The AHSN Network

Polypharmacy: getting the balance right

Polypharmacy Action Learning Set: Day 2 Links and Chat

Montgomerie ruling https://www.bmj.com/content/350/bmj.h1481

National Overprescribing Review

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

GP Evidence

GP Evidence

General Practice Medication Errors

General Practice Medication Errors - NHS Resolution The initial NHS Resolution data for general practice indicates that anticoagulants, antimicrobials, anticonvulsants and opioids are the most common medications to be implicated in incidents.

PINCER Evidence

pincer-evidence-v2.0.pdf (nottingham.ac.uk)

Proton Pump Inhibitor Deprescribing Algorithm

ppi-deprescribing-algorithm_2018_En.pdf

Consultant aid to help patients decide whether to continue their Proton Pump Inhibitor

Microsoft Word - PPI Consult PtDA Oct 11 v2 wt.docx (deprescribing.org)

Neal Maskrey: Tipping the balance towards individualised care (RNLI MODEL)

https://blogs.bmj.com/bmj/2014/08/21/neal-maskrey-tipping-the-balance-towards-individualised-care/

Deepak Ravindran Pain Free Mindset

https://www.amazon.co.uk/dp/1785043390/ref=cm_sw_r_awdo_W318JYGW8CQ6DY4E6Q

Relationship between realistic medicine and consent

Michael Stewart from Central Legal Office Discusses The Relationship Between Realistic Medicine and Consent – Realistic Medicine

Opioid Dashboard

A new opioid dashboard (looks like polypharmacy but for opioids.) See

New prescribing comparators available to help reduce harm in opioid prescribing (nhsbsa.nhs.uk)

Wessex AHSN Opiod page

Medicine Safety Improvement Programme (MedSIP) (wessexahsn.org.uk)

PCN Opiod checklists

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

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

Opioid Side Effects

https://livewellwithpain.co.uk/wp-content/uploads/opioid-side-effects-v02.pdf

Shared decision making between older people with multimorbidity and GPs: a qualitative study

https://bjgp.org/content/72/721/e609

https://realisticmedicine.scot/michael-stewart-from-central-legal-office-discusses-the-relationship-between-realistic-medicine-and-consent/

BRAN Patient Leaflet

https://www.choosingwisely.co.uk/wp-content/uploads/2020/11/CWUK_patient_leaflet_100120-1.pdf

Example of SDM from Professional Record Standards Body (PRSB)
https://theprsb.org/wp-content/uploads/2022/06/SDM-Example-Primary-Care-V1_0.pdf

Winton Centre resources on risk communication
https://wintoncentre.maths.cam.ac.uk/resources/

https://dtb.bmj.com/content/dtb/57/8/119.full.pdf

Shared Decision Making

- NB the requirement to do the SDM 30 min e learning is no longer mandatory this year for IIF / DES
- It is a straightforward e Learning module from the Personalised care institute

https://www.pulsetoday.co.uk/news/pulse-pcn/nhse-scraps-des-shared-decision-making-training-days-before-deadline/

SDM Support Tools

NHSE: https://www.england.nhs.uk/personalisedcare/shared-decision-making/decision-support-tools/

NICE: https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids

CONDITION SPECIFIC: https://www.england.nhs.uk/publication/decision-support-tools-making-a-decision-about-a-health-condition/

Management of chronic low back, osteoarthritic, and neuropathic pain in primary care https://www.cfp.ca/content/cfp/68/3/179.full.pdf

Medicolegal vulnerability paper re SDM

https://doi.org/10.3399/BJGP.2021.0529

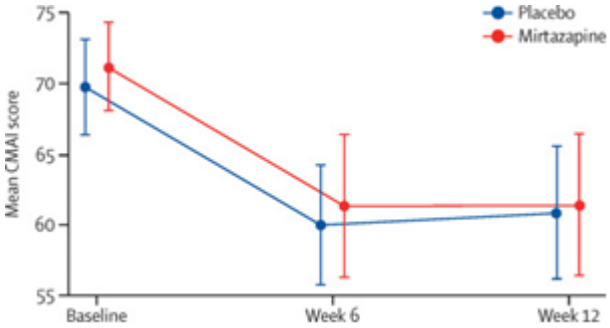
I prefer this to the one in systmone https://cvdcalculator.com/

