Professional Record Standards Body

Better records for better care

OVERPRESCRIBING

eDischarge Supplementary Implementation Support

April 2022

Document Management

Revision History

Version	Date	Summary of Changes
0.1	28-03-22	First draft
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Glossary of Terms

Term / Abbreviation	What it stands for
PCN	Primary Care Network
PID	Project Initiation Document
PRSB	Professional Record Standards Body
SMR	Structured Medication Review
SPS	Standards Partnership Scheme

Contents

1 Executive Summary

1.1 Background

Overprescribing is a significant issue for the NHS. Overprescribing is where people are given medicines that they don't need or want, or which may do them harm.

The PRSB eDischarge summary standard was reviewed in the context of overprescribing in terms of what supplementary implementation support could be provided to raise the overprescribing agenda.

The overall aims to reduce overprescribing and enable better management of medicines are set out clearly in the national overprescribing review report.

The aim of this project was to undertake a small, concentrated piece of work to raise the profile of the overprescribing agenda by focusing upon the existing eDischarge summary standard, with an emphasis on medications and overprescribing in the context of the first recommendation of the national report.

1.2 Method

General research was undertaken to expand upon the existing Implementation Support Report and identify areas which might specifically support the overprescribing agenda.

This was used to develop consultation questions and scenarios which included settings in addition to that within the scope of the original standard development (secondary care to GP), where there would be considerable impact and benefit e.g. secondary care to care homes.

A consultation event was held on 17th March 2022.

In parallel, work has been undertaken to produce supplementary implementation guidance specific to overprescribing, and a website refresh of existing materials for supporting implementation which will be widely promoted through PRSB membership and networks.

1.3 Findings

The project initially focused upon:

- People discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.
- Structured Medication Reviews

From the background research and consultation event, the following key themes emerged:

- Consultation question one identified that ensuring that **stop/review criteria** are communicated was considered the most likely to have the greatest impact on reducing overprescribing. This would apply to a) hospital-initiated medicines, b) other specific medicines where there are stop/review recommendations – for example, antibiotics, short-course steroids or medicines for which monitoring is needed.
- Consultation question two identified that **mental health and chronic pain** were seen as the most important therapeutic areas to tackle to reduce overprescribing.
- An important issue that was raised was that undertaking reviews will only have a limited effect whilst the **current culture of the repeat prescribing** system persists.
- There was a consensus view that inclusion of an **indication** for each drug (third in the question one priority list) would be of significant benefit to both professionals and patients.
- There was consensus that **structured medication reviews** carried out in a **shared decision making** capacity was a key to reducing overprescribing.

- Following on from the shared decision making theme, the concept of including the PRSB '**About Me'** standard within the eDischarge summary was discussed
- Concerns were raised regarding the **confidence of a professional in one setting changing medication prescribed by another**.

1.4 Supplementary materials and materials refresh

PRSB has developed Supplementary Implementation Guidance for the e-Discharge Standard to provide guidance to system suppliers to help them implement the PRSB e-Discharge Standard within their systems with tools and functions that will help to reduce overprescribing.

In support of the Supplementary Implementation Guidance, the PRSB web page materials have been consolidated to allow materials relevant to overprescribing to be accessed as one topic area.

2 Background

2.1 Context

The Department of Health and Social Care published a national overprescribing review report in September 2021[1] led by Dr Keith Ridge, Chief Pharmaceutical Officer for England, which addressed the question "What do we mean by overprescribing?":

Put simply, overprescribing is where people are given medicines they don't need or want, or where harm outweighs benefits. It occurs in every healthcare system in the world. It occurs in several ways:

- *the patient is prescribed a medicine, when there would have been a better alternative. An example of this would be a patient being given a medicine to reduce their blood pressure when changes to diet and lifestyle would be more appropriate for them*
- *the patient is prescribed a medicine which in itself is generally appropriate for that condition, but which is not appropriate for the individual patient. For example, a patient may have a second condition, such as kidney disease, that means the medicine taken for the first one could affect them adversely*
- *the patient is prescribed a medicine, their condition changes and the medicine is no longer appropriate, but the prescription is not reviewed. For example, anti-diabetic medicines prescribed to a patient in their 60s might not still be appropriate in their 90s*
- *the patient no longer needs or benefits from the medicine, but continues to be prescribed it. An example of this would be someone prescribed strong painkillers for the short term who is not offered alternative support to assist with pain management*

When a clinician issues a prescription, it is usually because they genuinely believe that it is something the patient needs. Overprescribing is rarely the result of a faulty diagnosis. As we shall see, the extent of overprescribing is a result of weaknesses in the healthcare system and culture, not the skills or dedication of individual healthcare professionals.

It is not easy to know the true extent of overprescribing, but the review has looked at the available evidence and our best estimate is at least 10% of the current volume of medicines may be overprescribed (though this will be less than 10% by value). There are over 1.1 billion prescription items dispensed each year in primary care and the community in England, which indicates the scale of the problem.

The report also identifies that:

In 1996, the number of prescription items dispensed in primary care and the community in England was 10 per head. By 2016, it had doubled to 20, as shown in Figure 1.

