Growing Old Normally

Deprescribing

20 January 2021

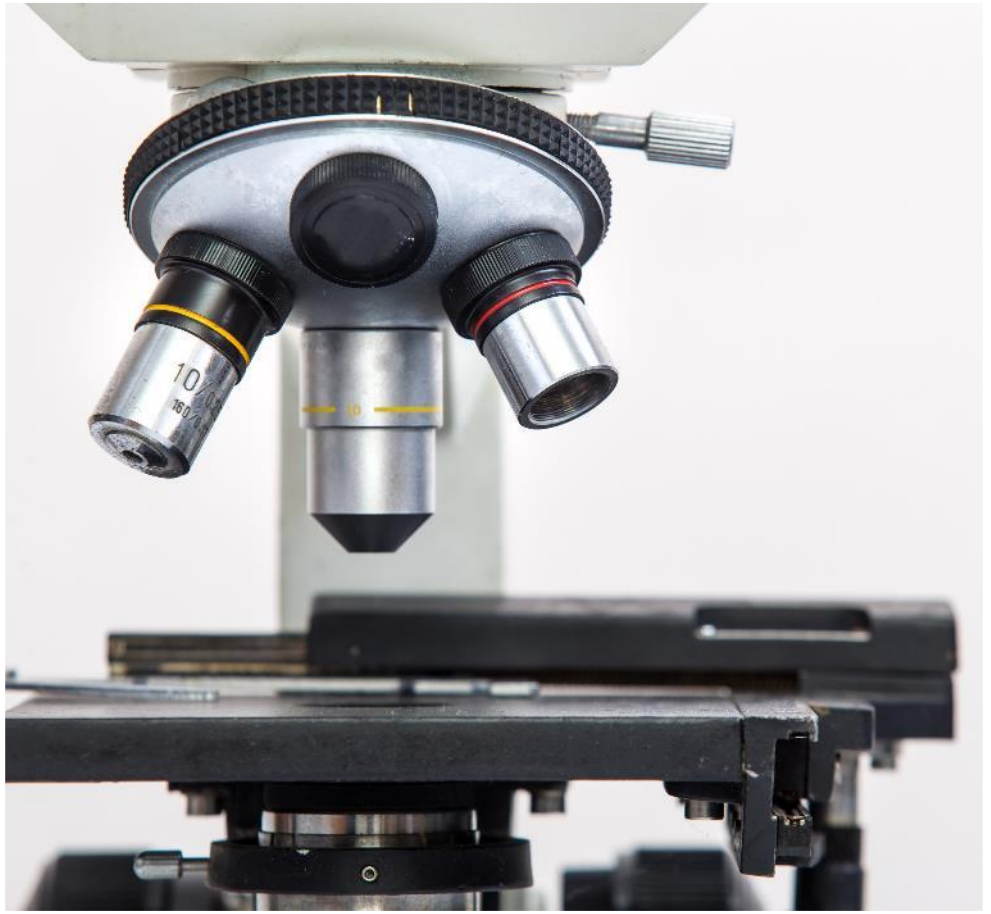
Somerset GP Education Trust

Brendon Jiang

BPharm IP MRPharmS MAPCPharm

- Senior Clinical Pharmacist
  CLICK Primary Care Network
- Clinical Lead Medicines Optimisation
  South West AHSN
- English Pharmacy Board member
  Royal Pharmaceutical Society
- Medicines and Prescribing Associate
  NICE
- SW Regional Ambassador
  Primary Care Pharmacy Association

Twitter @nzpharmer



Deprescribing

- Definition
- Context, policy, drivers and challenges
- Tools, resources and publications
- Practical tips
- Case studies

Jens Martensson

Deprescribing

Definition

The complex process required for the safe and effective cessation (withdrawal) of inappropriate medication. Takes into account the patient's physical functioning, comorbidities, preferences and lifestyle.

DTB 2014;52:25 http://dtb.bmj.com/content/early/2014/03/06/dtb.2014.3.0238

Frailty, polypharmacy and deprescribing DTB 2016;54:69-72 http://dtb.bmj.com/content/54/6/69.abstract

Jens Martensson

Polypharmacy

Appropriate or Problematic?

Medicines are the most common clinical intervention in the NHS[1].

Polypharmacy is very common in England. A recent study of medication use in older people, showed that over 20 years the number of people taking five or more medicines quadrupled from 12 to 49%. The number of people taking no medicines reduced from 1 in 5 to 1 in 13[2].

One third of people aged over 75 now take at least six medicines, and over 1 million people take 8 or more medicines a day[3].

