University of East Anglia

NHS Norfolk and Suffolk Primary and Community Care Research Office

Deprescribing in primary care- barriers, enablers and potential ways forward

Evidence suggests that 29% of prescribing within primary care in the UK may be inappropriate (1) . This could contribute to increased adverse drug reactions (2) (3) and preventable medication related hospitalisations (4) (5).

Consequently, the cost of inappropriate or unnecessary medicines extends beyond acquisition costs, to include those associated with additional unnecessary NHS resource use.

Deprescribing is defined as:

"the systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy, values and preferences" (6)

Despite the large proportion of medicines routinely identified to be potentially inappropriate, research suggests that proactive deprescribing i.e. not in response to iatrogenic disease, does not currently seem to be part of usual practice or prescribing culture within primary care (7).

Research has identified a large number of barriers and enablers to deprescribing, which exist at both the patient and prescriber level and our own work with patients suggests support for stopping medication when the benefits no longer outweigh harms.

We will describe the barriers and enablers to deprescribing and explain how knowledge of these could lead to the development of a systematic method of identifying suitable patients and a tool which could easily be employed in primary care to support prescribers and patients to meet their shared goals.

Evidence briefing produced by Jeanette Blacklock and Prof. David Wright at the School of Pharmacy, University of East Anglia, June 2017, for the Norfolk and Waveney Clinical Commissioning Groups following receipt of Research Capability Funding; *edited by the Development Team at the Norfolk and Suffolk Primary and Community Care Research Office, August 2017.*

Enablers and barriers to deprescribing

We identified systematic reviews which explored the literature on enablers and barriers to deprescribing (8) (9) (10) and summarised the information in Figure 1.

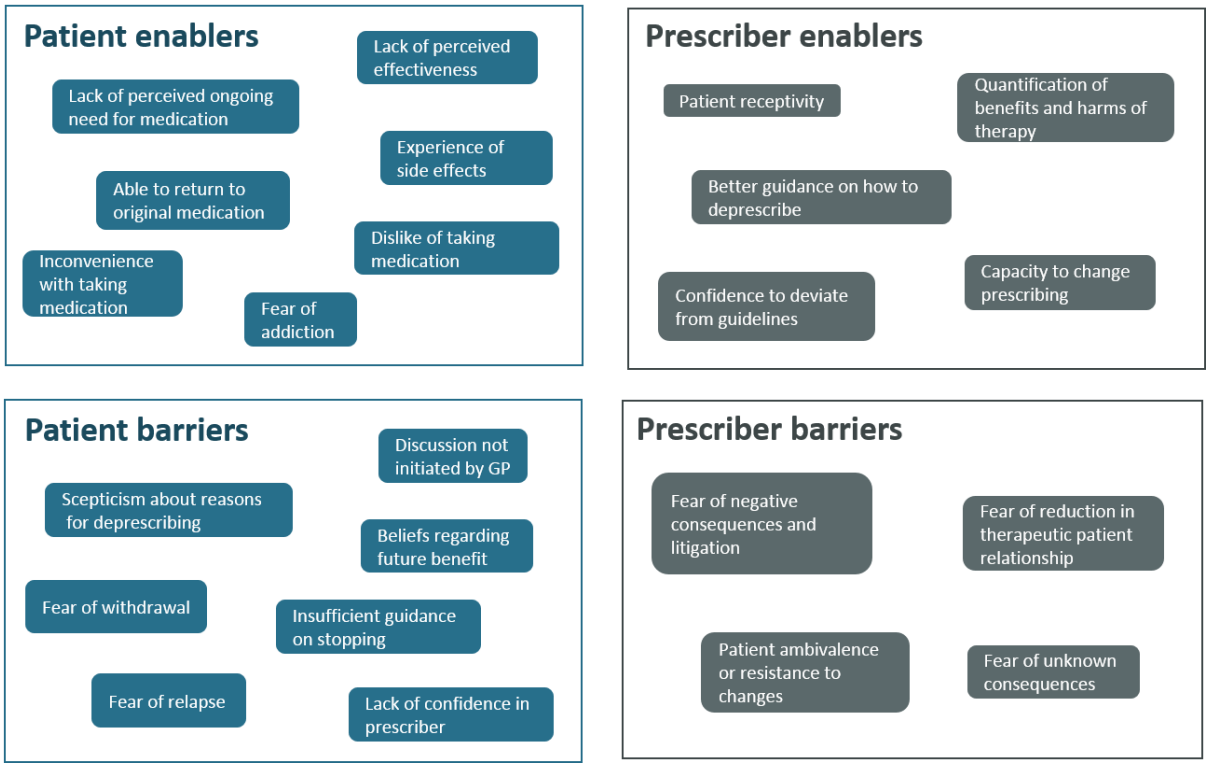

Figure 1. Summary of patient and prescriber barriers and enablers to deprescribing identified in the literature.

Patient enablers include fear of addiction and negative perceptions of the effectiveness of medication. Barriers to deprescribing centre on concerns about the potential negative health effects of stopping medication such as fear of withdrawal and a fear of symptom relapse.

Prescribers report barriers including a fear of unknown consequences and being unsure how to engage with patients who are resistant to change. They also suggest that better guidance on deprescribing would act as an enabler.

Consequently a consultation with a GP is more likely to be acceptable and effective if they have the appropriate information regarding deprescribing to hand, are able to accurately identify and address patient beliefs regarding deprescribing so they can address patient concerns and offer a trial discontinuation. The process should, however, be undertaken in an environment where prescribing incentives and quality schemes do not counter the desire to deprescribe and where discontinuing medication is perceived as equally important to initiating it.

Support to initiate deprescribing

There is an increasing literature reporting on studies which investigated ways of supporting the deprescribing of individual drugs.

NICE guidelines NG5 (Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes) (11) and NG56 (Multimorbidity: clinical assessment and management) (12) recommend the use of the Screening tool of older people's prescriptions (STOPP) and screening tool to alert to right treatment (START) criteria (13) to identify potential medicines related safety incidents. However, these criteria have been developed using an older population and may not be relevant to all ages.

In addition NG56 provides guidance on ensuring any decisions about medication are shared between patient and practitioner based on what is important to the patient in terms of treatments, health priorities, lifestyle and goals.

Currently, no research has taken place to develop a theoretically underpinned intervention for deprescribing which could be readily implemented within primary care to change the culture with respect to deprescribing.

Future research

Future research should focus on developing and testing an intervention which aids deprescribing and which considers:

- the consultation process between patient and practitioner,
- the information provided to prescribers and patients, including how and when it is provided
- monitoring processes and incentives
- whether other healthcare professionals should be involved in the process e.g. pharmacists, secondary care prescribers.

Unnecessary continuation of medicines, where the risks are likely to outweigh the benefits, not only wastes NHS resources but also creates unnecessary additional resource use through iatrogenic disease.

The outcome from the development of an intervention which aids deprescribing in primary care would be a reduction in problematic polypharmacy and iatrogenic disease, improvement in patient adherence and quality of life and significant cost savings to the NHS.

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