AGENDA

British Geriatrics Society
Improving healthcare for older people

Issue 89 | June/July 2023
ISSN 2754-4532

Managing medicines in older adults

PLUS

- **The case for more geriatricians**
- Marjory Warren's desk
- **Deprescribing approaches**

AGENDA
Publications information

Agenda is published every second month by:

British Geriatrics Society
Marjory Warren House
31 St John's Square London EC1M 4DN
Telephone 020 7608 1369 Fax 020 7608 1041
Email editor@bgs.org.uk Website: www.bgs.org.uk

Editorial Advisors: **Prof Anne Hendry, Dr Ruth Law**
Publishing and Production Editor: **Amy Brewerton**

ISSN: 2754-4532 (print)
ISSN: 2754-4540 (online)

Printed and distributed by Brown Knight & Truscott (BKT)

Images: Cover image: Adapted by Amy from original Canva graphic. Other images: © Pexels/Pixabay/Canva/BGS.

WORLD LAND TRUST™
www.carbonbalancedpaper.com
CBP013144

On the
AGENDA

President's *Message*

A major focus of this *AGENDA* is on polypharmacy and medications management. This is a provocative topic that exercises the BGS membership substantially.

Shortly before I wrote this editorial, I tweeted a suitably anonymised picture of a pile of medications I retrieved from a patients' overnight bag in the Emergency Department (*pictured right*). I wrote, simply: "this is why we have a pharmacist as part of our Frailty MDT in the emergency department." The tweet went somewhat viral, was accessed 200,000 times, and received over 60 comments.

The comments in response to my tweet were illuminating – there was widespread agreement about the substantial benefit pharmacists provide as part of multidisciplinary teams (MDTs). There was also, however, a lot of blame. The blame went in all directions with hospital doctors, GPs, community pharmacists, and even patients and relatives incurring the wrath of the 'twitterati'. Blame is easy but, in reality, the route to polypharmacy is complex and multifactorial. Deprescribing, meanwhile, is difficult and variably executed, even by those of us who know what we are doing and are exercised about the harms of multiple medicines. Multi-component responses are needed and include educational interventions focussed both on professionals and the lay public, standardised approaches to medication appropriateness, systems for medicine reconciliation, and team structures bringing together those with expertise on drugs in older people. Some of this is explored in this issue and there are further helpful resources on prescribing and medication management on the BGS website.

The skills needed to tackle the multiple contributors to polypharmacy are relatively generic, but are not widely held. The BGS set up the QI Hub on our website (available at **www.bgs.org.uk/QIHub**) as a way of building quality improvement competencies among the membership. If you haven't accessed this yet, then I commend it to you. It was good to see us providing further opportunities to develop quality improvement skills at the BGS Spring Meeting with an excellent keynote provided by Sam Riley on Statistical Process Control to drive change. There was a wave of

'Blame is easy but, in reality, the route to polypharmacy is complex and multifactorial.'

converts in the room who are no doubt accessing the NHS England Making Data Count resources as you read this.

The BGS Spring Meeting was a delight – as always there was a sense that BGS members are stronger when they come together as a community.

We also had an inspirational keynote from David Oliver, excellent sessions on cardiovascular health, frailty and pre- and perioperative geriatric medicine, and a humbling array of submitted posters sharing both research and quality improvement work. The magic of the Thursday night Ceilidh, with dancing until (just) after midnight, will never be captured online, but for the rest there's the opportunity to catch up with the full conference programme on the BGS website. It's not too late to register to view the recorded sessions if you missed them live in May - visit **www.bgs.org.uk/Spring23** for more information.

It all bodes well for our next meeting in Birmingham, from 22-24 November. This, again, will be a hybrid meeting – but if you weren't able to join us face-to-face in Edinburgh, surely it must be your turn to benefit from the opportunity to recharge, refresh and reconnect with colleagues that undoubtedly comes from meeting in person.

It's now clear, when we come together as a society as we did in Edinburgh, that we are well underway on our journey from being a purely medical membership organisation to a multidisciplinary collaborative of experts interested in improving care for older people. The society is much stronger for this. Multidisciplinarity also lies at the heart of building a workforce fit for care of older people. At the time of writing, the English government is dragging its heels over publication of the NHS England workforce strategy, with much of the hesitation appearing to relate to finance.

In an attempt to move the discussion forward, BGS started its **#moregeriatricians** campaign at the end of May. We commenced this by publishing a paper outlining the current wide variation in geriatrician numbers around the UK (for more information, turn to page 6 or visit **www.bgs.org.uk/MoreGeriatricians**). In it, we argue that this inequity undermines attempts to deliver comprehensive, evidence-based care for older people. We outline a straightforward ask – one geriatrician for every 500 over 85s in each region of the UK. Clearly, this is just a conversation starter. We have already begun conversations with Societies and Colleges representing other members of the MDT to ensure that we build a clear consensus of what a workforce fit for frailty looks like. We clearly need buy-in from wider stakeholders if we're going help drive forward the wider workforce agenda.

How many geriatricians we need will be shaped by discussions at the Colleges of Physicians about what shape General (Internal) Medicine should take in the future. Ensuring that undergraduate training is producing enough healthcare professionals, and that they are inculcated in the centrality of older people to effective healthcare delivery, will be key. There is much work to do, and we can't afford to wait on the government to get going.

Many of you reading this will have roles in healthcare leadership, education and policy. It will be a team effort to influence policymakers to get them to make the right decisions. Please use the resources we have produced so far and let us know what else we need to be doing to advance this issue of existential importance.

Adam Gordon
BGS President
@adamgordon1978

Optimising outcomes from medicines

In her latest editorial, BGS Honorary Secretary, Dr Anne Hendry, explains why medicines management in older people is about more than just prescribing.

As an interdisciplinary society I am proud that we value and celebrate all professionals who work together on our shared mission. This edition of *AGENDA* is an opportunity to celebrate the vital contribution of clinical pharmacists in improving outcomes for older people as part of the multidisciplinary team (MDT). The number of excellent presentations on adherence and medicines management at our recent Spring Meeting are a testament to how this small but mighty section of our membership punches well above their weight.

Throughout my career I have learned a lot from working alongside clinical pharmacists in both acute and community settings. A wise pharmacist transformed my fast track cerebrovascular clinic by bringing his expertise in supporting adherence to the challenge of secondary prevention and polypharmacy.

'Effective deprescribing initiatives are interdisciplinary and grounded in shared decision-making with patients and carers.'

We now have a more nuanced understanding of polypharmacy - less focus on the absolute number of drugs and more on their appropriateness and associated risk of harm. We appreciate that effective deprescribing initiatives are interdisciplinary and grounded in shared decision-making with patients and carers.

It is good to see medication management positioned as an evidence based intervention in NHS England's framework for proactive care. Optimising medicines features in *Choosing Wisely* in Wales. The *7 Steps* approach in Scotland grounds management of polypharmacy in person-centred anticipatory care planning conversations (see page 16 for more on this, including details of forthcoming updates).

The *7 Steps* approach has been adopted in Northern Ireland and the Republic of Ireland through the iSIMPATHY collaborative project. This aimed to develop a new approach to medicines reviews for patients prescribed multiple medicines. Clinical pharmacists worked in GP practices, inpatient and outpatient hospital services to deliver holistic person-centred medicines reviews for over 6,000 older people who had an average of six comorbidities. Through education and support for health literacy, medicine reconciliation and medicine reviews, 91% of patients were placed on a more appropriate medication regime. Evidence to date estimates savings of £120 per patient per annum on medicines expenditure for each review undertaken in Scotland, and €376 in Ireland. This excludes the additional savings due to preventable admissions to hospital or healthcare contacts.

You can access iSIMPATHY resources and training at **www.isimpathy.eu**

Although we should rightly celebrate progress on addressing polypharmacy, we still face many barriers to optimising adherence. Hospital at Home and intermediate care clinicians working in patients' homes can deliver very accurate medicine reconciliation but find titrating doses, switching drugs and introducing new medicines acutely remains a challenge. Navigating the system and the array of dosette boxes and compliance aids is an important area for innovation - please share some examples if your team has cracked this challenge!

Lots of dots need to be joined to improve how we prescribe, deliver, review and deprescribe medicines if we are to optimise adherence. In fact managing polypharmacy is a barometer for how well our services are integrated.

If you want to read more on this topic dip into the excellent report from the TAILOR project:

- Reeve J, Maden M, Hill R, Turk A, Mahtani K, Wong G, et al. Deprescribing medicines in older people living with multimorbidity and polypharmacy: the TAILOR evidence synthesis. *Health Technol Assess* 2022;26(32). https://doi.org/10.3310/AAFO2475

Dr Anne Hendry
BGS Honorary Secretary
@AnneIFICScot

Age and Ageing deprescribing collection

Curated collections of articles on specific topic themes are published periodically by *Age and Ageing*. The appropriate deprescribing in older people collection, with accompanying commentary, can be accessed by visiting www.bgs.org.uk/AAAdesprescribing.

Older people are often taking several medications for a number of different medical conditions.

Although physicians prescribe medications to treat diseases and symptoms, there may be also harmful side effects, especially so in older people taking several medications.

Unfortunately, regular review of the benefits or risks of prescribed medications is as of yet not part of standard care. Also, data on how and in whom to stop medications in older people is scarce.

The reason this is an important area of work is that medication-related issues in older people are a common cause of harm, including both expected and unexpected effects of medications. Research to date tells us that to ensure successful implementation of structured and appropriate deprescribing, careful planning within hospital systems is needed. This includes involving different members of the team to ensure the patients truly benefit.

This themed collection offers key articles providing tools to assist decision-making, implementation strategies, and multi-disciplinary interventions – all with the aim of improving patient outcomes and sustainability of deprescribing approaches.