With substantial and increasing medication use there is also a growing risk of harm[4].

Inappropriate polypharmacy leads to poorer health outcomes, fails to take into account what is important for individual patients and poses a serious medicines safety risk. A person taking ten or more medications is 300% more likely to be admitted to hospital[5].

Around 6.5% of hospital admissions are for adverse effects of medicines; this rises to rates of over 10% and up to 20% in the over 65 age group[6].

1 National Institute for Health and Care Excellence. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. (NG5) 2015. https://www.nice.org.uk/guidance/ng5

2 Gao et al. Medication usage change in older people (65+) in England over 20 years: Findings from CFAS I and CFAS I. Age and Ageing. 47. 1-6

3 Health and Social Care Information Centre. Prescriptions dispensed in the community, statistics for England, 2004 – 2014. www.hscic.gov.uk/catalogue/PUB17644

4 Prevalence and economic burden of medication errors in the NHS in England. Policy Research Unit in Economic Evaluation of Health and Care Interventions (EEPRU) February 2018. www.eepru.org.uk

5 Payne RA et al. Is polypharmacy always hazardous? A retrospective cohort analysis using linked electronic health records from primary and secondary care. British Journal of Clinical Pharmacology 2014; 77: 1073 – 1082.

6 Pirmohamed et al. Adverse drug reactions as cause of admission to hospital perspective analysis of 18,820 patients. British Medical Journal 2004; 329:15.

Drivers

How did we get here?

Demographics – increasing age and proportion of older persons

Multimorbidity

Therapeutic advancements

Increased accessibility to treatments

NHS guidance and targets (QOF, NICE quality standards, CQUIN, prescribing incentive schemes)

Multiple prescribers

Medicalisation and psychosocial issues

Patient or carer demand

Prescribing cascade

Policy

Enablers

NHS Long Term Plan

Primary Care Network DES – SMR* & MO, EHCH

Reducing inequalities

PHE Prescribing review 2019

QoF QI domains – medicines safety, PINCER

STOMP

Universal Personalised Care (23/24)

*Targeting affected patient groups (care home residents, opiates, antipsychotics, high risk medications)

Jens Martensson

Challenges

Why is deprescribing so difficult?

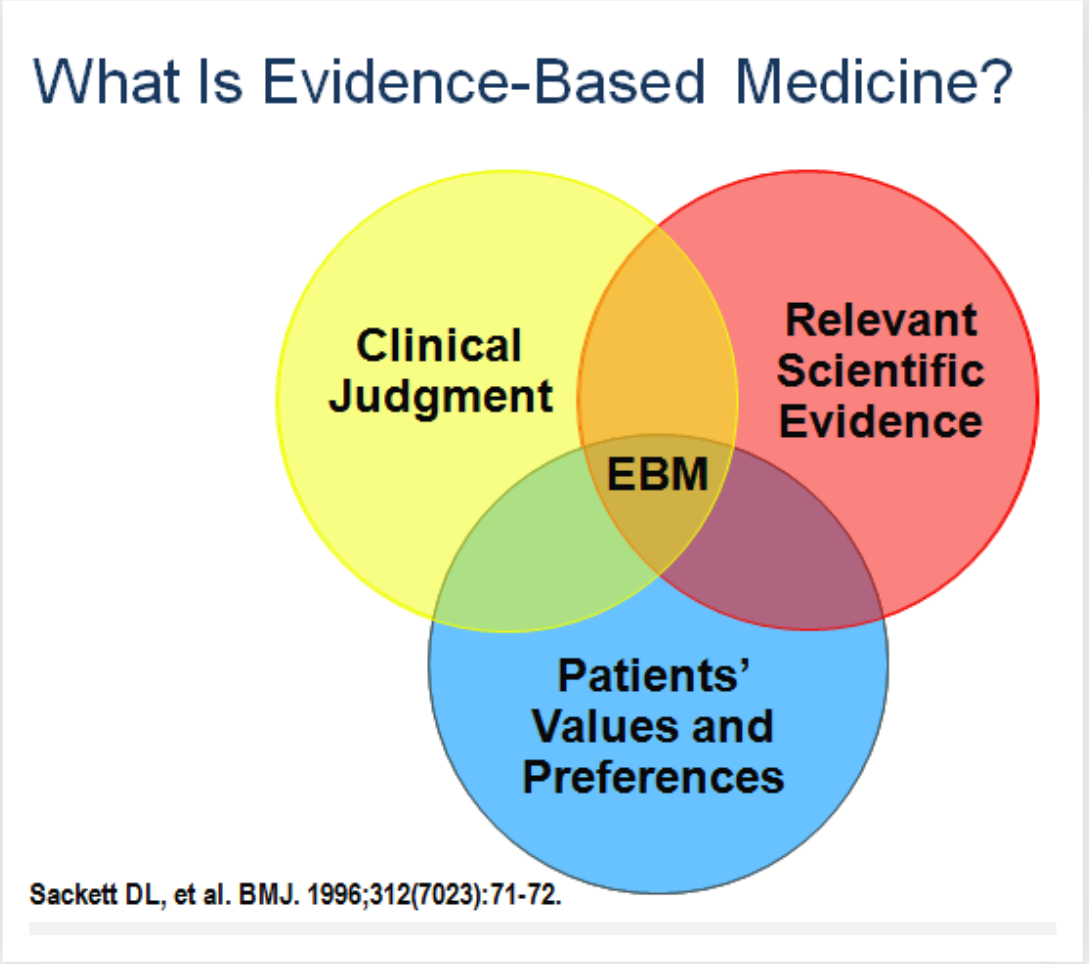
- Fear of litigation
- Poor evidence for stopping therapy/ clinical uncertainty (lack of guidelines/outcome data)
- Non-adherence interpreted as "therapeutic failure"
- Poor communication and transfer of information
- Poor medication review
- Treating condition vs. patient
- Non-pharmacological options not readily available or accessible

Jens Martensson

Personalised Care

Kings Fund 2018

- Why involve patients in their care?
  - Patients want it!
  - Ethical/right thing to do and professional bodies expect it
  - What patients want often differs from what we think they want
  - Well informed people make different choices about treatments -> less unwanted interventions
  - Enhances the way resources are allocated and reduces unwarranted clinical variaton



Tools and resources

- STOPP/START tool http://www.somersetccg.nhs.uk/wp-content/uploads/2020/07/STOPP-START-2.pdf
- STOPPFrail Stoppfrail-v1.pdf (sunderlandccg.nhs.uk)
- Beers criteria updated 2019 2019 AGS Beers Criteria for older adults (pharmacytoday.org)
- Anticholinergic Burden (ACB) scale http://www.medichec.com/assessment
- Scottish Polypharmacy Toolkit Polypharmacy: Manage Medicines (scot.nhs.uk)
- Canadian Deprescribing Network Deprescribing.org - Optimizing Medication Use
- NNT Homepage – TheNNTTheNNT
- Deprescribing - Somerset CCG
- English Deprescribing Network (EDeN) Join here

Jens Martensson

Publications

- NHS Scotland and The Scottish Government 2012, Updated April 2018. Polypharmacy Guidance, realistic prescribing
  http://www.therapeutics.scot.nhs.uk/wpcontent/uploads/2018/04/Polypharmacy-Guidance-2018.pdf
- Kings Fund 2013 Polypharmacy and medicines optimisation : Making it safe & sound.
  http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/polypharmacy-and-medicines-optimisation-kingsfund-nov13.pdf
- NHS Wales Health Board 2013 Polypharmacy: Guidance for Prescribing in Frail Adults Practical guide, full guidance, BNF sections to target
  http://www.wales.nhs.uk/sites3/documents/814/PrescribingForFrailAdults-ABHBpracticalGuidance%5BMay2013%5D.pdf
- NHS Specialist Pharmacy Services 2013: Polypharmacy and deprescribing resources.
  https://www.sps.nhs.uk/articles/polypharmacy-oligopharmacy-deprescribing-resources-to-support-local-delivery/
- NICE multimorbidity guidance and database of treatment effects
  https://www.nice.org.uk/guidance/ng56 https://www.nice.org.uk/guidance/ng56/resources/database-of-treatment-effects-excel-2610552205
- RPS polypharmacy Guidance 2018. Getting our medicines right
  https://www.rpharms.com/recognition/setting-professional-standards/polypharmacy-getting-our-medicines-right

Deprescribing – everyone's business

Prescribing

- Establish expectations
  - Treatment – short course? Explain and document course length
  - Treatment – Symptom relief? Discuss trial for effectiveness, explain, document and agree review date
  - Prevention – lifetime? Reframe as optimising for now with ongoing review
- Review, reassess, realign

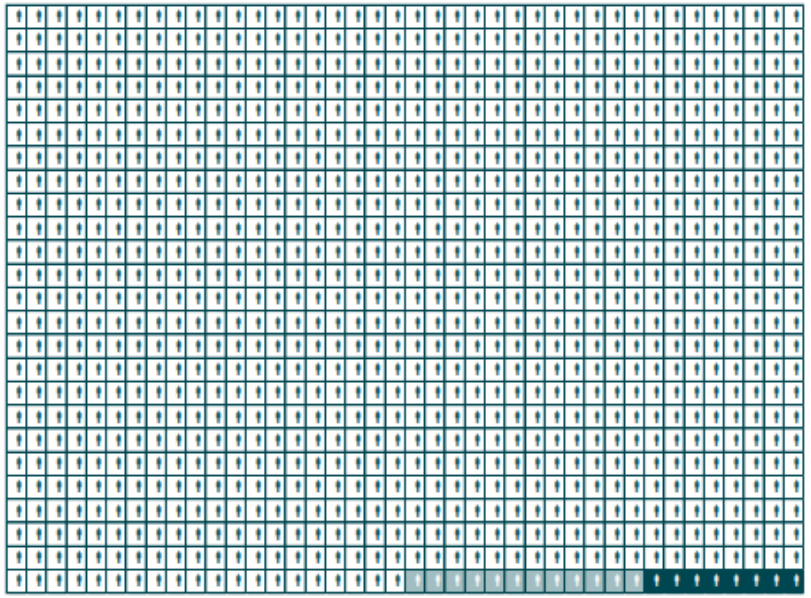
Deprescribing

- Question everything
- Agree to prioritise one or two things
- Balance:
  - Patient (what matters to you)
  - Evidence and clinical uncertainty (what's the matter with you)
  - Clinical judgement (risk/benefit, reasonable alternative)
- Communicate shared, values based decision and actions
- Document agreed decisions, monitor and review

Case studies?

NICE National Institute for Health and Care Excellence

Effect of antipsychotics on the risk of stroke over 6 to 12 weeks



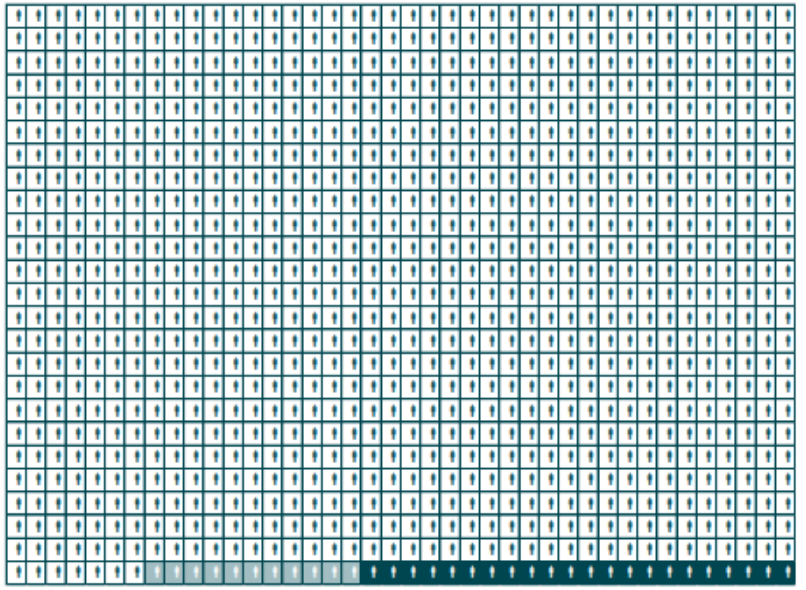
For every 1,000 people living with dementia who have hallucinations, delusions or agitation and who take an antipsychotic for 6 to 12 weeks, while they are taking it **on average**:

- 980 people do not have a stroke, whether they take an antipsychotic or not.
- 8 people have a stroke, whether they take an antipsychotic or not.
- 12 people have a stroke **because** they take an antipsychotic.

This is the **average**: some people will be at greater or lower risk of stroke. **It is not possible to know in advance what will happen to any individual person.**

NICE National Institute for Health and Care Excellence

Effect of antipsychotics on the risk of death over 6 to 12 weeks



For every 1,000 people living with dementia who have hallucinations, delusions or agitation and who take an antipsychotic for 6 to 12 weeks, while they are taking it **on average**:

- 967 people do not die, whether they take an antipsychotic or not.
- 22 people die, whether they take an antipsychotic or not.
- 11 people die **because** they take an antipsychotic.

This is the **average**: some people will be at greater or lower risk of dying. **It is not possible to know in advance what will happen to any individual person.**