Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Q & A to support the review of repeat prescribing and reducing harm from overprescribing

What is overprescribing and why is this important?

Overprescribing is the use of a medicine where there is a better non-medicine alternative, or the use is not best suited for the individual patient's circumstances and wishes. When medicines are overprescribed, they can lead to poor patient outcomes and harm, health inequalities, medicines wastage, financial inefficiencies, and a negative impact on the environment:

- 1 in 5 prescriptions for older people living at home may be inappropriate.
- A person taking 10 or more medicines is 300% more likely to be admitted to hospital because of an adverse drug reaction.
- People living in the most deprived areas are 2.8 times more likely to be taking 8+ medicines.
- Up to 50% of medicines for long term conditions are not taken as intended.

In 2021, the Department of Health and Social Care published the report of their national review on overprescribing in the NHS, Good for You, Good for Us, Good for Everybody (NOR) which outlined key recommendations to support greater review of repeat prescribing including the evidence base for safely deprescribing inappropriate medication. It also called for culture change to reduce reliance on medicines e.g. by increasing uptake of social prescribing and shared decision making with patients. Furthermore, the reports called for greater interventions to reduce waste and help the NHS deliver on its net zero carbon emissions target.

The response to the NOR report is now an NHS England Programme, which sets out 20 cross-system recommendations to be led by a range of NHS organisations. The PCN DES 2024/25 asks PCNs to consider NICE guidelines NG5 and the Royal Pharmaceutical Society's polypharmacy guidance, as well as the findings of the National Overprescribing Review, in identifying patients and determining their approach to developing SMR caseloads.

How can the patient's wishes be considered as part of a shared decision-making process?

Despite the concept of "no decision about me, without me" first being introduced to the NHS in 2012, effective shared decision-making is not yet the norm with many patients wanting more information and involvement in decisions about treatment than they currently experience. Reflecting this the PCN DES 2024/25 asks that "the patient's invitation to the SMR should explain what the SMR will involve, and that they will be coming in for a shared decision-making conversation to review all their medications and make sure they are working for them".

The **BRAN** acronym can be useful when encouraging patients to get the most from conversations about treatments with healthcare professionals and focuses on four questions:

B: what are the **B**enefits?

R: what are the **R**isks?

A: what are the **A**lternatives?

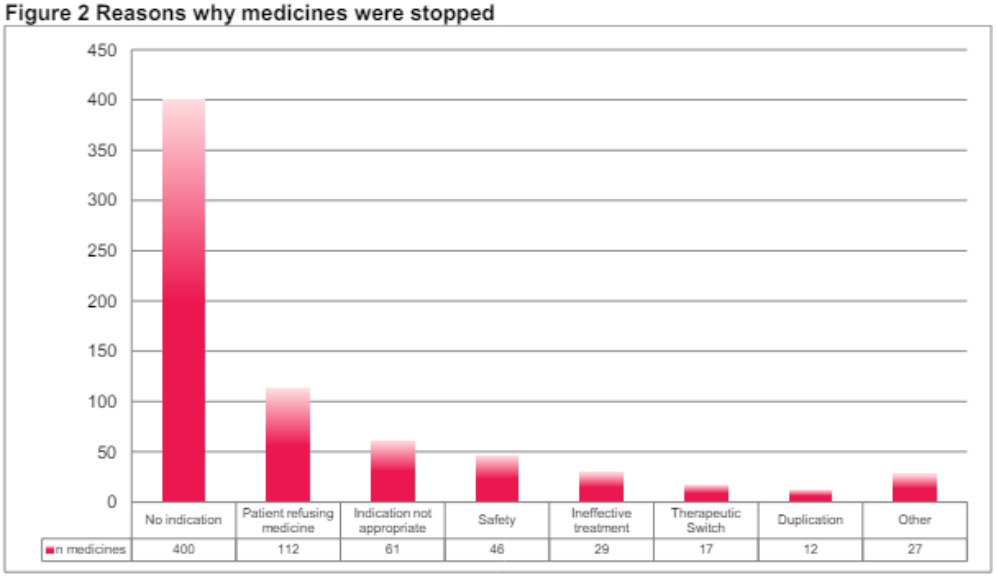
N: what if I do **N**othing?

Shared decision making should be an integral part of any medication review and people must be supported to:

- understand the care, treatment, and support options available and the risks, benefits and consequences of these options,
- make an informed decision about a preferred course of action, based on evidence based, good quality information and their personal preference.