The collection includes 15 papers which fall under the following topics:

- Polypharmacy and deprescribing
- Practical deprescribing tools
- Implementation in clinical practice
- Barriers and facilitators
- Shared decision making.

Visit **www.bgs.org.uk/AAAdesprescribing** to access the full collection.

BGS

New report out now

The case for more geriatricians

A workforce to care for the ageing population

#MoreGeriatricians www.bgs.org.uk/MoreGeriatricians

The BGS recently launched a report that examines the geriatrician workforce needed to provide high-quality care for an ageing population with increasingly complex needs.

While many professions are involved in the care of older people, geriatricians provide leadership of geriatric medicine services, particularly focusing on those patients with frailty and complex long-term conditions.

The case for more geriatricians: Strengthening the workforce to care for an ageing population reveals significant variation across the UK in the number of geriatricians available to care for older people. The report indicates that while there are 282 geriatricians for approximately every million people over the age of 65 years old in London, there are only 96 for a similar population in the East Midlands. This means that there are parts of the country where the lack of geriatricians results in older people waiting longer to receive a level of care that is inferior to what they would expect and to what their clinicians would wish to provide.

It is commonly accepted that there is a major workforce shortage within the NHS. A key part of the solution must be to increase recruitment. In particular, there are not enough skilled healthcare professionals to respond to the needs of older people, who are the most frequent and numerous users of health services. This report puts a number on how many more geriatricians are required in the NHS to meet the increasingly complex needs of an ageing population. The BGS is calling for a UK-wide target of one consultant geriatrician per 500 people aged 85 and over to be used as the basis of consultant workforce and training projections. The figures in the report, derived from the Royal College of Physicians Census published in 2022, show how many new geriatrician posts would be needed to bring all regions up to this national benchmark by 2030.

The report outlines some of the barriers affecting recruitment in the UK, such as current limitations on medical school places and training numbers. It makes six calls for Governments across the UK to address in terms of workforce planning and investment, in order to achieve the increase in geriatricians so urgently needed.

While recruiting geriatricians will play a key role in addressing the workforce crisis, this must go alongside increased investment in the wider multidisciplinary team and upskilling the entire workforce to care for older people with frailty.

As the number of people with frailty and long-term conditions increases, the BGS calls on the Government to plan ahead for an ageing population. We urge them to take action to boost numbers over the next ten years and to address regional disparities in the deployment of geriatricians. This must be part of a workforce strategy that not only considers recruitment, but also investment in the retention, development and support of NHS staff. The report calls for the wider NHS to be adequately resourced to provide high-quality care for all people in the UK, when and where they need it.

Professor Adam Gordon, BGS President, said: "Despite staff working flat out, the NHS is now providing the worst care for older people since metrics began. A major limitation is that in many parts of the country there is a shortage of professionals who specialise in care of older people. This means that we struggle to deliver both existing services and the new models of care needed to make things better. If we fix the NHS for older people, we fix it for everyone. The BGS calls on the government, NHS, education providers and health service leaders to urgently act to recruit and train more geriatricians. This is a matter of existential importance for our health service."

'This must go alongside increased investment in the wider multidisciplinary team and upskilling the entire workforce to care for older people with frailty.'

Dr Amit Arora, Vice President for Workforce of the BGS, commented: "How a country looks after its older people is a measure of societal attitudes. Getting the care of older people right holds the key to many of the capacity challenges currently facing the NHS.

This report will help to initiate the necessary conversations to support recruitment, retention, development and support for a multidisciplinary workforce caring for older people. This starts with recruiting the geriatrician numbers that we need, to maintain and lead further developments in the care of our ageing population. Older people deserve no less. The opportunity is huge and the time is now."

Dr Sarah Logan, Director of the Medical Workforce Unit, Royal College of Physicians, added: "For years the RCP has been calling for a long term workforce plan for the NHS that is underpinned by data about supply and demand. Our specialty societies understand better than anyone else the challenges facing their workforce, with this report adding to the critical conversation about how we expand the NHS workforce to meet the needs of patients."

In the report, the BGS calls on the Government:

- for a UK-wide target of one consultant geriatrician per every 500 people aged 85 and over to be used as the basis of consultant workforce and training projections.
- for detailed work to establish the number of additional training posts per annum on a deanery-by-deanery basis, with a view to meeting the proposed target across all deaneries by 2030.
- for an urgent expansion of National Training Numbers in geriatric medicine. We estimate this will require an additional 300 geriatric medicine National Training Numbers per year to meet the proposed target by 2030, if recruitment were to start in 2024.
- to take account of the number of trainees in Less Than Full Time employment and the projections on numbers of geriatricians retiring.
- for an urgent increase in the number of ST4 geriatric medicine posts available to support the expansion in national training numbers.
- for a national recruitment drive, highlighting the importance of geriatric medicine and career opportunities within the specialty. This should complement materials focused on expanding the numbers of nurses, AHPs and ACPs choosing a career in older people's healthcare.

Read or download at **www.bgs.org.uk/MoreGeriatricians**

6 Steps to Better Care for Older People in Acute Hospitals

The BGS and Getting It Right First Time (GIRFT) have published new guidance aimed at supporting hospital teams to improve care for older people living with frailty.

Six Steps to Better Care for Older People in Acute Hospitals is designed to accompany the new GIRFT *Hospital Acute Care Frailty Pathway*. It offers detailed measures teams should take to improve care and reduce 'hospital-acquired dependency' for those living with frailty, as well as stressing that interventions should be monitored and linked more widely to community-based services.

In 2021, GIRFT published its national report for geriatric medicine, following a review led by Dr Adrian Hopper. The report focused mainly on the management of frailty in older people, the area of geriatric medicine where there is the greatest risk of avoidable harm and biggest scope for improvement.

It showed that demand for frailty services is growing as people live longer; the number of over-85s in England with dementia or other long-term health conditions is predicted to almost double from 233,000 in 2015 to 446,000 in 2035.

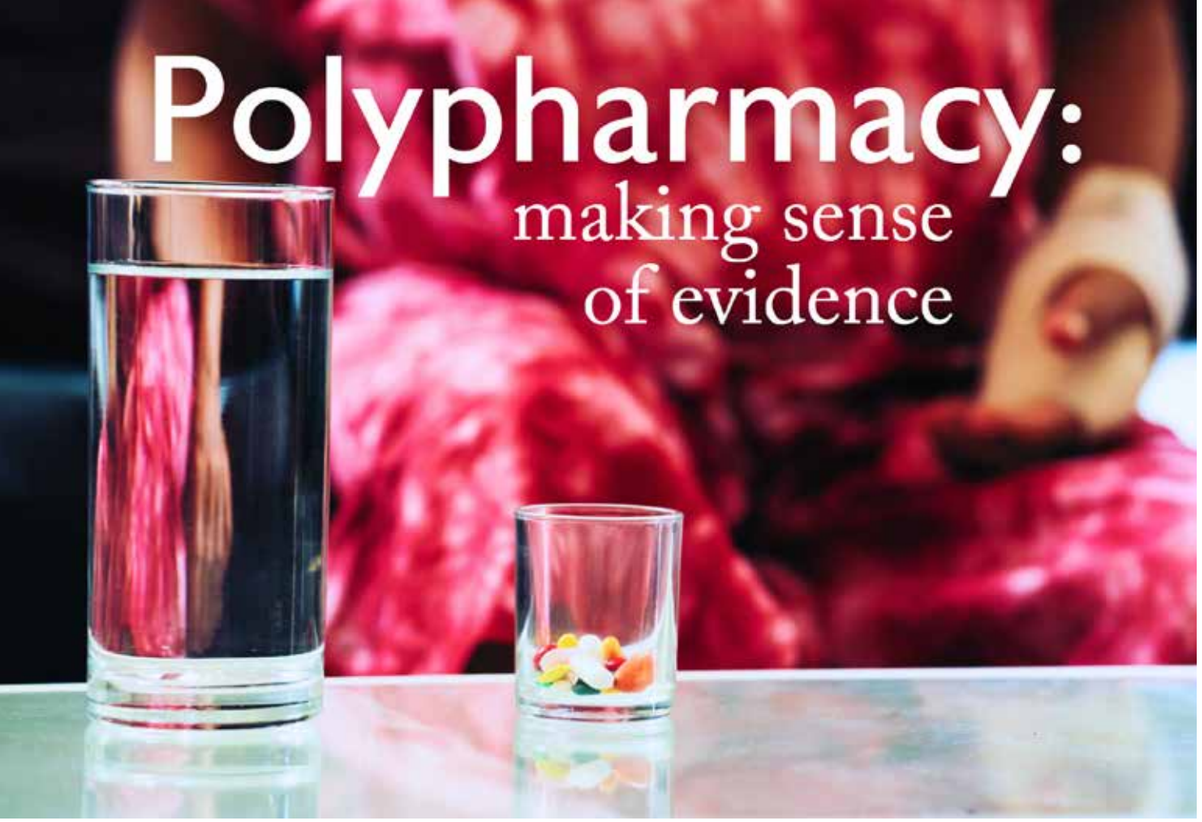
Pre-COVID data shows that between 5% and 10% of people attending A&E departments and 30% of patients in acute medical units are older and living with frailty, with more than 4,000 admissions daily of people with frailty, for reasons such as falls, minor infections and reactions to medications.

The six steps outlined in the guidance are:

1. **Assess for frailty:** Systematically identifying frailty in all settings using the Clinical Frailty Scale.
2. **Prevent complications:** Taking measures to prevent, identify and effectively manage delirium and reduce hospital-acquired deconditioning.
3. **Home First:** Starting discharge planning for older people with frailty and/or dementia as soon as possible after admission, using a 'Home First' principle.
4. **Surgical liaison:** Offering evidence-based surgical specialty liaison that improves individual and service-level outcomes for older people.
5. **Rehabilitation:** Taking steps to ensure there is effective recuperative rehabilitation for older people on all wards in hospital and in linked community services.
6. **Primary and community care:** Developing effective primary and community care services that support older people to remain in, or return to, their usual residence.