There are more people taking the same medicine for months or years to treat a long-term condition. Repeat prescriptions make up around three-quarters of all prescription items. They can be left without review for long periods, increasing the risk of overprescribing. There are also more people taking multiple medications. Currently, around 15% of people in England are taking five or more medicines a day, with 7% on eight or more. In some cases, people are taking one medicine to deal with the side effects of another. Side effects are a major cause of overprescribing, because what may be the right treatment for someone with a single condition, may need to be adjusted or stopped for someone who has multiple conditions. One medicine may interact negatively with another. There is also the cumulative burden on the patient's metabolism – and on their quality or life – of taking so many different medicines each day.

[1] "Good for you, good for us, good for everybody A plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions" Published 22 September 2021 Department of Health and Social Care

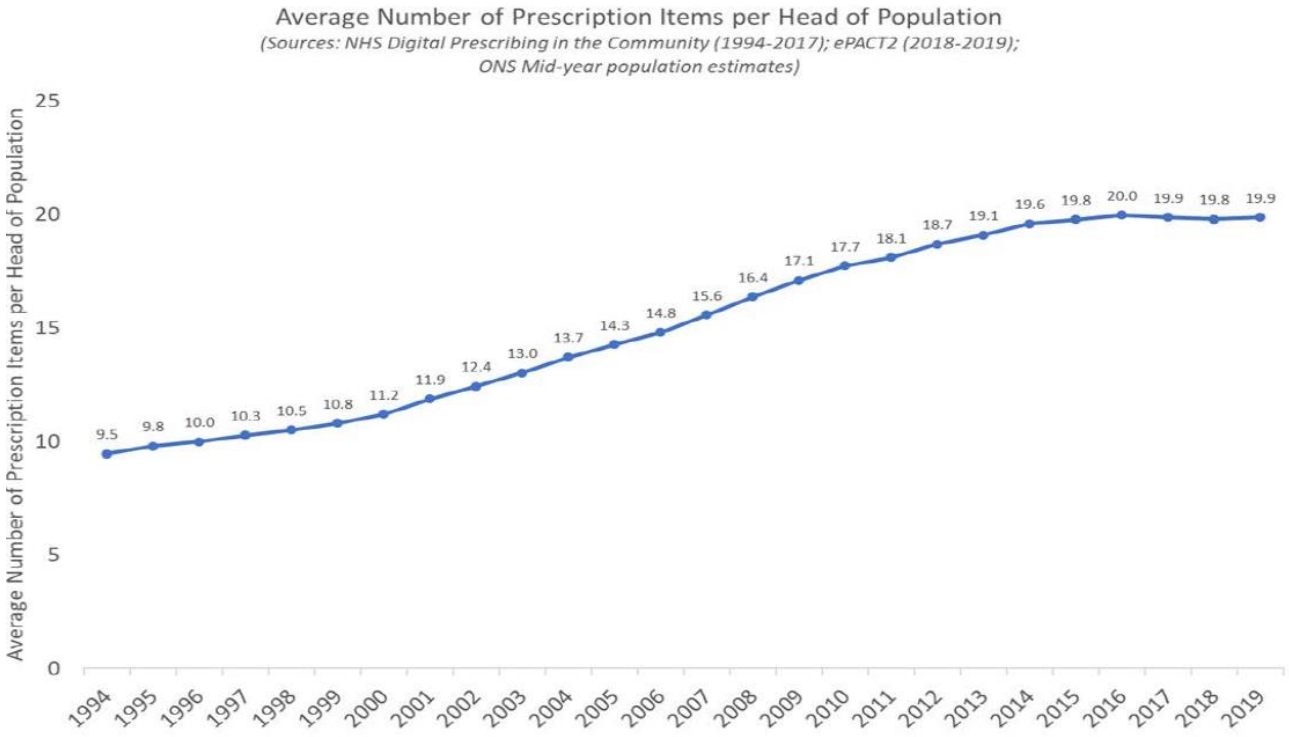


Figure 1: The Average Number of Prescription Items per Head of Population by year 1994-2019.

The report states:

We know what will reduce overprescribing: shared decision-making with patients; better guidance and support for clinicians; more alternatives to medicines, such as physical and social activities and talking therapies; and more Structured Medication Reviews (SMR) for those with long-term health conditions.

In Section 6.2, Patient records and discharge letters, the report identifies:

Although there is a great deal of work underway to improve the way patient records are kept and shared, we still have a national healthcare system where there is no single, complete comprehensive record of a patient's medical history. The ability to view such an integrated record would allow practitioners to prescribe more safely and review medicines with more confidence. It would also make it easier for people receiving care to be more informed about, and involved in, decisions about that care, and better able to engage with care providers, including being able to add information to their own record. There are several ways to achieve this, all of which will require interoperability standards, coupled with adoption, to enable data to be shared and to ensure that full electronic records of individual patient's medicines can be accessed and updated in real time by all those providing care.

If we are to make shared decision-making a reality, there are symbolic and practical changes that need to be made to discharge letters to involve patients and carers. But they will remain a vital channel to communicate clinical information to GPs and others. The universal availability of a single, consolidated patient record which can be accessed and amended by all those providing health and social care may allow the clinical and patient facing elements of a discharge letter to be separated at some future point.

