Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Polypharmacy and deprescribing

August 2025

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Hertfordshire and West Essex Integrated Care System

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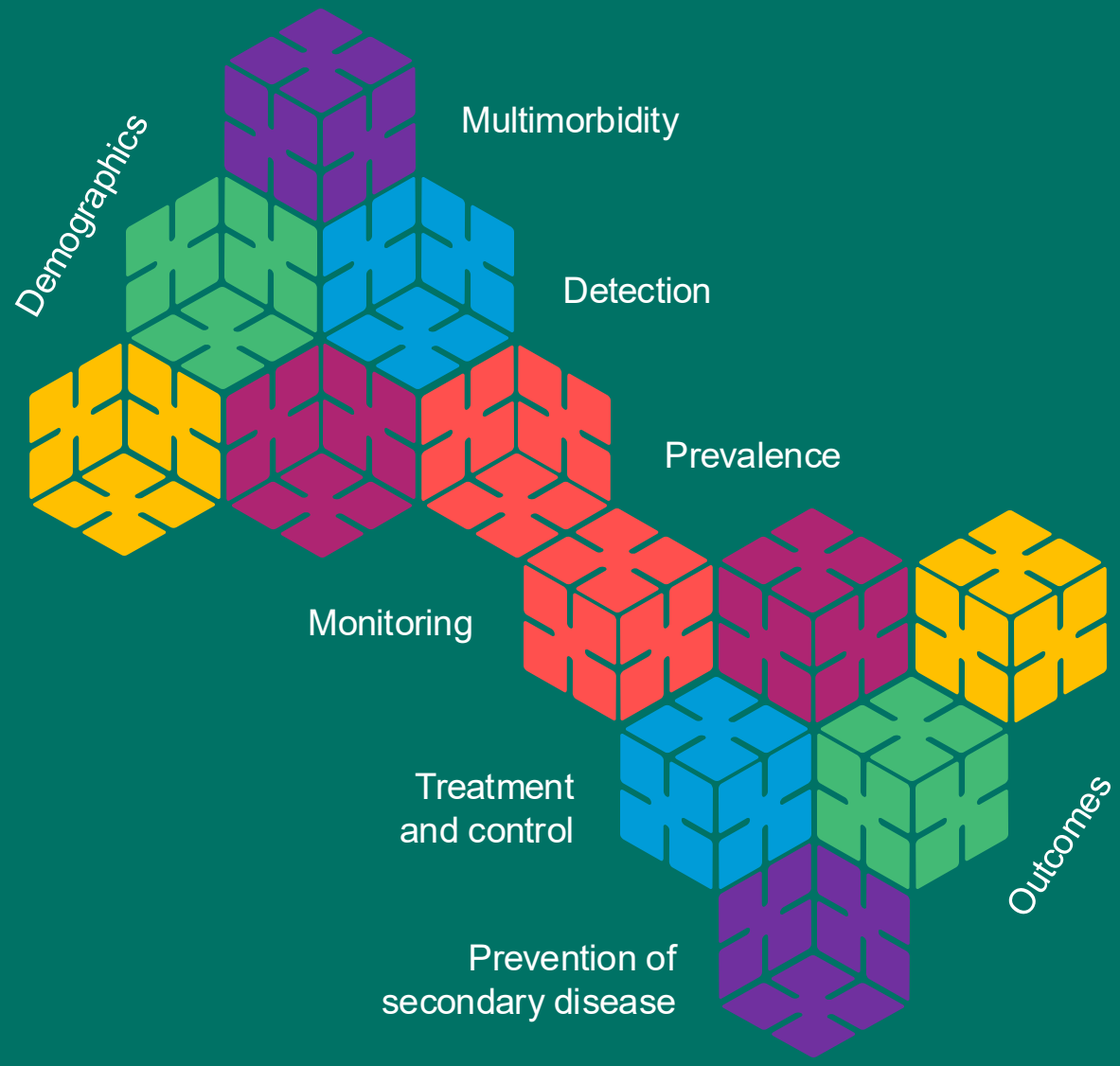

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Key Messages

- Medicines are the most common and most costly intervention in healthcare
- Approximately 1 in 5 admissions to hospital in those over 65 is due the harmful effects of medicines
- HWE ICB has a higher proportion of the population aged 40-64 years, compared to the national average. Consequently, in the next 5 - 20 years there will be more people in the older age groups who will be utilising more NHS resources to address their health needs
- The growth in older age population will translate into an additional 15,300 more people aged 60 years and over living with frailty by 2035 in HWE
- Physiological changes in older people result in changes in handling of medicines, increasing the risks of harm from adverse effects
- Chronic pain is pain that persists or recurs for more than 3 months. Opioids are not usually effective in the management of chronic non-malignant pain and should be reviewed with a view to deprescribing

Recommendations

- Adverse effects of medicines are common in the older population and prescribers should consider alternatives to pharmacological management of health conditions to reduce harm from medicines
- PCNs and GP practices should use the Network Contract DES to support the delivery of care, with PCN Clinical Pharmacists undertaking Structures Medication Reviews to manage people with complex polypharmacy
- Practices and PCNs should use Ardens Manager to review the proportion of eligible people who have not received a polypharmacy review as per the GP ECF 25/26
- Prescribers should use ACB calculator to calculate people's ACB scores
- Practices should review all people with an ACB score of 3 or more, in accordance with the GP ECF frailty indicators 25/26 and formulate an ACB deprescribing plan to prevent harm
- Clinicians should consider non-pharmacological management of pain
- PCNs and GP practices are required by the PCN DES to prioritise structured medication reviews for those using potentially addictive pain management medication

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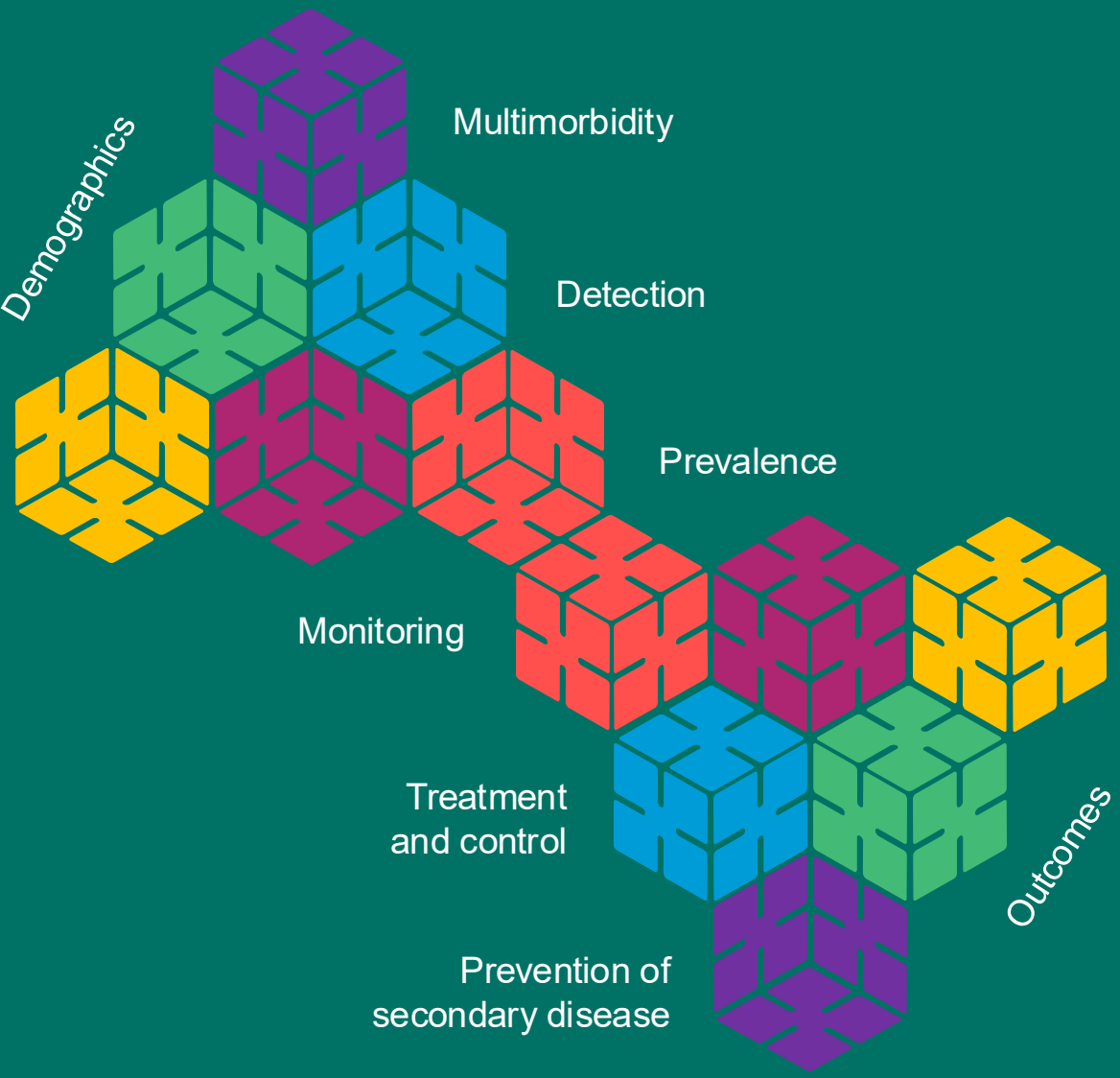
Introduction and Frailty population



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Outcomes we are aiming to achieve through Clinical Leadership
Strategic Priorities 2024-2026

The table below outlines the ICS strategic priorities with expected outcomes agreed by ICB board. Polypharmacy and effective medicines management, including deprescribing, supports the delivery of reduced rates of unplanned hospitalisation, particularly for people living with frailty. Chief medical officers annual report 2023-Health-in-an-ageing-society

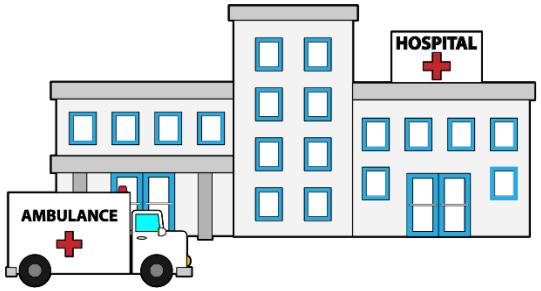
Priority	Expected outcome	Success measures
Reduce inequality with a focus on outcomes for CVD and hypertension	Reduce under 75 mortality from long term conditions	• 2 percent increase in hypertension QOF measures (March 2026) • Increase the percentage of people with GP recorded hypertension whose last blood pressure was in target to 80 percent • Increase the age of standardised prevalence of hypertension in the most deprived 20 percent of the population from 17.6 percent to 19 percent (March 2026)
Improve UEC through more anticipatory/ SDEC care	Reduce the rate of unplanned hospitalisations for chronic ambulatory care	• Decrease the rate of emergency admissions for falls within the community for people aged 65+ by 5 percent (March 2027) • 25 percent reduction in non-elective admissions in people living with frailty • Reduce the percentage of deaths with 3 or more emergency admissions in the last 90 days of life (all ages) from 6 percent to 5 percent across Herts and West Essex by March 2027
Better care for those in Mental Health crisis	Increase in the provision of early help to prevent mental illness and support the health and wellbeing of those with severe mental illness, learning disabilities or autism.	• Increasing our response to urgent referrals to Community Crises Services in 24/25 from 64 percent to 67 percent. • Reduce the use of out of area inappropriate beds for adults requiring a mental health inpatient stay across the ICS from 16 people to 4 people by March 2025. • 75 percent of inpatient discharges to have 72 hour follow up by March 2025.
Elective care recovery	Reduction in the numbers waiting for elective activity and diagnostics	• Reduce number of people waiting more than 65 weeks for treatment, to 0 by 30th Sept 2024 • 85 percent of surgery across HWE is consistently undertaken as day case by March 2026 • Reduce the number of people waiting more than 6 weeks for diagnostic services year on year and by March 2025 ensure that 95 percent of people have their diagnostics within 6 weeks.
Childrens care backlog reductions	All children will have the best start and live a healthy life	• Reduction in wait for community paediatric services to 65 weeks by April 2026 • Reduction in ED attendance and admission rates for children and young people by 5 percent (2028)