The guide also recommends the development of a local comprehensive strategy for supporting care for people living with frailty (using frameworks such as the NHS Rightcare Frailty Toolkit). It advocates for careful and creative use of the available workforce and development of a larger specialist workforce to ensure that staff with the required expertise are deployed where they can add most value.

Read and download the guidance and pathway at **www.bgs.org.uk/GIRFTsixsteps**



Polypharmacy: making sense of evidence

Professor Rowan Harwood, *Age and Ageing* Editor, explains how research evidence and guidance make up only part of the puzzle when it comes to managing polypharmacy in older people.

When I was a Senior House Officer in the 1980s, I worked for a wise geriatrician, Dr Arthur Alvarez. He told me that compliance on the fourth drug was 50%. But that you never knew which the fourth drug is. He also had a useful rule of thumb: limit discharge prescriptions to four drugs, and if there were more you had to prioritise which were the most valuable.

Multimorbidity means there is a lot to treat. Guidelines proliferate. Almost invariably, each one is for a single condition, making recommendations in isolation of other conditions and without the bigger picture. We invest heavily in drugs for prevention of cardiovascular disease and osteoporosis.

Abiding by guidelines is incentivised, for example through performance indicators in general practice. Prescribing cascades[1] build as we chase side effects with new prescriptions. Uncertainty means we undertake therapeutic trials, but stopping unhelpful drugs is harder than starting them. Generalists, including geriatricians and GPs, are often, understandably, reluctant to interfere with specialist treatments.

‘One in six hospital admissions has an adverse drug effect as a contributing cause.’

And yet we know adherence is poor. Compliance aids, from dosette boxes to blister packs and alarms, are largely ineffective. Complexity, and forgetfulness, bring opportunities for errors. Drug monitoring can be burdensome and intrusive.

Problems with polypharmacy abound. One in six hospital admissions has an adverse drug effect as a contributing cause. Adverse effects accumulate, especially anticholinergic burden.[2] Falls Risk Increasing Drugs[3] are well-recognised. The single commonest cause of faecal incontinence is use of laxatives.

Deprescribing has become part of the geriatrician’s vocabulary. In Andreas Stuck’s seminal meta-analysis[4] demonstrating the benefits of Comprehensive Geriatric Assessment, control over prescribing decisions was the single most powerful element.

‘Stopping trials’ have demonstrated the opportunities for discontinuing diuretics, anti-Parkinsonian and anti-epileptic drugs. Beers[5] and STOPP-START[6] criteria highlight risks and opportunities. Pharmacists can help us with medication reviews, and discussions around discontinuation.

We still lack a robust and accepted framework for deprescribing in practice. Maybe we need to return to some rules of thumb? We can certainly critically examine each prescription, and stop those for which there is insufficient evidence of benefit. We can think about and discuss problems with medication management with patients and families. NICE guidance on polypharmacy[7] emphasises shared decision-making, which is to be encouraged, but this makes the process very time-consuming and demanding. People vary in what they want to prioritise and what they can cope with. Taking many more than four different drugs a day is risky, and for many, will also be impractical.

Age and Ageing has championed research on polypharmacy and deprescribing. In addition to the papers referenced below, do look out Woodford and Fisher’s New Horizons review[8] and the themed collection curated by Van der Velde and Minhas.[9]

Rowan H Harwood
Editor, Age and Ageing
@RowanHarwood

References

1. O’Mahony D, Rochon PA. Prescribing cascades: we see only what we look for, we look for only what we know, *Age and Ageing*, Volume 51, Issue 7, July 2022, afac138, https://doi.org/10.1093/ageing/afac138.
2. Myint PK et al, Total anticholinergic burden and risk of mortality and cardiovascular disease over 10 years in 21,636 middle-aged and older men and women of EPIC-Norfolk prospective population study, *Age and Ageing*, Volume 44, Issue 2, March 2015, Pages 219–225, https://doi.org/10.1093/ageing/afu185.
3. Damoiseaux-Volman Birgit Aet al, Potentially inappropriate medications and their effect on falls during hospital admission, *Age and Ageing*, Volume 51, Issue 1, January 2022, afab205, https://doi.org/10.1093/ageing/afab205
4. Stuck AE, Siu AL, Wieland GD, Adams J, Rubenstein LZ. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet*. 1993 Oct 23;342(8878):1032-6. doi: 10.1016/0140-6736(93)92884-v. PMID: 8105269.
5. O’Mahony, D., Cherubini, A., Guiteras, A.R. et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 3. *Eur Geriatr Med* (2023). https://doi.org/10.1007/s41999-023-00777-y
6. American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *J Am Geriatr Soc*. 2023; 1-30. doi:10.1111/jgs.18372
7. *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.* National Institute for Health and Care Excellence. NICE guideline 5. March 2015. Available at: www.nice.org.uk/guidance/ng5
8. Henry J Woodford, James Fisher, New horizons in deprescribing for older people, *Age and Ageing*, Volume 48, Issue 6, November 2019, Pages 768–775, https://doi.org/10.1093/ageing/afz109
9. van der Velde N, Minhas JS, Appropriate deprescribing in older people: a challenging necessity. Commentary to accompany themed collection on deprescribing, *Age and Ageing*, Volume 50, Issue 5, September 2021, Pages 1516–1519, https://doi.org/10.1093/ageing/afab142

Recognising and celebrating diversity in BGS history

As part of our historical archives, the BGS collates and curates a selection of biographies profiling individuals whose contributions have made a significant impact on the Society or the field of geriatric medicine. Currently hosted on our website, the biographies section celebrates some of the prominent geriatricians throughout the 75-year history of the BGS.

We are aware that the current collection of biographies on our website is not reflective of our diverse, multicultural and multidisciplinary membership. It is important that we recognise and celebrate the achievements of members past and present while representing the full breadth of our membership. In updating this part of the website we wish to celebrate the work and achievements of an increased number of individuals, and hope this will inspire current and new members to realise their full potential regardless of gender and/or ethnicity. With this in mind we are working on a project to enhance and expand this collection of profiles.

Among the biographies are those of previous Presidents, and we have some more recent additions to make which illustrate the diversity within our society. However we know that there will be many other women members will wish to see, illustrated by the inspirational women nominated on International Womens Day (IWD) 2021 (see **www.bgs.org.uk/IWD21**).

Over the coming months, leading up to IWD 2024 on 8 March, we’ll be seeking nominations of the women our members would like to see added to the biographies section of the website, and people who would like to help with writing them. The aim to increase diversity is by no means exclusive to gender and we would also welcome nominations that enhance and celebrate diversity with regards ethnicity and also the multidisciplinary nature of the BGS.

If you have someone you would like to nominate then please do get in touch with Amy Brewerton, BGS Publications and Website Editor, at **editor@bgs.org.uk.**

Professor Emma Vardy
Chair, BGS North West Region
@emmavardy2

Polypharmacy, multimorbidity and frailty frequently go hand in hand, and managing medicines in older people is as much about identifying the priorities for the patient as it is about treating their health issues. Three experts from the BGS Pharmacy Group and Medicines Optimisation Special Interest Group (SIG) share their advice on navigating this complex landscape, and offer some practical solutions to help deliver positive, person-centred outcomes for patients.

Multimorbidity is prevalent in older age and increases the risk of problematic polypharmacy, which can present a significant burden for older people.[1] In England, more than one in 10 people aged over 65 are prescribed at least eight different medications each week, and nearly one in four people aged over 85 at least eight different medications, and these figures have risen since 2015.[2] Some medicines are clearly beneficial at the time of prescribing, but the development of frailty and new morbidities can affect the balance of risk and benefit. Regular medication review is required. It is estimated that around one in five prescriptions for older people living at home may be inappropriate[3] with older people who are already on multiple medications being most at risk.

A recent UK study reported that in 16.5% of hospital admissions, adverse drug reactions were the primary cause or an important contributing factor.[4] And this likely is an underestimate. Falls are the number one reason for older people to be taken to a hospital emergency department and causation is often multi-factorial. The contributory factor of medicines to falls is under-recognised[5] despite consensus about STOPPFall medicines increasing risk.[6] Clinicians are challenged to carefully balance the benefits and risks of any medicine prescribed with the aim of maximising benefits and minimising harms in accordance with patients' individual goals.

Studies suggest that many people would like to reduce their medications, if possible.[7] Yet prescribers can appear more concerned about potential harm of stopping a medication than by the potential harm associated with continuing a medication.[8] There appears to be a perception that continuing a prescription is 'doing nothing' whereas stopping a medication is 'an action'. This is despite clarity that legal responsibility for prescribing (including continuing a prescription) lies with the health professional who signs the prescription.[9] Numerous barriers to deprescribing have been identified, including clinician hesitancy to deprescribe,

'Clinicians are challenged to carefully balance the benefits and risks of any medicine prescribed with the aim of maximising benefits and minimising harms in accordance with patients' individual goals.'

automated repeat prescribing systems and clinical guidelines not designed to consider multi-morbidity.[10] Given the complexity of factors leading to polypharmacy, how may clinicians help older people to optimise their medications?

Prioritisation and case finding

This paper sets out to discuss different approaches to deprescribing with older people, whether ad hoc or as part of a planned review process. Ad hoc medication reviews may be triggered by patient events such as request, adverse effects, suspected non-adherence or hospital admission.