Recommendation R8 of the National overprescribing report (NOR) calls for patients to be prescribed medicines appropriately through a shared decision-making process. The report highlights the Northumbria SHINE QI project that found that clinical pharmacists undertaking SMRs within a shared decision-making framework were able to safely reduce prescribing by 17.4% through stopping medicines that were no longer indicated or causing harm. Figure 2 below shows the reasons why medicines were stopped:

Figure 2 Reasons why medicines were stopped



NOR also calls for the healthcare workforce to be trained to understand the causes and consequences of overprescribing and how it can be remedied through Structured Medication Reviews, shared decision making and the ability to access specialist support e.g. for patients with learning disability and Autism patients.

Resources:

Choosing wisely UK: Making the most of your appointment - BRAN patient leaflet
Choosing wisely UK: Making the most of your appointment – BRAN poster
NHSE Shared Decison Making - Summary Guide
Shared decision making NICE guideline 197 Published: 17 June 2021

What is the IMPACT tool and how can this help reduce overprescribing?

PrescQIPP have developed the Improving Medicines and Polypharmacy Appropriateness Clinical Tool (IMPACT) tool to be a single resource that brings together the most current evidence to support evaluating risk of harm from medication, optimise medicines use to meet treatment goals, and agreeing deprescribing priorities as part of a shared decision-making process. The IMPACT tool provides suggestions for consideration to optimise medicines use and provides practical advice (where it is available) about how to safely stop/discontinue/withdraw a medicine and issues to consider.

Problematic polypharmacy is where the potential for harm outweighs any benefits from the medicines, this includes:

- medicines that are no longer clinically indicated or appropriate or optimised for that person.
- combination of multiple medicines has the potential to, or is actually, causing harm to the person.
- practicalities of using the medicines become unmanageable or are causing harm or distress.

IMPACT can be used as a practical decision aid, in conjunction with other relevant patient specific data, to consider:

- clinical risk - the risks versus the benefits of continuing therapy based on usual maintenance doses as a general indication for classes of medicines.
- deprescribing priority - to help in situations where, for example a patient is on 12 drugs and five could be changed. It may not be possible (or desired by you or the patient) to stop these all at once, so the deprescribing priority can help decide which to do first. The priority assigned is based on clinical risk and medicine/patient safety factors.

Resources:

Improving Medicines and Polypharmacy Appropriateness Clinical Tool (IMPACT)
IMPACT – User guide and FAQs
Using IMPACT for a medication review – Webinar
How to use IMPACT resources when reviewing medicines - Presentation

What about STOPP/START, is this still being used?

STOPP/START version 3 was published in July 2023 and the content has been incorporated into the latest PrescQIPP IMPACT tool (see above), making the IMPACT tool the most comprehensive deprescribing resource. It also includes the BEERS criteria and other key evidence to support SMRs.

STOPP/START criteria for potentially inappropriate prescribing in older people: version 3
Supplementary file 1 Appendix 1
Supplementary file 2 Appendix 2

What is STOMP?

STOMP is a national project that was launched in 2016 and stands for stopping over medication of people with a learning disability, autism, or both with psychotropic medicines. STOMP reviews are supported in the PCN DES 2024/25 and the aim is to:

- encourage people to have regular check-ups about their medicines.
- make sure doctors and other health professionals involve people, families and support staff in decisions about medicines.
- inform everyone about non-drug therapies and practical ways of supporting people so they are less likely to need as much medicine, if any.

Resources:
Stopping the over medication of people with learning disability, autism or both – Easy Read Leaflet
The Challenging Behaviour Foundation - Medication Pathway: A resources for family carers
Preparing to visit a doctor to talk about psychotropic medication - a guide for support workers
How non-medical interventions can be used to support people with a learning disability - a GP view
Case Study: Helping Andrew to stop taking the wrong medicines in Hertfordshire

The number of appointments for structured medication reviews (SMRs) are limited, which patients should be prioritised for these appointments?

The PCN DES 2024/25 states that PCNs must "detail the measures a PCN will take to improve medicines optimisation and implement those measures, including ensuring medicines management and use of Structured Medication Reviews for high-risk cohorts, as specified in the guidance. This should include medicines optimisation strategies for reducing polypharmacy, minimising risk of prescribing harm, reducing over-prescribing, and managing the risk of dependency on prescription drugs".

Cohorts for prioritisation for an SMR is included in the PCN DES and includes people:

- in care homes
- with learning disabilities
- with complex and problematic polypharmacy, specifically those on 10+ medicines;
- on medicines commonly associated with medication errors and risk of harm;
- with severe frailty who are particularly isolated or housebound or who have had recent hospital admissions and/or falls
- using one or more potentially addictive medications from the following groups
- opioids; gabapentinoids; benzodiazepines; and Z-drugs.

Additionally, the 2024/25 ECF Frailty indicator includes deprescribing/IMPACT reviews for patients with moderate frailty who are taking 8 or more medications.

