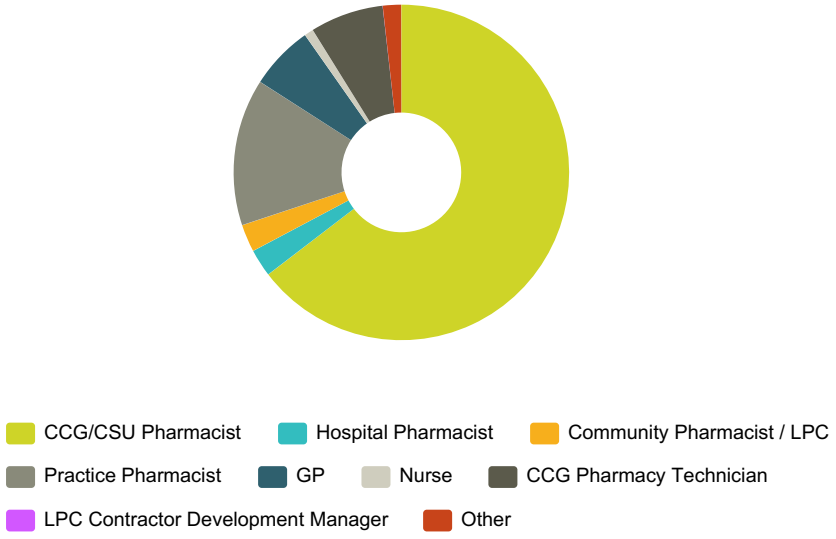
Q2 Respondent role type

Answered: 113 Skipped: 0

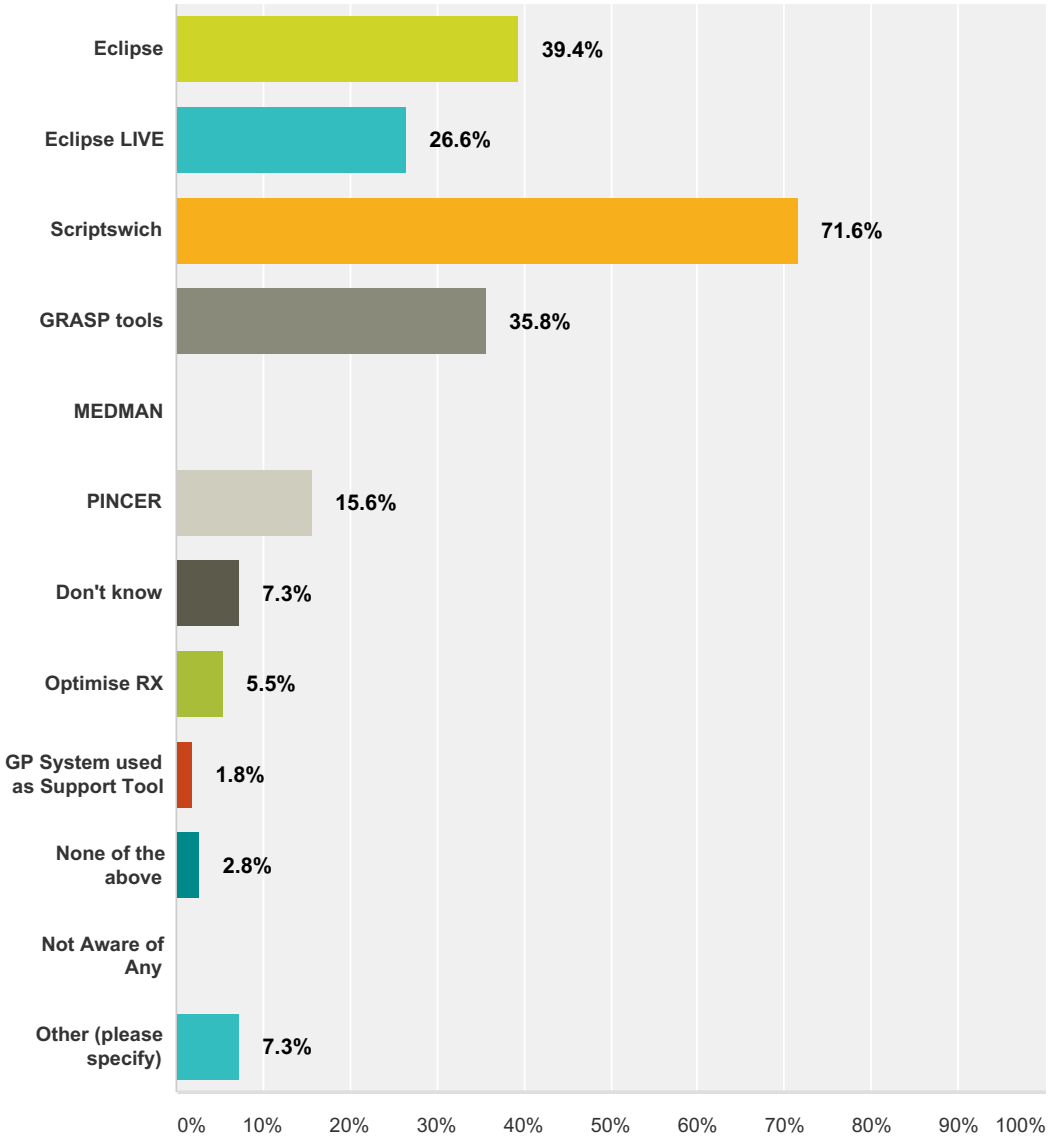


Answer Choices	Responses	
CCG/CSU Pharmacist	**64.60%**	73
Hospital Pharmacist	**2.65%**	3
Community Pharmacist / LPC	**2.65%**	3
Practice Pharmacist	**14.16%**	16
GP	**6.19%**	7
Nurse	**0.88%**	1
CCG Pharmacy Technician	**7.08%**	8
LPC Contractor Development Manager	**0.00%**	0
Other	**1.77%**	2
Total		**113**

#	Other (please specify)	
1	consultant pharmacist	
2	Prescribing Support Pharmacist	

Q3 GP system support tools used in your CCG

Answered: 109 Skipped: 4



Answer Choices	Responses	
Eclipse	**39.4%**	43
Eclipse LIVE	**26.6%**	29
Scriptswich	**71.6%**	78
GRASP tools	**35.8%**	39
MEDMAN	**0.0%**	0
PINCER	**15.6%**	17

Don't know	**7.3%**	8
Optimise RX	**5.5%**	6
GP System used as Support Tool	**1.8%**	2
None of the above	**2.8%**	3
Not Aware of Any	**0.0%**	0
Other (please specify)	**7.3%**	8
Total Respondents: 109		

#	Other (please specify)	
1	looking to implement eclipse	
2	ACG, DXS	
3	Harvey Walsh	
4	iPACT	
5	DXS	
6	STOPP START	
7	STOPP START	
8	Map of Medicines	