If a prescriber was considering compliance aids or covert administration, this should trigger a review to simplify their medication regime. Structured Medicine Reviews (SMRs) are an evidence-based and comprehensive review of a patient's medication, taking into consideration the patient's preferences and all aspects of their health. It is a person-centred and time-consuming process. There is an argument for prioritising patients most likely to benefit from SMR informed by local patient safety prescribing metrics.[11] For example, polypharmacy and anticholinergic burden go hand in hand. Many of the medications commonly prescribed have anticholinergic properties, which, when combined, build an anticholinergic burden. This can expose patients to adverse events, such as confusion and falls, as well as unpleasant side effects such as constipation, gastroparesis, dry skin, dry eyes and dry mouth and is associated with increased mortality.[12] It is common for items to be prescribed to manage anticholinergic side effects, such as laxatives, proton pump inhibitors, eye drops, emollients, artificial saliva – these prescribing cascades lead to polypharmacy. Targeting SMRs for patients with high anticholinergic burden has been associated with a reduction in polypharmacy.

Given the impact of falls on the individual and on health and social care services, maybe we could focus deprescribing SMRs to reduce falls risk? Primary care teams are tasked to identify and prioritise patients for SMR who have had recent falls, but communication across health and social care settings can present barriers to timely review.[13] Care home residents experiencing frequent falls have a high prevalence of fall risk-increasing drugs.[14] Systematic reviews and meta-analyses have demonstrated that medication review is effective in preventing fall-related injuries in general, and fractures specifically, in community-dwelling older adults.[15] However systematically identifying 'falling' residents for priority medication review can present challenges for healthcare systems charged with fall prevention strategies. Involvement of local multidisciplinary teams is also essential since person-centred medication review and deprescribing should not be stand-alone interventions, due to the multifactorial nature of falls.[16]

Person-centred medication review and shared decision making

Person-centred care was originally described in the 1960s as "understanding the patient as a unique human being."[16] Shared decision-making is important in deprescribing conversations, ideally with synergy between the clinician as the expert in their field and the older person as the expert in their lived experience and their own personal needs. Shifting from "what's wrong with you?" to "what matters to you?" can help in understanding a person's goals, values, beliefs and preferences for treatment.[18] In simple terms, person-centred SMR involves the clinician thinking about what they are trying to achieve with the medicine and whether that truly matters to the person they are treating.

Robust clinical trial evidence for medicines in older people, especially for those living with frailty and multimorbidity, is often lacking[19] so a coaching-style approach can be helpful in guiding the older person through complex or conflicting information or where there is considerable uncertainty of medication benefit. The acronym BRAN (denoting Benefits, Risks, Alternatives and do Nothing) can aid discussions about medicines review,[20] tailoring the information to the person's level of understanding. A myriad of tools exist to enable balanced conversations with older people as to potential benefits and harms of medicines. The Canadian tool, MedStopper,[21] can be useful for weighing up potential benefits and harms, is linked to numbers needed to treat and Beers/STOPP criteria, and has medicines tapering/stopping advice.[22-23] Where a decision is agreed with the older person to stop a medicine, using words such as "trial without" can be more reassuring and feel less final than "stopping". Following people up after deprescribing and/or providing them with contact details, in case symptoms worsen or medicine withdrawal effects occur, is also important in providing further reassurance, support and safety-netting.

Clinicians often express concern about deprescribing medicines prescribed by others, particularly where medicines are initiated by specialists; but focusing on the person's preferences and whether the benefit of the medicine outweighs the risks is the true test for whether a medicine should be continued. Continuing a medicine is not risk-free, and polypharmacy and frailty are independent risk factors for mortality[24] with one study finding that every additional medicine increases mortality by 3% in the oldest old.[25]

Person-centred SMR does take time, especially for complex older people with frailty on multiple medicines, or where difficult decisions need to discussed. However, not all a person's medicines need to be reviewed in one consultation and person-centred SMR can be broken down into manageable chunks by focusing on one medicine at a time, or by reviewing medicine as part of other interactions.[18] The time taken for SMR should also be seen as an investment in ensuring continued medicines are providing benefit, preventing long-term harm from inappropriate or unwanted medicines and preventing medicines waste and the consequent environmental impact.

Deprescribing and medicines optimisation

Medicines optimisation is a high-skill process that takes time to perform effectively. Factors influencing decisions relate not only to medicines (alone or in combination) but also to patient characteristics. When performed effectively, the result is individualised, person-centred care that differs from the standardised approach from simply following clinical guidelines for each co-morbidity. Patient factors of particular importance to older people with frailty include life trajectory and personal goals.

Table 1. Patient and medication-related factors influencing medicines management decisions

	Patient-related factors	Medication-related factors
Background information	• Personal goals • Functional ability (including falls risk, swallowing and cognition) • Life expectancy	• Complete list of medications • Rationale for each • Duration of therapy
Medication factors	• Therapeutic burden • Symptomatic benefit • Adverse effects • Adherence	• Efficacy/indication • Therapeutic target (BP, glucose) • Potential harm (both short-term and long-term exposure) • Drug-drug interactions • Drug-disease interactions • Drug-frailty interactions (e.g. risk of falls/delirium) • Prescribing cascades • Dose • Formulation
Follow-up	• Re-emergence of symptoms? • Withdrawal effects?	• Physiological effects

Medications can be categorised according to whether they provide symptomatic benefit or are prescribed for prognostic reasons alone. Reduced life expectancy can limit the potential benefit of medicines taken for prognostic reasons. For example, the one-year mortality after a hip fracture (mean age 82) is around 37%[26] and one-year mortality for people in nursing homes (mean age 84) is around 32%.[27]

The following five criteria can help to recognise that the end of life is near:[28]

- The 'surprise' question: a negative answer to 'Would you be surprised if this patient died in the next year?'
- Two or more unplanned hospital admissions in the last six months.
- Deteriorating performance status.
- Persistent symptoms despite optimal therapy.
- Developing secondary organ failure (e.g. renal failure super-imposed on heart failure).

Table 1 (above) suggests relevant patient and medication-related factors that should be considered. A follow-up, with review of the effects of deprescribing, is also important. There should be acceptance that some discontinued drugs will need to be restarted due to the recurrence of symptoms or the emergence of withdrawal effects.

Typically, therapeutic targets are adjusted in older people with frailty to recognise the changed balance of potential harms and benefits. Example conditions include hypertension and Type 2 diabetes.[29,30] Therapeutic goals vary between people.[31] Some favour symptom control over disease prevention. 'Problematic' or 'inappropriate' polypharmacy exists when the goal of prescribing is not being achieved. This occurs when medicine use is not evidence-based, the risk of harm exceeds the chance of benefit, hazardous drug interactions, therapeutic burden, reduced adherence and prescribing cascades.[32]

'Globally, half of all preventable harm in medical care is medication-related, a quarter of which is severe or life-threatening.'

Deprescribing may involve a single or multiple medications, reducing a drug dose or switching to a different formulation. Medicines optimisation and deprescribing is complex: there is no short-cut to reviewing medication with patients. Periods of stability, such as a planned medication review in a community setting, tend to favour the former. Health crises, such as an emergency hospital admission, may favour the latter. A hospital admission may present an opportunity for deprescribing, however, a study examining deprescribing activity in an acute UK setting found only limited deprescribing activity, dominated by reactive behaviour.[33] Successful deprescribing practices in hospital settings can be hindered by minimal interprofessional collaboration, time constraints, concern for negative outcomes, and absence of a systematic and evidence-based approach.[34]

Yet there is an increasing sense of urgency. Globally, half of all preventable harm in medical care is medication-related, a quarter of which is severe or life-threatening. The World Health Organisation is emphasising the global burden of medication harm, with older people most at-risk, especially those taking multiple medications.[1] Regular review and considered person-centred deprescribing is an effective tool for reducing medication-related harm.