Medicolegal study
https://bjgp.org/content/72/721/e609

Julian Treadwell Medico Legal blog

Medico-legal considerationsGP Evidence

Risks and (lack of) benefits of Mirtazepine in older people with dementia



Study of mirtazapine for agitated behaviours in dementia (SYMBAD): a randomised, double-blind, placebo-controlled trial

thelancet.com

Sertraline or mirtazapine for depression in dementia (HTA-SADD): a randomised, multicentre, double-blind, placebo-controlled trial - PubMed (nih.gov)

Appropriate prescribing of antipsychotic medication in dementia

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

Staff attitudes to antipsychotic use in residents with dementia in care homes

systematic review of quantitative studies exploring staff attitudes to antipsychotic use in residents with dementia in care homes | International Journal of Pharmacy Practice | Oxford Academic (oup.com)

With review of anti-psychotics, need to check who is driving the prescribing- is it care staff who think pills are the answer to everything or is there a need as resident in care home very aggressive? Ask about symptoms and why the care staff think an antipsychotic is needed, check pain relief has been regular first too.

Personalised Care and Social Prescribing

directed-enhanced-service-personalised-care-March-2022.pdf (england.nhs.uk)

Aural Apothecary podcasts

Lelly Oboh – Wicked problems, mindlines and the stripey zebra:

The Aural Apothecary: Episode 2.8 - Lelly Oboh - Wicked Problems, Mindlines and the Stripey Zebra. on Apple Podcasts

Lucy Pollock – Getting older and how to deal with it:

The Aural Apothecary: 4.1 - Getting Older and how to deal with it - with bestselling author Dr Lucy Pollock on Apple Podcasts

Jonathon Underhill – Shared Decision Making, NICE and POOs not DOOs:

The Aural Apothecary: Episode 2.1 - Jonathan Underhill, Shared Decision Making, NICE and POOs - not DOOs. on Apple Podcasts

Clare Howard – Multi-morbidity:

The Aural Apothecary: Episode 2 - Clare Howard and Multimorbidity on Apple Podcasts

Stephen Webber - Clinical Negligence and the perils of a no-fault compensation system:

The Aural Apothecary: 3.8 - Stephen Webber - Clinical Negligence and the perils of a no-fault compensation system. on Apple Podcasts

AHSN Polypharmacy Prescribing Podcast:

PolyPharmacy Prescribing Podcast. Clare And Robin (1) in Polypharmacy Prescribing podcasts (soundcloud.com)

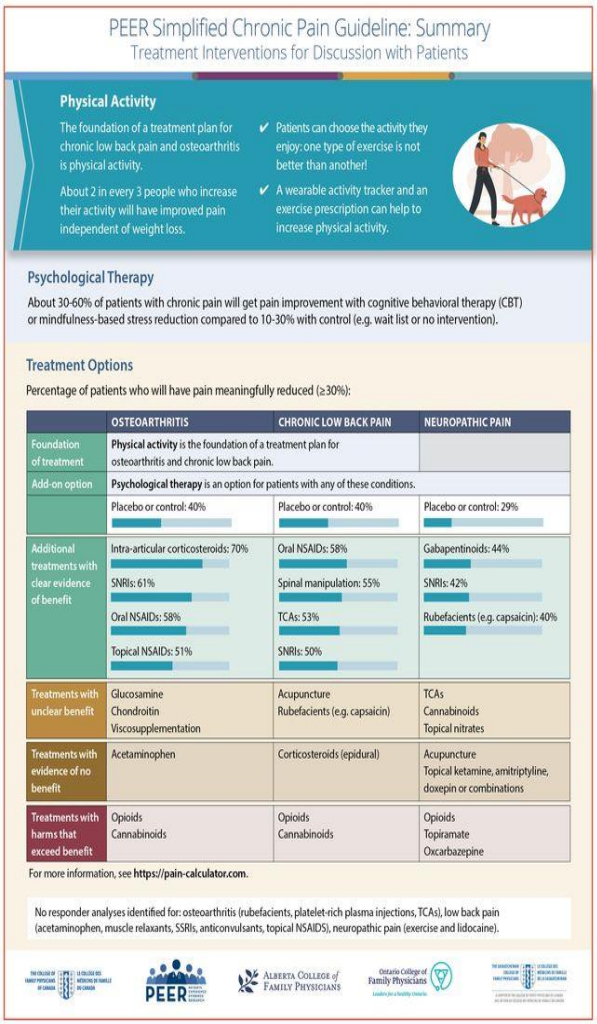
Shared Decision-Making Background Scenario – Primary Care learning example might be helpful re DOAC switch question https://theprsb.org/wp-content/uploads/2022/06/SDM-Example-Primary-Care-V1_0.pdf

NHS Patient Decision Aids https://www.england.nhs.uk/personalisedcare/shared-decision-making/decision-support-tools/

This is good to help us understand risks/benefits to then help patients understand risks/benefits https://realrisk.wintoncentre.uk/ https://www.youtube.com/playlist?list=PLos4drc7i4YjE6ZY5flokZ4rTWRvSzqCz

BGS webpage has some great resources if reviewing older complex patients: https://www.bgs.org.uk/resources/6-cga-in-primary-care-settings-medication-review

The SHINE project in Northumbria shows how valuable an MDT set up (including geriatricians and carers) is to reaching the RIGHT decision.
https://www.centreforpublicimpact.org/case-study/shine-project-optimising-medicine-use-care-home-residents-northumbria-healthcare-nhs-foundation-trust



PEER Simplified Chronic Pain Guideline: Summary
Treatment Interventions for Discussion with Patients

Physical Activity

The foundation of a treatment plan for chronic low back pain and osteoarthritis is physical activity.

About 2 in every 3 people who increase their activity will have improved pain independent of weight loss.

- ✔ Patients can choose the activity they enjoy: one type of exercise is not better than another!
- ✔ A wearable activity tracker and an exercise prescription can help to increase physical activity.

Psychological Therapy

About 30-60% of patients with chronic pain will get pain improvement with cognitive behavioral therapy (CBT) or mindfulness-based stress reduction compared to 10-30% with control (e.g. wait list or no intervention).

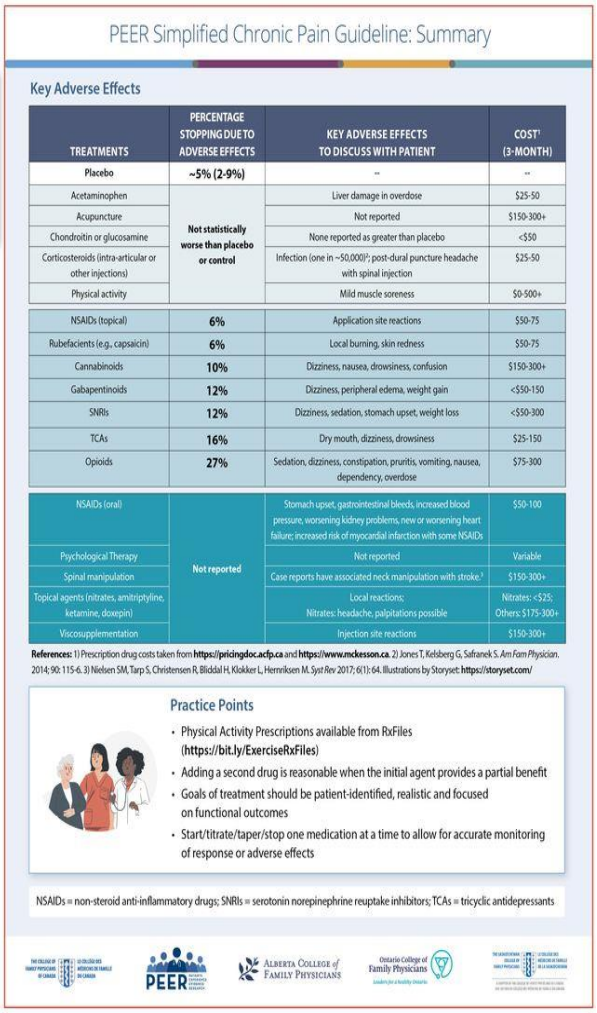
Treatment Options

Percentage of patients who will have pain meaningfully reduced (≥30%):

	OSTEOARTHRITIS	CHRONIC LOW BACK PAIN	NEUROPATHIC PAIN
Foundation of treatment	**Physical activity** is the foundation of a treatment plan for osteoarthritis and chronic low back pain.		
Add-on option	**Psychological therapy** is an option for patients with any of these conditions.		
	Placebo or control: 40%	Placebo or control: 40%	Placebo or control: 29%
Additional treatments with clear evidence of benefit	Intra-articular corticosteroids: 70% SNRIs: 61% Oral NSAIDs: 58% Topical NSAIDs: 51%	Oral NSAIDs: 58% Spinal manipulation: 55% TCAs: 53% SNRIs: 50%	Gabapentinoids: 44% SNRIs: 42% Rubefacients (e.g. capsaicin): 40%
Treatments with unclear benefit	Glucosamine Chondroitin Viscosupplementation	Acupuncture Rubefacients (e.g. capsaicin)	TCAs Cannabinoids Topical nitrates
Treatments with evidence of no benefit	Acetaminophen	Corticosteroids (epidural)	Acupuncture Topical ketamine, amitriptyline, doxepin or combinations
Treatments with harms that exceed benefit	Opioids Cannabinoids	Opioids Cannabinoids	Opioids Topiramate Oxcarbazepine

For more information, see **https://pain-calculator.com**.

No responder analyses identified for: osteoarthritis (rubefacients, platelet-rich plasma injections, TCAs), low back pain (acetaminophen, muscle relaxants, SSRIs, anticonvulsants, topical NSAIDS), neuropathic pain (exercise and lidocaine).



PEER Simplified Chronic Pain Guideline: Summary

Key Adverse Effects

TREATMENTS	PERCENTAGE STOPPING DUE TO ADVERSE EFFECTS	KEY ADVERSE EFFECTS TO DISCUSS WITH PATIENT	COST[1] (3-MONTH)
Placebo	~5% (2-9%)	"	"
Acetaminophen	Not statistically worse than placebo or control	Liver damage in overdose	$25-50
Acupuncture		Not reported	$150-300+
Chondroitin or glucosamine		None reported as greater than placebo	<$50
Corticosteroids (intra-articular or other injections)		Infection (one in ~50,000)[2]; post-dural puncture headache with spinal injection	$25-50
Physical activity		Mild muscle soreness	$0-500+
NSAIDs (topical)	6%	Application site reactions	$50-75
Rubefacients (e.g., capsaicin)	6%	Local burning, skin redness	$50-75
Cannabinoids	10%	Dizziness, nausea, drowsiness, confusion	$150-300+
Gabapentinoids	12%	Dizziness, peripheral edema, weight gain	<$50-150
SNRIs	12%	Dizziness, sedation, stomach upset, weight loss	<$50-300
TCAs	16%	Dry mouth, dizziness, drowsiness	$25-150
Opioids	27%	Sedation, dizziness, constipation, pruritis, vomiting, nausea, dependency, overdose	$75-300
NSAIDs (oral)	Not reported	Stomach upset, gastrointestinal bleeds, increased blood pressure, worsening kidney problems, new or worsening heart failure; increased risk of myocardial infarction with some NSAIDs	$50-100
Psychological Therapy		Not reported	Variable
Spinal manipulation		Case reports have associated neck manipulation with stroke.[3]	$150-300+
Topical agents (nitrates, amitriptyline, ketamine, doxepin)		Local reactions; Nitrates: headache, palpitations possible	Nitrates: <$25; Others: $175-300+
Viscosupplementation		Injection site reactions	$150-300+

References: 1) Prescription drug costs taken from **https://pricingdoc.acfp.ca** and **https://www.mckesson.ca**. 2) Jones T, Kelsberg G, Safranek S. *Am Fam Physician*. 2014; 90: 115-6. 3) Nielsen SM, Tarp S, Christensen R, Bliddal H, Klokker L, Henriksen M. *Syst Rev* 2017; 6(1): 64. Illustrations by Storyset: **https://storyset.com/**

Practice Points

- Physical Activity Prescriptions available from RxFiles (**https://bit.ly/ExerciseRxFiles**)
- Adding a second drug is reasonable when the initial agent provides a partial benefit
- Goals of treatment should be patient-identified, realistic and focused on functional outcomes
- Start/titrate/taper/stop one medication at a time to allow for accurate monitoring of response or adverse effects

NSAIDs = non-steroid anti-inflammatory drugs; SNRIs = serotonin norepinephrine reuptake inhibitors; TCAs = tricyclic antidepressants

Our local MSK provider has some good aids for common MSK conditions
https://healthshareoxfordshire.org.uk/shared-decision-making

https://apps.apple.com/gb/app/polypharmacy-guidance/id1072829127

PEER also have a website https://pain-calculator.com/ and patient leaflet
https://www.cfp.ca/content/cfp/suppl/2022/03/14/68.3.179.DC1/Appendix_2_Patient_Handout.pdf

Good (long sorry!) video on Deprescribing antidepressants
https://youtu.be/AltrDmZ0DM4

Legal implications of deprescribing: A case scenario

Legal implications of deprescribing: a case scenario - Barnett - 2017 - Prescriber - Wiley Online Library

Resource for pts on low carb for T2DM Ie less drugs!!

https://newforestpcn.co.uk/low-carb/

I like for low carb https://phcuk.org/resources/

Australia Deprescribing Resources

https://www.primaryhealthtas.com.au/resources/deprescribing-resources/

Canadian Deprescribing Resources

Do I still need this medication? Is deprescribing for you? (deprescribingnetwork.ca)

Regular Acetaminophen Use and Blood Pressure in People with Hypertension: The PATH-BP Trial
https://www.ahajournals.org/doi/pdf/10.1161%2FCIRCULATIONAHA.121.056015
"Regular daily intake of 4 g acetaminophen increases systolic BP in individuals with hypertension by ≈5 mm Hg when compared with placebo; this increases cardiovascular risk and calls into question the safety of regular acetaminophen use in this situation".

Blood pressure in frail older adults
Blood pressure in frail older adults: associations with cardiovascular outcomes and all-cause mortality | Age and Ageing | Oxford Academic (oup.com)

Regular paracetamol use and hypertension
https://dtb.bmj.com/content/60/10/147.full (may need to ask your healthcare library for access).

Supervision for roles recruited through the Additional Roles Reimbursement Scheme
https://www.hfgpfed.co.uk/media/3669/08-02-21_clinical_supervision_final.pdf
All ARRS roles should have regular clinical supervision with a GP.

"The Great Opioid Side Effect Lottery"
https://livewellwithpain.co.uk/resources/opioid-zone/resources-to-use-when-reviewing-prescribed-opioids/the-great-opioid-side-effect-lottery/

E-learning tool for medication safety e learning
https://www.medicinesafety.co.uk/p/welcome.html

Metformin UKPDS
https://pubmed.ncbi.nlm.nih.gov/9742977/

Me and My Medicines
Me & My Medicines, Medicines Communication Charter, It's OK to Ask – Home (meandmymedicines.org.uk)

Films

Sam's story www.youtube.com/watch?v=PRd_PhvdQe8

See also www.nice.org.uk/news/blog/my-laundry-list-of-health-conditions

Oliver's story https://youtu.be/DzihtjzdMGY

Overcoming Barriers to Deprescribing - https://www.youtube.com/watch?v=0VY3_skkFJE

Chat related to SDM AND SMR's

- Also, worth remembering the old BJGP paper that showed that if patients were written to about the risks of bezos - 1/3 came off their benzos themselves. Just reminds us that lots of people want to come off some meds.
- With hypnotics and benzos, also think about if patients buying OTC products. Think about mental health issues, what services do you have locally to signpost to, slow approach to deprescribing best- will need several consultations but it can be done
- Using scaling questions really help - based on research around motivational interviewing. Can ask on a scale of 0-10 (10 being the most important) how important is this medication for you, and also on a scale of 0-10 (10 being the most confident) how confident are you in taking this medication. Allows you to tailor your advice and information - helps with shared decision making

How do you currently identify patients for a SMR? Delegate responses.

- Stopp/start
- QOF / IIF necessary ones
- Rockwood frailty score
- Eclipse alerts
- Yearly review, out of hospital reviews and new patient as well as QOF/IIF
- Eclipse
- The driver for med reviews is repeat templates that need re-authorising
- We have regular use of the Ardens multi-morbidity template
- Prescqipp impact guideline
- Review date
- Prioritising care home, frailty, polypharmacy, IIF
- IIF, patient request, concern from other HCPs
- ACB burden
- Discharge letters from hospital
- Review date, 8+ meds, over 65

Delegate Actions: Stop and Start

- Look through some of the resources mentioned today such as GP evidence, deprescribing.org etc.
- Start using GP evidence tool in consultations.
- Get some actual numbers to hand, look closely at GP evidence.
- Audit need, need to use tools to ensure a good SMR, reflect on outcomes, share information.
- Suspend and then review.
- GP evidence, look forward to trying to use this in consults.
- STOP - working in silo; START - using tools more; MORE - discuss at MDTs.
- check out the available tools in more detail.
- Start using GP evidence tool to explain benefit/harms to patients.
- Suspend great idea. I will use this.
- Incorporate great use of SDM resources/deprescribing tools in consultations...
- Looking at medicines conversation guide phrases to introduce concepts of SDM.
- Lots of resources to look at and need to prioritise which will be most helpful, also talk to team about how to prioritise.
- Stop: Being fearful that patients will not be open to stopping medicines. Start: using GP Evidence and More: refresh knowledge of non-drug alternatives.
- Look into the resources and decision tools.
- Patient decision aids to share with colleagues.
- To me, jotting down a few key questions to ask at the consultation:
  - golden minute
  - what is important to you?
  - what would you like to know about your medicines
- Clarity of language.
- Start using GP evidence, ensure listen to patients and explain that medicines can only reduce the risk.
- I think the emerging issue here is how we link traditional patient medicines info with patient decision aids and how best to do this.
- Start: looking at resources, discuss with practice teams, like the concept of "moving the glass away from the edge of the table" (from video) to challenge the if it ain't broke... argument.
- Going to make sure I am up to date with the Oliver McGowan training.
- Stop- Being afraid to stop. Do more -Golden minute/ Use tool/suspend, Do More: speak more with colleagues + document + will use different terminology (reduce risk).

General Chat

- Warfarin and antiplatelets concomitantly - you'd want to check it is intentional that both are prescribed together and initiated or managed by specialist and why.
- I think that is the key, information to back up your conversations with pts
- the fear is legal action if something is stopped and then pt has stroke etc
- It is difficult because we feel like we don't have enough info to make decisions
- I worry if NNT is single condition not multi condition, let alone individual variation, so is this the right approach?

- NNTs useful, but based on trial data which typically excludes elderly, frail, multimorbid people
- Saying a SMR cannot be done in a 10-minute consultation and needs 20-30min is off putting. We don't get that time, but we can pick of little bits at each consultation and make a difference and this should be encouraged.
- 'SMRs should last a min of 30 mins' quote by Prof Tony Avery
- Another great example also shared was that some patients expect HCPs to do the telling ie paternalistic approach and not used to sharing their wants, they want someone else to make the decisions but actually that's not SDM.
- For those of you on Twitter worth following Adam Todd. His team at Newcastle are producing a lot of very helpful studies around older people and medicines. @adamtodd138
- I think incentives (QOF etc) around treating to target is one of the main causes of overprescribing
- Agreed but if moderate / severe frailty coded then QOF encourages lower bp / hba1c levels for example
- Incentives are about moving the mean in the direction of what 'good' looks like. They should never be the main reason for prescribing - that needs to be made on an individual basis. That is why QOF etc is never about getting 100% of people to a particular target
- Same Evidence + different preferences = different decision.
- Recording is very important- record your 'judgement'/thoughts based on the evidence and record patient's perspectives and then the agreed outcome based on Shared decision making
- Also there is always setting up a best interest meeting, and if v v high risks and complexity e.g patient with dementia, LD, complex cases, there is always a complex care pathway team in each locality (usually sitting in social care) set up to look more holistically.
- Agree Lelly, best interest meetings (which are best when MDT involved) are best approach to discuss highly complex issues or when difficult to make a decision or where there is lack of evidence. Record who was involved and the decision that was agreed and why
- one of our practices highlights who the buddy GP of the day is - they have no patient facing appointments so are free to support ARRs team (they do the telephone triage). They have protected time at the end of the day to review any cases
- Dr Julian Treadwell is developing a tool to help with the risk and benefit knowledge. I think it might be ready to test in the New Year 2023.
- "Don't go it alone" struck home re documentation esp re the PCN pharmacist team.
- Talking of qrisk, how can we campaign EMIS to ensure they replace the template that they are about to withdraw?! As it will mean hardly anyone will calculate qrisk any more even though this is so useful and widely needed.
  - ➔ We were just discussing this earlier. MHRA have really tightened up on case finding tools - they have to apply for medical device status. We think that the QRISK people haven’t applied for this so it will have to be withdrawn. We are watching carefully for what happens.
  - ➔ I think something will get sorted before April 23 at national level.
- On discussing the Montgomery law - Essentially - if someone wants to sue you, they can. Unless you give all information. I guess sending patient leaflets etc might give

one route around it. Any patient could argue - this was relevant to me. → Imagine thinking someone was faking occulogyrocrisis? → How does someone fake such a crisis? → I don't find that reassuring personally - its about probability. → There is a "defensible documentation" training package available too which I found quite useful. → The mental health impact of the litigation is still there though. → But reality is, the probability is low someone will pursue that route is low (most people are nice and its hopefully unlikely will make a big error) but if someone chooses to be malicious they can be.

- PCNs need to really think about how pharmacists and GPs work together, especially in complex polypharmacy cases. Geriatrician input also important and we will think about all of that on Day 3.
- His study [showed that GPs underestimate the risks and overestimate the benefits of medicines, (which is a clear issue in polypharmacy esp in older people).
- Interesting that someone with AF with CHADSVASC 2 and HASBLED 1 displays an equal stroke prevention and bleed risk!
- How best to manage patients who have been taking BZs for many years? → We had a great poster from the Wiltshire area - they have done superb work on reducing ACB and are now the lowest ICB in the country. They developed a pt leaflet and mandated that GPs come to training!
- Important to get proper debriefs. I see both good and bad practice in the surgeries I cover.
- Can’t emphasise enough the value of popping out to chat with another colleague or doing reflective practice.
- These decision aids are fantastic! But can be also very challenging when the benefit does not seem to be more than one or two "happy faces".
- If we think about language how often do we hear people say this will prevent you having a heart attack or stroke!
- I agree I often feel this way with statins.
- We overestimate the benefits of drugs and underestimate the harms of drugs.
- I think it has always been said that way to 'scare' the patient into to taking the meds and therefore not stopping them.
- NICE are currently working on a patient decision aid for hypnotics to facilitate conversations to think about safely stopping them...
- My top SMR tip is PLAN = Prepare, Listen, Agree, Notes.
- Tools are great starting points HOWEVER conversations/SDM are crucial to move to deprescribing inappropriate medicines.
- I like the concept of "suspending" not stopping. Having some easily accessible NNT graphics is invaluable.