The Case for Change

Medicines are -the **most common and one of the most costly interventions in healthcare**

Patient **nonadherence** is normal – with up to **50%** of medicines diligently prescribed but not **consumed or consumed incorrectly**

Medicines can **cause harm** as well as **benefit** and **sometimes less is more**



About **1 in 5** hospital admissions among **over-65s** are due to the **harmful effects of medication**

People on **10+ medications** are **300%** more likely to be **admitted to hospital** because of an **adverse drug reaction/side effect**

Clinician nonadherence is normal – **clinicians** are not always **aware of local guidance** or the **recommended drug choices**

It is **easier** to prescribe than **deprescribe**

There is a **lot to do** and we would like **to start** with **tackling problematic polypharmacy**

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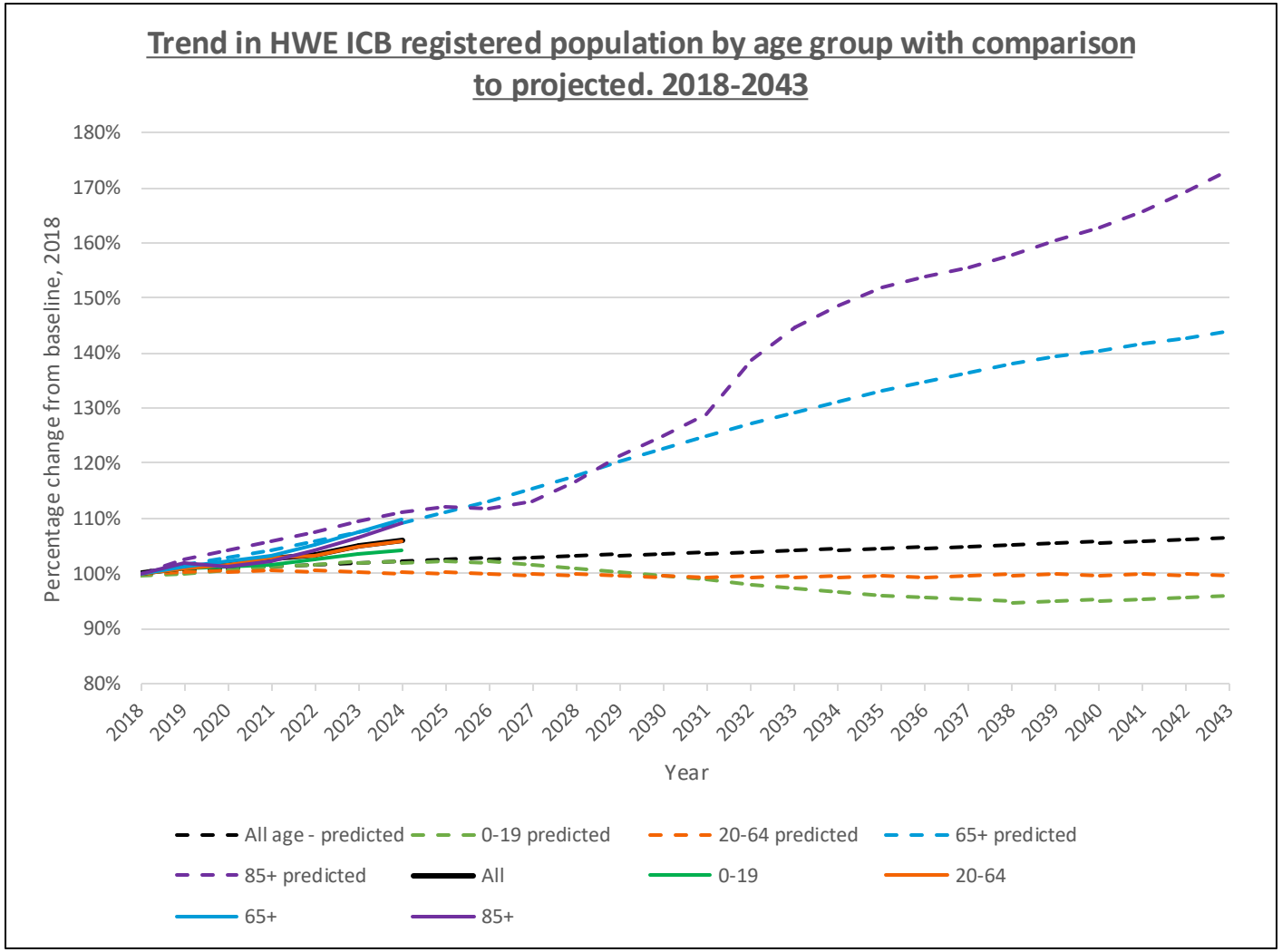
HWE Population projections

- Trends in the registered population in HWE show that the total population has increased by 6 percent from 1.57m in December 2018 to 1.66m in December 2024.
- The total population is increasing more than projected by Office for National Statistics (ONS), which estimated a 3 percent increase in population between 2018-2024. This is predominantly as a result of a larger than expected increase in the working age adult population.
- The fastest growth is observed in the 65+ and 85+ age groups (10 percent and 9 percent increase respectively). Rapid growth in these age groups is predicted, linked with the ageing population and people born after 1945.



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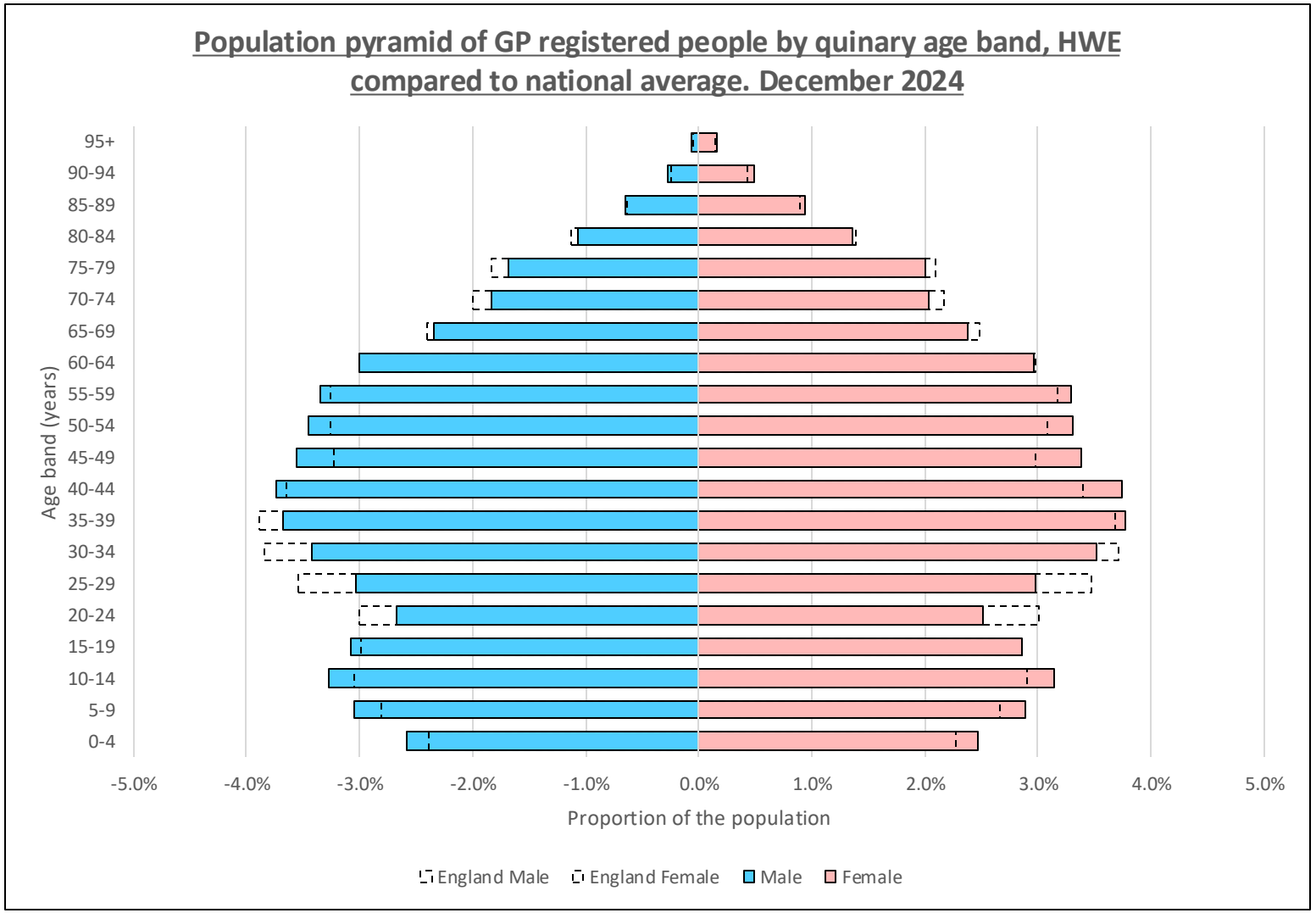
Source: ONS.gov.uk/Populationprojections

HWE Population profile

- HWE ICB has a higher proportion of the population aged 40-64 years, compared to the national average.
- Consequently, in the next 5 - 20 years there will be more people in the older age groups who will be utilising more NHS resources to address their health needs.
- The number of people living with multiple long term conditions and frailty will increase, with associated impacts on polypharmacy and medication related issues.