Anne Bentley
Chair, BGS Pharmacy Group

Heather Smith
Consultant Pharmacist, West Yorkshire ICB

Henry Woodford
Chair, BGS Medicine Optimisation Special Interest Group

References

1. WHO. WHO calls for urgent action by countries for achieving Medication Without Harm. 16 September 2022. Available at: www.who.int/news/item/16-09-2022-who-calls-for-urgent-action-by-countries-for-achieving-medication-without-harm
2. Medicines optimisation - polypharmacy | NHSBSA. Available at: www.nhsbsa.nhs.uk/access-our-data-products/epact2/dashboards-and-specifications/medicines-optimisation-polypharmacy
3. D Opondo et al. Inappropriateness of medication prescriptions to elderly patients in the primary care setting: a systematic review. *PLoS ONE* 2012;7(8):e43617
4. Osanlou R, 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
5. Lavan AH, Gallagher P. Predicting risk of adverse drug reactions in older adults. *Ther Adv Drug Saf.* 2016;7(1):11-22. doi: 10.1177/2042098615615472.
6. Seppala et al. STOPPFall (Screening Tool of Older Persons Prescriptions in older adults with high fall risk): a Delphi study by the EuGMS Task and Finish Group on Fall-Risk-Increasing Drugs, *Age and Ageing* 2021;50(4):1189–1199 https://doi.org/10.1093/ageing/afaa249
7. Weir et al. Consumer attitudes towards deprescribing: a systematic review and meta-analysis. *J Gerontol* 2021 doi:10.1093/Gerona/glab222
8. Anderson K, et al. Prescriber barriers and enablers to minimising potentially inappropriate medications in adults: a systematic review and thematic synthesis. *BMJ* Open. 2014; 4e006544
9. NHS England (2018). Responsibility for prescribing between Primary & Secondary/Tertiary Care. Available at: www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf
10. Doherty AJ et al. Barriers and facilitators to deprescribing in primary care: a systematic review. BJGP Open. 2020;25;4(3):bjgpopen20X101096. doi: 10.3399/bjgpopen20X101096.
11. Polypharmacy Programme: getting the balance right – AHSN Network. Available at: www.ahsnnetwork.com/programmes/medicines/polypharmacy
12. Mehdizadeh D et al. Associations Between Anticholinergic Medication Exposure and Adverse Health Outcomes in Older People with Frailty: A Systematic Review and Meta-analysis. Drugs Real World Outcomes. 2021 Dec;8(4):431-458. doi: 10.1007/s40801-021-00256-5. Epub 2021 Jun 23.
13. Sampson R, et al. Patients' perspectives on the medical primary-secondary care interface: systematic review and synthesis of qualitative research. *BMJ Open*. 2015;5:e008708.
14. Hart et al. *J Am Geriatr Soc* (2020) doi:10.1111/jgs.16369
15. Ming Y et al. Medication Review in Preventing Older Adults' Fall-Related Injury: a Systematic Review & Meta-Analysis. *Can Geriatr J*. 2021:1;24(3):237-250.
16. Seppala et al,Task Force on Global Guidelines for Falls in Older Adults, Medication reviews and deprescribing as a single intervention in falls prevention: a systematic review and meta-analysis, *Age and Ageing* 2022;51:(9)https://doi.org/10.1093/ageing/afac191
17. Balint E. The possibilities of patient-centered medicine. *J R Coll Gen Pract* 1969;17:269-276
18. Smith H et al. Person-centred care including deprescribing for older people. *Pharmacy* 2019;7(3):101 https://doi.org/10.3390/pharmacy7030101
19. Florisson S et al. Are older adults insufficiently included in clinical trials?- an umbrella review. *Basic & Clinical Pharmacology & Toxicology* 2021; 128(2): 213-223 https://doi.org/10.1111/bcpt.13536
20. Choosing Wisely UK patient poster. https://choosingwisely.co.uk CWUK_patient_poster_1020-1.pdf
21. MedStopper deprescribing resource. Available at: https://medstopper.com
22. American Geriatrics Society Beers Criteria Update Expert Panel. American Geriatrics Society 2019 updated AGS Beers Criteria for potentially inappropriate medication use in older adults. *J Amer Ger Soc* 2019;67(4): 674-694 https://doi.org/10.1111/jgs.15767
23. O'Mahoney D et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age and Ageing* 2015;44(2)213–218 https://doi.org/10.1093/ageing/afu145
24. Herr M et al. Polypharmacy and frailty: prevalence, relationship, and impact on mortality in a French sample of 2350 old people. *Pharmacoepidemiology and Drug Safety* 2015; 24(6): 637-646 https://doi.org/10.1002/pds.3772
25. Davies LE et al. Is polypharmacy associated with mortality in the very old: Findings from the Newcastle 85+ Study. *Brit J Clin Pharmacol* 2022; 88(6): 2988-2995 https://doi.org/10.1111/bcp.15211
26. de Joode et al., *J Orthop Traumatol* (2019) doi:10.1186/s10195-019-0529-z
27. Vossius et al., *PLoS One* (2018) doi:10.1371/journal.pone.0203480
28. Royal College of Physicians, Acute care resource: end-of-life care in the acute care setting: 2021. Available at: www.rcplondon.ac.uk/projects/outputs/acute-care-resource-end-life-care-acute-care-setting
29. National Institute for Health and Care Excellence. Hypertension in adults: diagnosis and management. Available at: www.nice.org.uk/guidance/ng136
30. National Institute for Health and Care Excellence. Type 2 diabetes in adults: management. Available at: www.nice.org.uk/guidance/ng28
31. Weir et al. Consumer attitudes towards deprescribing: a systematic review and meta-analysis. J *Gerontol* (2021) doi:10.1093/Gerona/glab222
32. Duerden et al. Polypharmacy and medicines optimisation: making it safe and sound. King's Fund (2013). Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/polypharmacy-and-medicines-optimisation-kingsfund-nov13.pdf
33. Edey R, Edwards N, Von Sychowski J, Bains A, Spence J, Martinusen D. Impact of deprescribing rounds on discharge prescriptions: an interventional trial. *Int J Clin Pharm*. 2019 Feb;41(1):159-166. doi: 10.1007/s11096-018-0753-2. Epub 2018 Nov 27. PMID: 30478496.
34. Scott S, et al. Deprescribing admission medication at a UK teaching hospital; a report on quantity and nature of activity. I*nt J Clin Pharm*. 2018 Oct;40(5):991-996. doi: 10.1007/s11096-018-0673-1. Epub 2018 Jun 20. PMID: 29926257.

What matters to you? Updating the Scottish Polypharmacy Guidance

Care for adults on multiple medications often with multiple pathologies remains a global challenge. The fourth edition of the Scottish Polypharmacy guidance will be launched in 2023. This article provides a sneak peek into the changes that can be expected in this edition. An example of a case summary is provided to highlight the process.

The fourth edition of the guidance benefits from input from the Scottish Intercollegiate Guidelines Network Research and Information service. A formalised literature search and considered judgement process has been used which includes a wide group of patient and public representatives, and clinicians from a range of health professions. The guideline retains a mixture of evidence base; clinical expertise; results from improvement methodology; and feedback from patients on outcomes as a result of medication review. It aims to give good practical advice to patients and prescribers alike.

Core to all sections is a '7 Steps' process for medication review that provides a useful framework to support holistic and patient-centred review of medications. This has been updated to place greater emphasis on person centred care. In short, *'What matters to the patient?'* is the core driver. Environmental impact and sustainability of medication use is now also included as a factor to consider. You can view a table illustrating this process on P18-19 of this issue.

Hot topics and case studies

The selection of Hot Topics provides concise guidance and advice for difficult areas of prescribing. Real world application each of these sections is illustrated with a series of worked examples for use in teaching or personal development. In this edition of the guidance the number of Hot Topics has increased from 7 to around 17 including new topics such as Chronic Pain, Benzodiazepines and Z drugs, and medicines for dementia. To support practitioners' learning, and in response to feedback, the number of case studies has increased from six to around 24, including a focus on frailty as a factor in medication review.

Tools to support decision making

Drug Efficacy (Numbers needed to treat - NNT) tables have been refreshed with up-to-date evidence. Harm reduction can still be targeted through the use of the Cumulative Toxicity and Anticholinergic Burden tools, and these have both been updated and amended in line with current practice. Some rarely used medicines have been removed from the Cumulative Toxicity tool and some others added.

Data and IT developments

A prescriber and a patient app to support patients in shared decision-making about their medicines was launched in 2018. This has been extensively updated in line with the 4th edition of the guidelines. The app also has PROMS that patients and their carers are able to fill in to support them getting the best out of their review. QR codes to download the app for both Apple and Android are shown below:

Polypharmacy: Manage Medicines app

For Apple For Android

In addition, the original case-finding tools at GP practice level have been developed to provide decision support information at the point of prescribing. This High Risk Medicines tool has been refined through testing in 12 GP practices and are currently being rolled out across all regions across Scotland.

Indicators to support appropriate polypharmacy

There are currently a suite of 20 medication safety indicators linked with ensuring appropriate polypharmacy. These prescribing atlases are being updated and can be found in the National Therapeutic Indicators from Public Health Scotland. This, along with accompanying data visualisation, is available at: **https://tinyurl.com/PHSdatavis**.

Conclusion

The draft guidance is due to be released for consultation this summer and comments and feedback would be welcome on this person-centred approach to addressing appropriate prescribing and supporting deprescribing where needed.

Alpana Mair
Head of Effective Prescribing and Therapeutics Division, Scottish Government; Associate Professor, Edinburgh Napier University

Martin Wilson
Consultant Care of the Elderly, Raigmore Hospital, NHS Highland

Kathryn Wood
Lead Clinical Pharmacist, Elderly and Rehabilitation, NHS Tayside

Dr Iain S Wilson
Clinical Lead (GP) for Effective Prescribing and Therapeutics Division, Scottish Government

Table 1. An example of a case summary

Case summary: Medication Sick Day Guidance in Nursing Home Resident	
Background (age, sex, occupation, baseline function)	**Lifestyle and current function (inc. frailty score for >65yrs) alcohol/ smoking/diet/ exercise**
• 83 year old male • Nursing home resident • Registered blind • Increasing forgetfulness - awaiting assessment by Older Adult Community Mental	• Does not smoke or drink. • Eats a normal diet and fluids. • Requires help of one staff member for personal care, washing and dressing. • Mobility - able to transfer using a zimmer and two staff. Wheelchair for longer distances. Moderate frailty, Rockwood 6. • Mini Mental State Examination (MMSE) score 20, referred to OA CMHT
History of presentation/ reason for review	**"What matters to me" (Individual's ideas, concerns and expectations of treatment)**
• Nausea and vomiting (twice 2 nights ago and once following morning) • Dapagliflozin, furosemide, macrogol, metformin, ramipril and senna suspended until 48 hours after nausea and vomiting resolved. Staff asked for advice from Advanced Nurse Practitioner (ANP) before suspending. ANP advised them to follow sick day guidance and in addition withhold laxative therapy.	• Individual understood why medication was withheld as had been counselled on sick day guidance at previous medication review. • Nursing home staff had the individual's personalised medicines list created in the Polypharmacy: Manage Medicines website/app. Future app development will provide screen reader option for sick day guidance. • Welfare Power of Attorney (POA) informed. • Prescribed prochlorperazine for duration of the illness.
Current medical history and relevant co-morbidities	**Results e.g. biochemistry, other relevant investigations or monitoring**
• Ankle oedema • Benign prostatic hyperplasia • Depression • Hypertension • Ischaemic heart disease • Registered blind • Type 2 diabetes mellitus	• Commenced on a fluid intake and output chart for monitoring. Blood results from 3 months ago: Sodium: 140mmol/L Potassium: 4.0mmol/L Creatinine: 70micromols/litre Urea: 7.5mmol/L eGFR: > 60 ml/min/1.73m2 CrCl: 87ml/min Serum cholesterol: 4.8 mmol/L Weight: 87kg Height: 1.73m BMI: 29 kg/m2 BP: 145/85mmHg Pulse: 65 BPM HbA1C: 53 mmol/mol
Current medication and drug allergies (include OTC preparation and herbal remedies)	**Most recent relevant consultations**
• Atorvastatin 80mg tablets – one tablet daily • Co-codamol 30mg/500mg tablets – one or two tablets up to four times a day • Dapagliflozin 10mg tablets - one tablet daily • Finasteride 5mg tablets – one tablet daily • Furosemide 40mg tablets - one tablet daily • Lansoprazole 30mg capsules - one capsule daily • Macrogol 3350 sachets – one or two sachets daily • Metformin 500mg tablets – one tablet twice daily • Mirtazapine 30mg tablets – one tablet daily • Ramipril 10mg capsules – one capsule daily • Senna 7.5mg tablets – one or two tablets at night • Tamsulosin 400mcg modified-release capsules – one capsule daily • Allergies or adverse drug reactions - nil • OTC medicines – nil	• No further nausea or vomiting since yesterday morning. • Restarted the temporarily withheld medicines.