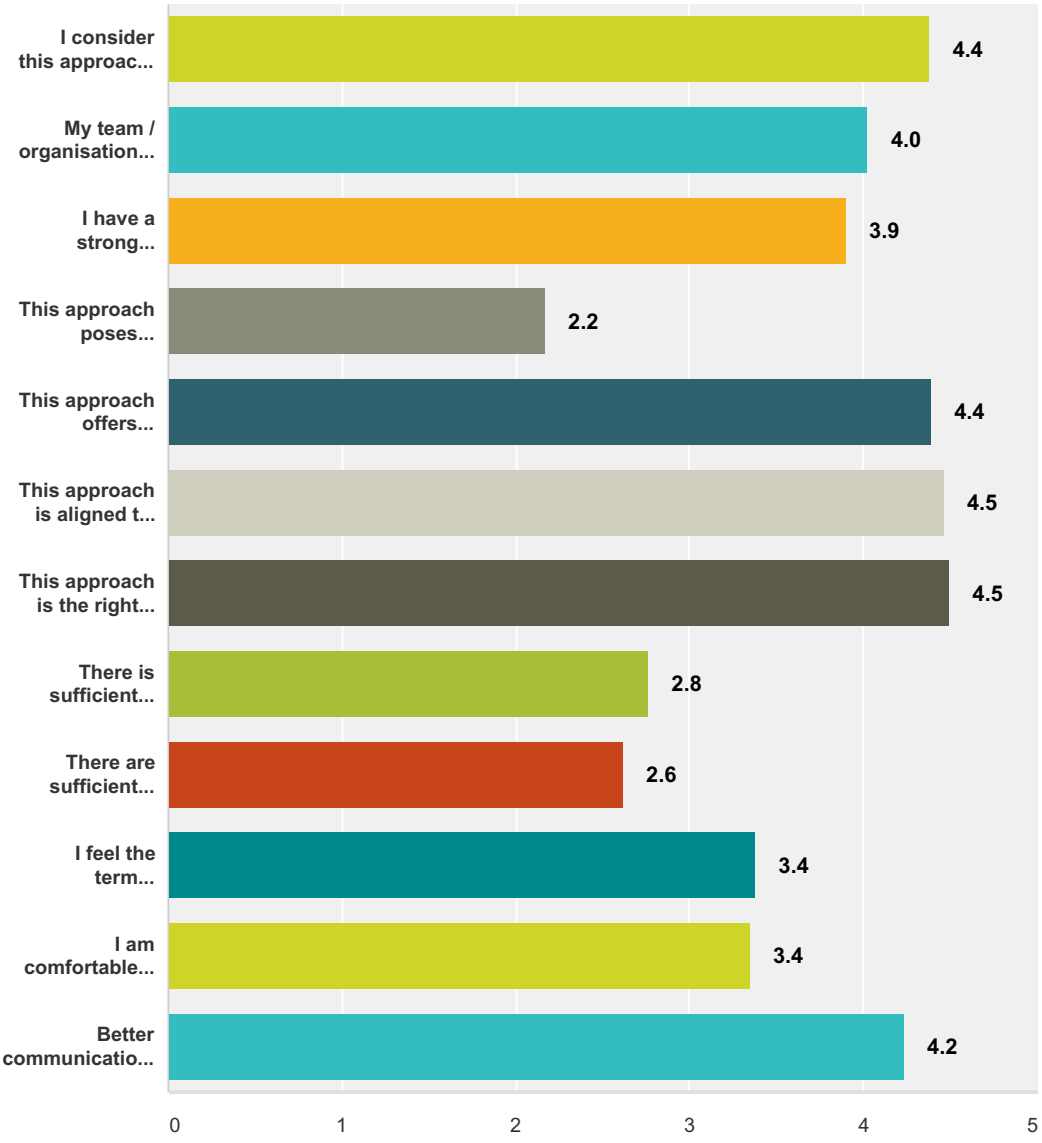
Q4 Please add further information here around GP system support tools

Answered: 23 Skipped: 90

#	Responses	Date
1	Also use epact data	[redacted]
2	Amendments to practice formularies on SystmOne and Emis Web as an aid to support appropriate prescribing.	
3	Eclipse Live used 2013/14 ACG used as part of unplanned admissions DES	
4	GP systems have bene populated with Interface Formulary medicines to help prescribers identify formulary and non-formulary options	
5	We are just starting to pilot Eclipse Live in 6/42 practices-not up and running yet. GRASP used occasionally by some practices eg for AF and COPD	
6	Eclipse Live via trial in 2 practices at the moment	
7	There may be others	
8	I believe we have access to eclipse but I have not used it for a long time We have access to some risk assessment software	
9	Optimise Rx is in use in[redacted]	
10	EMIS functionality!	
11	Emis Web alignment of all practices. limited support tools available for practices at the moment	
12	We use our own reporting tool system - Ventris.	
13	I have ticked the ones which I have used/been involved with am sure there are others available to the practices	
14	About to roll out STOPP START in [redacted] to test in polypharmacy reviews	
15	ePACT, NHSBSA Information Services Portal	
16	currently under discussion	
17	Pincer to be installed later this year. We are based in Jersey, outside the NHS	
18	Scriptswitch updated monthly after formal meeting reviews suggestions, needs active management for profile to be up-to-date. Care needed not to have -ve switches and for them to be read they need to be "good ones" requiring action or thought - not trivial!! As they teach good practice cost reports underestimate benefits - so if Fesulphate liquid not recommneded next time they should pick Fersamel directly; so no data from SS	
19	We are hoping to start Pincer, Eclipse is not up and running in all practices yet	
20	all our GPs use EMIS web so IT integration is more straightforward than other areas.	
21	GP systems accross the CCG are SystmOne, EMIS web, doc man	
22	Scoping changing Scriptswitch for optimise rx	
23	Scoping replacing Scriptswitch with Optimise Rx	

Q5 Evaluate the following statements around deprescribing

Answered: 112 Skipped: 1



	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree	Total	Average Rating
I consider this approach to be a priority area of work	**0.00%** 0.0	**2.68%** 3.0	**5.36%** 6.0	**43.75%** 49.0	**48.21%** 54.0	112	4.38
My team / organisation considers this approach to be a priority area of work	**0.00%** 0.0	**4.50%** 5.0	**18.92%** 21.0	**45.95%** 51.0	**30.63%** 34.0	111	4.03
I have a strong knowledge / understanding of this approach	**0.00%** 0.0	**8.11%** 9.0	**19.82%** 22.0	**45.95%** 51.0	**26.13%** 29.0	111	3.90
This approach poses significant risks to patient care	**16.22%** 18.0	**61.26%** 68.0	**13.51%** 15.0	**7.21%** 8.0	**1.80%** 2.0	111	2.17

