Health Innovation Network

Polypharmacy Action Learning Sets: Five Year Synopsis

A review of the development of the Polypharmacy Action Learning Sets and their importance to addressing overprescribing.

November 2023

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This report is dedicated to our friend, Professor Nina Barnett who inspired all of us to push on and excel with our efforts to address this complex challenge of polypharmacy.

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Introduction

We are delighted to launch this 'Polypharmacy Action Learning Set: Five Year Synopsis' report at our five-year celebration event held at the Royal Pharmaceutical Society on 23 November 2023.

The report showcases the Polypharmacy Action Learning Set model, its development journey and current national roll-out by the Health Innovation Network (formerly the AHSN Network). We share both our own learning and that of Action Learning Set delegates. Most importantly, the report includes recommendations to build upon our experiences and learning, with the ambition of bringing together key stakeholders and policy makers so that our initial aim to 'plug a gap' in GP and pharmacists' education is not 'lost to the system' and is sustained, both through ongoing funding and securing a long-term home for the model when the current Polypharmacy Programme closes (currently planned for March 2024).

Background

In 2018, the Health Foundation published a small study looking at safer prescribing for frailty[1] patients using the STOPP/START tool in Harrogate and Rural District Clinical Commissioning Group. At the time, Health Innovation Wessex had a vibrant Polypharmacy Group who had worked with the NHS Business Services Authority (NHSBSA) to develop the NHSBSA Polypharmacy Prescribing Comparators.

The group recognised that the training gaps related to stopping medicines in primary care were significant and this small Health Foundation project provided the founding idea of developing a training programme to grow prescribers' confidence to stop medicines safely, especially in older people.

Three pharmacists (Clare Howard, Zoe Girdis and Steve Williams) and a GP (Dr Lawrence Brad) worked on developing a training offer aimed at GPs to:

1. Help them understand the challenge of problematic polypharmacy,
2. Be more aware of the evidence-based tools available to help and,
3. Work as a multidisciplinary team to address the more complex polypharmacy cases.

In 2018, we piloted the first cohort in Southampton, face-to-face with mostly GPs and a very small number of clinical pharmacists. This became the first Polypharmacy Action Learning Set.

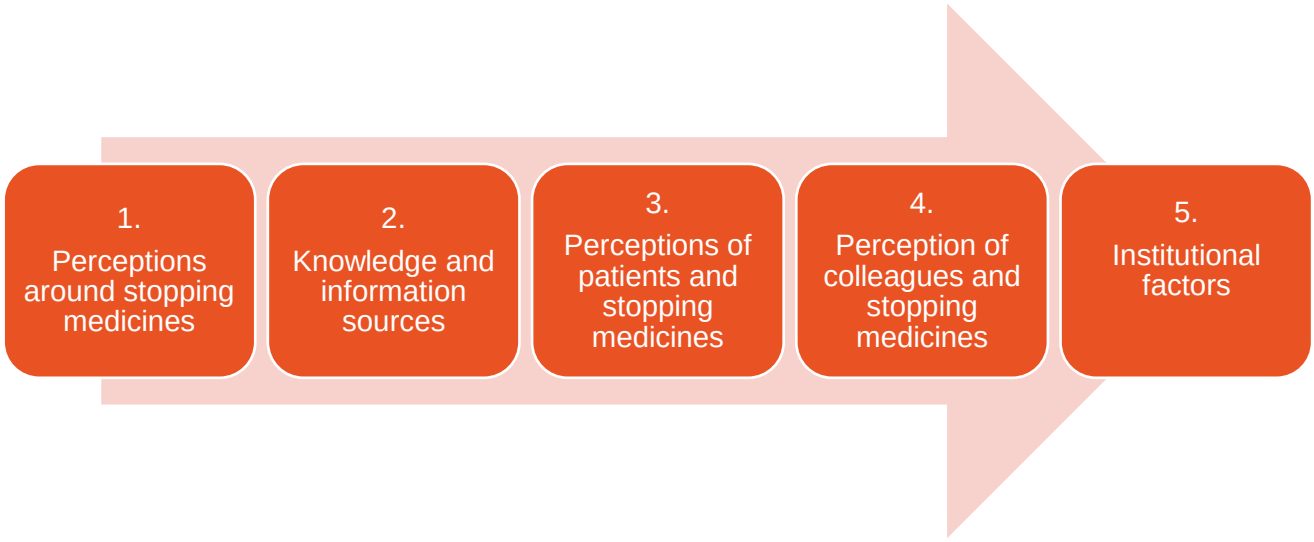
Learning objectives

The aims of the Polypharmacy Action Learning Set were to help clinicians get a better understanding of why medicines that are no longer clinically appropriate are not always stopped and provide support for GPs and pharmacists to conduct polypharmacy medication reviews by:

1. **Understanding** barriers (practical and cognitive) to systematically stopping medicines that are no longer warranted in older patients.
2. **Exploring** how we can address some of these barriers within general practice and support better medication reviews.
3. Providing a **deeper understanding** of shared decision making and how to incorporate this into all medication reviews (especially for older people with multimorbidity).
4. **Outlining** some of the many **tools** available to help prescribers to conduct successful medication reviews.
5. Building the evidence to support wider scale-up.