Resources:
See IMPACT links above
Q & A for Reduction of Co-prescribing of Dependence Forming Medicines with Opioids

The CQC remote searches on Ardens specifies that CQC will 'Check quality of review', is there an agreed standard for undertaking and documenting structured medication reviews?

NICE defines a medication review as 'a structured, critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste'. Therefore, it is reasonable to expect evidence of these considerations to be reflected in record keeping for an SMR.

The Structured medication reviews and medicines optimisation guidance developed by the NHS defines the key elements of an SMR as:

- **Shared decision-making** principles should underpin the conversation;
- **Personalised** approach – tailored to the patient;
- **Safety** – consider the balance of benefit and risk of current treatment and starting new medicines;
- **Effectiveness** – all medication must be effective, noting NHS guidance on certain exceptions to items that should not routinely be prescribed in primary care."

Furthermore, the Royal Pharmaceutical Society (RPS) outlines common principles for medication reviews:

- Seeking the person's (and/or their carer's) perspective of their medicines and how they will take them
- Identification of the aims of the drug therapy (from a clinical perspective and from the person's perspective)
- Assessment of whether the medicines are essential or not
- Assessment of the person's level of adherence to the medicines
- Assessment of the effectiveness (both clinical and cost effectiveness) of the medicines
- Assessment of the safety of the medicines, and
- Decision and actions regarding stopping or continuing the medicines.

Following the publication of the national overprescribing report, NHS England commissioned the Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP) to develop a national toolkit to enhance repeat prescribing in primary care with a particular focus on making repeat prescribing safer by providing guidance and training resources for clinicians. The final toolkit was expected to be published in May 2024 but is still awaited.

The CQC includes 'medication review' in the searches for general practice which are designed to identify patients whose records are suitable for clinical review, the search identities patients who have been coded as having had a medication review in the last 3 months. The process of quality assurance of medication reviews undertaken by CQC specifies that a random selection of patients will be reviewed by a "GP specialist advisor who is looking to be assured, for these patients, all of the necessary actions have been taken that would indicate a review of medication had been completed.

For instance,

- All monitoring necessary for the medicines/patient has been conducted, arranged, requested, or enquired about.
- Any potentially interacting medicines have been considered with a record of an appreciation of risks and actions to be taken if the patient remains on them.
- Any drug safety alert information relating to the patient's medicines has been actioned. If patients remain on medicines where there has been clear guidance to avoid for that specific category of patient then a record is made of the decisions and conversations with patients that support the prescribing,
- Any potential concerns regarding concordance have been identified and actions taken where necessary (when viewed in the context of prescription issue etc),

If a code had been added without the above considerations being addressed, then CQC would consider there to be insufficient evidence of review."

The 'target' of the search is not the code, it's the outcome for the patient which is why a clinical review of the notes is an essential part of the process. CQC do not determine the exact timing of medication reviews, this would usually be expected to be at least annually. The frequency should be

based on individual patient needs and may need to be more often than once a year. CQC have clarified the assurance process and evidence of review as they found "situations where there appear to have been medication review codes added to many patients' records, but the records show no evidence of the critical consideration of the patients' medicines and areas of care have been missed".

What is the best way to approach deprescribing priorities for a patient?

As described above, the IMPACT tool can help identify inappropriate prescribing and prioritise deprescribing decisions which is particularly useful in patients taking several medicines that could potentially be stopped. There are many tools to support reviewing and safely tapering or withdrawing medicines all of which are linked within the IMPACT tool. IMPACT also contains links to PrescQIPP and other deprescribing algorithms where available and the tool will be updated regularly as new evidence becomes available. If a medicine is no longer appropriate and needs to stop, the prescriber and patient should discuss and agree a decision. Good communication is essential for successful withdrawal of therapy that is no longer suitable.

In addition, to reduce low value prescribing the PCN DES advises that 'PCNs should take into account the National Medicines Optimisation Opportunities as part of their medicines optimisation stewardship plans. Due consideration should be given to national and local guidance on items which should not be routinely prescribed in primary care.' The ECF 24/25 also includes a low value prescribing indicator focused on reducing prescribing of low priority medicines in line to support this national priority.

When preparing for deprescribing/IMPACT reviews these priority areas should be taken into consideration and form part of the review with the patient.

This will be supported by the NHS BSA dashboards (Polypharmacy, Opioid and Antimicrobial comparators) and other open data e.g. OpenPrescribing which are freely available to GP practices.

Resources:
CQC Search Suite on Ardens
CQC Searches on Ardens - Search definition and criteria
Low Priority Prescribing PrescQIPP Bulletin 339i March 2024
Maudsley Deprescribing Guidelines

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