This approach offers significant benefits to patient care	**0.00%** 0.0	**0.90%** 1.0	**2.70%** 3.0	**53.15%** 59.0	**43.24%** 48.0	111	4.39
This approach is aligned to Medicines Optimisation	**0.00%** 0.0	**0.90%** 1.0	**2.70%** 3.0	**45.05%** 50.0	**51.35%** 57.0	111	4.47
This approach is the right thing to do	**0.00%** 0.0	**0.00%** 0.0	**1.80%** 2.0	**46.85%** 52.0	**51.35%** 57.0	111	4.50
There is sufficient information available around this topic	**9.91%** 11.0	**37.84%** 42.0	**24.32%** 27.0	**20.72%** 23.0	**7.21%** 8.0	111	2.77
There are sufficient processes / tools to support this approach	**10.81%** 12.0	**41.44%** 46.0	**27.93%** 31.0	**14.41%** 16.0	**5.41%** 6.0	111	2.62
I feel the term 'deprescribing' appropriately defines this approach	**2.70%** 3.0	**21.62%** 24.0	**22.52%** 25.0	**41.44%** 46.0	**11.71%** 13.0	111	3.38
I am comfortable with the term 'deprescribing'	**3.64%** 4.0	**24.55%** 27.0	**19.09%** 21.0	**38.18%** 42.0	**14.55%** 16.0	110	3.35
Better communication and coordination between CCGs around this approach would be beneficial	**0.00%** 0.0	**1.80%** 2.0	**9.91%** 11.0	**50.45%** 56.0	**37.84%** 42.0	111	4.24

Q6 Further thoughts, opinions on deprescribing

Answered: 43 Skipped: 70

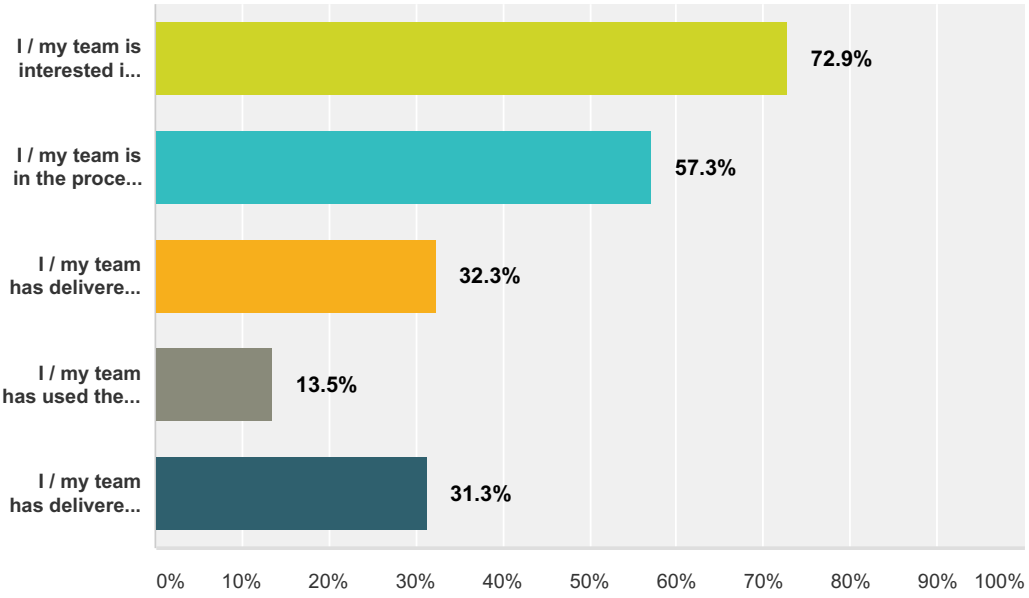
#	Responses
1	poly pharmacy has always been a burden to patients and the healthcare system. simplifying medicine regimes has great patient safety and experience benefits and will reduce waste. MURs NMS allow for this to some extent and MR on admission to hospital and a regular review during the hospital stay can reuslt in deprescribing but to empower pharmacists to do more with support and trainign would be a way forward
2	GPs not very comfortable to deprescribe due to lack of support materials and confidence. Also, a lot of presesure to prescribe comes from patients' families.
3	I agree better comms between CCGs would be useful as it saves each CCG from having to come up with different approaches. A unified way of working across the country to a degree is better as it means consistency for Drs, practice staff and patients.
4	The decisions regarding deprescribing in a particular patient after involving the patient in the discussion need to be followed through to the end.
5	Deprescibing is definitely a worthwhile venture, as it's proven that multiple medications increase the likelihood of a hospital admission, patients generally don't enjoy taking their medicines and may be safer and more content when medicines that are no longer indicated or appropriate are no longer prescribed. However, it is difficult to advise on these issues, as many doctors are hesitant to stop prescribing contentious drugs such as low-dose aspirin or statins on the basis that the chance of them doing harm is 'low', and despite having to treat many people in order to achieve the benefits (e.g. prevention of CV events), in the scenario where such a drug is stopped and a patient then goes on to develop such a complication (though they may have done anyway which the drugs may not have prevented) then that leaves the doctor (and those advising them on prescribing) in a vulnerable position. More information and guidance on the process would be very useful.
6	We need to involve patients and their carers and families. Without this unified approach, deprescribing will look like removal of treatment to save money and/or because the patient is not worth treating.
7	Further investment in people and skills to enable this to be done properly is needed
8	This needs to be considered from the patient and clinician perspective as well as the organisation/nhs as a whole. Patients need to supported to understand the evidence base and part of the decision to reduce or withdraw medication, confident that it can be restarted if they experience recurrence of symptoms. clinicians need guidance and evidence to support their decisions and someone to discuss complex cases with. The impact of stopping a long term medication for a patient and carers must not be miminised and extends beyond the pharmacology.
9	The term iteslf 'deprescribing' brings negative conotations to patients and their representatives. I prefer to use the term 'minimising polypharmacy'. Care staff and patients representatives, once the concept has been explained have been very positive about the thorough medication review and reduction in medication no longer considered appropriate to frail, elderly patients needs.
10	I think the approach needs to be better communicated to patients, their relatives and carers and put into an easy to understand way. GPs often feel conflicts as they are seen as "stopping treatment" and letting the loved one die.
11	Deprescribing is an awful term
12	Fine with the tern deprescribing with other HCPs but feel shouldn't be used in discussion with patients - optimising or getting the best out of medicines better
13	Potential for redcution in medication related admissions in the elderly. Simplification of medication regimes is beneficial for both patient compliance, unskilled carers who may help administer and also likely to reduce wastage through non compliance.
14	I conduct med reviews in Care homes . Deprescribing brings benefits to patients and care staff by reducing workload/errors indirectly.