Four Action Learning Set cohorts (two in Southampton and two in Bournemouth) were independently evaluated using the original questionnaires developed by the Health Foundation project, to understand if what had been delivered met the learning objectives. The findings from this evaluation[2] were published in 2022. **It showed that the Action Learning Set approach delivered significant improvements** in 14 of the 28 statements in the pre-post survey across five domains (see figure 1)

Figure 1: Five improvement domains identified by evaluation of the Action Learning Sets



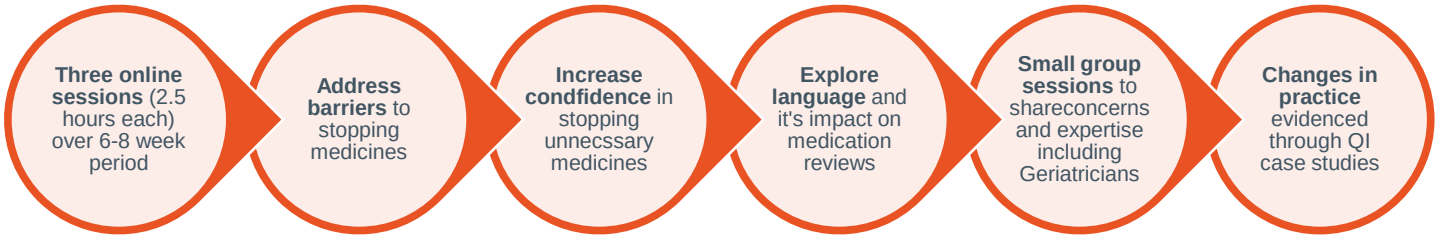
As a result of these findings, Health Education England South commissioned Health Innovation Wessex to deliver six further cohorts across the South of England which, in turn, led to national scaling through the Health Innovation Network Polypharmacy Programme in 2022 (see Figure 2.)

Figure 2: Action Learning Set delivery as of November 2023

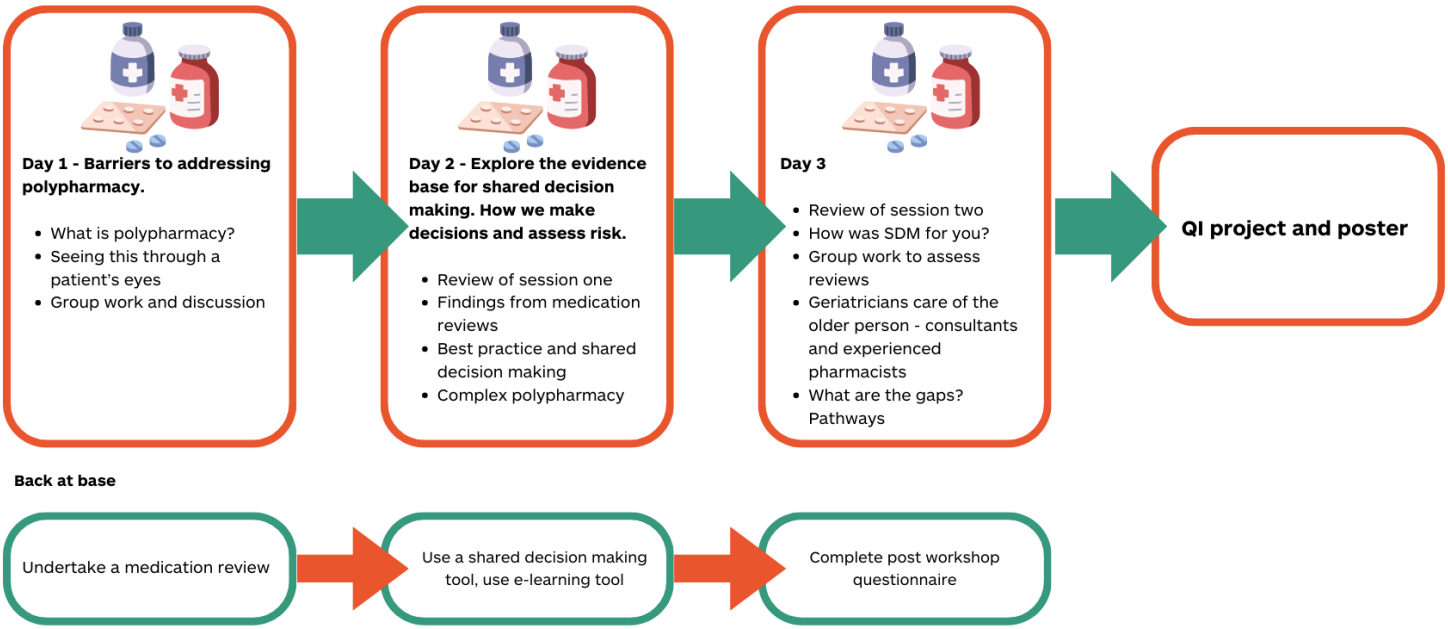
The Polypharmacy Action Learning Sets: what we do, how we do it and what we learn

Our Approach

What we do:



Overview of the three sessions:



Delivering 'Action' using an online learning approach

From March 2020, the Polypharmacy Action Learning Sets have been delivered online due to the Covid pandemic and lockdown across England. The team set about working out how to create the same energy and participation levels achieved during face-to-face training with online learning.

The programme's focus is on 'ACTION', so we use small groupwork 'breakout' sessions across the three days to encourage interaction and discussion. The trainers are all experienced educators and the feedback we capture at the end of each cohort consistently shows no reduction in outcomes since moving exclusively to online learning. Of course, one of the benefits of the online delivery is that we have been able to scale at pace to reach a greater number of people all over the country.

In small, multidisciplinary working groups, delegates get to know their group well and they move though the three sessions with this same group. Their facilitator stays the same for all three sessions. This really helps build the confidence and the feeling of security to share worries and clinical scenarios that delegates find difficult.

In between sessions 1 and 2 and again between sessions 2 and 3, delegates are asked to complete a medication review and come back to the next session willing to share what went well and what didn't. These real-life cases form the basis for the group discussion with geriatricians on Day 3 and help to keep the training focused on the patient.