Table 2. 7 Steps medication review process

Steps	Process	Person specific issues to address
1 **Aims** What matters to the individual about their condition(s)?	**Review diagnoses and consider:** • Therapeutic objectives of drug therapy • Management of existing health problems. • Prevention of future health issues, including lifestyle advice	• Presentation of nausea and vomiting (more than one episode of vomiting).
2 **Need** Identify essential drug therapy	**Identify essential drugs (not to be stopped without specialist advice)** • Drugs that have essential replacement functions (e.g. levothyroxine) • Drugs to prevent rapid symptomatic decline (e.g. drugs for Parkinson's disease, heart failure)	• None
3 Does the individual take unnecessary drug therapy?	**Identify and review the continued need for drugs** • what is medication for? • with temporary indications • with higher than usual maintenance doses • with limited benefit/evidence for use • with limited benefit in the person under review (see Drug efficacy & applicability (NNT) table)	• **Mirtazapine** - when was this last reviewed? Increased risk of ADRs including sedation and falls • **Co-codamol** - No known indication. Increased risk of ADRs in frailty. May manage with only paracetamol, thus less need for laxative. If only taking one tablet, subtherapeutic dose of paracetamol.
4 **Effectiveness** Are therapeutic objectives being achieved?	**Identify the need for adding/intensifying drug therapy to achieve therapeutic objectives** • to achieve symptom control • to achieve biochemical/clinical targets • to prevent disease progression/exacerbation • is there a more appropriate medication to achieve goals	• **Prochlorperazine** - commenced for treatment of nausea and vomiting only • **Co-codamol** - as per above • **Blood pressure** - at target, could reduce ramipril • **HbA1C** – at target, potential to reduce metformin
5 **Safety** Does the individual have or is at risk of ADR/ Side effects? Does the person know what to do if they're ill?	**Identify individual safety risks by checking for** • appropriate individual targets e.g. HbA1c, BP • drug-disease interactions • drug-drug interactions (see ADR table) • monitoring mechanisms for high-risk drugs • risk of accidental overdosing **Identify adverse drug effects by checking for** • specific symptoms/laboratory markers (e.g. hypokalaemia) • cumulative adverse drug effects (see ADR table) • drugs used to treat side effects caused by other drugs **Medication Sick Day guidance**	• Medication Sick Day Guidance followed - dapagliflozin, furosemide, metformin and ramipril temporarily paused during intercurrent illness. • Macrogol and senna also withheld. • Reason for temporary suspension of medicines explained and understood by individual and POA.
6 **Sustainability** Is drug therapy cost-effective and environmentally sustainable	**Identify unnecessarily costly drug therapy by** • considering more cost-effective alternatives, safety, convenience • Consider the environmental impact of • Inhaler use • Single use plastics • Medicines waste • Water pollution	**Ensure effectiveness and continued need for regular medicines.** • All medicines align with local formulary. • Nursing home only order medicines when necessary and do not stockpile. • Appropriate disposal of out-of-date medicines through local Community Pharmacy.
7 **Person centeredness** Is the person willing and able to take drug therapy as intended?	**Does the person understand the outcomes of the review?** • Consider Teach back **Ensure drug therapy changes are tailored to individual's preferences. Consider:** • is the medication in a form they can take? • is the dosing schedule convenient? • what assistance is needed? • are they able to take medicines as intended? **Agree and communicate plan** • discuss and agree with the individual/carer/welfare proxy therapeutic objectives and treatment priorities • include lifestyle and holistic management goals • inform relevant health and social care providers of changes in treatments across the transitions of care	**Agreed plan** • Nursing Home staff ensured correct medicines were temporarily withheld. • **Restart** - medicines were restarted once nausea and vomiting resolved and the individual was eating and drinking normally for 48 hours. • **Prochlorperazine** - stopped when acute illness resolved. • **Change** – co-codamol tablets to paracetamol tablets • **Reduce** – ramipril to 5mg once daily and metformin to 500mg once daily. Monitor response and adjust accordingly. • **Review** – mirtazapine and continued need for laxatives at next consultation
Key concepts in this case • Implementation of medication sick day guidance • Fluid intake and output monitoring during potentially dehydrating illness • Restarting medicines following sick days • Review of medicines following acute illness is an opportunity to complete full review of long-term conditions and medicines.		

Balancing
benefits and harms

Interpreting the scientific evidence for different medicines and aligning these with the unique needs and wishes of older patients can be a challenge. A website has been launched which aims to help GPs interpret the benefits and harms for treatments for long-term conditions and explain them to patients in a clear way.

Evidence based medicine (EBM) did not arise as a 'movement' until the beginning of the 2000's. The formation of The Cochrane Foundation was a core driver for EBM globally with a slogan of: "Trusted evidence. Informed decisions. Better health." This process has driven the development, publication and implementation of clinical practice guidelines in order to standardise care and improve patient outcomes,[1,2] and often have been associated with financial incentivisation in order to achieve disease-based targets.[3]

This approach has limitations, not least due to most patients seen in primary and secondary care having multimorbidity - the presence of two or more chronic physical and/or mental health conditions or symptom complexes (such as frailty).[4] US[5] and UK[6] research has reported that clinical guidelines rarely address comorbidity or patient-centred care. Furthermore, adherence to guideline recommendations in caring for an older person with multimorbidity would often lead to complex and sometimes contradictory drug and self-care regimes.[5-6] Clinical guidelines are commonly based upon clinical research, which historically excludes older patients and patients with multimorbidity or polypharmacy, who ironically are the very cohort who have most to gain from these medications due to higher rates of chronic disease.

In this context, there is extensive work attempting to square the circle of using clinical guidelines and treatment recommendations for the right patient. This has included targeted developments of clinical guidelines in order to be able to report absolute benefit patients are likely to gain from prescribed medications in the long-term for preventative treatments, and characterise applicability of recommendations to patients in relation to disease or drug interactions.[7]

Dr Julian Treadwell, a GP and Primary Care DPhil student at the University of Oxford, in conjunction with funding from the National Institute for Health and Care Research (NIHR), developed a website for clinicians in primary care

'Clinical guidelines are commonly based upon clinical research, which historically excludes older patients and patients with multimorbidity or polypharmacy.'

'What will be beneficial to one patient may carry different risks for the next, so allowing patients to understand these risks and benefits provides real patient-centred care.'

where the scientific background of recommended treatments can be found, understood and used with patients to guide management on an individual basis. What will be beneficial to one patient may carry different risks for the next, so allowing patients to understand these risks and benefits provides real patient-centred care.

GP Evidence is a tool that is free to use and provides up-to-date evidence from NICE and Cochrane reviews. It covers 13 common conditions in primary care from Atrial Fibrillation to Type-2 Diabetes covering Absolute Risk Reduction (ARR), Number Needed to Treat (NNT) and Relative Risk Reduction (RRR) with a handy link to 'Explain Stats'. Colourful and easy to see graphics of 100 faces provide good visuals for use with patients and colleagues to show the changing benefits of treatments. Handy graphs and tabulated information provides easy to access information to explain to patients.

The following case vignettes demonstrate two cases where the GP Evidence programme has been used with patients and family members to discuss prescribing decisions.

Case 1: 'My dad has been diagnosed with atrial fibrillation. He is in a nursing home, so what should we do?'

Bob is an 80-year old man who resides in a nursing home which your practice looks after. He is new to the practice, and you note a recent out-of-hours contact where the ambulance crew attended due to chest pain. Their assessment overall was reassuring, but they noted atrial fibrillation on his ECG, which was new, and advised GP review with his daughter, who is registered as active Power of Attorney.

Bob has a background of heart failure following two recent Non-ST-elevation myocardial infarction (NSTEMIs), Type 2 diabetes, essential hypertension, dyslipidemia and moderate to severe dementia. He is on aspirin 75mg OD, famotidine 20mg OD, bisoprolol 1.25mg OD, perindopril 4mg OD, furosemide 40mg BD, metformin 500mg BD, alogliptin 25mg OD and memantine 10mg OD.

Using the GP Evidence programme, you calculate a CHA2DS2-VASc score of 6, and an ORBIT score of 2 (low risk). You spend some time showing the pictorial diagrams of benefit and risks of anti-coagulation. With easily available information and figures, you explain that 13 people out of 100 people will avoid a stroke over the course of a year with treatment and that almost 3 people out of 100 people will experience a significant bleed due to the treatment.

His daughter feels on balance it would be of benefit to start anticoagulation, which you commence in line with your local protocol.

Case 2: 'Your colleague wants to add another medication! I'm 83 years old, I have to die of something!'

Betty is an 83-year old lady you are seeing in your chronic kidney disease (CKD 4) clinic, after 'being difficult' and declining a change in her diabetic medication, or to start a statin with your practice nurse.