For now, we can only set the desired outcome, which is that discharge letters and similar clinical communications are addressed to the patient, are written in clear, non-clinical language, are sent within the specified time and shared with all those providing care as appropriate, and which use mandated fields to ensure continuity of care on medicines. This work will also need to take account of

the potential for discharge letters to help meet other parts of this strategy: for example, how best to use clinical and discharge letters to facilitate structured medication reviews and deprescribing by including a recommended minimum review period for hospital-initiated medicines.

R1. NHSX should develop open standards and guidelines to ensure that records can be safely shared and accessed across care settings by patients and health and care professionals ultimately creating an interoperable consolidated patient medication record, and work with the Professional Record Standards Body to develop further mandatory standards for discharge letters.

2.2 Scope

The PRSB eDischarge summary standard was reviewed in the context of overprescribing in terms of what supplementary implementation support could be provided to raise the overprescribing agenda.

2.3 Aim and objectives

The overall aims of the report are to reduce overprescribing and enable better management of medicines are set out clearly in the national overprescribing review report.

The aim of this project was to undertake a small, concentrated piece of work to raise the profile of the overprescribing agenda by focusing upon the existing eDischarge summary standard, with an emphasis on medications and overprescribing in the context of the first recommendation of the national report.

The main use case for this standard when it was developed was secondary care to GP although the intention was that it could be used in other settings e.g. care homes. This is a mature standard that has been in use for some years and there is a potential opportunity to join forces with the current NHS initiative to enable updates to GP systems enabling electronic receipt of the messages and significantly increasing the benefit of standardised, structured discharges.

The key objectives were to:

- review and revise the eDischarge summary standard and supporting documentation (web site, implementation guidance, safety case) to highlight the importance of over-prescribing and provide useful and relevant guidance that helps users address the issues.
- identify other use cases (in addition to the original secondary care to GP) where the eDischarge summary standard could be adopted

Within the envelope of the budget for this project, any other additions or updates to standards identified will require full consultation and endorsement, and are not within current scope.

3 Method

3.1 General Research

General research was undertaken to expand upon the existing Implementation Support Report and identify areas which might specifically support the overprescribing agenda.

This was used to develop consultation questions and scenarios which included settings in addition to that within the scope of the original standard development (secondary care to GP), where there would be considerable impact and benefit e.g. secondary care to care homes.

3.2 Consultation

The national overprescribing review report was reviewed in the context of the current eDischarge Standard and a number of questions and scenarios developed for further discussion during consultation.

A consultation event was held on 17th March 2022. Appendix A lists the stakeholders in attendance and Appendix B shows consultation presentation scenarios.

3.3 Supplementary materials and materials refresh

In parallel, work has been undertaken to produce supplementary implementation guidance specific to overprescribing, and a website refresh of existing materials for supporting implementation which will be widely promoted through PRSB membership and networks.

4 Findings

4.1 General Research

Two key sets of recommendations were initially considered.

The first was NICE guideline [NG5] Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, and the associated NICE QS120 Medicines Optimisation quality statements:

Statement 1 People are given the opportunity to be involved in making decisions about their medicines.

Statement 2 People who are prescribed medicines are given an explanation on how to identify and report medicines-related patient safety incidents.

Statement 3 Local health and social care providers monitor medicines-related patient safety incidents to inform their learning in the use of medicines.

Statement 4 People who are inpatients in an acute* setting have a reconciled list of their medicines within 24 hours of admission.

Statement 5 People discharged from a care setting** have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.

Statement 6 Local healthcare providers identify people taking medicines who would benefit from a structured medication review.

*Secondary, Tertiary or Mental Health
** Hospital or Care Home

The second was the contractual requirement for Primary Care Networks (PCNs) to undertake Structured Medication Reviews:

From October 2020, all PCNs are required to identify patients who would benefit from a SMR, specifically those:

- in care homes;
- with complex and problematic polypharmacy, specifically those on 10 or more medications;
- on medicines commonly associated with medication errors;
- with severe frailty, who are particularly isolated or housebound or who have had recent hospital admissions and/or falls;

- using potentially addictive pain management medication.

From these recommendations, the project initially focused upon:

- People discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.
- Structured Medication Reviews

4.2 Consultation

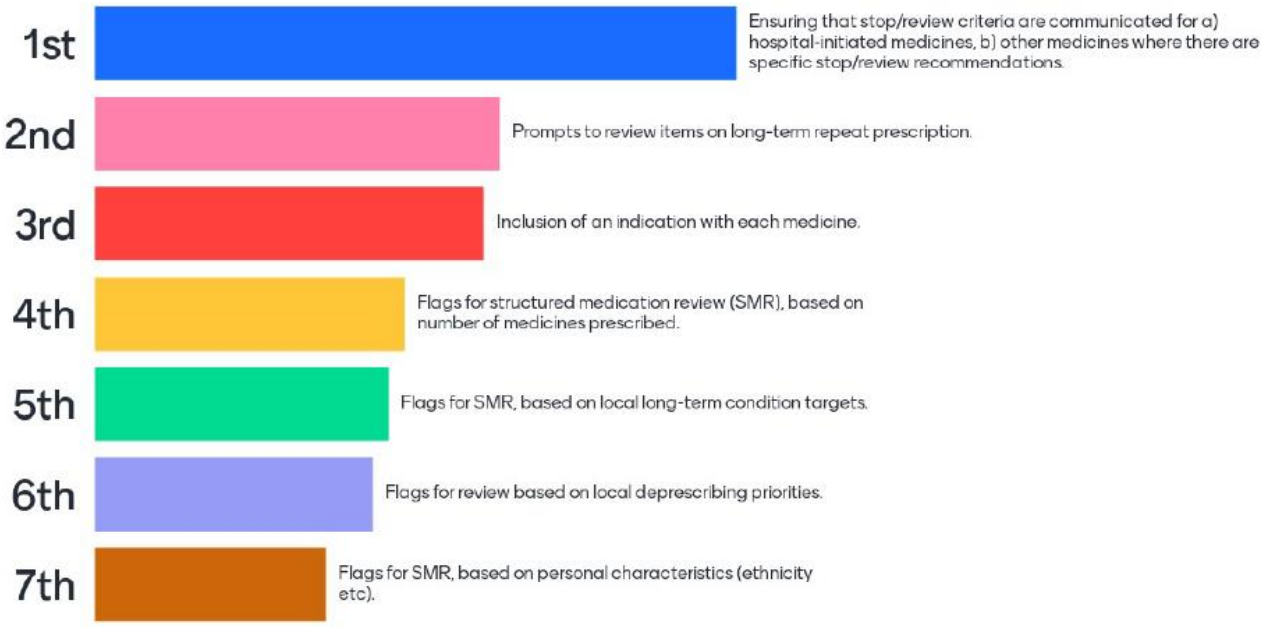
4.2.1 Consultation Event

Attendees were asked two key questions, and were then asked to consider a number of scenarios in the context of how could the e-Discharge prescribing record be used to facilitate a person-centred review that would have an impact on overprescribing? The scenarios are shown in Appendix B.

Q1: What resulting action of using the PRSB e-Discharge Standard do you think would have the greatest impact on reduction in overprescribing?

- Flags for structured medication review (SMR), based on number of medicines prescribed.
- Flags for SMR, based on local long-term condition targets.
- Flags for SMR, based on personal characteristics (ethnicity etc).
- Inclusion of an indication with each medicine.
- Ensuring that stop/review criteria are communicated for a) hospital-initiated medicines, b) other medicines where there are specific stop/review recommendations.
- Flags for review based on local deprescribing priorities.
- Prompts to review items on long-term repeat prescription.

Please rank these in order from 1 = most impact to 7 = least impact in the chat and explain your reasoning.

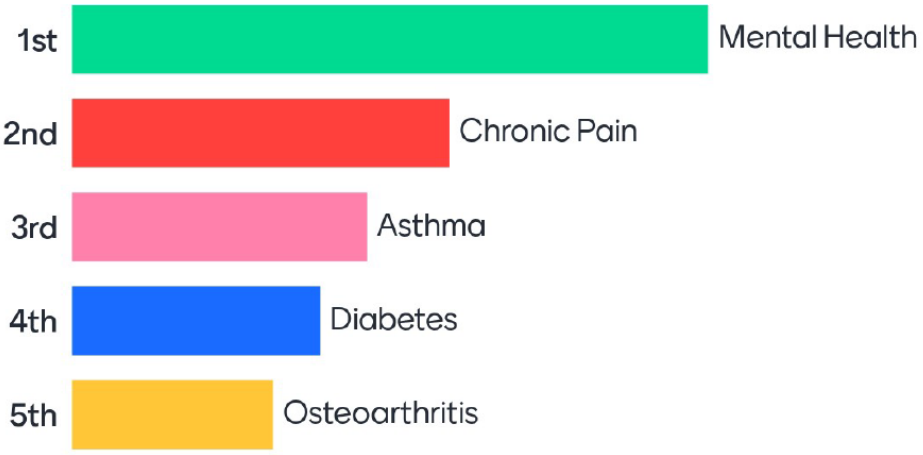


It should be noted that SMR flags were ranked as lower in impact than a) start/stop criteria, b) long-term repeat prescribing reviews and c) inclusion of indication. It is viewed that the standard should facilitate identification of SMR candidates (direction to SMRs was seen as important in the consultation) but the question is: how to do this in an intuitive way without a whole load of flags, which might lead to warning fatigue?

Q2: With which of the following long-term conditions would a process of review and shared decision-making have the greatest impact on overprescribing?

- Diabetes
- Asthma
- Chronic Pain
- Osteoarthritis
- Mental Health

Please rank these in order from 1 = most impact to 5 = least impact in the chat and explain your reasoning.



Mental health and chronic pain were seen as the most important therapeutic areas to tackle to reduce overprescribing. Both of these are prime areas where people could be directed to non-pharmaceutical alternatives, and the standard could facilitate this. Also, both are areas where certain drugs and combinations would suggest an obvious review candidate - for example, use of atypical antipsychotics in mental health, use of 10 or more drugs, including two opiate controlled drugs in pain.

4.2.2 Chat Log and Transcript Analysis: Key Themes

The key chat log comments for further consideration are listed in Appendix C. Key themes which emerged included:

4.2.2.1 Stop / Review Criteria

Question one identified that:

- Ensuring that stop/review criteria are communicated for a) hospital-initiated medicines, b) other medicines where there are specific stop/review recommendations.

was considered the most likely to have the greatest impact on reducing overprescribing.

There was some discussion about overprescribing scoring in the context of frailty scoring. The Toolkit for General Practice in Supporting Older People with Frailty[2] contains the STOPP / START Medication Review Tool which identifies potentially inappropriate drug prescriptions for those over 65. It was

[2] Toolkit for General Practice in Supporting Older People with Frailty NHSE 2017 Publication Gateway reference 06509

concluded that there was little evidence on the effectiveness of scoring tools in this context and that this was not a priority.

4.2.2.2 Repeat Medications

An important issue that was raised was that undertaking reviews will only have a limited effect whilst the current culture of the repeat prescribing system persists, and the number of people who just get all of their items on repeat, even when they don't need them. This issue is not addressed by the current standard which focuses on prescribing rather than dispensing. This is a key issue which requires further consideration.

4.2.2.3 Indications

The General Medical Council (GMC) has endorsed the use of Clinical Indications by all prescribers in its guidelines on good practice in medication prescribing[3] and refers to the definition on the Clinical Indications website:

"Clinical indications are a combination of three or four words that can be used on a prescription to describe the effect on the patient of a particular drug….. Clinical indication labelling is a simple and direct way to communicate with patients about their medicines. They have become routine in many practices and are viewed as normal and accepted by patients. Clinical indications have become essential in the last five years due to the rise of poly-pharmacy for many medical conditions, which often occur in the elderly.

Indication labelling is now possible due to the computer infrastructure that already exists and uses the existing computerised prescription pad. Patients do not need to have any computer knowledge or IT skills to access the benefits of this communication. A few extra words are simply added to their prescription to enhance communication.

Firstly the reason for the drug is explained, for example Atenolol 'to prevent migraine'. In many cases, drugs have a variety of uses and a precise reason can avoid confusion especially if drug insert leaflets are read.

Secondly, many elderly are on over ten different medications and it is easy for them to become confused about what each medicine is for.

Thirdly, key safety messages can be added to the specific prescription. These simple changes revolutionise the everyday prescription such that it empowers patients. They know why they are on specific medicine and they become involved with key safety issues. "It enables me to be in control of my own health".

There was a consensus view that inclusion of an indication for each drug (third in the question one priority list) would be of significant benefit to both professionals and patients.

[3] Good Practice in Prescribing and Managing Medicines and Devices GMC April 2021

4.2.2.4 Structured Medication Reviews

The introduction to the NHS Direct Enhanced Service (DES) contract guidance on Structured Medication Reviews and medicines optimisation[4] states:

2.1 SMRs are a National Institute for Health and Care Excellence (NICE) approved clinical intervention that help people who have complex or problematic polypharmacy.[5] SMRs are designed to be a comprehensive and clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.

2.2 Evidence shows that people with long-term conditions and using multiple medicines have better clinical and personal outcomes following a SMR.[6] Timely application of SMRs to individuals most at risk from problematic polypharmacy will support a reduction in hospital admissions arising from medicines-related harm in primary care. It is estimated that £400 million is spent annually in unnecessary medicines-related harm admissions to hospital.[7]

2.3 Undertaking SMRs in primary care will reduce the number of people who are overprescribed medication, reducing the risk of an adverse drug reaction, hospitalisation or addiction to prescription medicines. Further information on the rationale behind SMRs can be found on the Royal Pharmaceutical Society web page.

2.4 Most prescribing takes place in primary care. Through the increased collaboration with the establishment of PCNs, there is a significant opportunity to support the meeting of international commitments on antimicrobial prescribing.[8] Improved medicines use will also improve patient outcomes, ensure better value for money for the NHS (e.g. by reducing inappropriate prescribing of low priority medicines[9]), and reduce waste and improve its environmental sustainability (e.g. by supporting patients to choose lower carbon inhalers[10] where clinically appropriate and following a full medications review and shared decision-making process).

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[4] "Network Contract Directed Enhanced Service Structured medication reviews and medicines optimisation: guidance" Publishing approval reference: PAR0127 Sept 20

[5] Problematic polypharmacy arises when multiple medicines are prescribed inappropriately, or when the intended benefit of the medicines is not realised or appropriately monitored, potentially due to clinical complexity or clinical capacity

[6] NICE guideline 5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015.

[7] Parekh N, Ali K, Stevenson J, et al. Incidence and cost of medication harm in older adults following hospital discharge: a multicentre prospective study in the UK. Br J Clin Pharmacol 2018. doi: 10.1111/bcp.13613

[8] AMR action plan: https://www.gov.uk/government/publications/uk-5-year-action-plan-forantimicrobial-resistance-2019-to-2024

[9] https://www.england.nhs.uk/wp-content/uploads/2019/08/items-which-should-not-routinely-beprescribed-in-primary-care-v2.1.pdf

[10] Reducing the carbon impact of inhalers is a key commitment in the NHS Long Term Plan, to work toward a greener NHS. Providing informed patient choice on the environmental impact of treatment also forms part the NICE Shared Decision Aid and BTS/SIGN 2019 asthma guidelines: https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/. The UK's Environmental Audit Committee recommended the NHS set a target of reducing to 50% low GWP inhalers by 2022 (Creagh M, Labour MP, Clark C, 2018. Conservative MP. Environmental Audit Committee UK progress on reducing F-gas emissions).

There was consensus that structured medication reviews carried out in a shared decision making capacity was a key to reducing overprescribing.

Regular reviews were also considered key in helping patients understand why they were taking medications, identify issues which might prevent the patient taking as prescribed, and ensuring there was a holistic view of the patient's needs and wishes.

The whole question is not just choosing the right medicines, but getting the right people involved in a person's care. Helping to signpost people to non-medicine alternatives is also key.

4.2.2.5 About Me

Following on from the shared decision making theme, the concept of including the PRSB 'About Me' standard within the eDischarge summary was discussed. About Me information is the most important details that a person wants to share with professionals in health and social care. This information might include how best to communicate with the person, how to help them feel at ease or details about how they like to take their medication.

4.2.2.6 Changing another professionals medication prescription

Concerns were raised regarding the confidence of a professional in one setting changing medication prescribed by another. The following quotations from the chat log highlight the issues:

> "*Reviews can be challenging when meds are prescribed by multiple consultants and the person reviewing those medications does not have the specialist knowledge to identify the consequences of stopping a particular medication.*
> *Often understandably no one professional wants to take responsibility.*"

> *"Provenance - tracing back when, who, why a medication was started - should it be the norm for these to be standard data items within data structures?"*

> *"As you say, and has been mentioned before, confidence in altering a medicine that has been started by someone else, particularly a specialist, is a real barrier to medication review and therefore overprescribing. If letters and discharges from specialists and hospitals clearly stated why they had started something and criteria/time frames for when they could be reviewed, I think this would really help."*

> *"But the issue with incorporating this extra information on discharge summaries is that they are often written by the most junior doctors in the hospital, so they often will not know this information. We need to ensure documentation within hospital also contains this too for them to copy over."*

Concern was also expressed by a carer that an extensive review of medication undertaken in an acute setting was changed by a subsequent review in primary care without reference to the acute consultant.

This concern was felt to be particularly relevant to mental health.

"*overprescribing in mental illness is the most, in my opinion, the most dangerous area of the whole of the NHS*." - carer

The point was raised that if a patient is under the care of mental health professionals, because of the specialist nature, other healthcare professionals might not feel able to review medications, or may be unfamiliar with those prescribed.

It was suggested that this concern applied to any specialist area.

4.3 Supplementary materials and materials refresh

4.3.1 Supplementary Implementation Guidance

PRSB has developed Supplementary Implementation Guidance for the e-Discharge Standard to provide guidance to system suppliers to help them implement the PRSB e-Discharge Standard within their systems with tools and functions that will help to reduce overprescribing.

These tools and functions will include the following:

- Functions to ensure that medicines reviews take place where appropriate after a hospital discharge or transfer of care.
- Display of information on prescribing intention and medicine review period are transferred to support prescribing and deprescribing decisions.
- Presentation of options for non-pharmacological treatment and signposting to other services.

Functions to ensure that patient wishes are displayed at all points in the patient journey, and that healthcare professionals are encouraged to take those issues into account

4.3.2 Materials Refresh

In support of the Supplementary Implementation Guidance, the PRSB web page materials have been consolidated to allow materials relevant to overprescribing to be accessed as one topic area.

1 Appendix 1 Consultation Event - Stakeholder Attendees

First Name	Last Name	Job Title	Associated Company
Mary	Rehman	Chief Pharmaceutical Officer's Clinical Fellow	NHS Digital
Ali	Mohamadi	Clinical Pharmacist	Sussex Community NHS Foundation Trust
James	Whannel	Prescribing Product Manager	Civica
Harikrishnan	Nair	Market Analyst	RioMed
Chandni	Shah	Pharmacist	Archway medical centre
Rebecca	Tanswell	Clinical Lead	Shropdoc
Richard	Goodman	Regional Chief Pharmacist	NHS England and Improvement
Claire	Hilton	BA, C&B Lead	NECS
Oliver	Tyler	Commercial Executive	EMIS Group
James	Goddard	Hospital ePrescribing Lead	NHS Wales
Julie	Gowland	Product Owner / Clinical Specialist	IMS Maxims
Gemma	Ramsay	Senior Policy Lead	NHS England and Improvement
Chris	O'Brien	Programme manager - digital medicines	NHSx
Isabel	Crump	Standards Partnership Assessor	PRSB
Sian	Musto	Lead Specialist - Data Standards	Digital Health and Care Wales
Robert	James	PhD Student	Cardiff University
Kerry	Burrows	Medicines Optimisation Pharmacist: Care Homes	Hampshire, Southampton and Isle of Wight CCG
Annette	Gilmore	PRSB Partnership Scheme Assessment Lead	PRSB
Andy	Hall	Head of Marketing & Communications	PRSB
Ron	Newall	Patient representative	N/A
Ojaih	Willow	Speech and Language Therapist	N/A
David	Jordan	Hon President - Cambridgeshire & Peterborough Carers Groups	Rethink Mental Illness
Ian	Woodburn	Quality Partnership Assessor	Northern Care Alliance
Emma	Melhuish	Informatics Specialist	NHS Digital
Lynne	Wright	PPI Volunteer	N/A
Fran	Husson	Person with lived experience	N/A

2 Appendix B Consultation Presentation Scenarios

SCENARIO 1 - DIABETES

Professional Record Standards Body

Abdul Ridsour is a 55-year-old gentleman of Arabic ethnic origin who has Type 2 diabetes and has recently been discharged from hospital following vascular surgery to improve his circulation following a serious leg ulcer.

On collecting his medicines from the community pharmacy, Abdul's wife has mentioned that he has been started on some new medicines in hospital, and is now taking so many medicines, he gets confused about them and can't remember what he needs to take when.

Abdul's medicines are as follows:

- Sitagliptin 100mg Tablets – one to be taken daily.
- Metformin 500mg Tablets – one to be taken four times a day.
- Gliclazide 80mg Tablets – one to be taken twice a day.
- Simvastatin 80mg Tablets – one to be taken at night.
- Furosemide 40mg Tablets – one to be taken in the morning and at lunchtime.
- Candesartan 4mg Tablets – one to be taken daily.
- Lercanidipine 10mg Tablets – one to be taken daily.
- Bisoprolol 2.5mg Tablets – one to be taken daily.
- Omeprazole 20mg Capsules – one to be taken twice a day.
- Gaviscon Advance Liquid – 10ml four times a day.
- Novorapid Insulin Injection – 10 units prior to evening meal if blood glucose exceeds recommended level.

SCENARIO 2 - ASTHMA

Emma Sanders is a 25-year-old woman, who enjoys sport and an active outdoor lifestyle.

By her own admission, she is not always good at remembering to take her medication when she feels well, but her asthma control has deteriorated recently, and she has had two bad attacks in rapid succession, one of which led to a hospital admission. Emma has been referred to her local community pharmacy.

Emma is on the following medicines:

- Fostair (Beclometasone/Formoterol) 100/6 Inhaler – two puffs twice a day
- Salbutamol 100mcg/dose Inhaler – one or two puffs up to four times a day when required.
- Beclometasone 100mcg/dose Inhaler – one puff to be taken twice a day.
- Montelukast 10mg Tablets – one to be taken daily.
- Prednisolone E/C 5mg Tablets – three to be taken daily.
- Cetirizine 10mg Tablets – one to be taken daily.
- Amoxicillin 500mg Capsules – one to be taken three times a day for seven days (just-in-case medicine if she develops symptoms of a chest infection).

SCENARIO 3 – CHRONIC PAIN

Paul Fenton is a 46-year-old man with hypertension and also a history of chronic back and shoulder pain.

He is a sales representative, so spends many hours in his car between meetings. Also, recently, he injured his ankle falling off a ladder at home.

Paul's medicines are as follows:

- Losartan 100mg Tablets – one to be taken daily.
- Amlodipine 5mg Tablets – one to be taken daily.
- Naproxen 500mg Tablets – one to be taken twice a day.
- Diclofenac Gel – apply two to three times a day.
- Diazepam 2mg Tablets – one to be taken up to three times a day when required for back muscle spasm.
- Co-Codamol 8/500 Tablets – one or two to be taken up to four times a day.
- Lansoprazole 30mg Capsules – one to be taken twice a day.
- Ibuprofen 400mg Tablets – one to be taken three times a day (prescribed by Hospital Minor Injuries Unit for ladder fall).
- Salbutamol 100mcg/dose Inhaler – Two puffs when required for breathlessness.

SCENARIO 4 - OSTEOARTHRITIS

Ethel MacDonald is an 86-year-old woman living in a care home. Ethel has osteoarthritis and poor mobility. Lately, she has had some physiotherapy, but her progress is limited by the pain she is in when trying to walk.

Also: due to a previous hiatus hernia, she struggles with swallowing large tablets.

Ethel is currently prescribed the following medicines:

- Adcal D3 (Calcium and Vitamin D3) Tablets – one to be taken daily.
- Alendronic Acid 70mg Tablets – one to be taken once a week (upright with plenty of water).
- Multivitamins Capsules – one to be taken daily.
- Co-Codamol 30/500 Tablets – two to be taken four times a day.
- Senna Tablets – two to be taken at night.
- Movicol (Macrogols) Sachets – the contents of two sachets to be taken twice a day (in water).
- Amitriptyline 25mg Tablets – one to be taken on alternate nights, alternating with two on the other nights.
- Levothyroxine 100mcg Tablets – one to taken daily.
- Ferrous Sulphate 200mg Tablets – one to be taken three times a day.

SCENARIO 5– MENTAL HEALTH

Helen Greening is a 35-year-old with a history of depression and OCD. Her mental health difficulties began with a sudden onset episode of psychosis in early adulthood.

Despite adequate antidepressant therapy, Helen's mood remains low, and she is convinced that her illness is, in part, related to the side-effects of medicines she is taking.

Helen is on the following medicines:

- Fluoxetine 20mg Capsules– two to be taken at night.
- Lorazepam 1mg Tablets - two to be taken up to twice a day for anxiety.
- Risperidone 2mg Tablets– one to be taken twice a day.
- Zopiclone 7.5mg Tablets – one to be taken at night.
- Domperidone 10mg Tablets – one to be taken three times a day.
- Forceval (Vitamin & Mineral) Capsules– one to be taken daily.
- Glandosane Spray – Apply as required for dry mouth.
- Miconazole 20mg/g Oral Gel – Apply four times a day.

3 Appendix C Consultation Event Chat Log Summary

Full chat log and transcript are available on request.

Comments for consideration:

- SMR should be considered whenever medications are changed or stopped. This should include when this happens in primary and secondary care
- Indications - need to be carried through records so professionals are not completing these data items each time meds are updated - it all adds time to the data administrative burden
- Reviews can be challenging when meds are prescribed by multiple consultants and the person reviewing those medications does not have the specialist knowledge to identify the consequences of stopping a particular medication.
  Often understandably no one professional wants to take responsibility.
- It's a cultural thing - indications and medicines prescribing really should be hand and hand but isn't
- There should be a pain management plan, with non-pharmacological options also detailed to help reduce long term pain medication .
- [In the context of introducing an overprescribing score] There is potential for an overprescribing score to unintentionally increase health inequalities
- The PRSB nursing assessment standard work highlighted how nursing information helps pharmacists understand the person and their circumstances so they know more about how a person will and can take their meds. I think this needs to be considered more when prescribing and reviewing meds more - how the whole person record it used for a holistic view.
- [in the context of a scenario medication list] This list shows that indication would be good for the patient to know why they are taking each of these so they can have an informed discussion about are they all needed and why.
- We've discussed before locally with our ambulance service that when bringing someone into hospital, it is almost more useful for staff to know what their medicines looked like - were there lots of boxes/full boxes/chaotic rather than the list of them as we can see the prescriptions on our systems. Information found out about HOW someone is taking (or not!) their medicines would be really useful to know for conducting an SMR
- It can be really tricky working out practically when to take each medication whilst by abiding by the restrictions, e.g. If you have to take a medication 3 times a day with no other meds 4 hours before or after. Often prescribes don't consider this and then blame the patient for not taking all their meds despite taking them all at the right time being almost impossible
- Need to consider that people also don't want to take more meds than are needed so they may miss a dose if they think it is not needed (and easier to forget if they don't consider it's that important). Our patients used to try and regulate there dosage themselves e.g. by reducing their daily dose or omitting a couple of doses per week . So regular review with person and two way conversations are important - could be in actions for professionals and patients in the discharge summary.
- Contingency, care plans will help inform this piece of work e.g. rescue meds etc
- Therapeutic duplication of NSAIDs, should be flagged by system to be reviewed
- [In the context of scenarios} Removing ambiguity is critical for all these scenarios and one of the key aspects that helps to do this is having an indication, wherever possible. Also if we have an SMR flag or ask for a review then we are relying on someone identifying what they should review. Therefore should individual medicines have markers?

- to ensure patient centred reviews, could discharges not recommend advice from the primary care social prescriber as they are such a valuable resource now?
- Trust is a huge issue here for people with long term conditions. You might have spent years getting the combination of drugs that works best for you and professionals are trying to reduce them because the list of drugs appears to be too long. The relationship and understanding is key in achieving a positive outcome for the patient. This also requires the professional reviewing to have an extremely broad and deep understanding of the drugs and conditions.
- my team carry out SMRs for care home residents, so a way for the discharge to alert us to this resident would be ideal. this would need to be a local setup for what care teams you have in place
- Provenance - tracing back when, who, why a medication was started - should it be the norm for these to be standard data items within data structures?
- Its looking like a lot of people should have a personal care and support plan so they have all the right people actively and concurrently involved in the person's care with the person/ and carer being actively involved.
- As you say, and has been mentioned before, confidence in altering a medicine that has been started by someone else, particularly a specialist, is a real barrier to medication review and therefore overprescribing. If letters and discharges from specialists and hospitals clearly stated why they had started something and criteria/time frames for when they could be reviewed, I think this would really help.
- But the issue with incorporating this extra information on discharge summaries is that they are often written by the most junior doctors in the hospital, so they often will not know this information. We need to ensure documentation within hospital also contains this too for them to copy over.
- The About me standard captures what and who is important to the patient
- There's an NIH research project beginning soon looking at GP confidence in de-prescribing of mental health medications in primary care. Not directly relevant to this chat, but may be of interest to attendees to keep an eye out for