Who can attend the Action Learning Sets?

The Action Learning Sets are aimed primarily at **GPs and prescribing practice pharmacists**. A small number of other non-medical prescribers working with patients exposed to polypharmacy have completed the course such as Frailty Advanced Nurse Practitioners and Advanced Paramedic Practitioners. However, it should be noted that the programme wasn't designed specifically with them in mind.

Eligibility to attend the course requires competence in medicines optimisation and is designed to increase participants' capability back in the workplace. To participate, delegates must:

1. Work in primary care or within the community (e.g., home visits).

2. Be an independent prescriber for a minimum 12 months.

3. Work with patients with multi morbidity and be responsible for the holistic care of such patients (i.e., not specialists in single long-term conditions).

4. Work with patients where multiple medicines taking can be problematic especially those deemed to be 'frail'.

Why we have delegate exclusion criteria.

When the Action Learning Sets first moved to online delivery, especially in the early days of the Covid-19 vaccine roll out, we came under pressure to widen our criteria to permit all pharmacists onto the programme. We found that accepting more junior pharmacists who were not prescribers on the cohorts radically changed the dynamics of the groupwork conversations. Instead of discussing the complexities of, for example, cardiovascular medicine in frail older people, we were spending a lot of time talking about how general practice operates and what is and isn't acceptable for a pharmacist to be asked to cover within their roles.

Whilst these are valid topics for discussion, they are not the focus of our training and risked changing the learning outcomes of the programme for GPs and senior prescribers. As a result,

strict delegate criteria are now upheld. This has dramatically improved the quality of the group work discussions and put the sessions firmly back in the space of how to stop medicines safely and be braver about deprescribing.

Addressing the gaps in junior prescribing: Polypharmacy ALS Foundation.

The Health Innovation Network recognises many junior prescribers would benefit from a training offer like the Action Learning Sets. To address the gaps seen in junior prescribing, Health Innovation Wessex has developed a pilot programme called Polypharmacy ALS Foundation. Run over two mornings, and with GPs supporting rather than geriatricians, this first small-scale pilot is currently being evaluated. It is important that the work complements the Centre for Pharmacy Postgraduate Education (CPPE) primary care pharmacist pathway training.

Why GP attendance is key:

The Polypharmacy Action Learning Sets were originally designed for GPs with only a small number of practice pharmacists joining, reflecting the relatively new role of practice or PCN pharmacists, introduced in 2018. Since then, pharmacists have increasingly become the predominant group. Since scaling nationally, we found some of the cohorts with very few GPs didn't work as well. Conversations were diverted to exploring local dysfunctional primary care environments and therefore took the focus away from managing complex medication reviews in older people. We continue to focus efforts to target GP colleagues and ensure each small group discussion has at least two GPs.

Driving attendance has been hard especially during winter months when primary care is most pressurised with flu vaccinations, Covid vaccination clinics, winter pressures with respiratory illness and so on. Pharmacists who meet our criteria are benefitting from the programme. However, in our view, if the work of stopping inappropriate medicines falls predominantly to pharmacists, we will never educate our GP workforce about how hard it is to stop medicines and that medicines need to be started in a much clearer way with patients. Very few medicines are taken 'for life' with no review or adjustment, especially as the patients reach older age. For these reasons, GPs need to be skilled in the art of medication review and deprescribing and it is important that practices work as a team to address this. *Learning together will be key to this in the future and there is still much to do.*

Barriers to tackling problematic polypharmacy: delegate views

On Day 1, delegates are asked to share what they see as the **local system** barriers to addressing polypharmacy, and then asked to share their own **personal** barriers to stopping medicines that they know may not be helpful to their patients.

Local system barriers	Personal barriers
Time: • to review medicines thoroughly and prepare for the medication review. • to undertake a good, structured medication review • to follow up.	**Confidence:** Delegates describe knowing that a medicine may not be needed or may be causing harm but lack the confidence to stop it for fear of the consequences.

Transfer of care when patients move from secondary care to primary care: Poor communication contributes to misunderstandings about why a medicine has been started or indeed when it should be stopped. Concerns at this lack of information when patients are discharged home.	**Lack of knowledge of:** • **risk and benefits of medicines** specific to the person they are managing. • **indications for the medicine** in the first place (if they do not know why it was prescribed, they are reluctant to stop it).
Single organ specialists: Adding to patient's medicines lists without understanding the context of the patient's wider medical history or social environment.	**Patient relationships:** If the patient is not known to the clinician, there may be a lack of trust which is needed to stop medicines in a way that patients feel confident in.
Fear of litigation or medicolegal implications from stopping medicines.	**Fear of litigation or medico-legal implications from stopping medicines or fear of patient complaints.**
IT systems: Interoperability issues between different systems.	**Other clinicians:** • Concerns that their team members have started the medicine, so by stopping it, they may be "treading on toes". • One clinician stopping a medicine only for another member of the team to reinstate it without discussion. This is especially pertinent to dependence forming medicines such as opioids, gabapentinoids and benzodiazepines. • Lack of support and supervision from other colleagues related to decision making.
Drug shortages: Taking up lots of primary care time that then can't be used for structured medication reviews (SMR) or other work.	**Worries about challenge from family and or carers:** Misinterpreting stopping medicines in older people as "giving up" on their loved one.
Administrative support: Capacity to call patients and set up a proactive SMR.	**Numbers:** The number of patients requiring a medication review is overwhelming.
Communication: Between clinicians, between places of services.	

What does this session tell us?

Our findings support the published literature[3] that confidence is a significant barrier to stopping medicines. Clinicians know there is a lack of evidence to support prescribing large numbers of medicines in older people, but they worry about the consequences of stopping medicines and lack the confidence to try.

Delegates benefit from seeing that their peers and colleagues share the same worries about stopping medicines. We keep both the small groups and the facilitators the same for all three sessions and it becomes clear that they learn as a group. Confidence grows significantly on Day 3 when they hear from the geriatricians.

What do delegates learn to help them overcome these barriers?

Over the course of the three sessions, we share the experience of the group facilitators, the collective views of the whole group and the input of the geriatricians on Day 3 to help delegates work through some of the major barriers that they have identified. Examples include:

Barrier identified	Mitigation
Time	Over the three sessions, we share examples of how the better performing PCNs **risk stratify their patients using NHS BSA polypharmacy prescribing comparators**[4] and link the number of people identified for an SMR to the capacity (and capability) of the team. We show how **pharmacy technicians and administrative teams can share the workload prior to a proactive SMR** and then how much time is needed for a good SMR and possible follow up. A team approach is vital.
Lack of understanding of the evidence base	We share a range of tools to help with this. Feedback from delegates show NHS Scotland[5], GP Evidence[6] and deprescribing tools from Canada[7] and Australia[8] are consistently the most popular.
Fear of litigation	One of the ALS developers and current trainers is also a clinician expert witness in prescribing-related legal cases. They share their experience and advice about the actual rates of litigation cases and how to ensure best practice to prevent or help manage any complaints. We highlight the importance of documenting the thinking behind decisions, encourage multidisciplinary discussions in trickier cases and good follow up with patients. We cover Montgomery case law in detail in session 2 to ensure delegates understand the changes that case brought about and the importance of material risk to the patient in front of you.
Single organ specialists	Heart failure is one of the most frequently mentioned challenges. Delegates consistently report feeling under pressure to apply the '4 Pillars' to older frail patients who may not be able to manage the number of medicines or the side effects that they induce. To address this, Health Innovation Wessex developed a heart failure in older people masterclass[9]. Similar masterclasses are planned for other frequently mentioned challenging areas of prescribing including managing pain in older people and antipsychotics in people with dementia.
The desire to do something	We share with delegates the 'righting reflex' that we know many clinicians feel. This is the strong desire of the clinician to medically fix something or put it right. We encourage clinicians to use the **BRAN**[10] approach in consultations and discuss with the patient the **B**enefits, **R**isks, **A**lternatives and doing **N**othing.

Shared decision making is hard, and it takes longer	Delegates may believe that they are already engaging in good, shared decision making or that it is too difficult to achieve in current practice. We explore in session 2 how clinical decisions are made and how we all make different decisions based on the same risks and facts. We remind delegates that we are not living with the conditions that our patients are, and we need to listen to what that feels like. We explore what options we can offer and help to reach an informed decision and the importance of documenting that process.

You are not alone

Delegates benefit from realising that this is complex work, and to an extent all clinicians are working in the grey in managing medicines in older, frail people. They see that their peers are feeling the same about this topic and indeed that the geriatricians don't have all the answers because there may not be an evidence-based answer, but they have experience of stopping medicines safely and that helps them enormously.

Language matters!

We ask delegates to think about the words they use to help patients open up about their issues, concerns and expectations (ICE) related to their prescribed medicines. These have been collated and discussed with Consultant Pharmacists Lelly Oboh and Professor Nina Barnett to incorporate their views of the best ways to open a shared decision-making consultation about medicines. A summary of all these contributions is below.

Phrases to help patients open up about their medicines taking and concerns.

How do you feel about taking all these medicines?

We know that people find it difficult to take lots of medicines. Are there any here that you aren't taking?

Which of these medicines concerns you the most?

Please tell me about some important things for you that your medicines are helping you with.

What is your key priority for today's appointment? I can rebook you again to look at my issues if they are different?

Wow! That's a lot of medicines how to manage taking them all?

Let's look at your active medical issues and your repeat medicines and see if we can match them up?

Do you feel your medicines can work better for you? Tell me more about that.

Tell me a bit about how your medicines fit into your daily routine or life right now?

Please tell me what important things your medicines are preventing you from doing OR how do your medicines get in the way of important activities you need to get on with.

Now, this means I need to add in another medicine to this list, do you think there are any we should consider stopping?

Tell me what you'd like to change about your medicines if you could.

Are there any medicines you'd prefer not to take? Tell me more about that.

What would you like to be better for you (or change about your medicines) at the end of our conversation?

The Role of the Geriatrician

Geriatricians join the Action Learning Set on Day 3. Throughout the course, delegates have shared their concerns, worries and issues, worked through the evidence base and tools to support shared decision making and then on Day 3 are supported by geriatrician colleagues to help explore some of the trickier topics and cases. In small groups of 8-10, we ask delegates to share a difficult clinical scenario that they have encountered, and the geriatricians then share with the group how they manage such situations.

The answers broadly fall into two key areas.

1. **Technical** - geriatricians share with delegates how to approach prescribing challenges and stopping medicine in older, frail patients. Topics such as managing heart failure, treating diabetes, managing pain and when to stop anticoagulants are the areas that delegates highlight as causing them the most concern.

2. **Holistic** – geriatricians share how they do shared decision making with patients and their carers. This often requires a reminder about what the evidence DOESN'T tell us about prescribing in older people and so the answer to how to proceed lies in the quality of the conversation between clinician and patient (or carer or wider family)

Having geriatricians join on Day 3 always feels like the highlight of the programme. These sessions are consistently well evaluated, and we are enormously grateful to all the wonderful geriatricians who have supported us over the years.

Geriatrician quotes:

"The moment I saw the work the Action Learning Set team were doing I wanted to be part of it. Supporting GPs and prescribers to put their patients at the centre of their decisions, to understand patients' goals, to be honest about uncertainty, side effects and unwanted medicine and to recognise good medicines too - wow what a goal! This project is all about improving the lives of patients and prescribers and I love it." **Dr Lucy Pollock**, **Consultant Geriatrician, Somerset Foundation NHS Trust.**

"I love to contribute to the ALS teachings because I know our older patients often are subjected to polypharmacy and suffer the associated side effects. Also, it is clear to me that clinicians very often lack confidence to deprescribe and don't feel they know how to go about it. I have learnt much in the sessions myself, by sharing experiences with others and listening to their own anecdotes. I always say that deprescribing is one of the few areas where we have control and can make a definite difference. Many other problems in our patients are irreversible and progressive but we CAN stop medication that has or can become harmful." **Dr Ana Phelps, Consultant Geriatrician working at Buckinghamshire Healthcare NHS Trust**

"I am very passionate about highlighting the negative effects of polypharmacy and the consequence to patients' quality of life. This is a fantastic forum of ideas and discussion to socialise the principles of deprescribing and drive a better future for our patients." **Dr Robin Fackrell, Consultant in Geriatric and General Medicine, Royal United Hospitals Bath NHS Foundation Trust**

What delegates tell us after attending the Polypharmacy Action Learning Sets

"As a GP partner with a significant number of elderly and vulnerable patients under my care, I found the action learning sets invaluable for building confidence in working with patients to tackle polypharmacy. This includes the provision of patient support aids and approaching difficult 'de-prescribing' conversations with more structure and clearer objectives". *GP Partner at St Clements Surgery, Winchester*

Increased awareness: "I presented to our GPs and shared the data from (NHSBSA) ePACT2. We were quite high on anticholinergic burden. We had a great discussion and it led to 5 actions from across the team to address this".

"We also realised that patients don't understand the different roles in community pharmacy and general practice so we are developing a leaflet to help patients understand where they can get help with their medicines".

A safe space to share concern: "I really appreciated having a place to share with other colleagues the issues and worries that I have about polypharmacy. It was good to hear that others share those worries".

The data: "The practice data showed us that polypharmacy is everyone's business it adds the context. Practices often don't know what their prescribing looks like. I work with undergraduates and its vital that they embrace deprescribing as part of their prescribing qualification in the future."

Secondary care: "So much of polypharmacy is influenced by secondary care. Important that we feel braver about challenging prescribing decisions. And if we (in secondary care) provided more information at discharge we could make things a lot easier".

It's like turning an oil tanker: "Addressing polypharmacy is a huge challenge but by doing small things locally we can have an impact slowly."

Better conversation with patients: "Since attending the ALS I have had some lovely conversations with patients. I have been braver about suggesting we perhaps trial stopping a dose and see what happens. Then when it goes well, the patient trusts you and we can try stopping something else. It has improved my consultations."

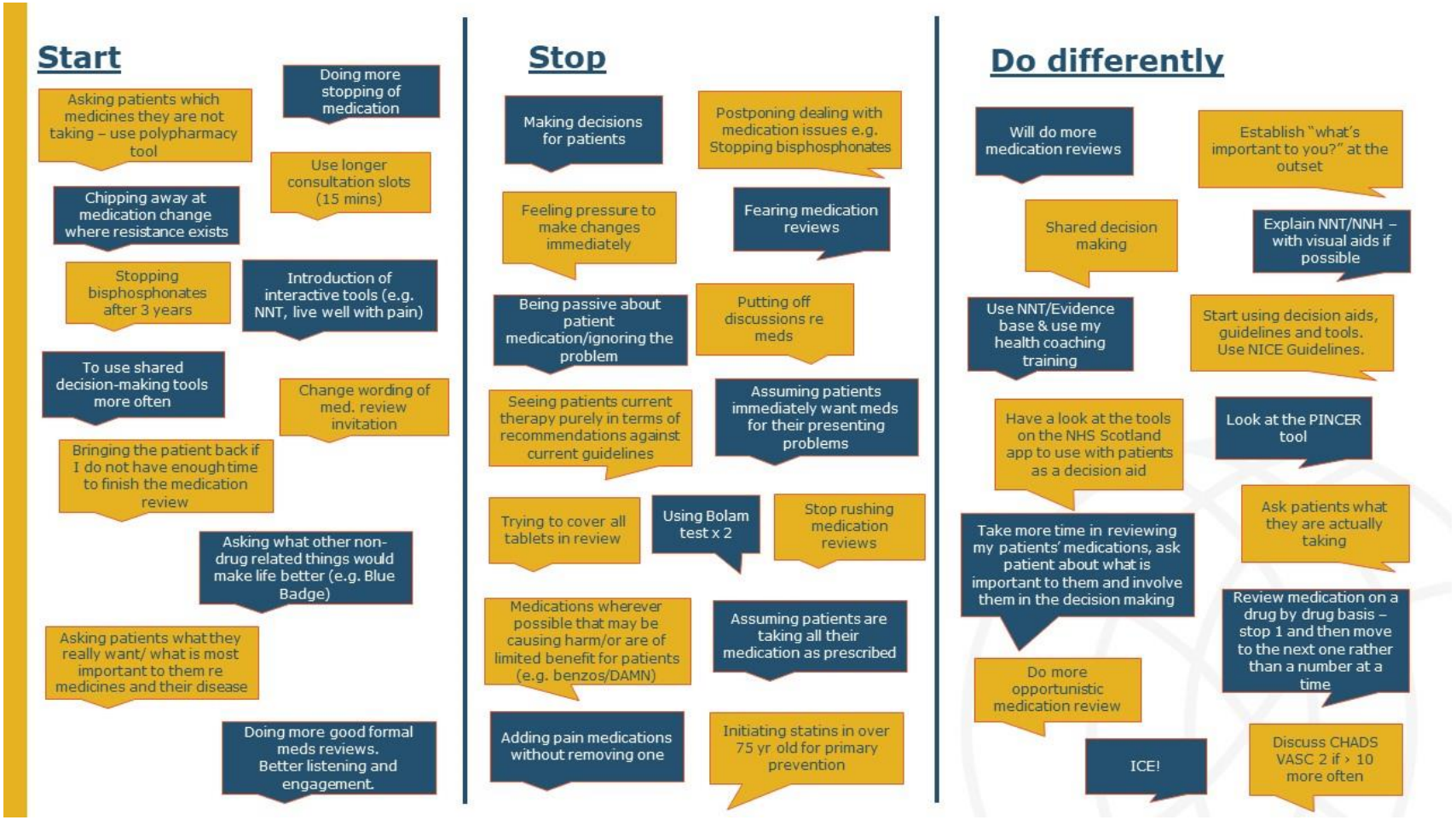
Reassurance: "I found it reassuring to know there isn't a right answer and that we can be better at working in the grey areas."

Language: "Deprescribing is part of prescribing, and I liked the section on language to help the consultation."

Redressing the balance: "For so many years we have had huge pressure to prescribe from Pharma, QoF, etc that it's great that finally we are getting the balance back (especially for older people)."

Confidence: "I finished the course and felt I CAN do this. I work in the care of older people and have always felt many of the medicines are unnecessary but now I feel empowered to have a go at stopping them."

At the end of day 2, we ask delegates what they would now **"start, stop and do differently".** Their responses are summarised below.



Shared decision making with patients

The Polypharmacy Action Learning Sets constantly brings the focus back to patients and what it feels like to be on the receiving end of our care and polypharmacy. We hear frequently patients have not had the concept of shared decision making or multi-disciplinary team work clearly explained to them, with GPs reporting that some patients still defer to "what would you do doctor?" We also hear delegates describing patients feeling dissatisfied because they had been referred to a pharmacist or frailty nurse for a review.

We address these issues and support shared decision making through our focus on:

Patient films	On Day 1 we show delegates a video from Bradford University sharing the thoughts and views of patients when they have moved between care setting and changes have been made to their medicines. On day 2 we share 'Sam's Story' who is encouraged to have honest discussions with his GP following the publication of the NICE multimorbidity guidance. Delegates recognise the issues that the patients describe in the video.
Patient stories	We share Oliver's story[11] and ensure that whilst we talk lot about older people, we also highlight that patients with learning difficulties and other vulnerable groups can quickly experience harm from medicines that are inappropriately prescribed or that can't be managed.
Shared decision making	1. At each session, delegates share a medication review that they have done recently and are asked to share what they think the experience was like for their patients. 2. On Day 2 we outline the Montgomery case law[12] which made a significant change to how we need to think about shared decision making and material impact on patients. 3. We discuss how we make decisions as individuals and consider what the experience has been like as a patient/carer – we try to guide our delegates to see shared decision making through the patient's lens/experience rather than solely as clinicians. 4. Promote Health Innovation Network developed patient resources to support and prepare patients for a Structured Medication Review.
Health inequalities	We talk about the impact of deprivation on polypharmacy and how low educational attainment, language barriers and the impact dementia can have on the ability to do good, shared decision making.

Evaluation feedback

Our interim evaluation[13] demonstrates that outcomes achieved in the Health Innovation Wessex pilot have been maintained through national scaling of the Action Learning Sets. Delegate feedback collected between July 2022 – March 2023 showed:

- Of 168 respondents, **82% of pharmacists and 86% GPs** said the Action Learning Sets **met or exceeded** their expectations. **97% of respondents would recommend** the Action Learning Sets to colleagues.
- **Respondents rated** the provision of specialist input, practical application of learning, space for open discussion with peers and the resources and information shared.
- **Increased confidence:** Most respondents self-reported an increase in confidence to conduct structured medication reviews, with evidence of a small self-reported increase in confidence to stop medicines.
- **Shared decision making with patients:** out of 150 respondents, **83% of pharmacists, 88% of GPs, and 76% of nurses** noted they had made **at least one change to their practice** involving decision-making with patients (n150).
- **Decision making with colleagues:** out of 146 respondents, **93 indicated that they had made a change** to their practice around decision making with colleagues.

Delegate quotes:

"The learning action set was brilliant. The discussion groups were particularly useful for sharing experiences and learning. The provision of resources was also helpful. I feel more confident to apply my learning and champion deprescribing in polypharmacy".

"I found the Action Learning Sets very useful, there really is nowhere else for GPs to get this kind of training. For me, it really highlighted the global issue around polypharmacy and the tools and resources that are available for GPs and their teams to get this right for our patients".

"Wonderful interactive discussions around polypharmacy barriers and useful pointers for how to overcome in practice. Day 3 with the geriatricians was especially beneficial to provide insight to problems around pressure to work to targets in general practice".

"I found the group discussions where we discussed actual cases particularly helpful. Getting support on my own cases and also hearing how others have managed theirs.
[It was] also reassuring to know that many of the reasons I struggle with deprescribing are reflected by other prescriber".

Action Learning Set: Train the Trainer Model

The National Polypharmacy Programme established a Train the Trainer model to facilitate accreditation of regional level Polypharmacy Educators and additional Action Learning Set Trainers and Facilitators to deliver local education sessions and support the national scale up of the Action Learning Sets.

The model is based on the National Prescribing Centre/ NICE Associates model and supported by Jonathan Underhill, Consultant Clinical Advisor at NICE who sits on our assessment and accreditation panel:

"At NICE we're big supporters of the Polypharmacy action learning sets. They have been shown to improve clinicians' confidence in stopping medicines. We have a team of wonderful geriatricians working with us to share their advice and guidance". Jonathan Underhill, NICE.

Accredited Polypharmacy Educators and Action Learning Set Trainers must:

- Attend the Action Learning Set as a delegate.
- Complete two 'Train the Trainer' assessment days.
- Complete a quality improvement case study showcasing learning into practice.
- Attend the Action Learning Set as an observer.

To date we have accredited 17 Polypharmacy Educators working with their regional Health Innovation Network to design and deliver local Polypharmacy learning and education. The Polypharmacy Educators provide the wider system with an opportunity to harness this knowledge and skills; to accelerate better understanding of problematic polypharmacy and widen the reach of education and learning across a range of health professions at both junior and senior levels.

Mentoring and support for our trainers is available within the current Train the Trainer but will need to be sustained when the Health Innovation Network Polypharmacy Programme closes.

Comments from delegates as to why they became a Trainer:

"I found the action learning sets really useful. As a GP I've come from a different viewpoint from pharmacists who have learnt about a lot of this before, and for a moment it was a little bit new. But I found it extremely useful, and it really highlighted the global issues around polypharmacy and the resources that are available to help GPs, Pharmacists and patients."

Dr Priti Kaddo, GP.

"After I attended the Polypharmacy ALS, I adjusted the way I approach consultations and train colleagues on shared decision making and structured medication reviews. The Action Learning Sets are a fantastic vehicle to inform and improve the way we conduct structured medication reviews."

Graham Stretch, Primary Care Pharmacy Association President, Partner and Chief Pharmacist, Argle Health Group.

"For me the reasons were multi-faceted. Not only was it a programme that I wanted to be a part of due to it being well-designed and inspirational to the multi-disciplinary team. But it was delivering in areas, I thought were important, both personally and professionally. From a family perspective, when the programme first presented, my Grandad was struggling with the burden of his medication, and it had been a real struggle to get these rationalised. And then professionally, the frustrations of polypharmacy were present in everyday practice, requiring a bigger solution, a collaborative approach, which hopefully this may give. Additionally, I had

almost completed my post-graduate certificate in education and were looking for additional opportunities to expand and reflect on my teaching and training skills. By becoming a trainer, therefore, I hoped to influence change both to myself, patients, team members and systems".
Sarah Partridge, Lead Senior Clinical PCN Pharmacist, Nottingham City GP Alliance.

What have we learnt as Action Learning Set trainers?

1. **Confidence to stop medicines safely is a significant issue** amongst GPs[11] and Pharmacists. Clinicians know that older people are being tipped into harm by the volume of medicines we ask them to take, but prescribers often lack the knowledge and skill to accurately assess the risk and benefits of medicines, especially in older people where the evidence base for benefit is poor.

   As more health care practitioners and clinicians are involved with the care of older people (who often have multiple Long-Term Conditions (LTCs) the **holistic view of the patient can be lost.** Primary Care teams are the default coordinators for patient care, but they find it difficult to deal with requests from single organ specialists to add in yet another medicine(s).

2. **Shared decision making with the patient is the key to solving this issue**. But both patients and clinicians need much more support to do this well and systematically. Many delegates at the start of Day 1 often report that they feel they do shared decision making well but as we highlight best practice and the evidence base, delegates appear to appreciate how much more work is needed to get this right consistently.

3. **Primary care has the data and the tools** to be able to manage populations and risk stratify groups of patients to be prioritised for a Structured Medication Review, **but there is a huge amount of education and training needed to embed these tools** until they become usual practice and drive the case load that General Practice and PCN Pharmacists deliver. Ideally 80% of SMRs should be carried out proactively in patients who have been identified as being at high risk of harm from polypharmacy, for example via population health management tools such as the NHS BSA polypharmacy comparators available in ePACT 2.

4. **Geriatricians see the impact of overprescribing and they are essential to help primary care** to tackle this issue, especially in patients with very complex needs such as those with multiple LTCs including dementia. Geriatricians know that taking fewer medicines as patients reach their later years and are managing increasing frailty, is a key component to healthier later years. Geriatricians are a very stretched resource and need to be deployed within the community working together with primary care to address this. With the right resources, geriatricians could be supporting primary care to review patients BEFORE things go wrong and not just seeing patients when they are admitted after something has gone wrong.

ICBs should be thinking about how services across the care sectors support multidisciplinary team working for older, frail people with multiple long-term conditions and complex health and social care needs.

5. **PCN Teams are hugely variable in their make-up, expertise, seniority and, most crucially, clinical leadership**. We have met some incredible clinicians working in highly functioning Multi-Disciplinary Teams, proactively reviewing patients taking 10 or more medicines. At the opposite end of the spectrum, we have met pharmacists working in isolation from home (due to lack of space in the GP practice) cold calling patients with very limited clinical supervision or support. Where these pharmacists are relatively junior, we have been concerned about them and the care they are able to give patients. This silo approach will not be successful in tacking such a multi-factorial problem.

6. At policy level, the **implementation of the NHS Long Term Plan to move Pharmacists into general practice has been broadly welcomed** and in the good practice examples is making a huge difference. What we have learnt is:

    - Incorporating a medicines expert into the MDT can significantly improve the quality of patient care when capacity is created to offer dedicated Structured Mediation Review appointments, and ensure medicines reconciliation is timely, accurate and sense checked.

    - This provides a strong platform for optimising patient consultations with all other clinicians in the team.

    - In particular, if a proactive, risk-stratified approach is adopted this can have positive benefits to mitigate against unplanned hospital admissions and improve access in primary care.

    - Pharmacists are ideally suited to help improve repeat prescribing systems which is critical given the high volume of (increasing) workload this entails.

    - Educational support, especially relating to medicines, is almost certainly best led by a pharmacist within the MDT. A blend of informal and formal input helps develop and improve knowledge transition, including for students attached to teams.

    - Finally, pharmacists can be a great asset in contributing to research in those organisations involved.

    However, many practices and PCNs have not been given a template of how this could work well, and, in some areas, it is far from ideal. We have met some pharmacists in this position, and it is worrying. We have seen a small number of pharmacists who are really suffering because a lack of support, supervision mentorship in this new role. NHS England will need to look at mentoring and training for these pharmacists. We could also do much more to describe to GPs what the opportunities are if pharmacists are deployed in the right way.

7. **We need to engage our secondary care colleagues** so we can all appreciate the impact of our clinical decisions on older people and their families (and work together to solve them). This will also help address some of the system barriers such as poor communications across the secondary / primary care interface, particularly relating to the initiation of medications which contribute to operational failures in coordinating patient care.

Securing funding to expand the Polypharmacy Action Learning Set offer to include secondary care colleagues or even ICB wide participation should be considered.

8. **Funding needs to be guaranteed and for a minimum of two years (ideally five)** to secure delivery of a robust and well-resourced training offer to GPs and pharmacists. Funding uncertainties have impacted on the Polypharmacy Programme throughout the two years to date and have resulted in us being unable to diarise a rolling delivery programme since March 2022. This has made it difficult to secure and sustain trainers and facilitators for ongoing delivery, as well as providing the advance notice required by clinicians to secure time off work to attend.

9. The Polypharmacy Action Learning Sets are part of the wider Health Innovation Network Polypharmacy Programme, which has led to the development of local Polypharmacy Communities of Practice to enable people interested in this topic to share worries and concerns in a safe space and then learn, develop and grow together as clinicians. **This network could form the basis of a relaunch of the English Deprescribing Network** to accelerate the spread of shared learning across England, which is a recommendation of the National Overprescribing Review (NOR) report[14] .

What's next?

Quality Improvement: Learning into practice

Delegates are encouraged to showcase how their learning has been applied by undertaking a quality improvement case study and presenting their learning in a conference-style poster format at one of our online shared learning sessions.

To date, 40 posters have been submitted and these can be viewed on the **Polypharmacy Quality Improvement Poster Library:**
https://healthinnovationwessex.org.uk/projects/606/polypharmacy-qi-posters .

In Spring 2024, we plan to hold a nation-wide conference inviting Action Learning Set delegates to submit their QI posters to encourage wider write up and sharing of learning into practice.

The future of the Polypharmacy Action Learning Sets

The Action Learning Sets remain oversubscribed. The Health Innovation Network has **funding to deliver a further 4 cohorts until April 2024**. Our aim is to have trained a total of **1,000 delegates** by April 2024 when the Health Innovation Network National Polypharmacy Programme is currently due to close.

We believe there is an ongoing demand to support continuing delivery post April 2024 if funding can be secured. Funding needs to be made available before April 2024 to enable us to offer a rolling training programme to ensure momentum is maintained.

The Polypharmacy Action Learning Set model cannot be held by the Health Innovation Network indefinitely. To ensure sustainability, a host organisation needs to be identified to enable the Polypharmacy Action Learning Sets to continue, and to support the existing network of Polypharmacy Educators and Action Learning Set Trainers onboard and committed to local and national polypharmacy education.

Expert knowledge from policy, primary and secondary care, academia, and patients

The Action Learning Set Five Year Celebration event on 23 November 2023 brings together a diverse range of colleagues passionate about addressing problematic polypharmacy in England. During the day we will hold several small group discussion sessions to capture feedback and ideas for the future. This learning will be incorporated into a second version of this report, which will be published December 2023.

Recommendations

The recommendations below are based on learning from implementing the Action Learning Sets and hearing from our delegates, trainers, facilitators and geriatricians as to what is needed to address problematic polypharmacy at patient, clinician and system level:

Polypharmacy education and learning

1. Polypharmacy education needs to be part of under/post graduate education for all prescribers.
2. Polypharmacy education should be offered to colleagues early in their Independent Prescribing journey through a training offer such as the Action Learning Set Foundation piloted by Health Innovation Wessex, pending evaluation.
3. The focus needs to be on increasing awareness, skills and confidence in both GPs and pharmacists.

System-wide support

1. The Polypharmacy Action Learning Set model requires further funding to continue delivery post March 2024 and a sustainable host organisation identified when the Health Innovation Network Polypharmacy Programme closes.

2. The establishment of a national Deprescribing Network or Academy to facilitate shared learning and access to education and learning related to Polypharmacy.

Changing Public Behaviour

1. GPs and pharmacists need to have adequate time allocated to proactively identifying patients who would benefit from a Structured Medication Review and to carry out a Structured Medication Review using shared decision-making tools and patient facing materials.

2. A public facing campaign targeting older people on 10 or more medicines is needed to encourage discussion about their medicines with GPs and pharmacists and drive public behaviour change.

3. Adoption of routine use of patient facing materials in Structured Medication Reviews[15], as successfully tested, evaluated and launched by the Health Innovation Network in September 2023.

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