15	Key will be communication to all involved in "deprescribing" to ensure it is not swiftly followed by "represcribing." Include dispensing pharmacies in communications, there will be a financial impact on them which can in part be mitigated by engaging them from the start in the planning process rather than letting them know as an afterthought, or worse not at all.	
16	In my view many GPs are not comfortable with the idea of deprescribing. There are exceptions to this - we have a few GPs who are prepared to stand back and say, "What are we trying to achieve herer?" but many find conversations with families around this concept difficult to have. I think we need national support and resources to help with this.	
17	Ethos of deprescribing (DP) needs to sit as an element of meds optimisation. DP needs to be much more highly publicised in UK as good prescribing practice to prescribers and CCGs - in particular to GPs. Explain this DP principle applied tor ALL patients, but especially those at risk of ADEs from meds- e.g. elderly; to avoid hospital admissions. Is there pulished evidence that deprescribing (and thus meds optimisation) reduces hospital admissions, medicine costs, overall NHS resource comsumption - to encourage CCG to commission DP/MO/ Polypharmacy reduction services rather than traditional CCG work Would like to see all info from other countries brought together for use in uk with guidance on how to approach step down/stopping medswith patients/relatives (as part of a med review), simple step down/ stop specific drug types guidance and how to monitor for AEs from this process	
18	There needs to be clear support and information for GPs regarding the impact this may also have on QOF.	
19	GPs are scared to do it.	
20	Need to get prescribers on board with the concept	
21	Deprescribing as a definition is fine for healthcare proffesionals but I don't think it should be used when talking to patients, it may sound to them as though you are taking something away that they need?	
22	The term 'deprescribing' is appropriate amongst health professionals, however maybe perceived negatively by patients and carers.	
23	"Deprescribing" doesn't seem to me the right term, it should be a general part of regular quality medication review with a patient, reviewing by changing dose or stopping a medication is still prescribing	
24	more information and GP training is definately needed	
25	I think that deprescribing describes a very narrow technical part of the overall polypharmacy review and decision to stop medicines. It doesn't sound like an approach that involves shared decision making.	
26	Deprescribing would probably be misconstrued by patients and other healthcare professionals as a cost-saving initiative, so needs a more positive turn of phrase, but I can't currently think of one.	
27	De-prescribing is only useful if done by competant clinically qualified staff! Looking at a reduction in number of medicines prescribed as an outcome measure is no better than unnecessarily prescribing them in the first place! If done appropriately in line with medicines optimisation principles great!	
28	There is too much conflicting evidence about which clouds decision making. Protocols for treating Chronic Disease and targets seem more important than treating the individual	
29	I don't like the word! Too jargonistic, and American-English sounding! Would be clearer to say "stopping medicines that are no longer of benefit" (especially for patients). Having said that this activity is essential and something that can be very tricky to implement - e.g. GPs can feel uncomfortable stopping medicines started by a specialist.	
30	This is an absolute priority and must be supported froim the centre too	
31	Wider publicity on the topic would be beneficial. Its not a subject that I think patients and their carers are used to. Also having support materials for clinicans are a must if this is to progressed in an organisation	
32	There is always the background thought among clinician and patients that 'deprescribing' will be used as a means of saving money instead of making the patient better. The central question here for me will be; who will be the right person to take the decision to deprescribe considering the fact that the medication may be initiated by a consultant, reviewed by a specialist, prescribed by a GP and monitored by a pharmacist?	
33	Good idea, hard to do, time intensive. Requires GP involvement and whole system culture change.	
34	Essential that this becomes part of everyday life for all prescribers. We need to change the prescriber culture so that they look at the patient as a whole when they review them. Ideally it needs to be part of QOF or some other vehicle	

35	I think that some national endorsed guidelines would be most beneficial in this area. Such guidelines will certainly make me feel more comfortable stopping/tapering off certain medications.	
36	'Deprescribing' is a very odd term, but I can't think of an aalternative!	
37	Shared care records, between all HCP including community pharmacy would greatly benefit deprescribing	
38	I feel that organisations and trusts that are thinking about doing work around deprescribing would benefit from sharing experience from those who have already implemented this.	
39	Currently undertaken by pharmacy teams attached to Practices but Practice team themselves (GPs, nurses...) don't have any time with current pressures on appoitments to follow the same approach	
40	I am comfortable with the term deprescribing as I know exactly what it means. However I am uncomfortable with it when talking to GPs because some of them do not fully understand it until it is explained	
41	There has to be a national debate on the issue - involving patient groups etc - to ensue acceptability at that level. Often relatives become alarmed when deprescribing is attempted.	
42	I am comfortable with the term deprescribing as I understand what it means, I am uncomfortable that other people such as GPs do not understand it fully	
43	I don't really like the word, the first few characters register at first glance as depressing	

Q7 Implementation - which of these applies?

Answered: 96 Skipped: 17



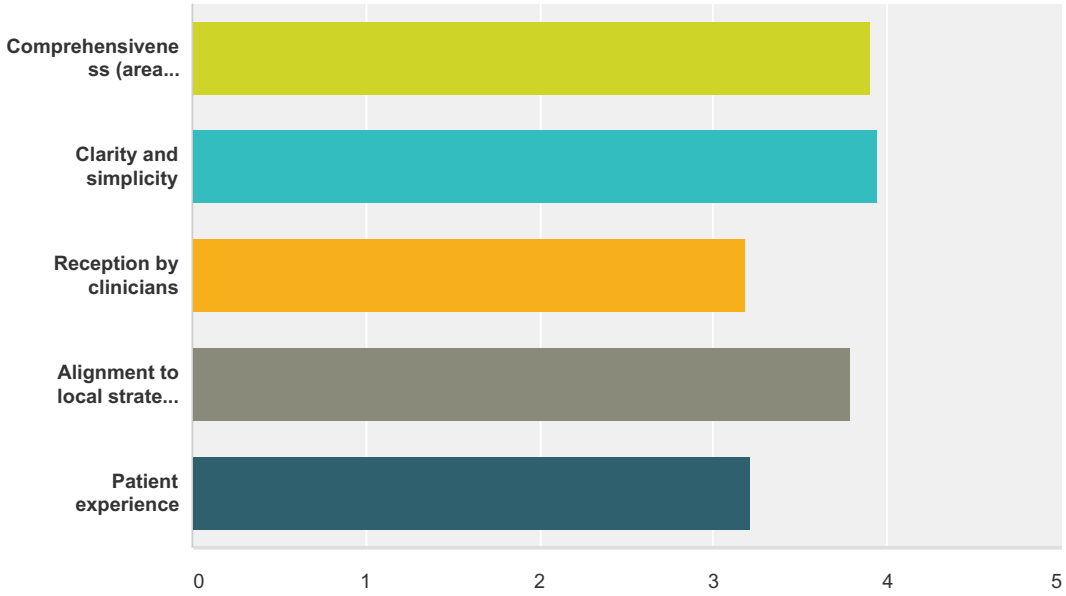
Answer Choices	Responses
I / my team is interested in delivering projects in this area	72.9% 70
I / my team is in the process of implementing some work in this area	57.3% 55
I / my team has delivered work, and achieved outcomes in this area	32.3% 31
I / my team has used the Optimising Safe and Appropriate Medicines Use (OSAMU) Tool	13.5% 13
I / my team has delivered work partially or fully using another medicines optimisation / deprescribing tool (e.g. NHS Scotland Polypharmacy approach, STOPP START, PINCER)	31.3% 30
Total Respondents: 96	

#	Comments	Date
1	we undertook a polypharmacy pilot for patients taking 10 or more items.	
2	Not personally but CCG Pharmacists are currently engaged in complex patient reviews both patients at home and in care/nursing homes with a view to deprescribing.	
3	My team are currently focussing on reducing hospital admissions related to medicines (HARMs) and visit GP surgeries to help review the 2% register of patients idenfitied as at risk of an unplanned hospital admission. Part of our work involves rationalising current prescribing and advising on medicines optimisation/cessation as part of an initiative to prevent patients being admitted, alongside commenting on monitoring and interactions, etc.	
4	We have recently started a medicines optimisation enhanced service but there is very little structure to the actual process and it varies between practices as to how to deliver this	
5	Started to adapt STOPP/START for local use and working with local acute hospital to have one guide across the entire health Economy.	
6	Used NHS Scotland toolkit plus article from Autratlian Prescriber - very useful, since short and simple.	

7	started to use the STOPP START in care homes	
8	See previous comments- community pharmacy will support these initiatives IF there is proper engagement.	
9	Our care home pharmacists have started some of this work but come across reluctance to "deprescribe" as per my previous comment.	
10	I am part of a medication review service for care home patients. I have worked in this field for 4 years, previously being a specialist clinical pharmacy for older people in a hospital for many years. Our level 3 reviews use clinical pharmacists to deliver reviews and provide recommendations to GPs based on expert older person clinical pharmacy / disease and drug monitoring knowledge and localpractice, local disease/drug monitoring guidelines combined with STOP START, Scotland Polypharmacy doc, the OSAMU combined with Nina Barnett PREVENT tool, as part of person-centred reviews. However, the numbers we can see are small and we need something that can education/ train or support GPs do this type of work across the whole of the community they are prescribing incorporating safe prescribing as well as deprescribing	
11	eg care home meds review	
12	I have developed a Polypharmacy template in Emis web which has been shared accross [redacted] This collates a a vast majority of the clinical data, investigations, relavent risk factors (intrinsic factors) and histroy of admission and falls. Pharmacists have then used this tool to assist them with their reviews. This document is then saved into the patients MR for the GP to review and make any nessary changes.	
13	Our team hasn't discussed much but we are tiny and understaffed!	
14	Practices used a tool that was heavily based on the original OSAMU tool to audit a sample of patients at risk of HARM's.	
15	Technician and pharmacist review paperwork has been finalised. Lack of resource has meant we have not yet commenced work in this area.	
16	In Care Home settings	
17	In process of developing resources	
18	We have completed some initial work and are now consuidering the next steps	
19	Have put tool into an enhanced DES for GP practices around the DES for the top 2% at risk. It can't just be work delivered by the MMT	
20	We have tentatively began looking at the STOPP START tool.	
21	we would appreciate more information about how to proceed in identified areas	
22	Work has begun and is ongoing with an updaated STOP:START toolkit revised specifically to reflect local policy	
23	We are developing education sessions for practices and also involved with education of registrars ST3s last year speciality on this topic We have a team of pharmacist/technicians working in practices applying the principles of optimising medication and de-prescribing , whether is in the form of face to face consultations or pre-reviews information for GPs/nurses to take with them on home visits I am also personally integrating with the newly formed "integrated care team" at each practice were a multidisciplinary approach is used to try and keep patients out of hospital. This work has got two different approaches: 1. a referral system for unplanned medication reviews (ie. patient recently discharged from hospital not able to cope with medication) 2. a routine medication review service for patients in the community matron caseload Using any implementations tools is reasonable when you actually have time to review everything properlly which is what our team does, but for other stakeholders to be able to use a deprescribing tool, this needs to be quick to access and linked to the IT systems that GPs use, anything that is not integrated on the IT system gets ignored not intentionally but due to time pressures	
24	We are incorporating deprescribing in to our medicines management strategy for frail and elderly patients	

Q8 If you have used the Optimising Safe and Appropriate Medicines Use (OSAMU) Tool, or if you are familiar with the tool then please rate the OSAMU tool on the following

Answered: 20 Skipped: 93



	Very Poor	Poor	Average	Good	Excellent	Total	Average Rating
Comprehensiveness (area covered)	**0.00%** 0	**0.00%** 0	**15.00%** 3	**80.00%** 16	**5.00%** 1	20	3.90
Clarity and simplicity	**0.00%** 0	**5.00%** 1	**15.00%** 3	**60.00%** 12	**20.00%** 4	20	3.95
Reception by clinicians	**0.00%** 0	**23.53%** 4	**35.29%** 6	**41.18%** 7	**0.00%** 0	17	3.18
Alignment to local strategic priorities	**0.00%** 0	**10.53%** 2	**15.79%** 3	**57.89%** 11	**15.79%** 3	19	3.79
Patient experience	**7.14%** 1	**7.14%** 1	**42.86%** 6	**42.86%** 6	**0.00%** 0	14	3.21

#	Please provide any comments or feedback that you have on the tool or what you think could help improve this tool:	Date
1	Not used so could not give a fully-formed answer re recption by clinicians and patient experience	9/22/2014 5:00 AM
2	Not familiar.	9/22/2014 4:41 AM
3	I have not witnessed or been made aware of the patient experiance around the OSAMU tool.	9/22/2014 4:26 AM
4	The information that would be very useful to include would be NNH. Or at least some correlation of the data from the SPCs about the risk of side effects e.g common / very common etc. The red and amber colouring are too vague and don't really help without the hard numbers that the clinicians / patients / families are interested in. The latest document frmo the AWMSG is easier to read, and contains NNTs We also look at anticholinergic score, and are considering HAS-BLED and CHAD2DS2 - VASC scores	9/22/2014 3:56 AM

5	not familiar with this tool yet	
6	not used the tool direct with clinicians or patients so np comment on these areas	
7	Widely known in the EoE, but less well in other areas of my patch	
8	We have not had any negative/positive feed back from clinicains regarding the tool.	
9	never heard of it	
10	Used this tool and STOPP START Toolkit alongside each other - some information duplicated, some unique to each	
11	I agree with the clinical risk categories. I don't like the term 'cost risk' applied in this approach. I am not sure that it adds value and isn't a good approach to sign up clinicians.	
12	Not used	
13	Using Welsh tool but will be adapting for a more local tool. We looked at available tools and found most of them useful and agreed the MMT would follow but we really wanted to embed the review of our most at risk patients and our over 75s into "normal GP Practice". Felt strongly that GPs would not follow a tool that involved them doing a lot of reading. Needed something simple and easy to follow that prompted them to ask the right questions. So at this stage we have embedded the welsh tool into the local enhanced service. The plan is to then develop and approve our own toold taking the best from all available tools.	
14	Not aware of this tool sorry	
15	I find although it covers a lot of the main general reviews, it could be expanded a little bit more The clinical/cost differenciation and the use of red amber and green is excellent and easy to understand My experince with GPs using the tool is that they can't always spend time looking at it, there consultations are very much dealing with an acute problem, and the regular medication review process has been relegated to a tick box exercise. I find a lot of them would be prompted to review certain things if this tool was integrated with Systemone/emisweb... As per other non-medical prescribers are more receptive to use these tools, sometimes you find they lack the knowledge on how to stop medicines (not many resources to do this, guidelines for each condition to start meds but not to stop/reduce)	

Q9 If you have used another related tools / processes then please provide details below (e.g. name of tool, why it was selected, feedback and outcomes)