She has stable CKD 4 (eGFR 25) with significantly increased proteinuria (Albumin creatinine ratio 40), Type 2 diabetes (HbA1c 69 mmol/mol), moderate depression and anxiety, and osteoarthritis.

She is currently taking lisinopril 5mg OD, felodipine 2.5mg OD, metformin 750mg BD, gliclazide 40mg BD, escitalopram 10mg OD, zolpidem 5mg nocte, paracetamol 1000mg QDS and nefopam 30mg TDS.

Her blood pressure in the clinic is 115/75, bloods note a normal cholesterol and her proteinuria levels have remained static now for three years. Previous up titration of lisinopril by your colleague in 2019 led to postural hypotension and a few falls.

Firstly, you discuss commencing a statin for primary prevention. You outline a recommendation that patients with a cardiovascular risk score of 10% or more over 10 years are offered a statin, and her risk using the recommended Q-Risk 2 score is almost 60%. She laughs, and says she takes enough tablets as it is.

Secondly, you discuss recent evidence that a new diabetic medication has good evidence for cardiac and renal protection above its benefit as a medication which lowers sugars. Using Evidence Based Medicine, you show Betty the chart which outlines the potential benefit to her. You explain that without treatment, out of 100 patients with CKD, proteinuria and diabetes, 7.5 people will develop end-stage renal failure over 2.5 years. With treatment over this period, 2.3 people will avoid progression. You spend more time discussing the medications, common adverse reactions and sick day rules.

After consideration, Betty is willing to trial this medication, she remembers being at the renal clinic and being terrified of dialysis, so is keen to trial something that may reduce a risk of an outcome she feels is important to her. You commence dapagliflozin 10mg, and agree to see her in a few weeks time to see how she is getting on.

Conclusion

How do we know what to prescribe? How do we know what works and for what condition? How do we know that medication will reduce risk? These are all common questions asked by practitioners regularly.

We have been lucky enough to use this website with patients in real time during consultations and have found this to be easy to use during our limited time consultations. It has enabled our patients to make decisions for them based on the easy-to-understand statistics. Granted there are more

clunky areas of this website which may be better used once you have had time to look at it in depth and consider how you might embed this into your own consultation styles.

There are some gaps in available recommendations, which merely reflect the limitations of the current evidence base. Overall, a useful tool in the clinic room to support shared-decision making and patient-centred care.

References

1. Grimshaw J, Freemantle N, Wallace S, Russell I, Hurwitz B, Watt I, Long A, Sheldon T. Developing and implementing clinical practice guidelines. Qual Health Care. 1995 Mar;4(1):55-64.
2. Freemantle N, Grilli R, Grimshaw J, Oxman A. Implementing findings of medical research: the Cochrane Collaboration on Effective Professional Practice. Qual Health Care. 1995 Mar;4(1):45-7.
3. Wenghofer EF, Williams AP, Klass DJ. Factors affecting physician performance: implications for performance improvement and governance. Healthc Policy. 2009 Nov;5(2):e141-60.
4. Skou ST, Mair FS, Fortin M, Guthrie B, Nunes BP, Miranda JJ, Boyd CM, Pati S, Mtenga S, Smith SM. Multimorbidity. Nat Rev Dis Primers. 2022 Jul 14;8(1):48.
5. Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. JAMA. 2005 Aug 10;294(6):716-24.
6. Hughes LD, McMurdo ME, Guthrie B. Guidelines for people not for diseases: the challenges of applying UK clinical guidelines to people with multimorbidity. Age Ageing. 2013 Jan;42(1):62-9.

Dr Iain McNab
General practitioner, Riverside Highland Medical Group

The GP Evidence website can be accessed at **https://gpevidence.org**

Using clear and helpful language to discuss medicines is crucial for effective shared decision-making with patients.

Polypharmacy, the use of multiple different prescribed medications, has become part of everyday life for many and tends to increase the older we become. Older people are more likely to experience adverse effects from polypharmacy due to pharmacokinetic and pharmacodynamic changes associated with age; i.e., changes in how the body processes and responds to specific medications. While medicines can be beneficial, polypharmacy and frailty are independent risk factors for mortality:[1] the Newcastle 85+ study observed a 3% increase in mortality for every additional medication prescribed. [2]

The NHS has developed recommendations to reduce overprescribing, which is where people are given medicines they do not need or want, or which may do them harm.[3] Responses to overprescribing include medicines optimisation, structured medication reviews and deprescribing. Sluggett et al found a 4.4% lower risk of mortality over 12 months when a medication review was undertaken for residents within 6-12 months of entry to a care home.[4]

Health literacy can impact how people understand and contribute to prescribing and deprescribing decisions. It refers to people having the appropriate skills, knowledge, understanding and confidence to access, evaluate, use and navigate health and social care information and services.[5] Health literacy is affected by cultural, social and individual factors and is regularly needed by older people, e.g., when they consult with their GP, use a peak flow meter or take their medicines. The language we use to communicate with older people impacts on shared decision-making around both prescribing and deprescribing, and on the success of these interventions. We need to use helpful language to ensure people understand their treatment and to manage their expectations both now and in the future.

"I take my levodopa for a few days then stop when I feel better"

We can all help patients by using simple language, avoiding medical terminology and asking the patient to repeat back the information in their own words to make sure they understand. Rather than using the terminology 'medicines optimisation' or 'rationalisation', we can tell the older person that we are reviewing their medicines to make sure they are getting the most benefit from them.

"You're just trying to save money"

The word 'deprescribing' can have negative connotations for people. They can think that the health system is giving up on them or cost-cutting. Instead, explain to the person that it is about gradually reducing the dose of a medication or a trial without a medication. The purpose is to reduce side effects or the number of medicines being taken. Likewise, when starting a medicine, advise the patient that this is a trial with the medicine and if there is no benefit, it will be stopped or changed.

"I get on fine with my tablets as far as I know…"

Asking a patient if a medicine actually helps their condition is better than asking them if they are okay on the medication. Not all side effects will be obvious to the patient: e.g., the cognitive effects of anticholinergic drugs.

"I was told it's my dog that causes my asthma – I spray it [salbutamol inhaler] on him all the time but it doesn't seem to help..."

Ask patients to show you their medicines and how they use them, especially if you are in their home. This can help identify non-adherence or misunderstandings. Other examples of helpful language include using pain "reliever" rather than "killer". "Painkiller" suggests all pain will be removed, which is often unrealistic.

"You're saying I should stop this but the specialist told me I should take it lifelong…are you giving up on me?"

Similarly, "longer-term" is preferred to "lifelong" when starting long-term treatments, e.g., anticoagulants for AF. This makes subsequent deprescribing conversations easier when the risks of treatment become greater than the potential benefits.

We can all make simple changes to our language to help and empower older people.

Jayne Agnew
Consultant Pharmacist Older People SHSCT NI
@AgnewJayne

Heather Smith
Consultant Pharmacist Older People, West Yorkshire ICB
@Heatherspharm

Rosie Marchant
Frailty Pharmacist, North Bristol NHS Trust

References

1. Herr M, et al. *Pharmacoepidemiol Drug Saf.* 2015;24(6):637-46. Polypharmacy and frailty: prevalence, relationship, and impact on mortality in a French sample of 2350 old people (doi: 10.1002/pds.3772)
2. Davies L, et al. Is polypharmacy associated with mortality in the very old: Findings from the Newcastle 85+ Study. *British Journal of Clinical Pharmacology* 2022, 88: 2988-2995 (doi: 10.1111/bcp.15211).
3. Department of Health and Social Care. *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.*
4. Sluggett JK, et al. Provision of a comprehensive medicines review is associated with lower mortality risk for residents at aged care facilities: a retrospective cohort study. *Age and Ageing* 2022,51:1-11 (doi:10.1093/ageing/afac149).
5. PHE. Improving health literacy to reduce health inequalities. Practice resource summary: September 2015.

A quality improvement (QI) project in East Sussex sought to find out whether a Frailty Link Nurse/AHP, based in the acute ward, could reduce unplanned hospital admissions by identifying patients who would benefit from follow-up in the community.

Healthcare related issues due to frailty are a common cause of hospital admission among older people and there is significant focus on admission avoidance.[1] Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.[2] The NHS in England is the first health system in the world to systematically identify people, aged 65 and over, who are living with moderate and severe frailty using a population-based stratification approach.[3] The Community Frailty Practitioner Service (CFPS) has a referral criteria of aged 75 years or over, Rockwood Clinical Frailty Scale (CFS) score of 5, 6 or 7 and one hospital conveyance or attendance to A&E. In 2022, an initiative conceived by the Community Frailty Practitioner Service in East Sussex was to undertake a Quality Improvement (QI) project to measure the effectiveness of a Frailty Link Nurse/AHP role in an acute ward.

It was felt that a Link Nurse/AHP for Frailty would help to identify appropriate patients who would benefit from follow-up in the community after discharge, including progressing advance care planning (ACP) and reviewing the efficacy of clinical management plans initiated while in hospital. Ultimately, it was hoped this model would reduce the number of unplanned hospital admissions, ensuring the patient remains at home for longer periods with an improved quality of life.

The project was undertaken in two phases. The first in March 2022, which ran for three months, and the second phase in October 2022, again for three months, on acute frailty wards. A questionnaire was constructed and placed in the front every patient's note's and designed to support clinicians' decision-making when considering whether to refer to the CFPS. In addition to this, a poster was placed in a high traffic area to assist healthcare professionals identify the Community Frailty Practitioner Service referral criteria, CFS (Rockwood) score and the referral process.

In total there were a total of 265 admissions over the lifespan of the project; 116 of these were excluded due to incorrect CFS (outside of referral criteria); being aged below 75; being out of area; patients who remained an inpatient after the three-month period; and those who had died. The remaining 149 patients (73 male and 76 female) were included, and all information was gathered via hospital electronic records. The age range of all patients varied from 75 to 99 years of age.

One of our aims is to reduce inappropriate or unnecessary hospital admissions wherever possible. Looking at the number of admissions over a 12-month period, these ranged from 1 to 9 admissions. Out of 149 patients, 28 (18.79%) were readmitted to an acute ward within several months of being discharged and the length of stay varied from several days to over a month. A working hypothesis was that if there was a ward-based frailty link Nurse/AHP in place, then they could have sent a referral to the CFPS, and our input through the assessment process may have reduced the risk of a hospital re-admission.

The role of the Frailty link Nurse/AHP would include how to correctly use the CFS to identify an individual's degree of frailty on a scale of 1 (very fit) to 9 (terminally ill). People who score a 5 or higher are living with frailty.[4] Due to the questionnaire not being completed on discharge it was impossible to determine the CFS of the patient prior to admission. However, after auditing the GP discharge letters of the remaining 149 patients, 68 (45.64%) did not have a CFS score documented. It should be noted that the BGS[2] states that it is inappropriate to use the CFS as a method of identifying frailty without a formal clinical assessment. It is not validated for measuring improvement in individuals after an acute illness. However, the Frailty link Nurse/AHP would be key in making a clinical decision to highlight patient who may be identifying as frail.

It was noted that out of the 149 patients 114 (76.51%) were referred onto other services and only 3 (2.01%) were referred to the CFPS. The Community Frailty Practitioner Service referral form in comparison to other services is simple and easy to complete and asks for little in the way of clinical detail. It was therefore difficult to understand the reason that more patients had not been referred. One reason might be that the ward clinicians believed that as the patient has been assessed and treated on an acute frailty ward, this negated the need for a referral onwards. If so, this reflects a lack of understanding of the CFPS by the acute ward team. 79 patients (53.02%) had documented on their GP discharge letter that they had been through the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process and taken a completed form home with them. The remaining 70 patients (46.98%) were discharged without going through the process. Advance care planning enhances the clinical decision-making of other healthcare professionals including professionals such as ambulance crews, out-of-hours doctors, care home staff and hospital staff especially in emergency situations.

An added stress factor on the older adult living with frailty is medication. Polypharmacy has been described as one of the factors which make frailty more likely, as older people living with frailty often have other, multiple co-morbidity and where the risk is that each long-term condition will be treated separately.[5] Many long-term conditions require treatment with medications, but the increasing risk of side effects from medication is associated with frailty hence, older people who are frail are likely to suffer from the hazards of polypharmacy.[5] Again, the Frailty link Nurse/AHP may be more inclined to notice polypharmacy and report this to the MDT or refer to the CFPS for further input post discharge. It is important to remember that many of the medications prescribed have anticholinergic properties. In older patients these can cause adverse events, such as confusion, dizziness and falls and if missed could contribute to unnecessary or inappropriate re-admission to hospital.

Some of the key points raised from the project are summarised below:

Referral process

Should the process of referring a patient to the CFPS be simplified? It can be argued that the referral form is quick and easy to use. Discussions are underway within the CFPS to introduce the service on to the generic referral form so when referrals are being sent to multiple teams, Frailty can also be included negating a separate referral form being completed.

Readmission

Although the readmission rate was fairly low, it still opens up the question of hospital acquired infections, prolonged length of stay and the financial implications of readmitted patients. The CFPS has significantly reduced the number of admissions with the older adult living with Frailty.

Polypharmacy

The potential, adverse effects of medications in the older people living with frailty are significant. Polypharmacy reviews should be done as part of the review in hospital. Failing this, it is key aspect of what CFPS provides including a review of the efficacy of hospital-introduced medication changes and which benefit from a review on discharge. In addition, the existing Medicines Optimisation in Care Homes (MOCH) team provide an annual medication review to all residents of residential and nursing homes. The project showed that perhaps education is needed to highlight the importance of referring patients to the CFPS and more specifically to the nursing staff who have more patient facing contact. Frailty Link Nurses should be a Trust-wide programme. This can be supported by e-learning and frailty study sessions, which are now being developed. Frailty is everyone's business and as such every ward should be looking towards helping the trust achieve outstanding in frailty by 2025.

Advance care planning

The ReSPECT form is one of the most important discharge documents and every patient should be given the opportunity to go through that process or someone on their behalf if they lack the capacity to sufficiently participate in making decisions of this nature.

Conclusion

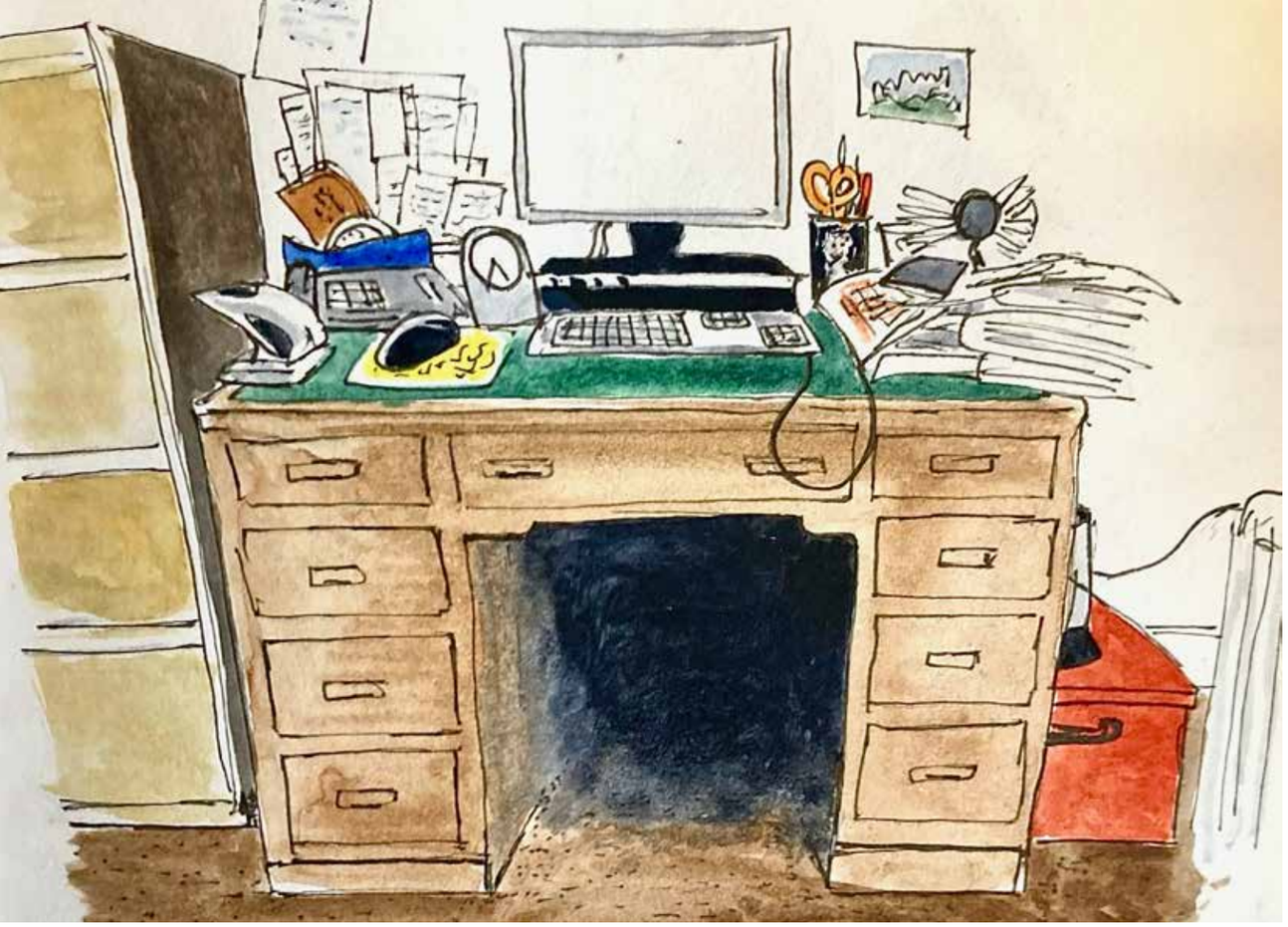
The outcome of the QI project signified a need for frailty link nurses in acute wards who can play a key role in the early identification of the older adult living with frailty and subsequent referral to our service. Formal teaching sessions are being provided to ensure an understanding of frailty and correct use of the CFS. This is being consolidated by the introduction of e-learning being added to the Trust's catalogue of learning opportunities. This, coupled with changes to the referral process highlight that the role of a Frailty Link Nurse/AHP, is an important step that should be considered on all appropriate acute ward.

Twenty one Frailty Link roles within the acute wards are now in place and appropriate referrals are being received. This will impact on readmission rates; clear concise planning will reduce length of stay and number of bed days. Our aim is to support the Frailty Link staff through further education and training and therefore optimising patient care.

Nikki Frankis
Frailty Practitioner & Clinical Facilitator, Frailty Practitioner Office, East Sussex Healthcare NHS Trust

References

1. Keeble E, et al. Outcomes of hospital admissions among frail older people: a 2-year cohort study. *British Journal of General Practice*. 2019;69(685), pp.555-560.
2. Turner G. 2014. Fit for Frailty Part 1; Consensus best practice guidance for the care of older people living in community and outpatient settings. British Geriatrics Society. Available at: www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff_full.pdf
3. NHS England. (No Date). Identifying Frailty. Available at: www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-risk-identification/#:~:text=The%20NHS%20in%20England%20is,any%20other%20appropriate%20assessment%20tool.
4. Cox NJ, et al A systematic review of the evidence for deprescribing interventions among older people living with frailty. *BMC Geriatrics* 2021;21(258).
5. