Polypharmacy Action Learning Set: Day 1 Links and Chat

Deprescribing in Frailty: Guidelines

https://www.gloshospitals.nhs.uk/gps/treatment-guidelines/deprescribing-frailty/

Patient Awareness Information Opiates and Zopiclone

https://www.pathfields.co.uk/opiate-acute/

https://www.pathfields.co.uk/opiate-awareness/

https://www.pathfields.co.uk/zopiclone-aware-yp/

https://www.pathfields.co.uk/zopiclone-aware-op/

NICE Guidance 5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes

https://www.nice.org.uk/guidance/ng5/resources/endorsed-resource-benzodiazepine-zdrug-bzra-deprescribing-algorithm-6716834893

NICE eLearning tool Shared Decision Making
https://www.nice.org.uk/guidance/ng197/resources/shared-decision-making-learning-package-9142488109

NICE BENZO endorsement of Canadian evidence

https://www.nice.org.uk/guidance/ng5/resources/endorsed-resource-benzodiazepine-zdrug-bzra-deprescribing-algorithm-6716834893

Health Foundation Multidisciplinary review of medication in nursing homes: a clinico-ethical framework

https://www.health.org.uk/improvement-projects/multidisciplinary-review-of-medication-in-nursing-homes-a-clinico-ethical

Information mastery

https://medicine.tufts.edu/about/academic-departments/clinical-departments/family-medicine/center-information-mastery

https://www.spreaker.com/user/13841341/episode-9-aural-apothocary-season-2

Aural Apothecary Podcast

https://linktr.ee/auralapothecary

Lots of episodes re polypharmacy, Clare, Lawrence and Jonathan have all been on as guests.

Pirmohamed Paper

https://bjgp.org/content/early/2023/01/23/BJGP.2022.0181

Specialist network to increase confidence with Parkinson's patients

Parkinson's Disease Specialist Pharmacy Network | Parkinson's UK (parkinsons.org.uk)

Appropriate prescribing of antipsychotic medication in dementia

Antipsychotic-Prescribing-Toolkit-for-Dementia.pdf (england.nhs.uk)

Bisphosphonates paper

PowerPoint Presentation (nottsapc.nhs.uk)

PCN Opiods Checklist

PCN Checklist Final V (Opioid Exposed).pdf (wessexahsn.org.uk)

Healthcare Inequalities and Prescribing in England

healthcareInequalitiesScrollytellR (shinyapps.io)

'The book about getting older' by Luck Pollock

The Book About Getting Older by Lucy Pollock | Waterstones

GP Evidence

GP Evidence

Virtual Patients - Personalised Care Institute

Virtual Patient Avatars (personalisedcareinstitute.org.uk)

ePACT Polypharmacy Comparators Data

Q - What's the turnaround for getting the NHS numbers back?

A - My experience is getting data back within 2-4 weeks once registered fully with IG in place. The last time I asked the NHS BSA (July 2022) I had a bit of back and forth with NHSBSA Team re the lead prescriber was on the NHSA BSA database. (Which is understandable in terms of IG). Even with that it took 3 weeks.

NHSBSA is just starting a pilot with an ICS to get live NHS numbers within a population health management dashboard so eventually hopefully PCNs will be able to access MUCH more easily....

Register to access ePACT2 by emailing Registration@nhsbsa.nhs.uk

https://bit.ly/Polypharm

Access ePACT2:

https://www.nhsbsa.nhs.uk/access-our-data-products/epact2/registering-epact2

Data chat:

- I wasn't aware this data was available so has been helpful.
- What surprised me was the ACB burden in my practice in those aged> 65
- But it is brilliant to help stratify who to call for proactive SMR's.
- Anticoagulant/antiplatelet data for 75+ is awful for my practice in comparison to local/national data. Need to sort this…
- Really surprised with the number of patients prescribed multiple anti-platelet/anticoag drugs - I'm keen to understand the reason behind this.
- I was surprised by the % or all age patients on 5 or more analgesic meds (very high)
- I found the data helpful as the issues weren't where I necessarily thought but that may be due to actions, we have taken already to tackle the areas where we were doing not so well.
- We are benchmarking well on anticholinergic burden but looking high in NSAID plus one other DAMN medicine.
- I am afraid that we are in a pocket of deprived population, and this is clearly indicated in our numbers.
- As my practice have a significant diabetes burden, polypharmacy is prominent.
- If the chart down include or pracice, does it mean we have no patients on it? For example, on multiple presc of anticoag → Yes Alex nil pts if not shown.
- This data is a great starting point and helps prioritise who we see. I worked in Portsmouth for 21 years and when we discovered this 4 years ago it really helped us understand where to focus our energy.
- We looked at 10+ medicines data recently and realised higher percentages in our younger population 55-74 years vs 75+ years. So, we are prioritising 65+ for SMRs. This has generated a lot of interest with our public health colleagues as it confirms what we already know about deprivation and multi morbidity at younger age in our local population.
- Ardens searches reveal 375 pts are on 10 or more meds in my practice.
- Anticoagulant/antiplatelet should be v small numbers but high risk so easy to review and fix. Can get errors if issued clopi in Jan and then switched to DOAC in same month.

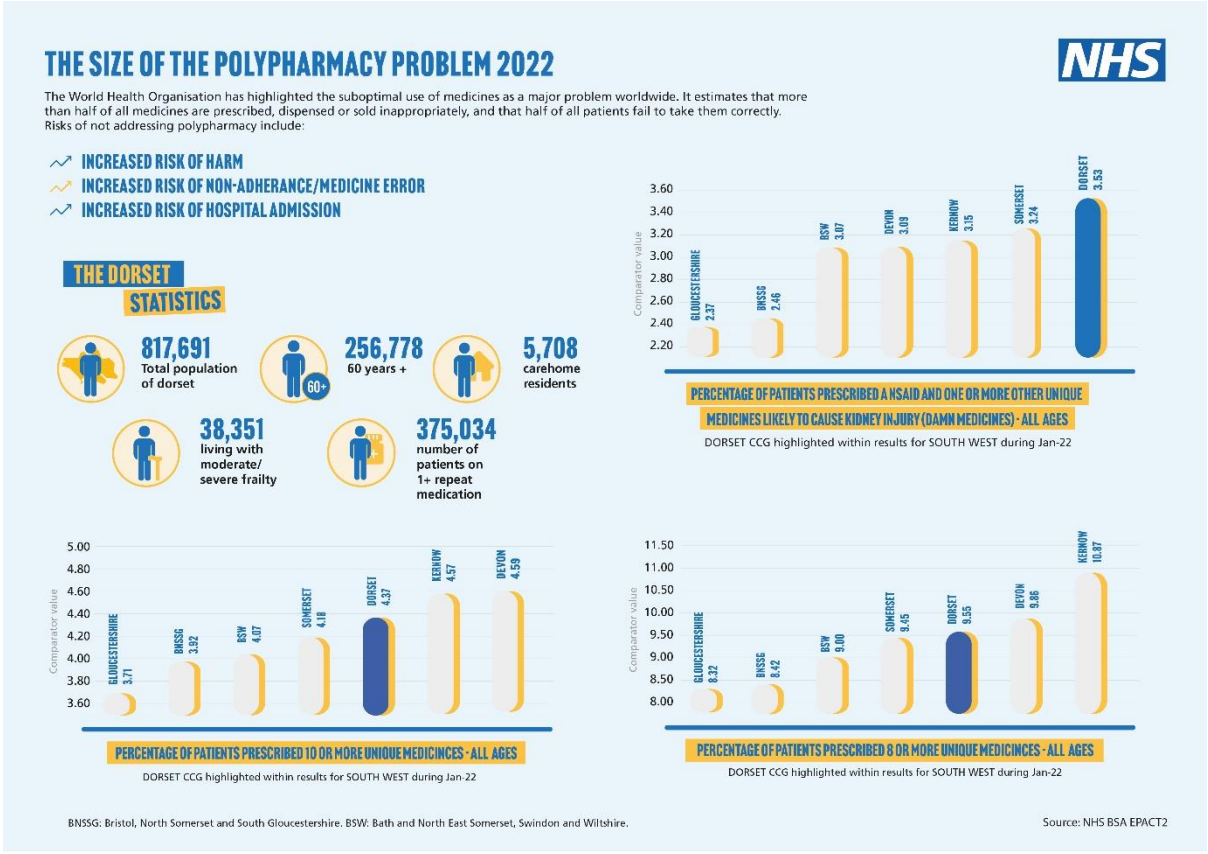
- We are benchmarking well on anticholinergic burden but looking high in NSAID plus one other DAMN medicine. Everyone has better areas than others which is why need a PCN strategy on all this. Ardens is not reliable!!! BSA only includes real meds- chapters 1-4 and 6-10 BNF.
- Can the BSA data be filtered down to only care home residents? → once have the NHS level data you can manipulate the xl sheet by address.
- Our recall team tasked with sorting out invites based on the PCN strategy as to who to call.
- Health care inequalities and prescribing in England. Jan 2023 key points:
  - Core20 population >prescription items and
  prescribing peaks at earlier age vs non-Core20
  • Core20 population less likely to pay for prescriptions and more likely to claim non-age-related exemptions.
  • Prescribing rates spike 10 -15 years earlier for Core20 population: multimorbidity sets in earlier in deprived communities.
- Higher proportion of Core20 population on 10+
- Notable differences in prescribing in COPD,
- Hypertension and SMI Core20 vs non-Core20
- We get these PP datasets twice a year to help stratify which patients are invited for SMRs and see progress.

Other Chat:

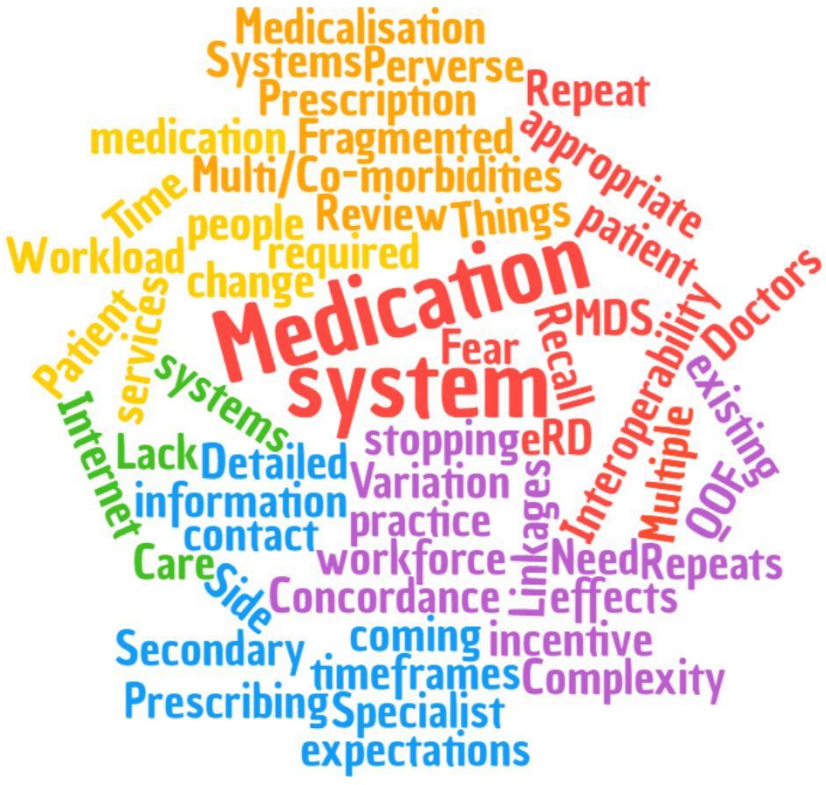
- I was just going to pick up on one thing mentioned in our group about deprescribing guidelines-loads available now compared to when I first started doing clinical medication reviews-helps with confidence in stopping (alongside a shared decision-making conversation)
- What would happen if 100 people aged over 60 years take sleeping tablets for more than a week...
  https://twitter.com/Trisha_the_doc/status/1382076967239946245?s=20&t=TnnNIDwjtQpK2ftL79UJ5Q
- From somebody in our group, worth sharing with everyone "I find honesty goes a long way, accepting we have made mistakes. For example, tramadol was prescribed as a ground breaking analgesic and no advice was provided around dependence risk for ongoing use. Today, we are challenging these patients and need to take responsibility that we contributed to their dependence as we did not provide the information of risks historically / diminished their ability to make an informed decision" 👍
- If interested lots of chat re polypharmacy and multi morbidity on this podcast. I co-host but episodes with Clare, Jonathan and Lelly Oboh.
  https://podcasts.apple.com/gb/podcast/the-aural-apothecary/id1552559905
- Concurrent prescription of 5 or more analgesic. Is this a one-off prescription or repeat?
- Each months data is everything that was prescribed that month but 77% of all items are repeat and even for analgesics if you look at the trend data for your practice you will see it is mostly people on long term repeats rather than acutes. The acutes are in there but they tend to only get one or two analgesics, not 5. I hope that makes sense.

- 100% accurate all this happens all the time. The only solution is to have a system that primary and secondary care use.
- gpevidence.org - A new website Dr Julian Treadwell starts 1st Feb with lots of PDA s to help SDM re absolute benefits and risks.
- I also have a GP who is strict and says no to prescribing more opioids and the patients now refuse to see them and are seen by another GP in the practice. So, it's not always about being the "bad guy" but about not damaging the relationship.
- Personal barriers: changes and the need to up skill again, need headliner support nationally i.e. we will review your medicines and this is to help you get the most out of them vs 'you are the barrier to me getting my medicines'
- Personal barriers: experience of a complaint, sessional GP and not able to follow up.
- Any guidelines to stop Alendronic acid? NOGG guidelines give flowchart for review. Also, important to evaluate frailty, patient expectations, falls risk and other clinical factors when looking at this.
- Regular supervision and reflection absolutely necessary!
- Loving the Cs - lets have the list in the chat box :-)
➔ Complexity, Continuity, Conflict, Communication, Conversations, Courage, Confidence, Certainty, Capability
➔ Add in caring, careful and cognitive biases.
- I feel health literacy is a big barrier and also inequalities.
- The system is very disjointed, with multiple IT systems across the community and acute trust that don't communicate.
- Poor quality of eDDs from hospital is our problem.
- I feel deprescribing needs to be embedded within the RPS Competency Framework for all prescribers.
- A quote I use is that the G in NICE TAG stands for guideline not gospel.
- I feel deprescribing needs to be embedded within the RPS Competency Framework for all prescribers, it kind of is, but maybe that term isn't used explicitly. SDM is a key element of the competency framework.
- One interesting barrier shared in our group was the increased digitalisation due to Pandemic response and lack of face-to-face consultations. Some patients benefiting as GP able to text and explain why something stopped but others not being seen and difficult to reach.
- I often refer to deprescribing as a trial stoppage and have found that has more positive response.

Polypharmacy Infographic example from Dorset ICS: Suggest each ICB have a PP calling card like this Dorset one.



Locality barriers Polypharmacy ALS day 1 word cloud:



Personal barriers to deprescribing ALS day 1 word cloud: