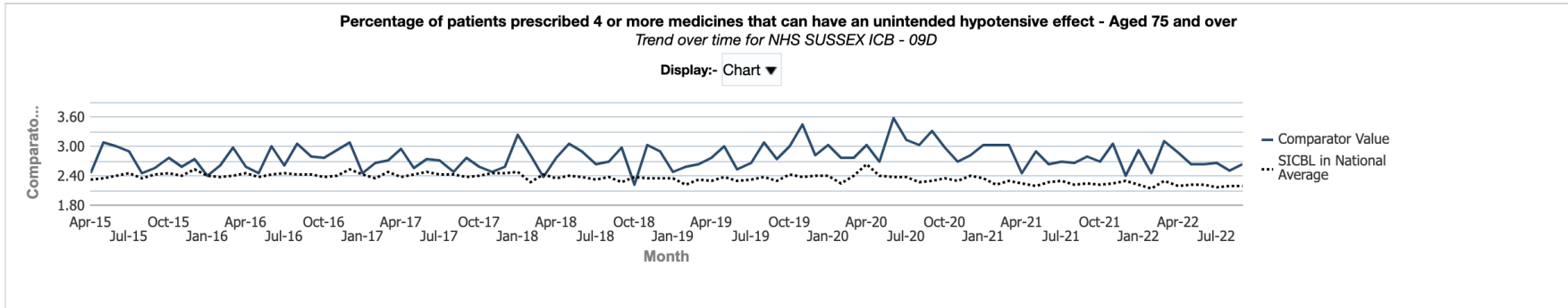
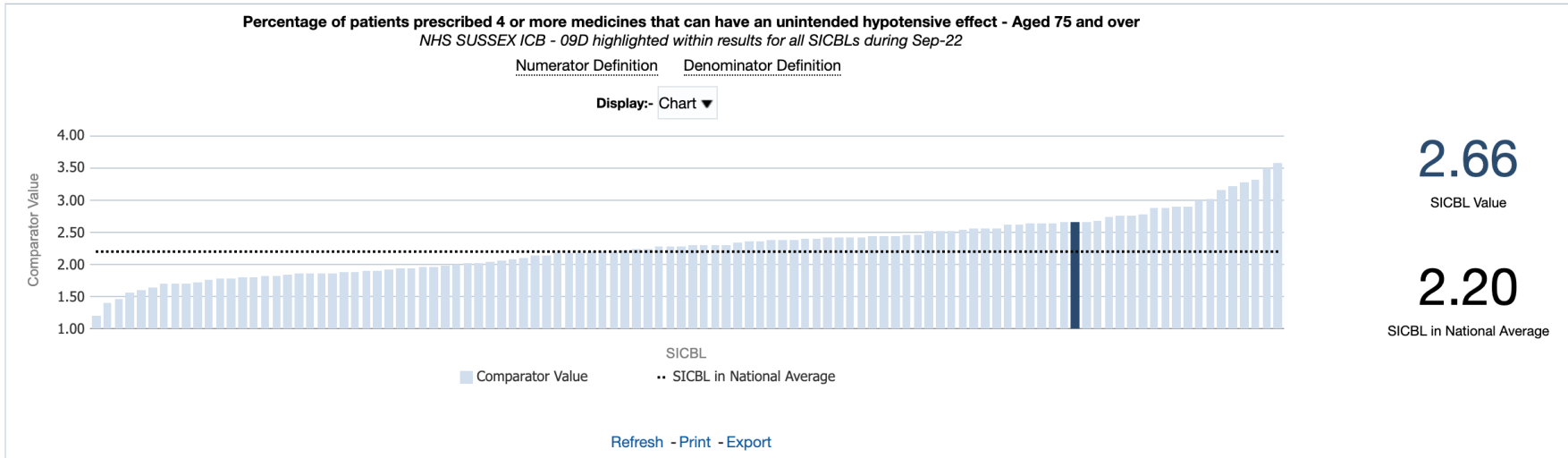
* Comparator

* Age Band * Period * SICBL



* Comparator Percentage of patients prescribed 4 or more medicines that can have an unintended hypotensive effect

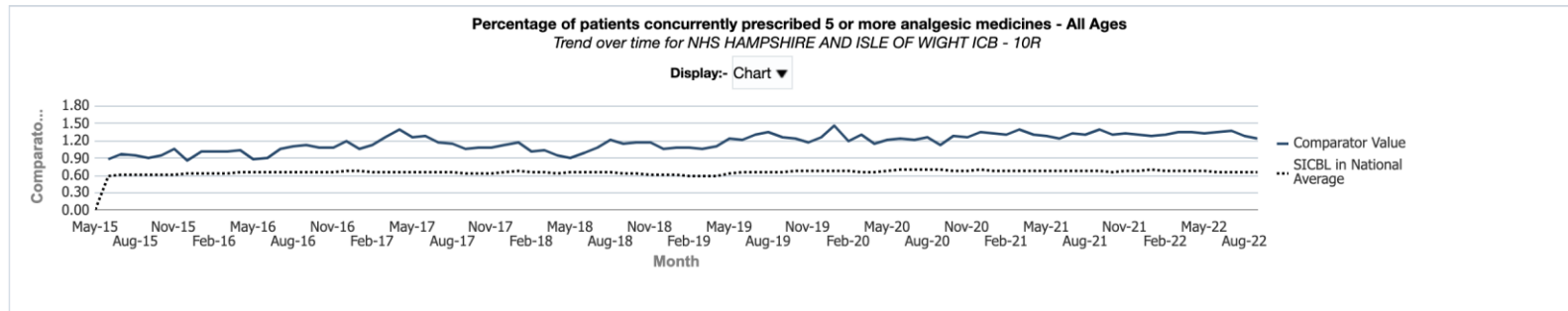
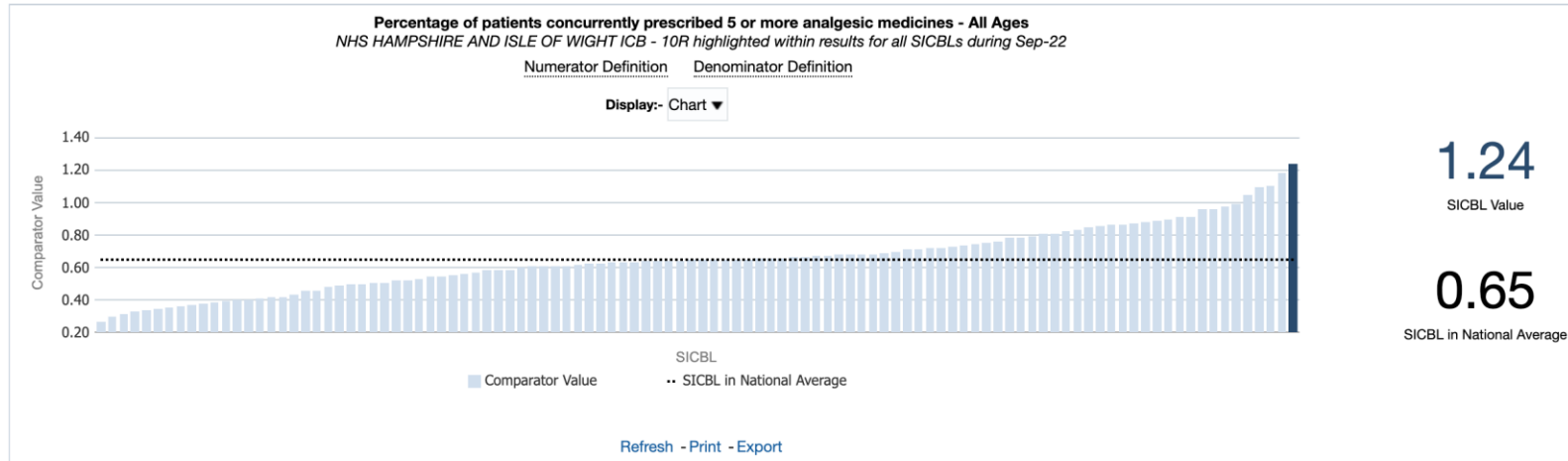
* Age Band Aged 75 and over * Period Sep-22 * SICBL NHS SUSSEX ICB - 09D



SICBL PCN Practice Datasets Supporting Information

SICBL in National | SICBL in Region | SICBL in AHSN | SICBL in ICB | SICBL in Similar 10

* Comparator Percentage of patients concurrently prescribed 5 or more analgesic medicines ▾
 * Age Band All Ages ▾ * Period Sep-22 ▾ * SICBL NHS HAMPSHIRE AND ISLE OF WIGHT ICB - 10R ▾



* PCN PORTSDOWN PCN

Percentage of patients concurrently prescribed 5 or more analgesic medicines - All Ages
 PORTSDOWN PCN highlighted within results for PORTSMOUTH CCG during Feb-22

[Numerator Definition](#) [Denominator Definition](#)

Data

1.72

PCN Value

1.25

PCN in Reporting CCG Average

0.66

PCN in National Average

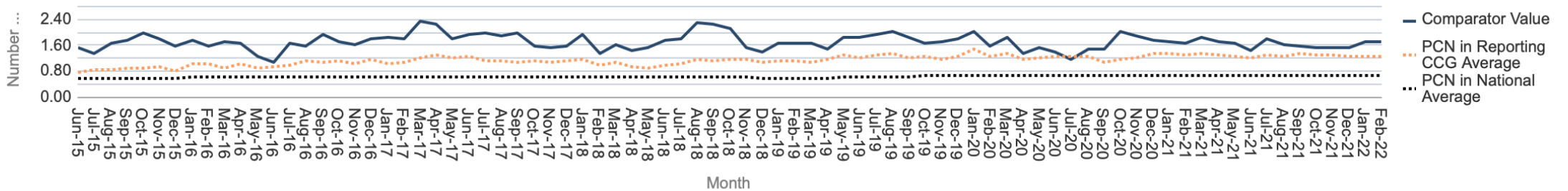
PCN	Numerator	Denominator	Comparator Value	PCN in Reporting CCG Average	PCN in National Average
PORTSDOWN PCN	40	2,321	1.72	1.25	0.66
PORTSMOUTH NORTH PCN	20	1,325	1.51	1.25	0.66
ISLAND CITY PCN	23	1,952	1.18	1.25	0.66
PORTSMOUTH SOUTH COAST PCN	11	1,165	0.94	1.25	0.66
BRUNEL PCN	10	1,116	0.90	1.25	0.66

[Refresh](#) - [Print](#) - [Export](#)

Percentage of patients concurrently prescribed 5 or more analgesic medicines - All Ages

Trend over time for PORTSDOWN PCN

Graph



[Refresh](#) - [Print](#) - [Export](#)

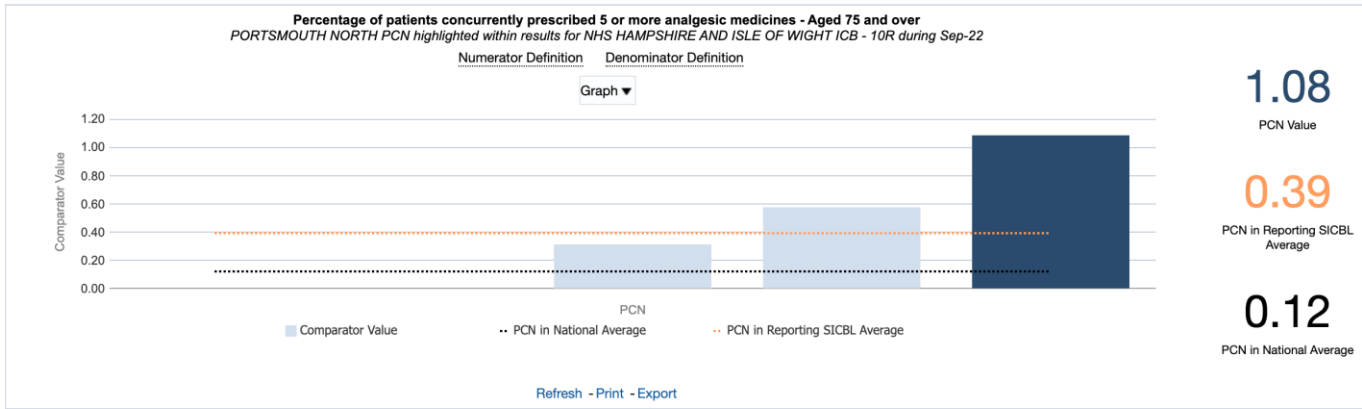
SICBL **PCN** Practice Datasets Supporting Information

PCN in Reporting SICBL Practice in PCN

* Comparator Percentage of patients concurrently prescribed 5 or more analgesic medicines

* Age Band Aged 75 and over * Period Sep-22 * Reporting SICBL NHS HAMPSHIRE AND ISLE OF WIGHT ICB - 10R

* PCN PORTSMOUTH NORTH PCN



Percentage of patients concurrently prescribed 5 or more analgesic medicines - Aged 75 and over
 PORTSMOUTH NORTH PCN highlighted within results for NHS HAMPSHIRE AND ISLE OF WIGHT ICB - 10R during Sep-22

Numerator Definition Denominator Definition

Data

PCN	Numerator	Denominator	Comparator Value	PCN in Reporting SICBL Average	PCN in National Average
PORTSMOUTH NORTH PCN	5	463	1.08	0.39	0.12
PORTSDOWN PCN	3	525	0.57	0.39	0.12
BRUNEL PCN	1	320	0.31	0.39	0.12
ISLAND CITY PCN	0	442	0.00	0.39	0.12
PORTSMOUTH SOUTH COAST PCN	0	421	0.00	0.39	0.12

1.08
PCN Value

0.39
PCN in Reporting SICBL Average

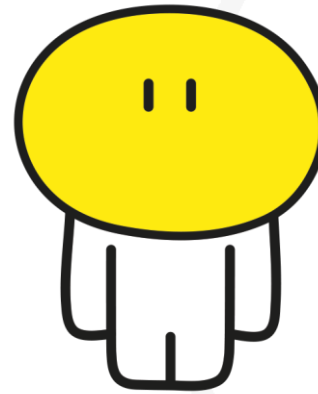
0.12
PCN in National Average

Refresh - Print - Export

Core patient messages.....

- ✓ Polypharmacy is not about reducing medicines costs – it is about making sure you are only on the medicines you need, to live well and avoid unnecessary or unplanned visits to hospital.
- ✓ As you get older, medicines may no longer be appropriate for you as your body changes. It may be time for a medication review.
- ✓ Taking too many medicines increases your risk of going into hospital.
- ✓ So – you should know your medicines. If not, speak to your Pharmacist or GP.
- ✓ Don't stop taking medicines without a review. Your local Community Pharmacist can review how you use your medicines and make recommendations to your GP. Ask them today.

Meet Mo: <https://vimeo.com/228944919>



Patient stories.....

← Tweet



David Baddiel ✓
@Baddiel

My dad has long been on various medications. I spoke to his GP a while back and asked whether they'd all be still working, as they all have side-effects, and he agreed to take him off one or two to see: and he's now much brighter. Maybe such reviews are often worthwhile.



By *Helen Santoro* 9th September 2021

From **Knowable Magazine**

Older adults often take several medications each day. But there's growing evidence that this could sometimes be a mistake.

W

hen my grandmother Carol Mitchell was diagnosed with Parkinson's disease in 2010 at the age of 72, she was prescribed a drug called carbidopa/levodopa. She swallowed the little oblong pill four times a day – at 7am, 11am, 3pm and 7pm.

In the years that followed, her doctors prescribed her a steroid cream for skin issues and drugs for depression, motion sickness, anxiety, acid reflux and early breast cancer. "I walked into her bedroom and there were vials everywhere," says Elizabeth Mitchell, Carol's daughter and my mother. "I was Googling each one to see what they were for."

For Carol, who is now 82, taking all her drugs precisely when she's meant to has been a tough goal. "I don't want to take medications like that. It's too much, I think," she says. "You can't leave the house because you've got all these medications to take."

Inevitably, she would find herself missing doses of her Parkinson's drug – and when she did, her symptoms of tremors, stiffness and difficulty with speaking and walking would

What about patients?

COMPARING DATA FROM BEFORE JULY 2017 (PUBLICATION DATE OF COMPARATORS) TO JUNE 2019:



9,400 fewer patients
prescribed 10 or more unique
medicines



25,900 fewer patients
prescribed a NSAID and one or
more other unique medicines
likely to cause kidney injury



58,300 fewer patients
prescribed two or more unique
medicines likely to cause kidney
injury (DAMN medicines)



4,800 fewer patients
with an anticholinergic burden
score of 6 or more



7,500 fewer patients
with an anticholinergic burden
score of 6 or more aged 65 and
over and



700 fewer patients prescribed
two or more anticoagulants and
antiplatelet medicines

A Case Study

- Using the data, the North East Hampshire and Farnham CCG Care Home Pharmacist has undertaken over 250 reviews and made over 800 interventions. As a result;
- The average number of medicines per patient has reduced from 9.4 to 7.6
- The average anticholinergic burden score has reduced from 1.39 to 1.00

WHO have cited evidence that pharmacist-led medication reviews reduce hospital admissions.

The NHS Long Term Plan relies on Pharmacists working in GP practices to carry out structured medication reviews - If they can't find and prioritise the patients to review then they may not make best use of precious time and risk missing patients who will be harmed.

Bringing it all together



ePACT2

Step 1: review your data and identify key areas for your PCN/ Practice



Step 2: Think about your skill mix and capacity. Think about how many sessions you have for Multimorbidity structured medication reviews.

Step 3: Request the NHS numbers of the patients that the NHS BSA data shows make up the comparator you have decided to focus on. (could be volume, could be therapeutic) nhsbsa.informationssystem@nhs.net



Step 4: Triage the list, some patients may have been seen already, prioritise e.g older, not been seen recently, in a care home, overdue blood test.

Step 5: Carry out shared decision making structured medication reviews.

Step 6: Review the polypharmacy data. What has been your impact? What did you learn?



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