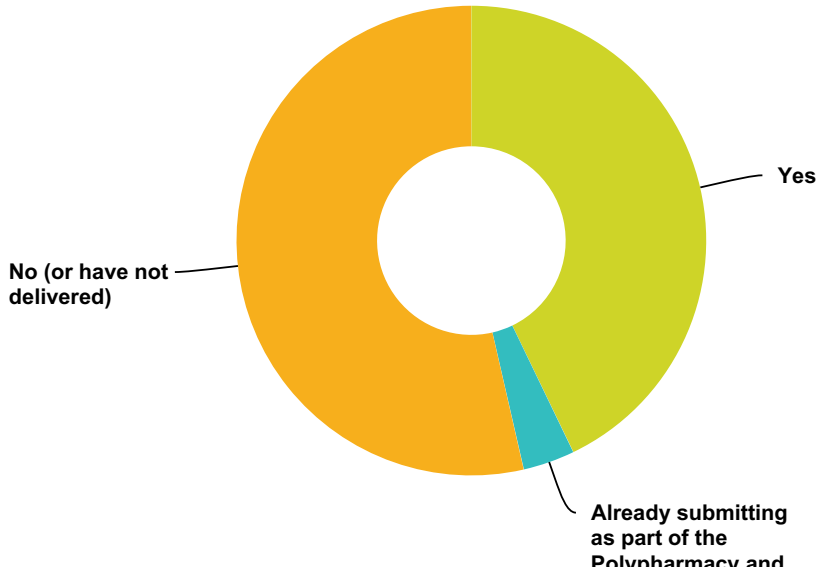
Answered: 29 Skipped: 84

#	Responses	Date
1	Will be using START/STOP tool as widely used/recognised and gives options to consider inappropriate prescribing in terms of patients NOT on medication. Same level of prescriptiveness as STOP/START tool so good in that respect and traffic light risk score seems really useful.	
2	N/A - CCG pharmacists	
3	We have focussed on interventions selected from the range of tools available in the literature to align themselves with our local priorities.	
4	STOP START, PINCER	
5	medication review in care home, polypharmacy, housebound patients - trial without implemented, as safe way of reducing/stopping medicines with option to restart if needed e.g. angina drugs in patients who haven't had angina for years	
6	PrescQIPP optimising medicines tool: Used during care homes reviews. Pharmacists found tool easy to use, although a little longwinded until used to it. GPs had not heard of it, so harder to use as part of discussions. STOP START: Used during care home or desktop medication reviews by the medicines optimisation pharmacists. Known to GPs allowing easier discussion of recommendations. Tool suggested in a new frality toolkit launched by NHS Endgland[redacted]	
7	STOPP was used to develop local guidance.	
8	Our team has developed our own document and GP system template for polypharmacy review	
9	I have not heard of OSAMU tool. STOPP/START was chosen as it is widely available and has been validated.	
10	STOPSTART as easy and already used by frailty team.	
11	NHS Scotland toolkit - very comprehensive and practical. Article from Autratlian Prescriber - very useful, since short and simple.	
12	STOPP - selected as had seen more work based on this tool	
13	OptimiseRx uses a range of national tools including PINCHER, STOP, START etc to produce messages for prescribers that are tailored to the individual patient.	
14	PREVENT -[redacted] STOPP START Bear in mind anticholinergic burden scale in reviews	
15	local prescribnig guidance in easy topics	
16	I have developed a Polypharmacy template in Emis web which has been shared accross [redacted] CCGs. This collates a a vast majority of the clinical data, investigations, relavent risk factors (intrinsic factors) and histroy of admission and falls. Pharmacists have then used this tool to assist them with their reviews. This document is then saved into the patients MR for the GP to review and make any nessary changes.	
17	We have reviewed the Start Stopp tool and just starting looking at the OSAMU tool	
18	STOPP START TOOLKIT Supporting Medication Review. Assessment & management of falls in generaL Practice.	
19	Scottish polypharmacy document, STOP/START	
20	STOPP/START came out earlier, just a few sides in the summary sheets, easy to share with clinicians	
21	no tools used	

22	STOPP START Toolkit as specified above	
23	We are looking to use STOPP START electronic tool as this will give personalised recommendations for patients.	
24	Useful in conjunction with hollistic patient review medicines do not define a patient	
25	STOPP-START integrated software - on pilot at present to assess benefit.	
26	Not used	
27	Looked at Scottish guide to Polypharmacy and Stop, start tool briefly	
28	STOPP:START was used. It seemed a comprehensive tool which was easily adapt to reflect updated guidance and local polocy. We were not aware of the OSAMU tool	
29	PINCER and RCGP indicators, they are so specific that I don't think they pick up combinations of drugs in specific high risk patients, maybe issues that may be seen not as risky/important but related to frailty	

Q10 If you have delivered work or achieved outcomes around polypharmacy and deprescribing would you be willing to share what you have done? (+ key point of contact within your organisation)

Answered: 56 Skipped: 57



Answer Choices	Responses	
Yes	42.86%	24
Already submitting as part of the Polypharmacy and Deprescribing Innovation Awards category	3.57%	2
No (or have not delivered)	53.57%	30
Total		56

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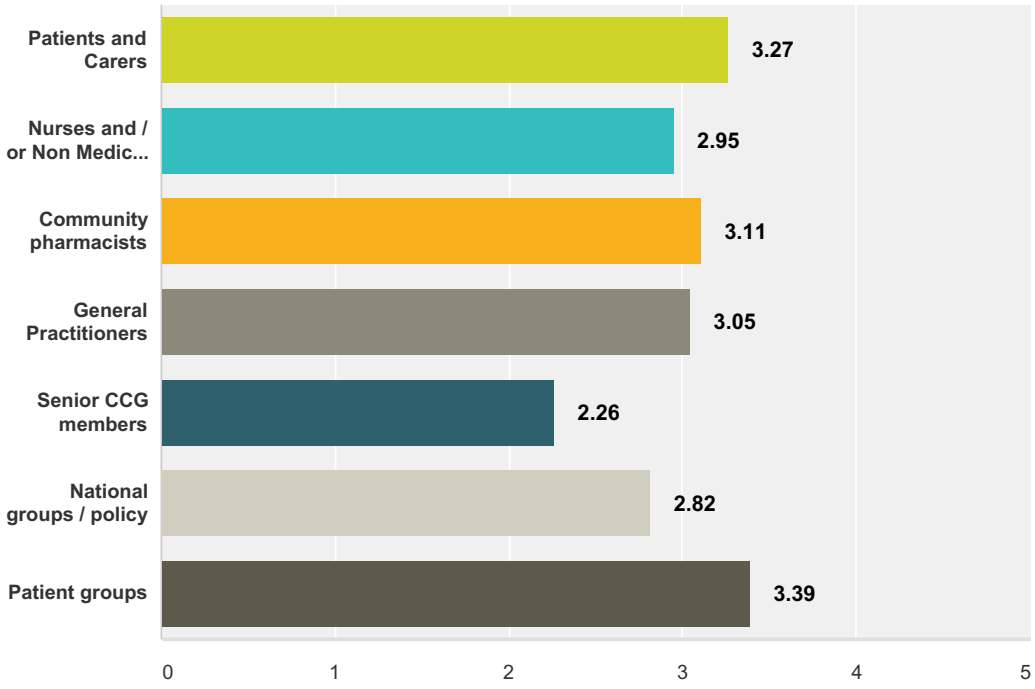
Q11 To what extent do you feel the following groups could be resistant to implementation of deprescribing projects?

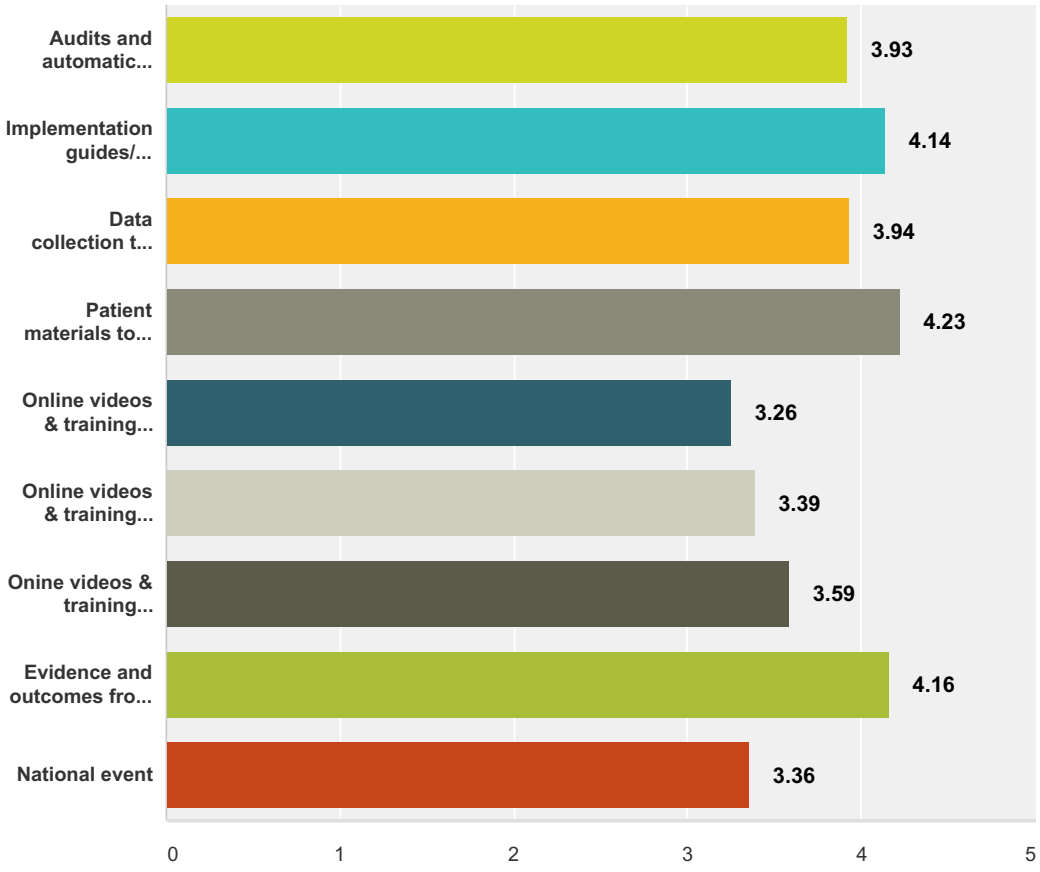
Answered: 98 Skipped: 15



	Very low	Low	Average	High	Very high	Total	Average Rating
Patients and Carers	**0.00%** 0.00	**21.43%** 21.00	**36.73%** 36.00	**35.71%** 35.00	**6.12%** 6.00	98	3.27
Nurses and / or Non Medical Prescribers	**2.06%** 2.00	**34.02%** 33.00	**34.02%** 33.00	**26.80%** 26.00	**3.09%** 3.00	97	2.95
Community pharmacists	**3.06%** 3.00	**27.55%** 27.00	**35.71%** 35.00	**22.45%** 22.00	**11.22%** 11.00	98	3.11
General Practitioners	**3.06%** 3.00	**25.51%** 25.00	**36.73%** 36.00	**32.65%** 32.00	**2.04%** 2.00	98	3.05
Senior CCG members	**12.24%** 12.00	**56.12%** 55.00	**26.53%** 26.00	**4.08%** 4.00	**1.02%** 1.00	98	2.26
National groups / policy	**4.12%** 4.00	**36.08%** 35.00	**34.02%** 33.00	**24.74%** 24.00	**1.03%** 1.00	97	2.82
Patient groups	**0.00%** 0.00	**14.74%** 14.00	**35.79%** 34.00	**45.26%** 43.00	**4.21%** 4.00	95	3.39

Q12 Please rate how useful you would find the following tools to support improving polypharmacy and deprescribing

Answered: 99 Skipped: 14



	Not at all	Slightly	Moderately	Very	Extremely	Total	Average Rating
Audits and automatic system searches	**1.01%** 1.00	**2.02%** 2.00	**26.26%** 26.00	**44.44%** 44.00	**26.26%** 26.00	99	3.93
Implementation guides/ guidance	**0.00%** 0.00	**5.05%** 5.00	**9.09%** 9.00	**52.53%** 52.00	**33.33%** 33.00	99	4.14
Data collection to support building an evidence base	**1.01%** 1.00	**7.07%** 7.00	**11.11%** 11.00	**58.59%** 58.00	**22.22%** 22.00	99	3.94
Patient materials to support shared decision making	**0.00%** 0.00	**1.02%** 1.00	**12.24%** 12.00	**48.98%** 48.00	**37.76%** 37.00	98	4.23
Online videos & training materials for general practitioners	**2.02%** 2.00	**19.19%** 19.00	**36.36%** 36.00	**35.35%** 35.00	**7.07%** 7.00	99	3.26
Online videos & training materials for non-medical prescribers / nurses	**2.02%** 2.00	**15.15%** 15.00	**31.31%** 31.00	**44.44%** 44.00	**7.07%** 7.00	99	3.39
Onine videos & training materials for medicines management/ optimisation teams	**4.04%** 4.00	**12.12%** 12.00	**24.24%** 24.00	**40.40%** 40.00	**19.19%** 19.00	99	3.59

Evidence and outcomes from implementation in other local areas	**0.00%** 0.00	**1.01%** 1.00	**15.15%** 15.00	**50.51%** 50.00	**33.33%** 33.00	99	4.16
National event	**4.12%** 4.00	**13.40%** 13.00	**37.11%** 36.00	**32.99%** 32.00	**12.37%** 12.00	97	3.36

#	Other (please specify)	Date
1	National Event would be amazing. This issue is only going to get bigger as population ages and disease prevalences increase.	
2	Some GPs more keen on deprescribing than others. Some feel they do not have skills to stop medications which may have been initiated in secondary care. Access to an experienced care of the elderly consultant has been suggested as an aid to doing work in this area.	
3	Templates with appropriate READ codes to use on GP systems	
4	National campaign across all sectors to raise awareness of the approach	
5	Any training materials for arms-length teams (eg meds management/optimisation) need to include communication skills and patient facing messages, many of these professionals have spent too long looking at medicines budget bottom lines and have forgotten the human element.	
6	on line info for pts may be worthwhile?!	
7	Information on impact on QOF and how to manage this.	
8	Time contraints limit most people e.g. national event impractical for many clinicians, local events/ train the trainer to enable lunch sessions more popular in my area, opportunities to discuss local concerns	
9	Patient information posters/leaflets that can prompt a patient to start a conversation with their health professional on deprescribing and if it is appropriate for them	
10	A coordinated approach that primary and secondary care are going to agree to and then informing nurses and carers of the approach to be taken to gain support	
11	Case studies, national leaders and patinet groups must be engaged.	
12	We need a proper model of how to do this in a time efficient manner. It requires a whole change in culture.	
13	I want actual specific guidance on reducing / stopping the most commonly over-prescribed drugs, e.g amitryptiline for insomnia	
14	community pharmacists could be used to implement and support deprescribing due to the closer relationships with patients	

Q13 And finally - your commentsPlease use this area to provide any further comments, feedback etc. around deprescribing, in polypharmacy or otherwise, that was not covered anywhere in the landscape review

Answered: 26 Skipped: 87

#	Responses	Date
1	Pulling together all the evidence for deprescribing so that it is in a single document that is easy to use would be the most helpful thing. A brief overview of the evidence with links to more detailed information as needed.	
2	The biggest gripe we get from prescribers is: "we don't have the time." Also, as a team we have attempted to introduce local medicines review system templates but if, when taking a blood pressure for example, it isn't filled in in the correct locations on clinical systems, it won't then pull out from automatic data. Additionally, I feel the best way forwards is for prescribers to treat polypharmacy, complex patients with multiple meds etc as a "complex disease in itself." By this I mean it should be mandatory that they run specific clinics just to address these issues. As they do this for other complex diseases, e.g. diabetes, CHD, Asthma, COPD.	
3	GPs vary widely in their approach to stopping medication, some of ours are very happy to stop, others very reluctant. However as time progresses, more and more see the actual benefits to the quality of life for these frail elderly patients. There is a significant problem with secondary care restarting meds stopped after GP / pharmacist review, and with trainee GPs starting / restarting meds without a more holistic consideration of the patient. We have many examples of this! Much of the polypharmacy is driven by NICE guidance and QOF targets Nurses and patient representatives have in general been very positive about the process of a thorough medication review to ensure that a patient is now on what they need at this point in their life. Perhaps we could limit all elderly frail to absolute maximum of 5 meds - that would hone the clinicians minds! Or revert to the old mind set that the more medication a patient was actually represented poor prescribing practice.	
4	You will need to engage more robustly with social care providers, whether care homes, nursing homes or domiciliary care providers for this to be sustainable.	
5	As previously mentioned this is a great area that a lot of people (GPs and Patients) are interested in, however there are a few concerns about the potential impact on QOF and the medico-legal aspect of stopping a drug and a patient suffering an adverse effect due to this.	
6	In my experience when identifying patient's suitable for deprescribing, this is often ignored by the GP.	
7	We are using a word document template for EMIS web which is very useful.	
8	The term deprescribing is not favoured by some people high up, but it is the term used in the literature internationally.	
9	I fully agree with de-prescribing, the problem I see is GPs having the time to review even if meds man have given them suggestions for each pt. And if the pt then makes an appointment due to deprescribing GPs won't buy into it	
10	GP's need much more information to be ambe to make informed choices.	
11	It is important that patients understand that when a drug is deprescribed they may need to be followed up for a time afterwards- perhaps this could be done 'NMS style' in community pharmacies with appropriate funding	
12	Prescribers need to be incentivised to prescribe cost-effectively, not just safely and effectively, as per their current contract.	
13	unknown what barriers are amongst the groups in Q 11- it would be a good piece of research though!	
14	Deprescribing needs to be done on an individual patient basis eg a 95 year old senile patient in a care home will need a different approach and decision taken to a 95 year old active patient who is still living independently	
15	Tools are out there but it's about their practical application. Recent workshop was led by of what could be stopped and how. This was really useful and something that needs developing.	

16	Polypharmacy results from a medicla model mindset that needs to be challenged from the top down. Without a co-ordinated approach this will fail.	
17	In my view, any project such as deprescribing will only be successful if there is integrated care, joint up working. The initiator of any drug should clearly define expected outcome, possible time line and what is to be done if expected outcome is not being achieved and by whom. Such information should be made known to the patient or carer and made absolutely clear that the action is for the benefit of the patient.	
18	I think we need GPs to engage with the idea of stopping meds being integral to their meds review. More published evidence on stopping meds being a good thing / resrearch money for this area is needed. Clinicians are willing but to do it properly would be very expensive if we need to pay for pt reviews.	
19	I personally feel this is an area where many groups (patients/carers/prescribes) will be reluctant to get into unless supported by nationally endorsed guidelines. The fear is by stopping for e.g. Statins or hypertensive medications that if a future adverse event was to occur that there could be retribution from patient or patient's family. Also if meds started by secondary care may be difficult to convince patient no longer needed. I do feel we need some national guidance to support pharmacist/prescribes and patients regards de-prescribing.	
20	perhaps a need to start in care homes with guidance for relevant clinical areas. In addition more trainign for care home staff	
21	Huge value in sharing practice from other areas, consideration and understanding of practical issues, way of prioritising work to be able to make a start amongst a huge agenda. Build into medication review, would need commissioning as could not be built into GP 10min consultations/ current model. new models of care around neighbourhoods lends itself to new services in eg care homes	
22	"Deprescribing" is no doubt of great importance with the target of QIPP savings now more than ever is quality over quantity important. However I believe an important thing missed out here is the absolute vital importness of patient education around medicine at initiation, especially around mental health medication.	
23	I think a big barrier to de-prescribing is that the current landscape has been driven by a huge NHS campaing about cost. for many patients, they may feel this is just a PR exercise to reduce cost without saying so., It is crucial that patients are involved in the decision and PR so that they can see real examples of how inappropriate polypharmacy occurs and the risks associated with that.	
24	There are no well evidenced guidelines on prescribing and deprescribing in the elderly - a big gap - people extrapolate other guidelines and end up over prescribing.	
25	I agree that reducing the use of unwanted and unhelpful medicines is a key part of medicines optimisation, but I worry that the focus / nomenclature around depresscribing / stopping medicines could be seen a further evidence of rationing and may be viewed as discriminatory (eg if patients were selected for deprescribing on the basis of age). I would support a medicines optimisation approach that could give guidance on improving, changing, starting AND stopping as the same process, rather than on deprescribing as a strand on its own (though I feel deprescribing would be appealing to many individual patients and to clinicians).	
26	I think this area is the best use for a pharmacist skills at the moment.	