Specialist Pharmacy Service

Older People Pharmacy Network Annual meeting

NHS

South East London Integrated Care System

Reducing Overprescribing in people living with frailty, multimorbidity and polypharmacy

Online Learning Event

Wednesday 23rd November 2022: 1pm – 4.30pm

#OPnet2022
#TacklingOverprescribing is 'Everybody's business'
@SPS_NHS
@LellyOboh

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NHS South East London

Overview of the National Overprescribing Review (NOR) Report Sept 2021

*'Opportunity for the NHS to **RESET** prescribing in a new, patient centred way*

NHS Specialist Pharmacy Services Older People Network Annual event

Lelly Oboh

Overprescribing Lead Pharmacist,

South East London ICS

23/11/2022

National Overprescribing Review (NOR) Report Sept 2021

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Content

- Background
- Scale of polypharmacy
- Health inequalities and unwarranted variation
- Causes and drivers of overprescribing
- Our response
- The approach
- Recommendations and implementation
- Local actions and discussion

https://www.gov.uk/government/publications/national-overprescribing-review-report

Overprescribing: Basics

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Definition: The use of a medicine where there is a better non-medicine alternative OR the use is inappropriate for that patients' circumstances and wishes

- A **COMPLEX** problem
- Lack of understanding of causes at **INDIVIDUAL** and **SYSTEM** levels
- Challenging to know which aspects or outcomes to focus on ….**more research!**
- Opportunities for pharmacy teams to drive medicines optimisation
- Focus on high prevalence and vulnerability e.g. older people, multi-morbidities
- Ambition is 10% reduction in items per annum

Overprescribing - Findings

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Consequences

- Problematic polypharmacy, poor patient outcomes and harm
- Widening health inequalities
- Medicines wastage, financial inefficiencies and environmental impact

Tackle by strengthening weaknesses in the system and changing culture that creates overprescribing

- System wide response
- Support for clinicians and patients
- National Clinical Director (NCD) to lead implementation program

Integrated and collaborative working in ICS can deliver system wide solutions to tackle overprescribing

Overprescribing

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Causes and drivers are multifactorial and complex : involve systems, cultures and individuals (patients and clinicians)

Systemic

- Single-condition clinical guidelines
- Lack of non-drug alternatives
- Need on-going review and deprescribing built into prescribing process incl. repeats
- Inability to access comprehensive patient records
- Lack of digital interoperability
- Pressure of time

Cultural

- A healthcare culture
  - that favours medicines over alternatives
  - in which some patients struggle to be heard
- Inadequate shared decision making
- Pharma conflict of interest

Scale of polypharmacy in primary care in England (Oct-Dec 2019)

Spread of medications by number and rate per population

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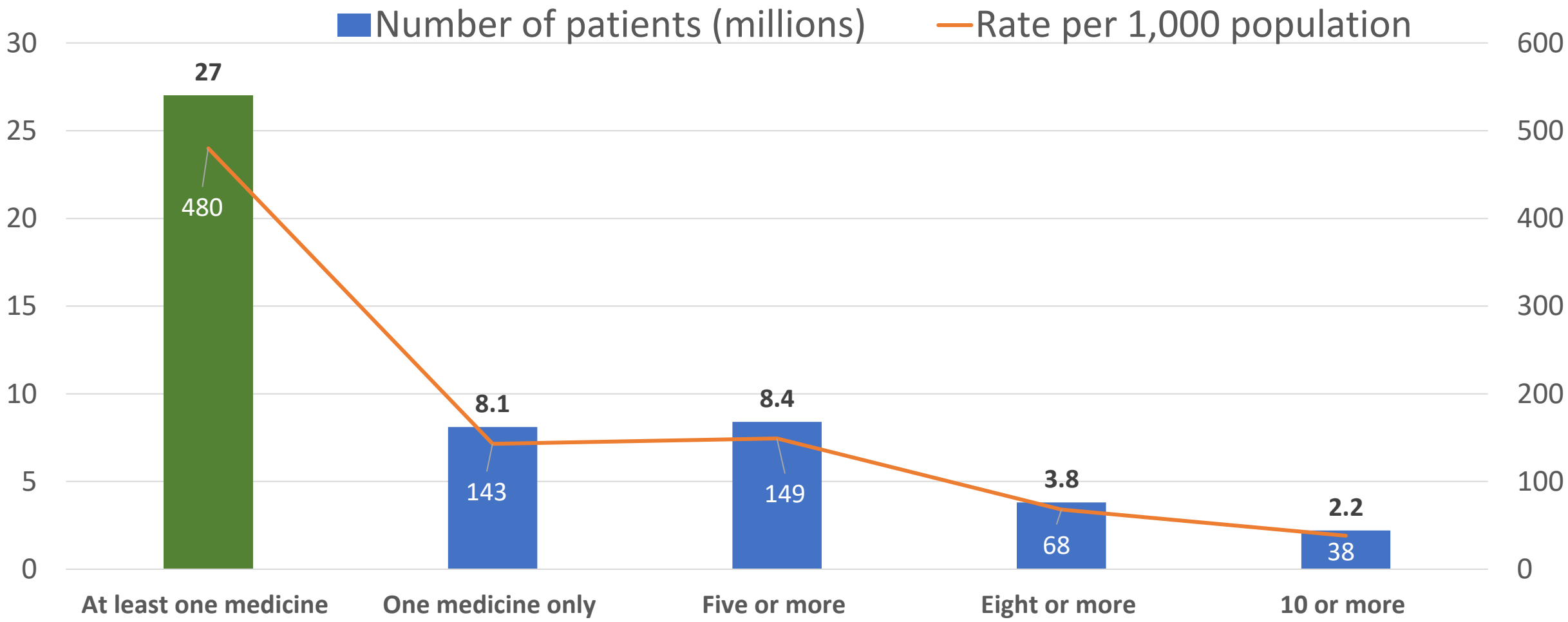


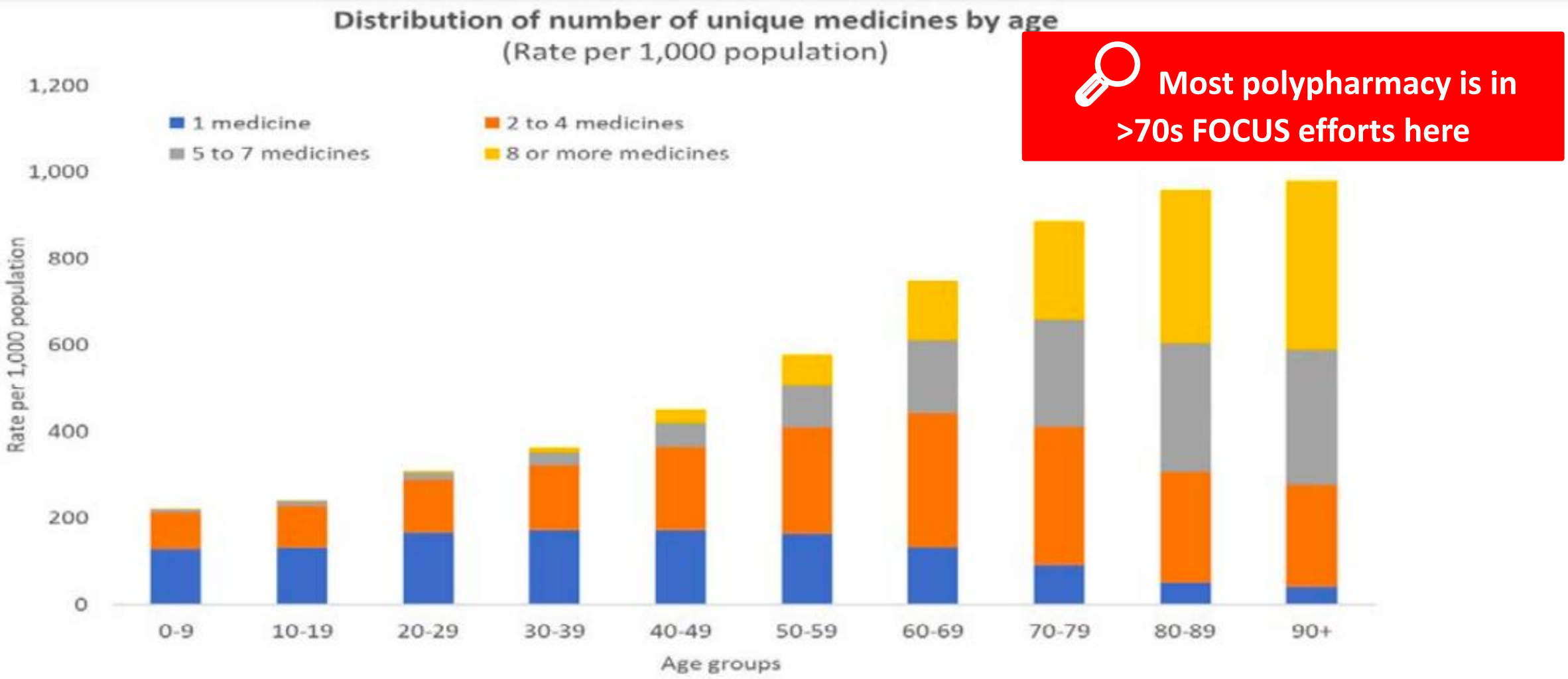
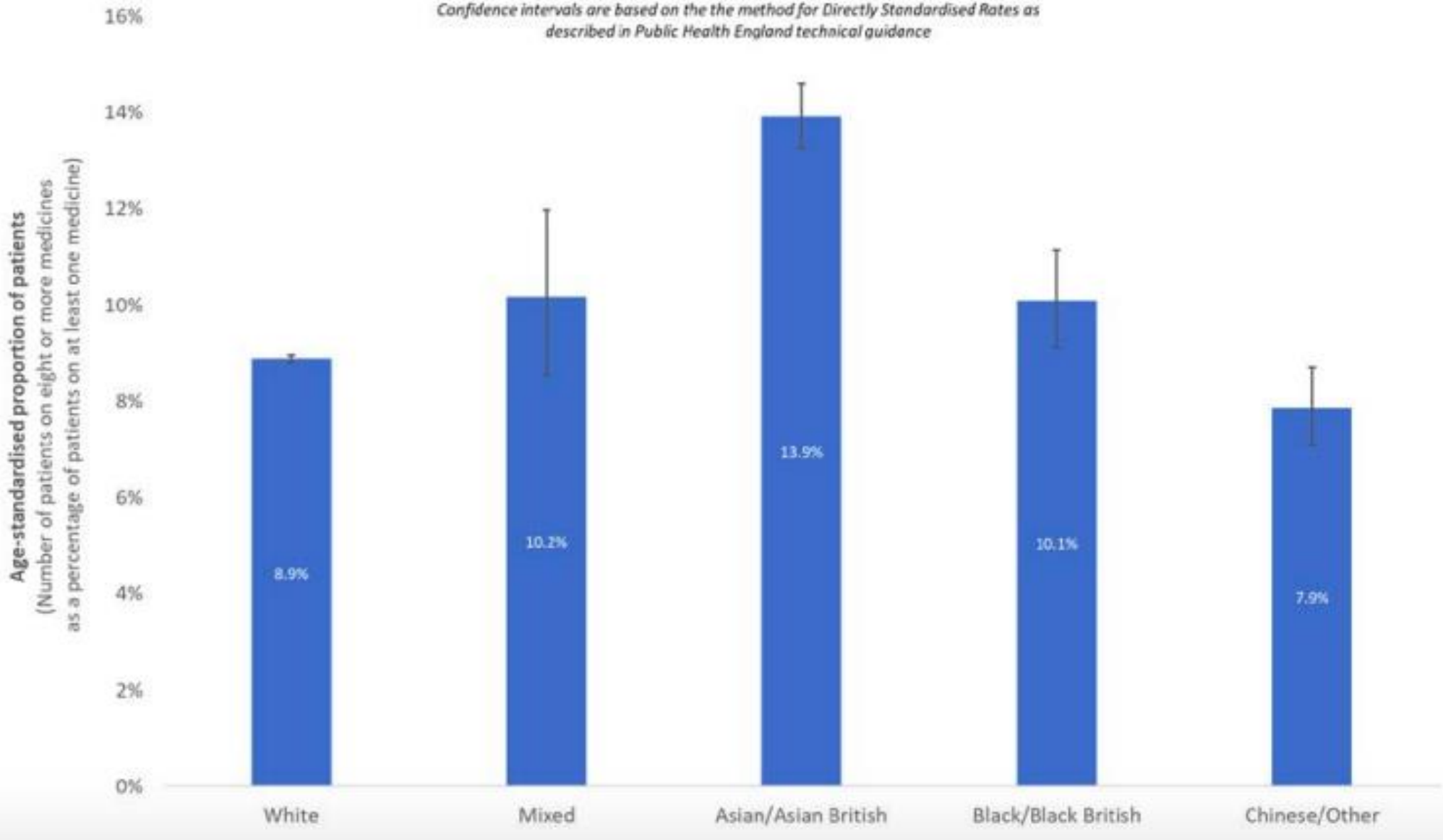


Figure 2: Distribution of number of unique medicines by age (rate per 1,000 population)

Age-standardised proportion of patients on eight or more medicines, by ethnicity

(Source: Clinical Practice Research Database (CPRD). Sample size = 1.1m)

Confidence intervals are based on the the method for Directly Standardised Rates as described in Public Health England technical guidance



Most deprived 2.8 x higher vs least deprived

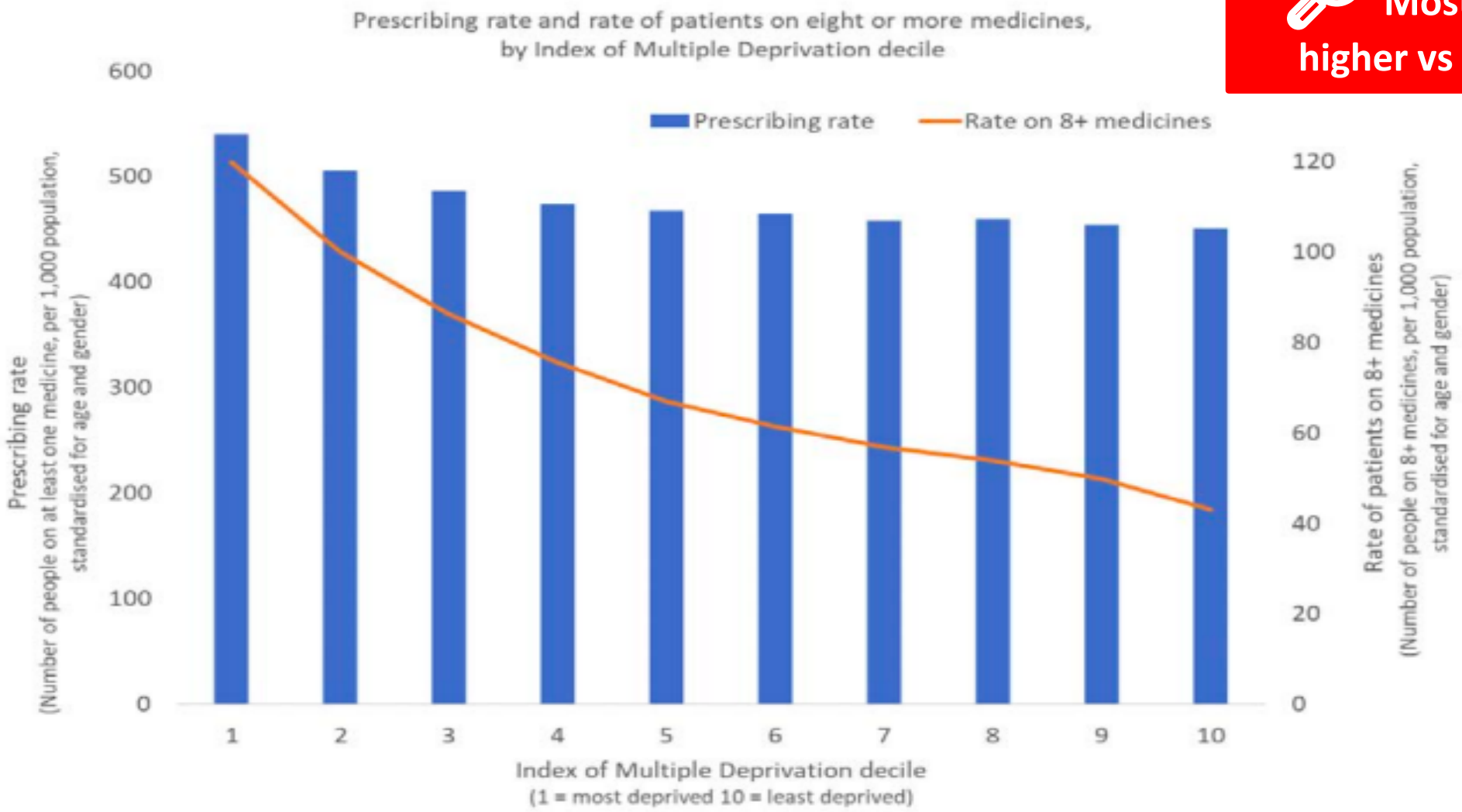


Figure 3: Prescribing rate and rate of patients on eight or more medicines by IMD decile, standardised by age and gender.

20 NOR Recommendations

Aim is to **achieve long term sustainable reductions to overprescribing** through delivery of systemic and cultural improvements across the NHS

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Systems	Culture	Implementation
R1. Sharing records and discharge letters standards	R9. Awareness and behavioural change on prescribing (clinicians/public)	R13. Leadership -Implementation programmes, National Clinical Dir, ICS Senior Pharmacy Lead
R2. Clinical indications- Revise prescribing competency framework	R10. Patient engagement and cultural competence	R14. Strengthen evidence base on impact/priorities of overprescribing
R3. Include discontinuing medicines in treatment guidelines	R11. Digital decision support tools	R15. Health Inequalities: links to overprescribing & impact on pop.
R4. Clinical evidence to support deprescribing	R12. Industry transparency	R16 & R17 & R18. Workforce (standards), Training & Education
R5. Alternatives to medicines- referral templates		R19 Data analytics
R6. Medicines rec. at care transitions (expand)		R20. Sustainability: Waste
R7. National toolkit for repeat prescribing	*Driven at National level*	
R8. Expand use of SMRs in Primary Care: high risk patients with support from trained Social prescribers	*Driven at National level, implemented at ICS and Place* *Driven at ICS, implemented at Place* *Driven and implemented at place*	

Implementation at ICS

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Leadership: Overprescribing group and Overprescribing lead pharmacist drive work with stakeholders across SEL ICS

- Translate recommendations to local actions
- Innovate on small scale initiatives that have a high impact /enable others
- Integrate national-level programs and local priorities
- Set direction, engage, ignite passion and pace, lead delivery, ‘do once and share’, keep momentum, monitor progress & build capacity
- Lead training & education for workforce and patients
- Leverage relationships with SEL and external networks to accelerate changes

SEL ICS leadership and implementation

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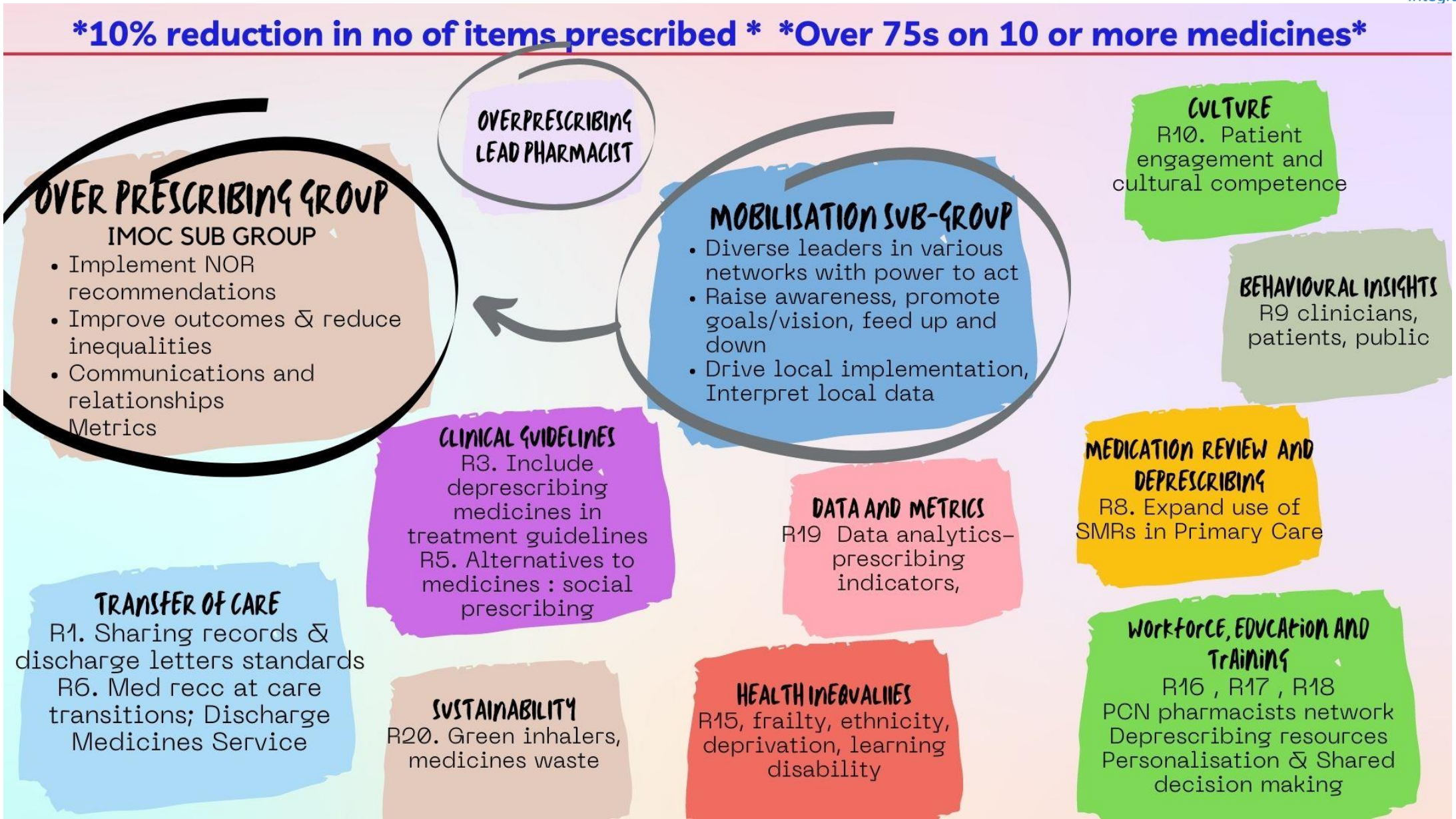

Pharmacy teams #Together are integral to drive implementation at Place

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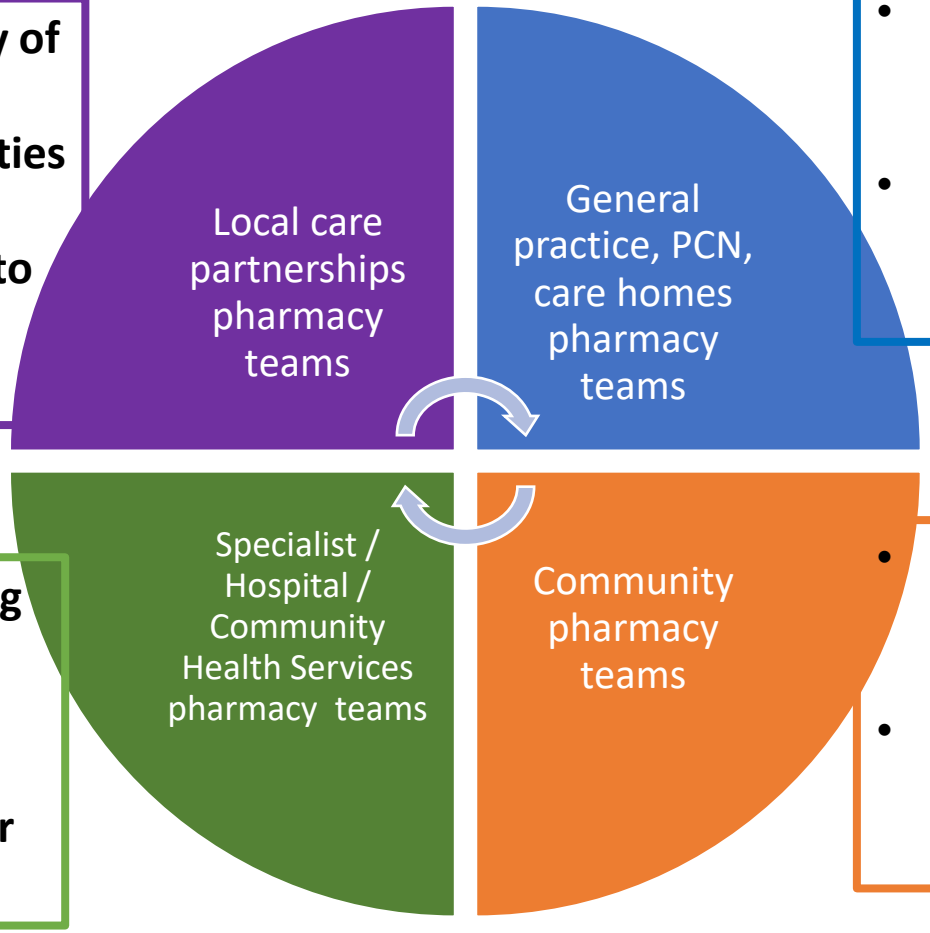
- Co-ordinate planning & delivery of action plans & pathways within localities & alongside communities
- Collate population health data to identify gaps and monitor progress



- Prioritise patient facing medicines optimization
- Deliver SMRs to reduce overprescribing

- Specialists advise and support e.g MH, frailty, LD, LTC
- Support primary care to make decisions about deprescribing for complex patients

- Med rec and review at transfer of care - DMS, NMS
- Reducing waste

PCN leads/Community pharmacy PCN leads

Where to start: National Implementation programs

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NHS England

Stopping Over-Medication of People with a Learning Disability, Autism or Both

(STOMP)

Classification: Official

Publication approval reference: B1357

NHS

Network Contract Directed Enhanced Service

Personalised Care: Social prescribing; shared decision making; digitising personalised care and support planning

Version 1.0, 31 March 2022

Classification: Official

NHS

Network Contract Directed Enhanced Service

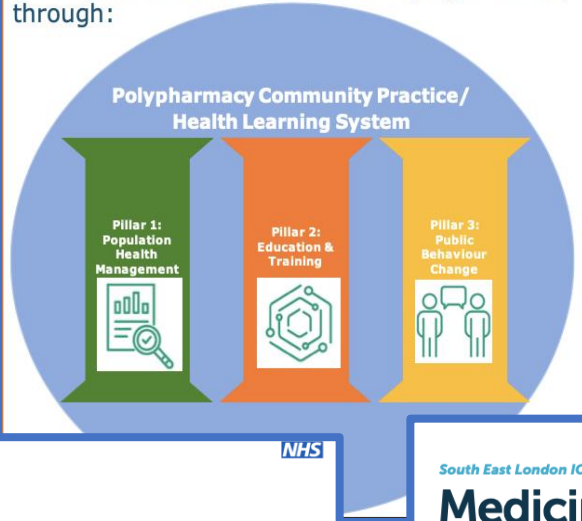
Structured medication reviews and medicines optimisation: guidance

31 March 2021

The AHSN Polypharmacy Programme: Getting the Balance Right

Polypharmacy: 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. [illegible]nes, Are Your Medicines

NHS

The Framework for Enhanced Health in Care Homes

Version 2

March 2020

NHS England and NHS Improvement

South East London ICS

Medicines

Medicines account for the largest carbon emission 'hotspot' in primary care; however, it is important to bear in mind that medicines are beneficial in the care of patients. High-quality, person-centred clinical care using medication that supports patients to thrive within their communities has a lower clinical and non-clinical carbon footprint.

The Ridge report states that 'there are times when people are given the medicines they don't need or want, where harms of medicines outweigh the benefits, or where a better alternative could be given'. Although medicines use has always needed an assessment of patient outcome, there is increasing acknowledgement of the risks of medicines.

It is estimated that 30-50% of medications prescribed for long-term conditions (LTCs) are not taken as intended; in airways diseases, e.g., asthma or chronic obstructive pulmonary disease (COPD), non-adherence rates are even higher. Overprescribing can have a considerable impact on healthcare expenditure, patient wellbeing, and the carbon footprint of healthcare.

Lower carbon alternatives

Prevention of illness is the best way to reduce carbon emissions from medicines. Low-carbon models of care will require cross-organisational approaches that involve different professional groups including digital teams in the NHS, social prescribing link workers, and VCSE communities.

Non-pharmacological alternatives to medicines include nature-based prescribing, social prescribing, active travel to healthcare settings, smoking cessation, availability of physiotherapy, and psychological therapies. These domains are addressed in the models of care section of the plan.

Where to start at Place?

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Analysis Paralysis

over-analyzing (or over-thinking) a situation so that a decision or action is never taken.

- Health inequalities and population health management –data analytics
- Personalisation in SMRs incl. SDM, establish social prescribing links
- Complex patients and MDT pathway, and support for primary care staff clinical decision making
- Education, training and pharmacy peer support networks
- Transfer of care- discharge letters and medicines reconciliation
- Vulnerable groups -Care homes, MH, LD, Frailty, Housebound
- Safety – Opiates, Multi-compliance aids
- Sustainability and waste

Data: NHSBSA Polypharmacy indicators

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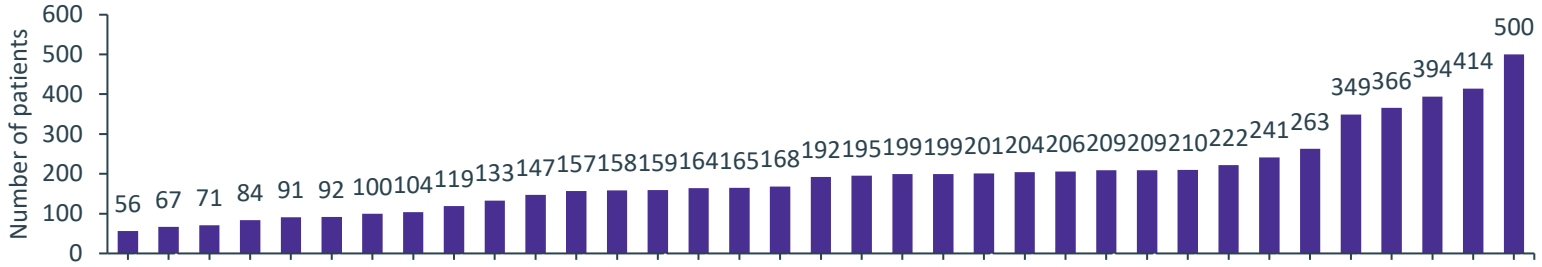
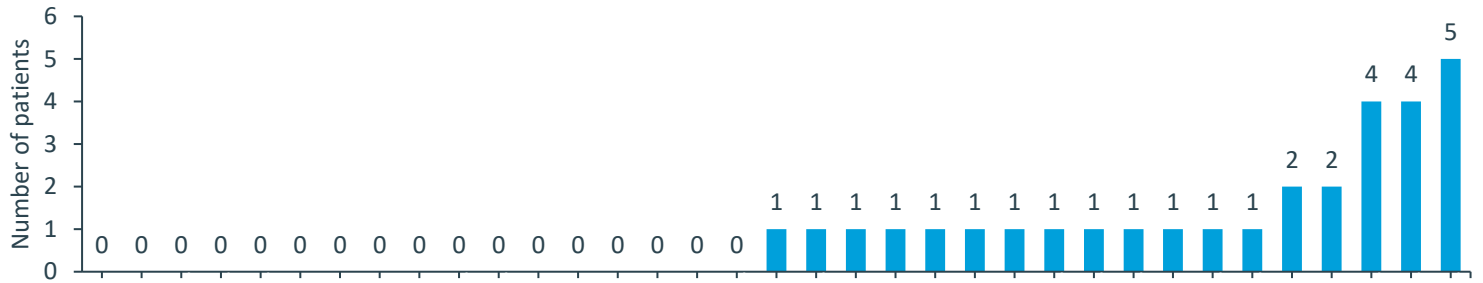
*** Patients aged 75+ prescribed 10 or more unique medicines**



Patients with an anticholinergic burden score of 12 or more



Identifying inequalities in overprescribing : Age and Gender

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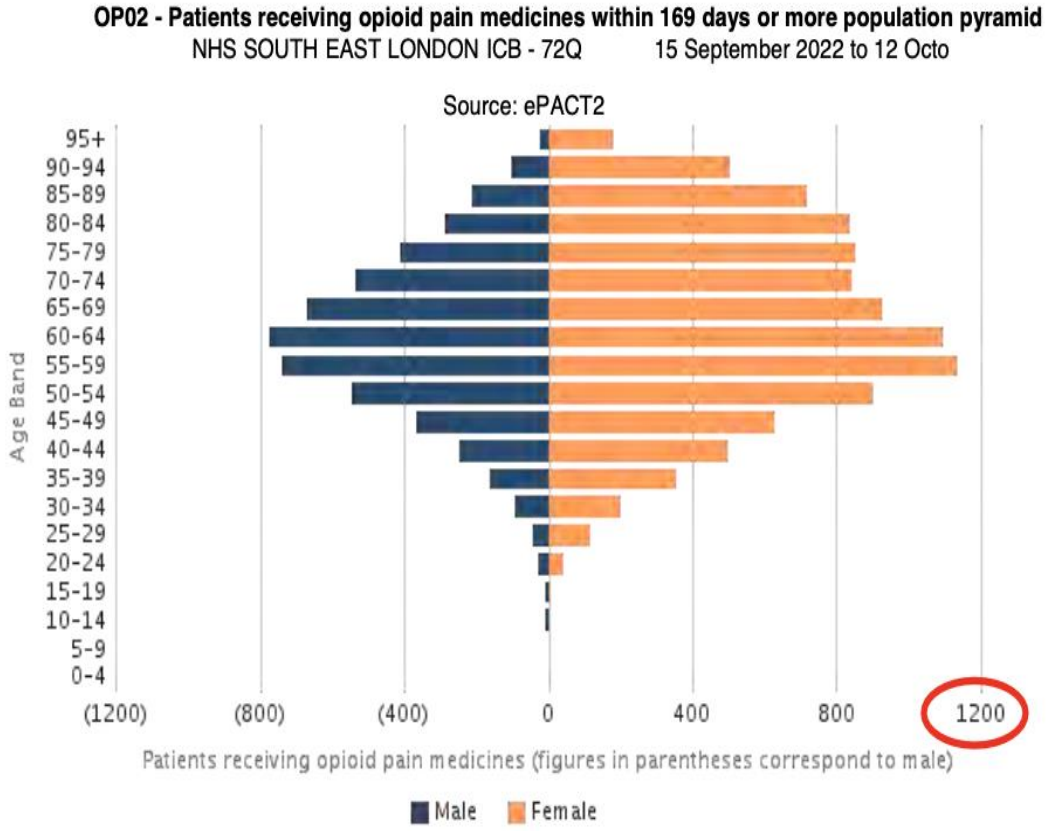

Key points

- Duration 169> 1-84> 85-168 days
- Females> Males
- Older age>younger volume
- Older age>younger longer duration
- 1-84 days- less variation
- 55-89 years key group

- How do we target those at higher risks across ICB and place?

Summary

- Overprescribing is caused by **multiple interdependent** systems and cultural factors
- Tackling overprescribing is **‘everybody’s business’** and needs to happen at individual, place, ICS, national and international levels

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Thank you for listening
Questions