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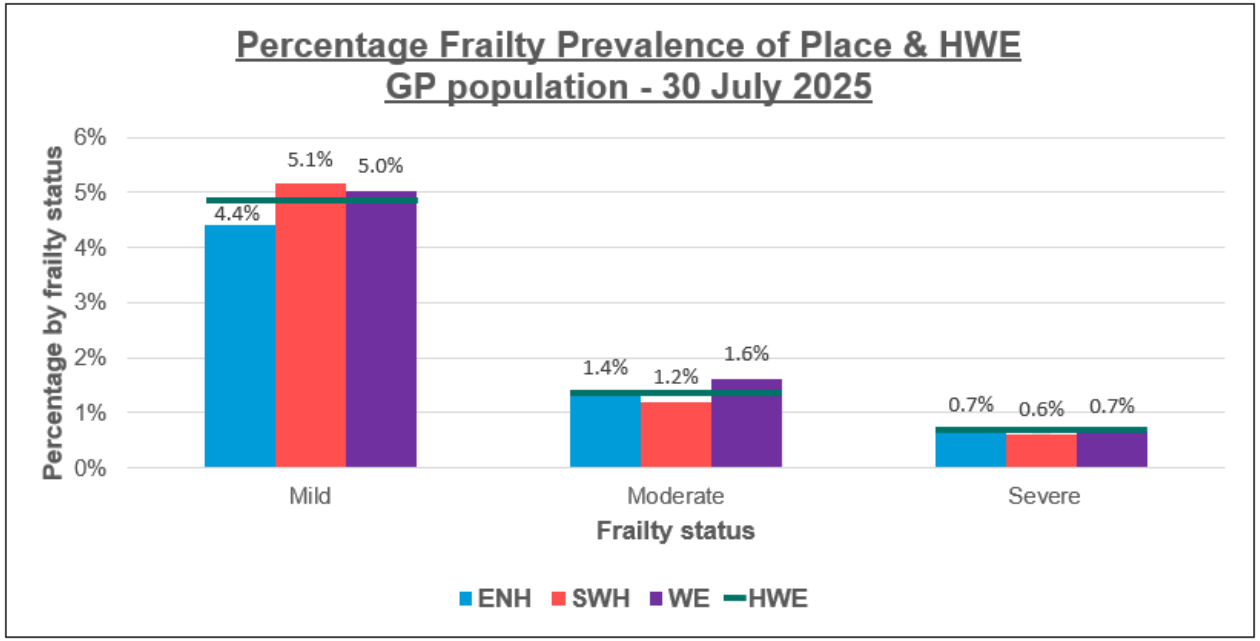
Source: Patients registered at a GP Practice - December 2024

HWE Frailty Prevalence

- In July 2025 there were nearly 114,000 people in HWE who were identified as living with frailty. This represents approximately 6.8 percent of the population.
  - 4.8 percent of the population have mild frailty
  - 1.3 percent of the population have moderate frailty
  - 0.6 percent of the population have severe frailty
- The frailty prevalence in HWE is significantly higher than the national prevalence (data from over 2000 GP practices) and is likely to reflect:
  - Improved detection, with frailty diagnosis part of the Enhanced Commissioning Framework
  - Local population differences (a higher proportion of the population aged over 85 years)
- There is significant variation in frailty prevalence at practice level, ranging from <0.3 percent to 25.5 percent (July 2025). Whilst this may be driven by differences in the registered population (e.g. high proportion of people living in a care home). Differences in frailty identification and coding in GP practices will contribute to this variation.
- The growth in older age population will translate into an additional 15,300 more people aged 60 years and over living with frailty by 2035.



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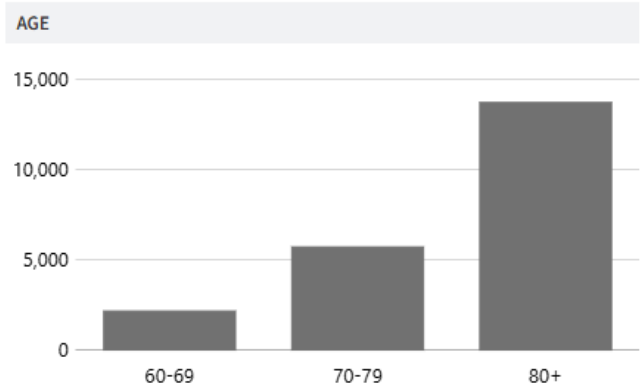
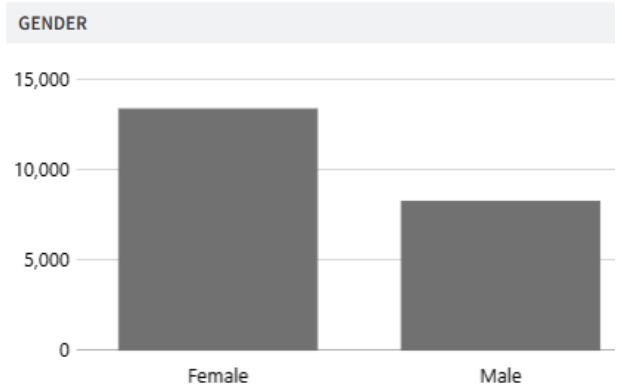
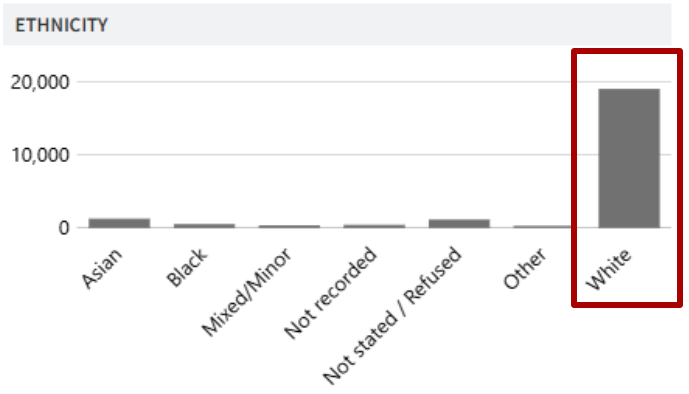
Source: Ardens Manager/services/conditions/frailty-&-end-of-life/frailty

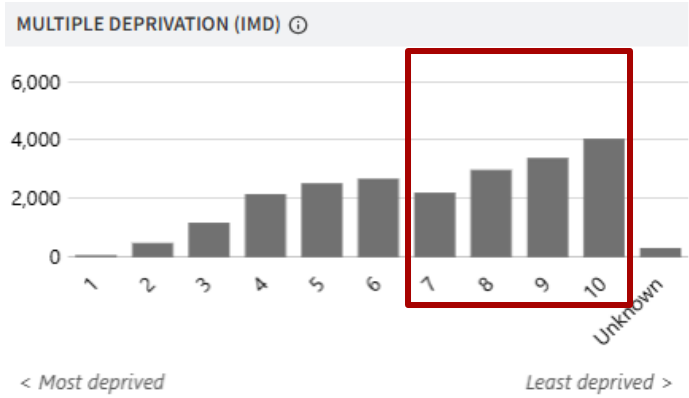
Demographics for HWE Moderate Frailty

- There are over 22,000 people living with moderate frailty, of which 96 percent are aged 60 years and over with women forming a significant majority (62 percent)
- 87 percent of people with moderate frailty are classified as white, compared to the 63 percent of the ICB population
- 58 percent of people classified as moderately frail are in the 2 least deprived IMD quintiles, compared with 57 percent in the total population.
- Among individuals with moderate frailty, 83 percent have cardiovascular disease, 55 percent have diabetes, and 28 percent experience mental health concerns as co-morbidities









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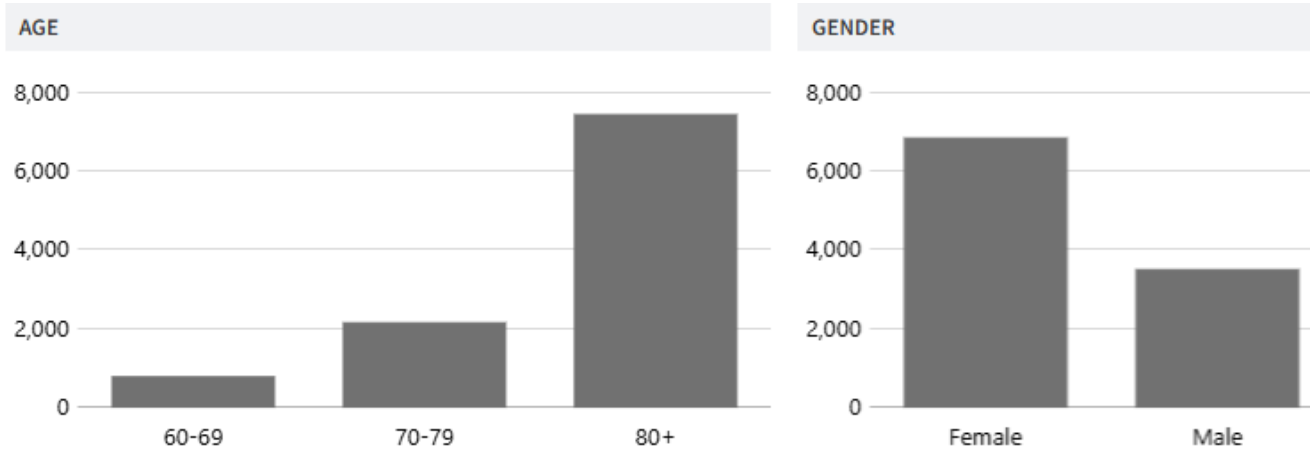
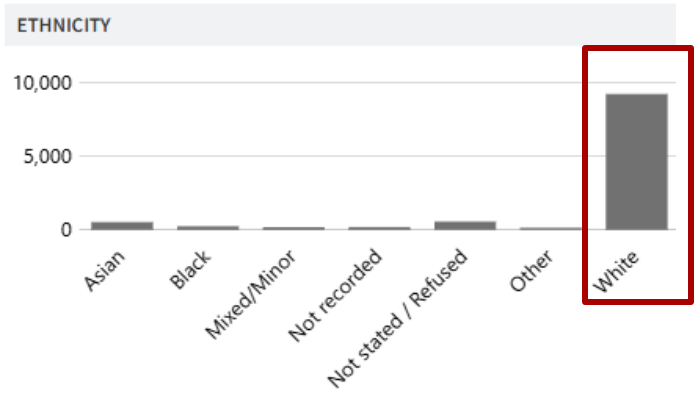
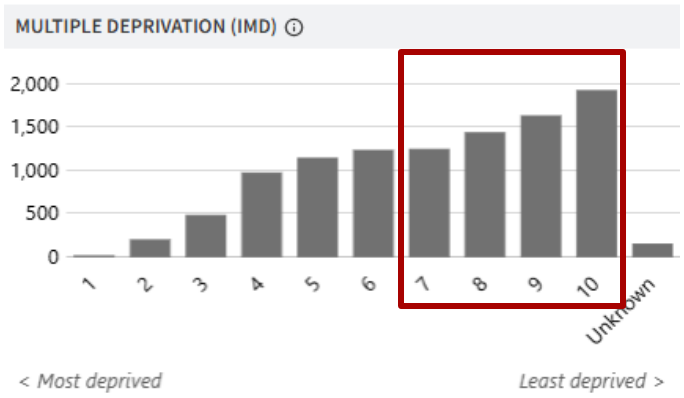
Source: Ardens Manager/services/conditions/frailty-&-end-of-life/frailty/Overview - Register / Ardens Manager/services/population/overview/Overview-Registration / Health Analytics - Population Profile

Demographics for HWE Severe Frailty

- There are 10,800 people living with severe frailty, of which 95 percent are aged 60 years and over with women forming a significant majority (66 percent)
- 88 percent of people with severe frailty are classified as white compared to the 63 percent of the ICB population
- 60 percent of people classified as severely frail are in the 2 least deprived IMD quintiles, compared with 57 percent in the total population.
- Among individuals with severe frailty, 82 percent have cardiovascular disease, 50 percent have diabetes, and 31 percent experience mental health concerns as co-morbidities







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Source: Ardens Manager/services/conditions/frailty-&-end-of-life/frailty/Overview – Register / Ardens Manager/services/population/overview/Overview-Registration / Health Analytics - Population

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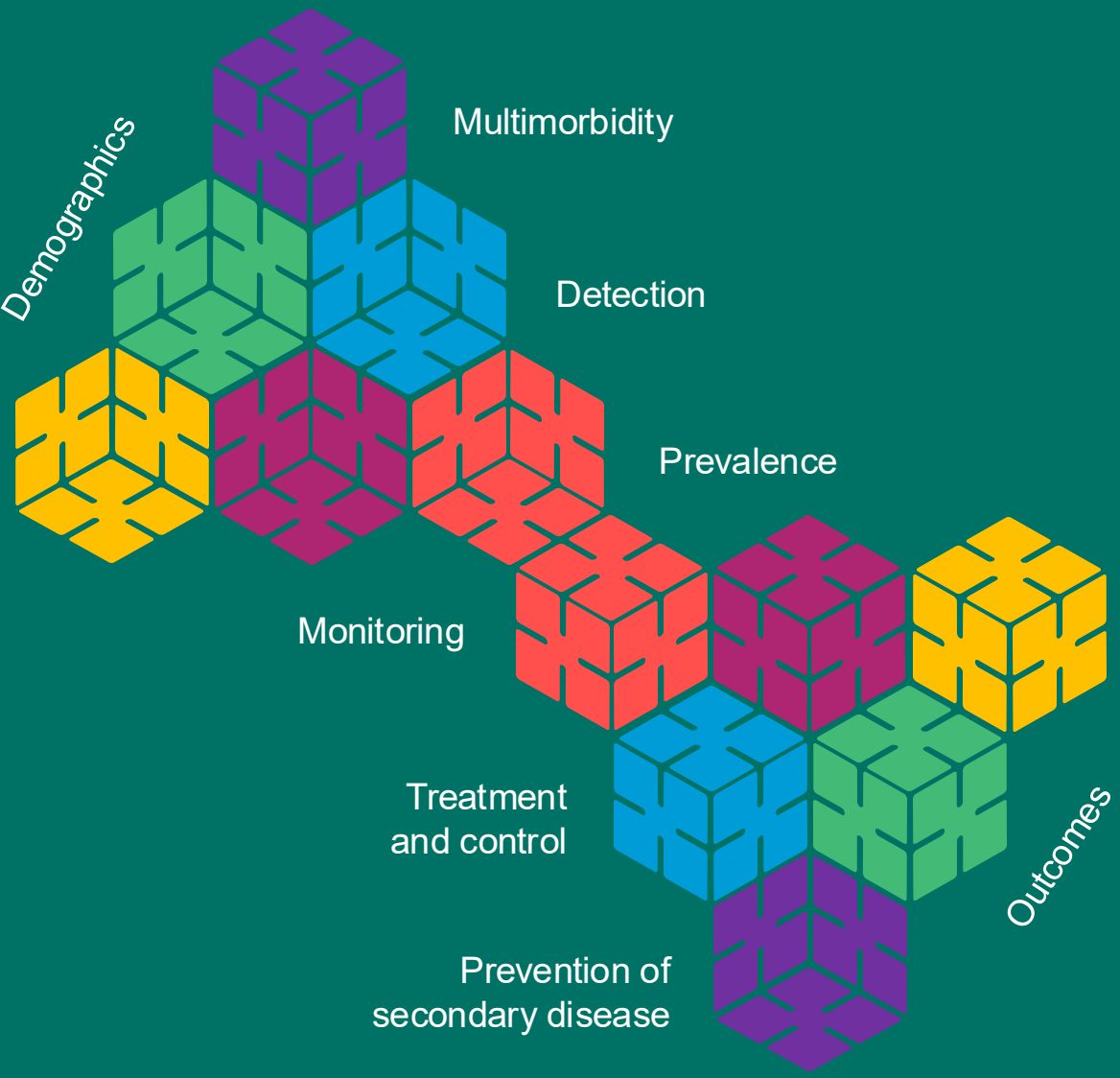
Polypharmacy and Anticholinergic Burden



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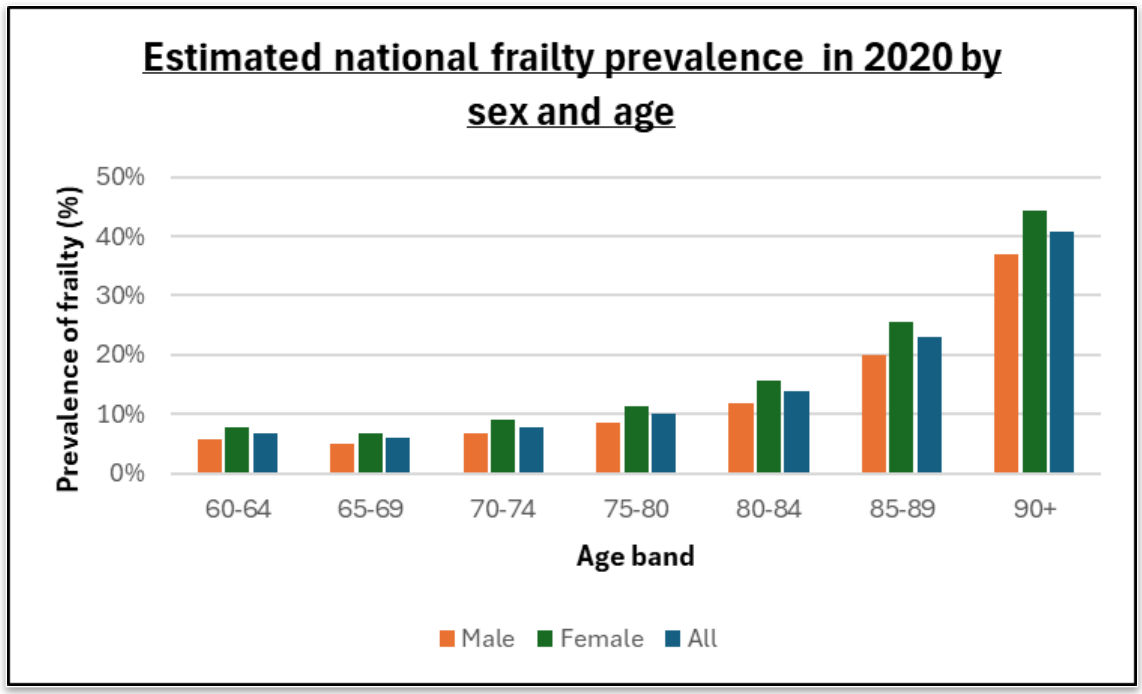
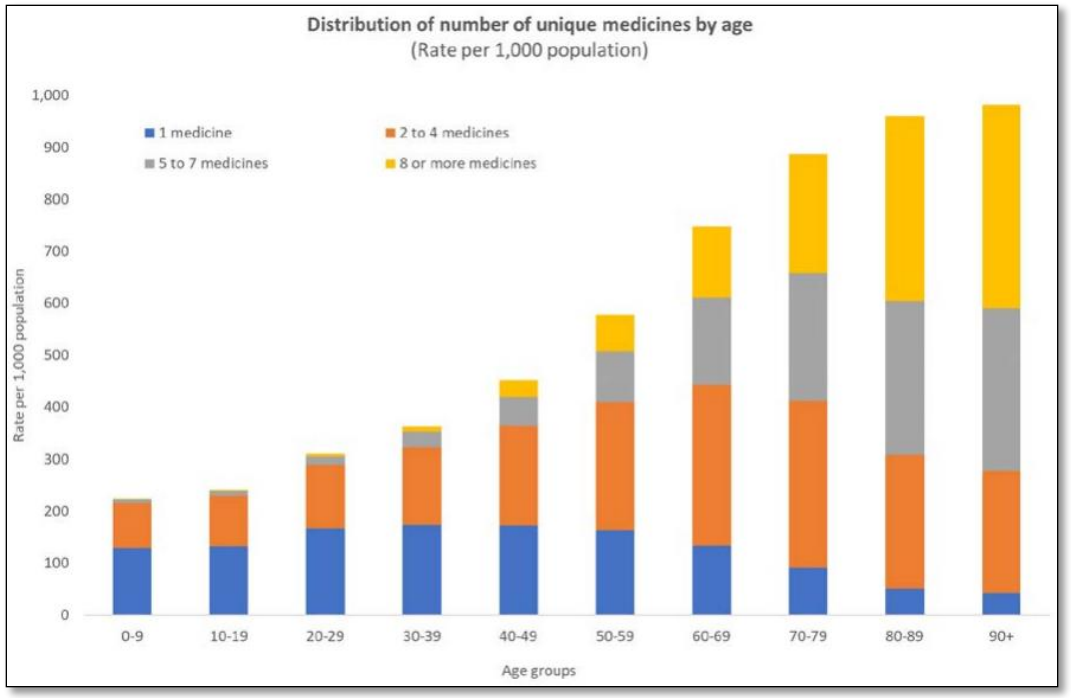
National Frailty prevalence with age vs Polypharmacy with age

- As people age, their risk of frailty increases and are more likely to be prescribed multiple medicines to manage increasing co-morbidities
- Physiological changes in older people result in changes in handling of medicines, increasing the risks of harm from adverse effects
- After the age of 80, over half of people are taking 5 or more medications.





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Sources: Frailty among Older Adults and Its Distribution in England; 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

Risks of polypharmacy and anticholinergic burden in the older population

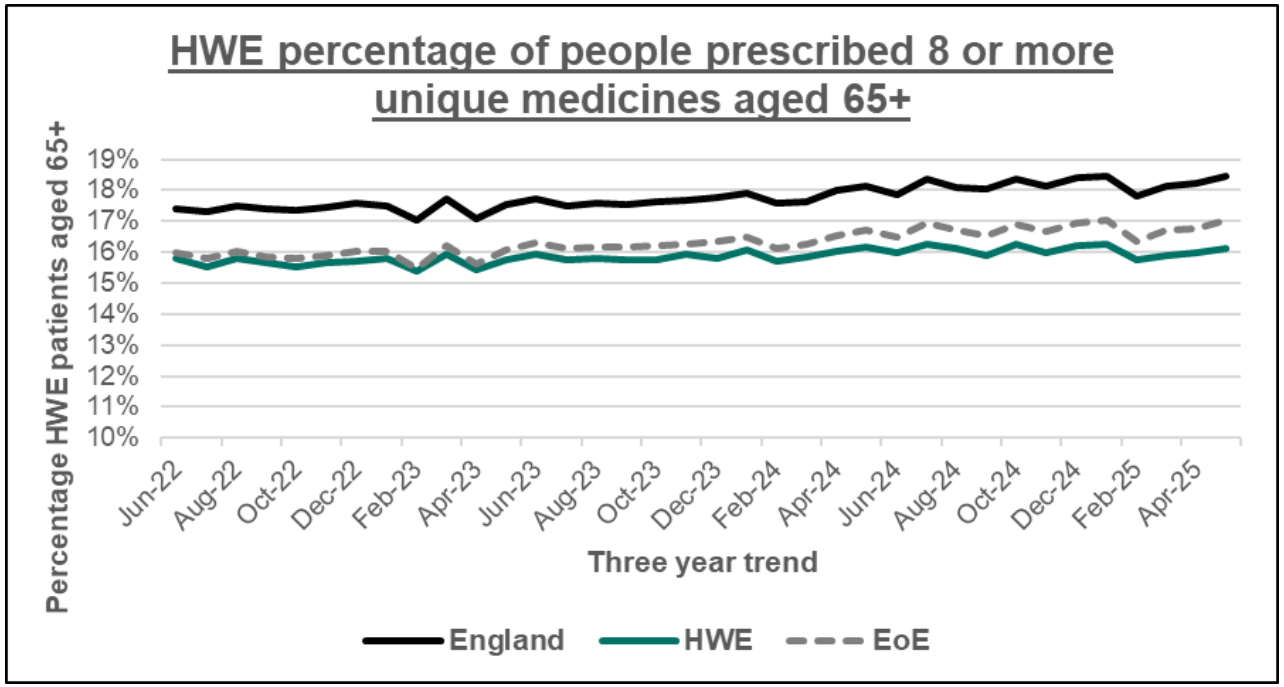
- Physiological changes in older people result in changes in handling of medicines, increasing the risks of harm from adverse effects
- Drugs with an Anticholinergic burden increase the risk of death.
  - One in five people taking medications with an ACB score of 4 or more died within 2 years compared with 7 percent of those taking no anticholinergics.
- **Cumulative anticholinergic use is associated with a higher risk for dementia and cognitive impairment (45% increase).**
- Drugs with anticholinergic effects also impact on cognitive impairment, falls and all-cause mortality in older adults Systematic review - Meta-analysis of 3 studies showed **significant increase in cognitive impairment** (odds ratio = 1.45, 95 percent CI 1.16-1.730). Significant association between ACB and **all-cause mortality with an increase of 1 point approximately doubling the risk** (OR=2.06, 95 percent CI 1.82-2.33)[3]
- Association between anticholinergic medication use and cognition, brain metabolism and brain atrophy in cognitively normal older adults[4]-Use of medicines with medium to high ACB score associated with:
  - Poorer memory
  - Poorer executive function
  - Brain hypometabolism
  - Brain atrophy
  - Increased risk of clinical conversion to cognitive impairment[4]

People aged 65 and over taking 8 or more medications as a proportion of the population taking any dispensed medicine

NICE Guidance 5: Adverse events of medicines represent a considerable burden on the NHS and have a significant impact on patient health. Patients at risk should be supported to effectively manage prescriptions.

- National benchmarking shows a year-on-year increase in the number of people aged 65 or over prescribed 8 or more unique medicines
- HWE have less people age 65 and over who are dispensed 8 or more unique medicines as a proportion of this age group taking any medicines than the East of England average and the national average
- The rate of increase in the percentage of people aged 65 and over dispensed 8 or more unique medicines is less than the regional and national trend

Action:
Older people and those taking multiple medications should be supported with decision aids and medication reviews to actively manage medications.



Note: Numerator: number of unique medicines dispensed for people aged 65+ from BNF chapters 1 to 4 and 6 to 10. Denominator: total number of people aged 65+ dispensed one or more medicines from BNF chapters 1 to 4 and 6 to 10.
Based on dispensed medicines information from ePACT2

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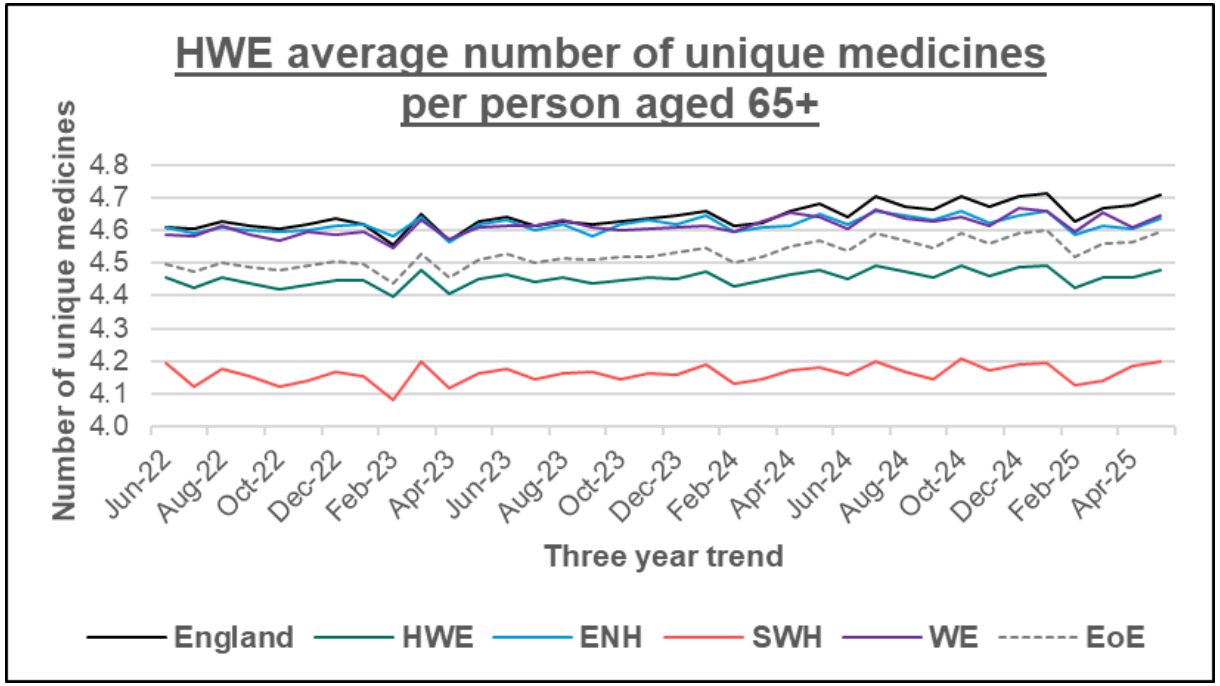
Source: ePact2/dashboard/polypharmacy prescribing comparators/sicbl

Prescribing in people aged 65 and over taking 8 or more medications as a proportion of the population taking any dispensed medicine

NICE Guidance 5: Adverse events of medicines represent a considerable burden on the NHS and have a significant impact on patient health

- On average, people in HWE aged 65 years and over are taking 4.46 unique medicines (April 2025)*. This compares favourably to the national (4.68) and EOE (4.57) averages.
- However, there is disparity in prescribing rates in people aged 65 and over across Hertfordshire and West Essex. The unique medicine rate in this patient population in April 2025 in SWH is 4.19, in ENH is 4.61 and in West Essex is 4.61.

Action:
Older people and those taking multiple medications should be supported with decision aids and medication reviews to actively manage medications.



***Rates reported are number of unique medicines per person in the cohort of people taking any medicines (BNF chapters 1-4 &6-10) age 65 and over**

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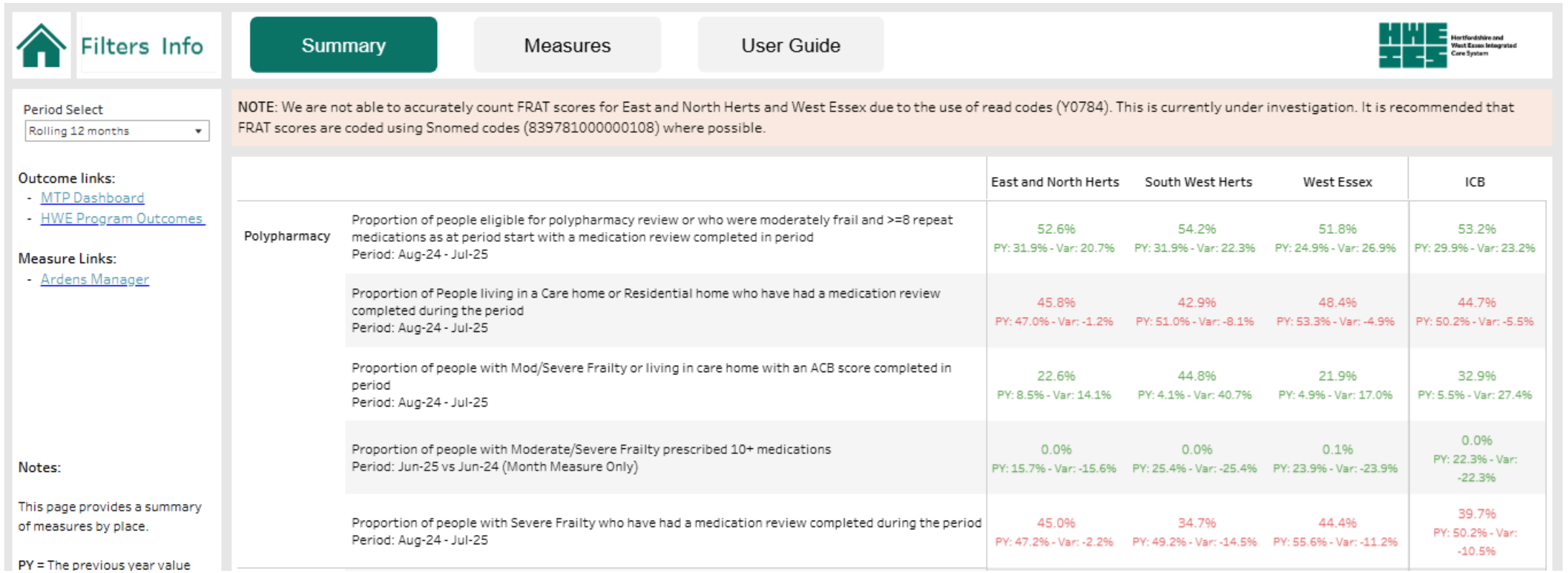
Source: ePact2/dashboard/polypharmacy prescribing comparators/sicbl

Frailty interventions dashboard - Polypharmacy summary



Filters Info

Summary | Measures | User Guide

Period Select: Rolling 12 months

Outcome links:
- MTP Dashboard
- HWE Program Outcomes

Measure Links:
- Ardens Manager

Notes:

This page provides a summary of measures by place.

PY = The previous year value

NOTE: We are not able to accurately count FRAT scores for East and North Herts and West Essex due to the use of read codes (Y0784). This is currently under investigation. It is recommended that FRAT scores are coded using Snomed codes (839781000000108) where possible.

		East and North Herts	South West Herts	West Essex	ICB
Polypharmacy	Proportion of people eligible for polypharmacy review or who were moderately frail and >=8 repeat medications as at period start with a medication review completed in period Period: Aug-24 - Jul-25	52.6% PY: 31.9% - Var: 20.7%	54.2% PY: 31.9% - Var: 22.3%	51.8% PY: 24.9% - Var: 26.9%	53.2% PY: 29.9% - Var: 23.2%
	Proportion of People living in a Care home or Residential home who have had a medication review completed during the period Period: Aug-24 - Jul-25	45.8% PY: 47.0% - Var: -1.2%	42.9% PY: 51.0% - Var: -8.1%	48.4% PY: 53.3% - Var: -4.9%	44.7% PY: 50.2% - Var: -5.5%
	Proportion of people with Mod/Severe Frailty or living in care home with an ACB score completed in period Period: Aug-24 - Jul-25	22.6% PY: 8.5% - Var: 14.1%	44.8% PY: 4.1% - Var: 40.7%	21.9% PY: 4.9% - Var: 17.0%	32.9% PY: 5.5% - Var: 27.4%
	Proportion of people with Moderate/Severe Frailty prescribed 10+ medications Period: Jun-25 vs Jun-24 (Month Measure Only)	0.0% PY: 15.7% - Var: -15.6%	0.0% PY: 25.4% - Var: -25.4%	0.1% PY: 23.9% - Var: -23.9%	0.0% PY: 22.3% - Var: -22.3%
	Proportion of people with Severe Frailty who have had a medication review completed during the period Period: Aug-24 - Jul-25	45.0% PY: 47.2% - Var: -2.2%	34.7% PY: 49.2% - Var: -14.5%	44.4% PY: 55.6% - Var: -11.2%	39.7% PY: 50.2% - Var: -10.5%

- This dashboard has been developed using 7 key interventions that have been identified, that will aid in reducing EA for people with Frailty. One of the key interventions is Polypharmacy – see link to get trends for polypharmacy in the measures section by place DELPPHI - Frailty Intervention Dashboard

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Source: DELPPHI - Frailty Intervention Dashboard

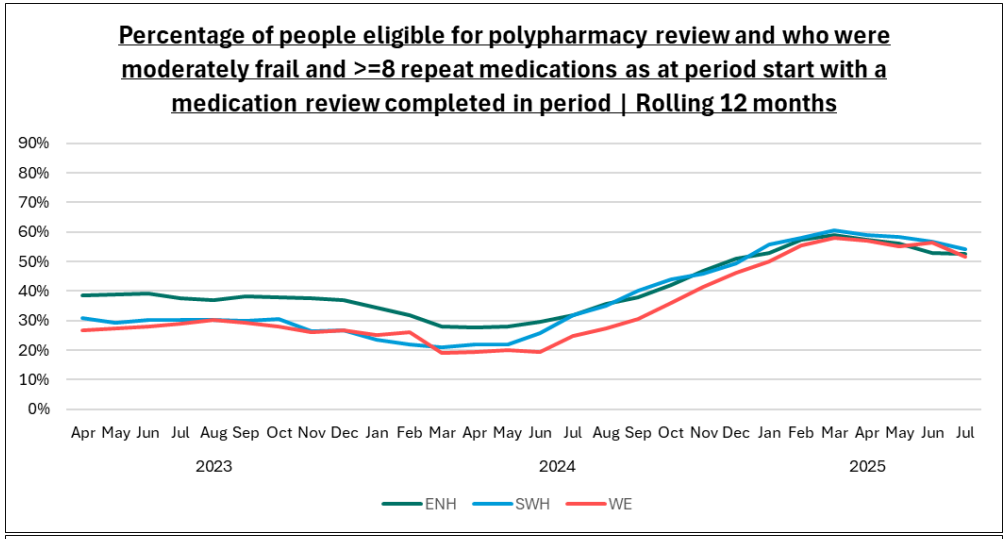
Polypharmacy & Structured medication reviews

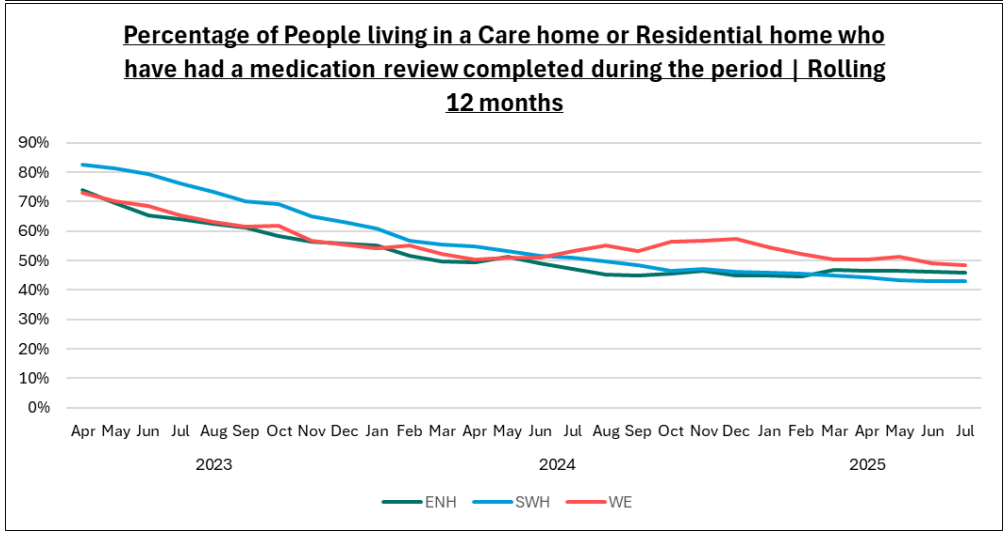
Medicines Optimisation QS120 Quality statement 6: Structured medication review: A structured medication review, with the clear purpose of optimising the use of medicines for some people can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. Structured medication reviews can lead to a reduction in adverse events.

- In 24/25 GP practices across HWE were asked to carry out a polypharmacy medication review in the moderately frail patient population who were identified to be taking 8 or more medicines
- 52 percent of people in HWE who were identified to be moderately frail received a medication review in the period Aug 24 to Jul 25. 44 percent of people living in a care or residential home had a medication review in the period Aug 24 to Jul 25. This coincided with an increase in the population identified to be frail.
- In 25/26 GP practices are again required to identify their frail population and prioritise medication reviews in those taking 8 or more medicines.

Action:

- PCNs should use the Network Contract DES to support the delivery of care, with PCN Clinical Pharmacists undertaking Structures Medication Reviews to manage people with complex polypharmacy
- Practices/ PCNs should use Ardens Manager to review the proportion of eligible people who have not received a polypharmacy or structured medication review as per the ECF 25/26 and Network Contract DES.





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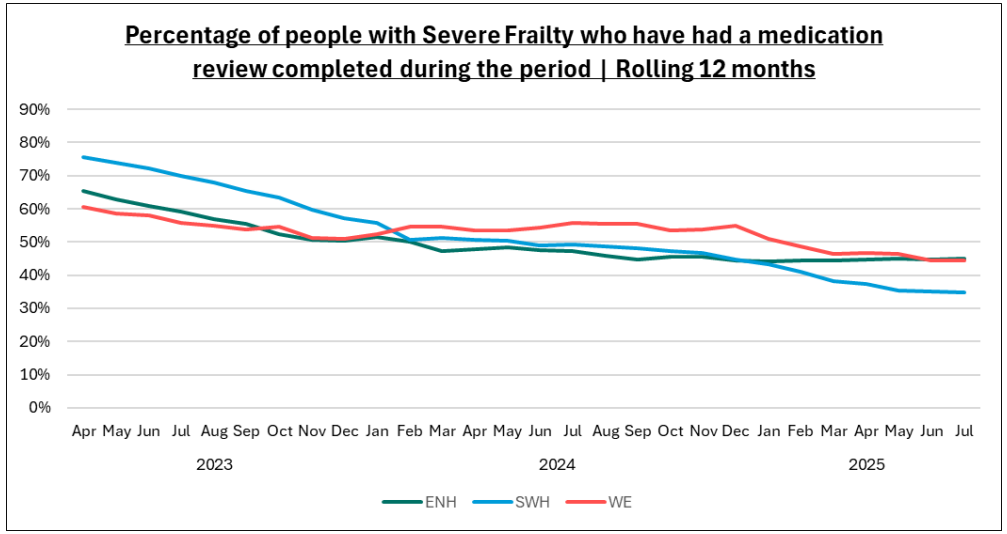
Source: DELPPHI - Frailty Intervention Dashboard

Polypharmacy & Structured medication reviews

Medicines Optimisation QS120 Quality statement 6: Structured medication review: A structured medication review, with the clear purpose of optimising the use of medicines for some people can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. Structured medication reviews can lead to a reduction in adverse events.

- In 24/25 GP practices across HWE were asked to carry out a polypharmacy medication review in the severely frail patient population
- 39% of people in HWE who were identified to be severely frail received a medication review in the period Aug 24 to Jul 25. This coincided with an increase in the population identified to be frail. There has been a significant reduction in the proportion of people with severe frailty receiving a structured medication review.
- In 2025/26 clinicians are calculating anticholinergic burden in the frail older population and this is reflected in the ACB score recording reported since April 2025



Action:

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- Practices/ PCNs should use Ardens Manager to review the proportion of eligible people who have not received a polypharmacy or structured medication review as per the ECF 25/26 and Network Contract DES.

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Source: DELPPHI - Frailty Intervention Dashboard

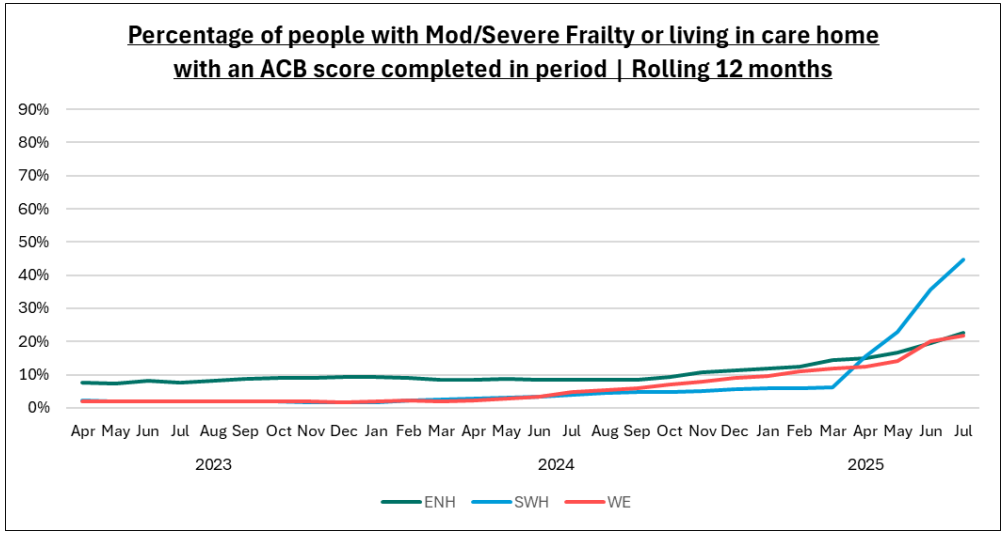
People with an Anticholinergic Burden (ACB) score of 6 or more aged 65 and over

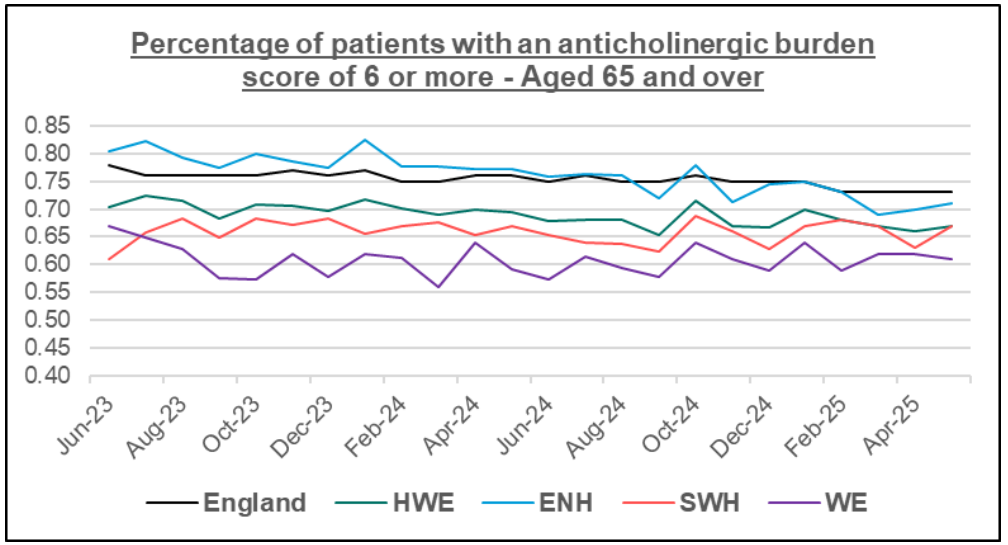
NICE Guidance 97: Dementia: Some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment. Consider minimising the use of medicines associated with increased anticholinergic burden.

- In 2025/26 clinicians are calculating anticholinergic burden in the frail older population and this is reflected in the ACB score recording reported since April 2025
- The percentage of people in HWE with an ACB score of 6 or more is consistently less than that of England
- The percentage of people with an ACB score of 6 or more in HWE has been steadily declining to a rate of 0.67 in May 25
- There are disparities in the three places relating to ACB score in people age 65 and over with ENH having the greatest potential to reduce

Opportunity:

- Prescribers should use ACB calculator to calculate people's ACB scores
- Practices should review all people with an ACB score of 3 or more, in accordance with the GP ECF frailty indicators 25/26 and formulate an ACB deprescribing plan to prevent harm
- Particular attention should be paid to those with an ACB score of 6 or more because the higher the ACB score the greater the risk of adverse effects.





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Note: Numerator: number of people aged 65+ prescribed 1 or more ACB medicines with a combined ACB score of 6 or more/ Denominator: total people aged 65+ prescribed 1 or more medicines from BNF chapters 1 to 4 & 6 to 10. Source: ePact2/dashboard/polypharmacy prescribing comparators/sicbl

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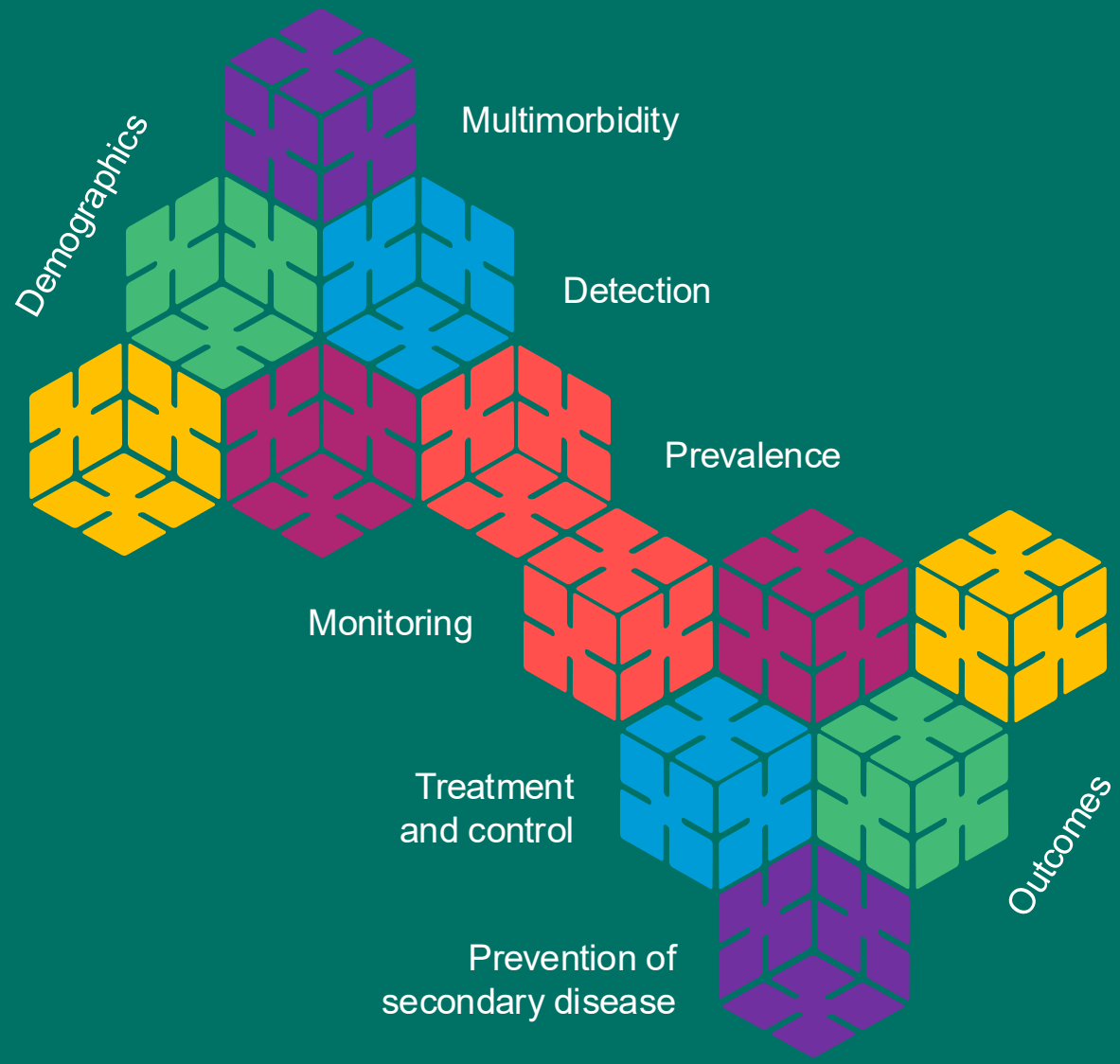
High risk medicines with a focus on opioids



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High risk medicines

- High risk medicines are those that are most likely to cause significant harm to patients even when use is as intended.
- High risk medicines may have a narrow therapeutic range or be associated with serious side effects when administered correctly or incorrectly.
- Examples of high-risk medicines are opioids, anticoagulants, anaesthetics, insulin, antibiotics, chemotherapy, antipsychotics and infusion fluids.
- An analysis of all medical admissions to a large university teaching hospital over a 1-month period found Adverse Drug Reactions (ADRs) in 18.4 percent of hospital admissions; a significant percentage of which were associated with high risk medicines.
- In 16.5 percent of admissions, the medicines was the primary cause for admission or a contributing cause.
- 40.4 percent of ADRs were classified avoidable or possibly avoidable.
- The risk of harm of opioids increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.
- The Care Quality Commission requires practices to provide assurance of appropriate monitoring of high risk medicines.

Drug class	No of ADRs (%)	Offending drug	ADR
Diuretics	31 (14.2)	Furosemide (13), spironolactone (8), bumetanide (6), bendroflumethiazide (2), co-amilofruse (1), indapamide (1)	Renal impairment (18), electrolyte derangement (12), postural hypotension (1)
Steroid inhaler	27 (12.4)	Steroid inhaler (27)	Pneumonia (26), oral thrush (1)
Anticoagulants	21 (9.6)	Warfarin (7), apixaban (5), edoxaban (4), rivaroxaban (4), enoxaparin (1)	Minor bleeding (10), anaemia (4), intracranial haemorrhage (4), gastrointestinal bleed (3)
Proton pump inhibitor	18 (8.3)	Lansoprazole (9), omeprazole (6), pantoprazole (3)	Hypomagnesaemia (11), hyponatraemia (6), *Clostridium difficile* (1)
Antiplatelet	16 (7.4)	Aspirin (13), clopidogrel (3)	Intracranial haemorrhage (5), gastrointestinal bleed (4), minor bleeding (4), anaemia
Chemotherapy	16 (7.3)	Chemotherapy (16)	Neutropenic sepsis (8), sepsis (4), constipation (1), deranged electrolytes (1), rash (1), thrombocytopenia (1)
ACE inhibitor/ angiotensin receptor blocker	14 (6.4)	Losartan (4), ramipril (4), irbesartan (3), candesartan (1), lisinopril (1), perindopril (1)	Renal impairment (9), postural hypotension (3), hyperkalaemia (1), renal failure (1)
Antidepressants & antipsychotics	13 (6.0)	Mirtazapine (2), sertraline (2), sulpiride (2), carbemazapine (1), dosulepin (1), nortriptyline (1), olanzapine (1), risperidone (1)	Confusion (3), hyponatraemia (3), parkinsonism (3), constipation (1), gastrointestinal bleed (1), prolonged QTc (1)
Opiates	13 (6.0)	Codeine (5), morphine sulfate (3), oxycodone (2), tramadol (2), buprenorphine (1)	Constipation (6), confusion (4), respiratory depression (2), hallucinations (1)
Other	49 (22.4)	Other (49)	Other (49)

*In those with multiple ADRs, only the most severe ADR was included in this table, as defined by the Adapted Hartwig Severity Scale[16] (see online supplemental material 1 for full list).
QTc, corrected QT interval.

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Source: Osanlou R, Walker L, Hughes DA, et al Adverse drug reactions, multimorbidity and polypharmacy: a prospective analysis of 1 month of medical admissions BMJ Open 2022;12:e055551. doi: 10.1136/bmjopen-2021-055551

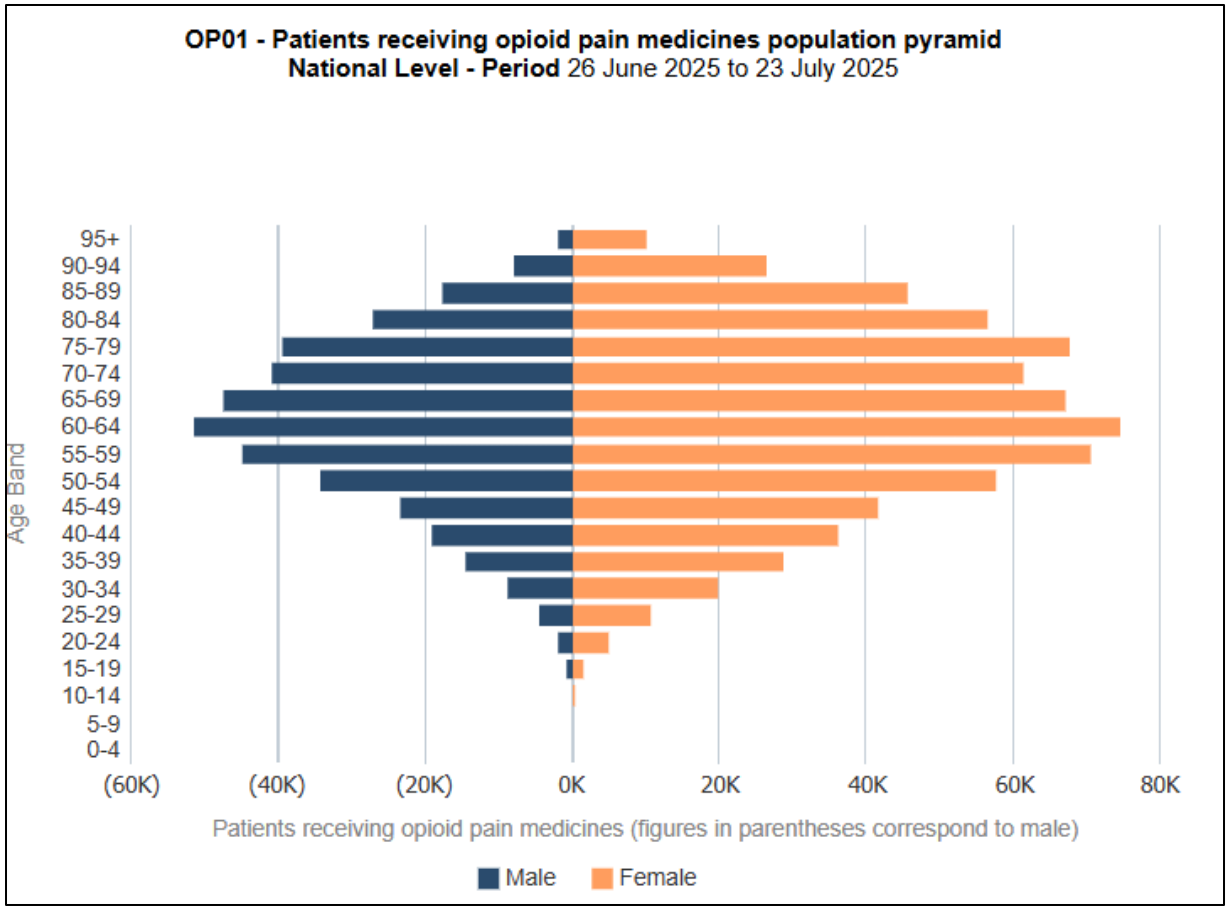
Focus on opioids: HWE people receiving opioid medicines population pyramid – 26th June 2025 to 23rd July 2025

PHE Prescribed medicines review: In 2016/17 13% of the adult population were dispensed an opioid medication, this rate was strongly associated with deprivation and was 1.5 times higher in women than men and increased with age

- Rates of prescribing in opioids in HWE is higher in females than males across all age groups
- In HWE the majority of opioid pain medicines are prescribed in age groups 55-65
- As these adults age, side effects of opioids will become more prevalent; when continuing treatment beyond 3 months stopping treatment can be more difficult due to the development of addiction and tolerance

Opportunity:

- Personalised care and shared decision making is key when supporting a patient to manage pain
- Clinicians should consider non-pharmacological management of pain



Note: In this comparator opioid pain medicines excludes injectables and compound analgesics such as co-codamol and co-dydramol

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Source: ePact2/Opioid prescribing comparators (snapshot)

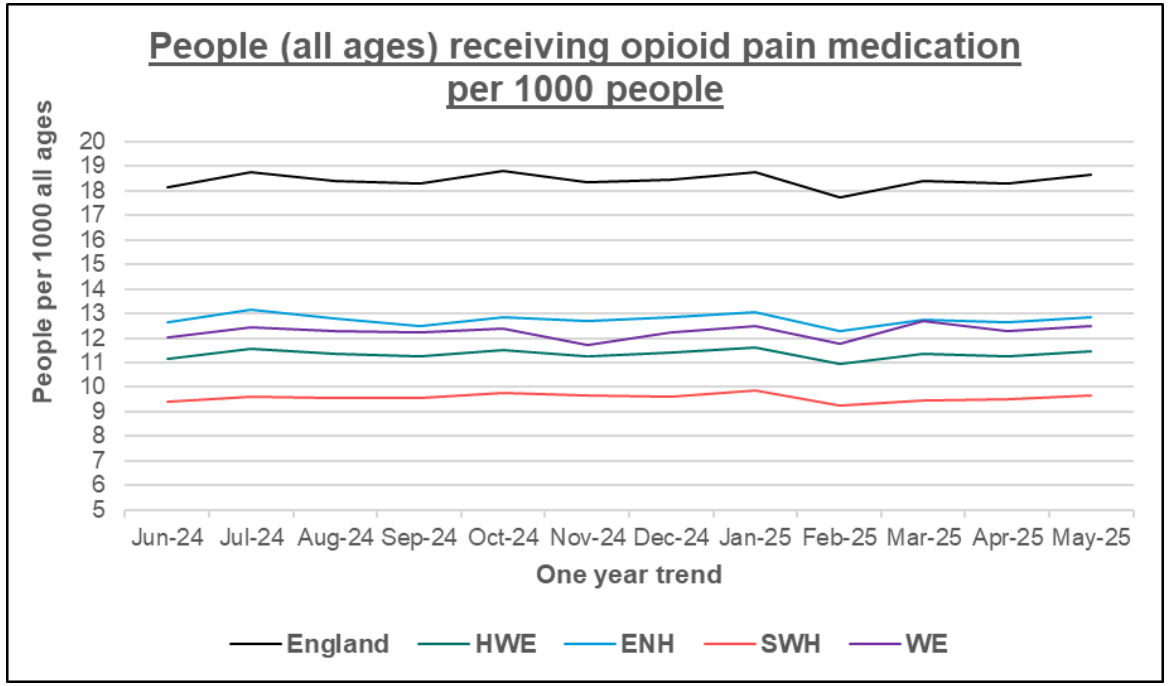
Focus on opioids: people receiving opioid pain medicines per 1,000 people (crude rate) – June 2024 to May 2025

Faculty of Pain Medicine - Opioids Aware: Pharmacological management of chronic non-cancer pain is associated with minimal benefits, and potential harm, when compared to effective biopsychosocial interventions

- HWE benchmarks well compared to national colleagues when looking at total opioid prescribing per 1000 people however there is marked variation in prescribing rates across HWE (and at practice level).
- Opioid medicines are useful in the management of acute pain but have limited use in the management of chronic pain.
- Between 50% and 80% of patients in clinical trials experience at least one side effect from opioid therapy, however in everyday use the incidence may be even higher.

Opportunity:

- All clinicians should consider non-pharmacological options for managing pain
- Opioid medications should be prescribed as an 'acute' item in GP clinical systems to reduce the risk of inadvertently continuing long term
- Agree individualised treatment goals for each person when starting an opioid medication that include discontinuation plans



Note: Numerator: people receiving opioid pain medication (excludes injectables and compound analgesics such as co-codamol and co-dydramol)/ Denominator: practice list size (latest prescription month so historical data varies the numerator only)

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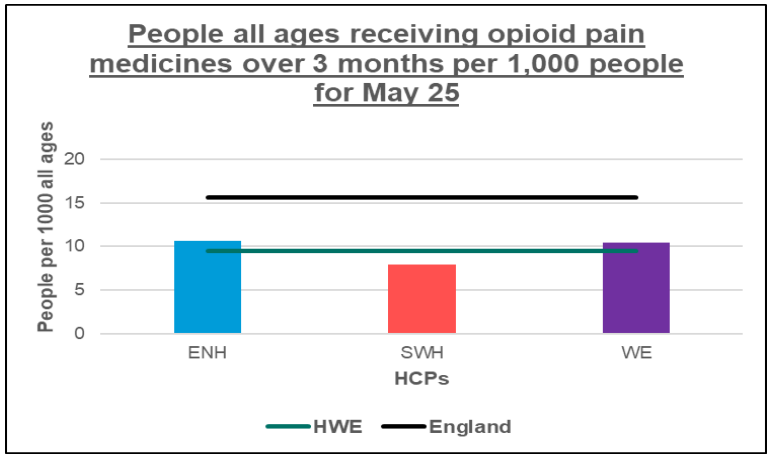
Source: ePact2/Opioid prescribing comparators (trends)

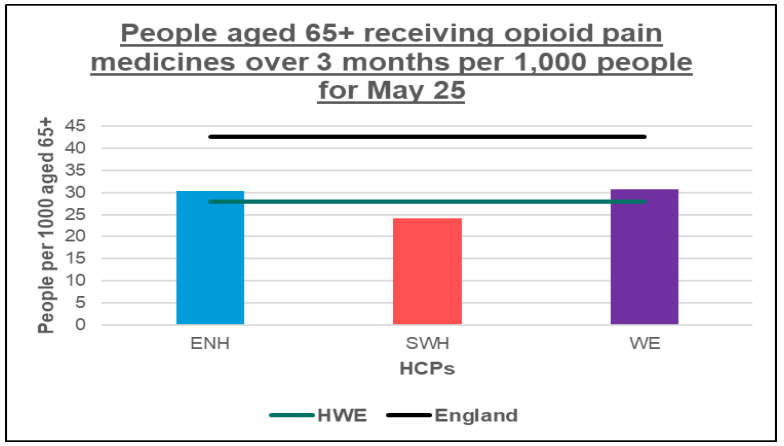
Focus on opioids: people all ages vs aged 65 and over receiving opioid pain medicines over 3 months per 1,000 people (May 2025 crude rate)

NICE guidance 193 Chronic pain: Chronic pain is pain that persists or recurs for more than 3 months. Opioids are not usually effective in the management of chronic non-malignant pain and should be reviewed with a view to deprescribing

- Whilst HWE practices benchmark well compared to national colleagues relating to prescribing of opioid medication for more than 3 months duration there remain opportunities to reduce prescribing in all three places
- Opioid prescribing rates are considerable higher in the older age group; this age group are more likely to suffer from adverse effects from opioid prescribing due to changes in physiology
- When continuing treatment beyond 3 months stopping treatment can be more difficult due to the development of addiction and tolerance

Opportunity:
- Opioid medications should be prescribed as an 'acute' item in GP clinical systems to reduce the risk of inadvertently continuing long term
- PCNs and GP practices are required by the PCN DES to prioritise structured medication reviews for those using potentially addictive pain management medication





Note: Numerator: people receiving opioid pain medication (excludes injectables and compound analgesics such as co-codamol and co-dydramol)/ Denominator: practice list size (latest prescription month so historical data varies the numerator only)

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Source: ePact2/Opioid prescribing comparators (trends)

Focus on opioids: people receiving opioid pain medicines in combination with other dependence forming medicines (opioids, benzodiazepines, gabapentinoids, Z-drugs and antidepressants)

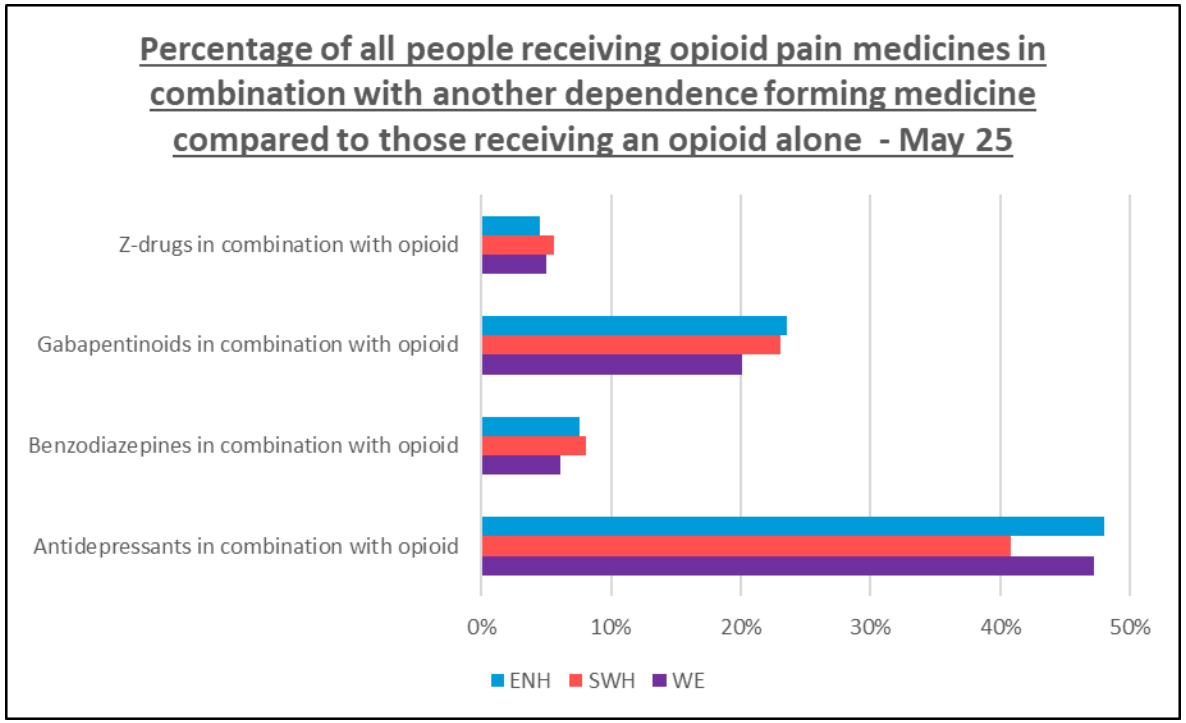
MHRA Drug Safety Update - Benzodiazepines and opioids

Benzodiazepines and opioids can both cause respiratory depression, which can be fatal if not recognised in time. Only prescribe together if there is no alternative and closely monitor patients for signs of respiratory depression.

- Between 40 and 50% of people who are prescribed an opioid in HWE are co-prescribed an antidepressant.
- Co-prescribing of opioids with other dependence forming medicines (DFMs) is common and can lead to falls, drowsiness (ACB score related), respiratory depression, dependence and addiction if taken for longer than 3 months.
- Nationally, prescribing patterns in these DFMs were higher in women and older patients, and in areas of deprivation.

Opportunity:

PCNs and GP practices are required by the PCN DES to prioritise patients who are using one of more DFM or withdrawal symptoms, (antidepressants, opioids, gabapentinoids, benzodiazepines and z-drugs) for structured medication review.



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Source: ePact2/Opioid prescribing comparators (snapshot)

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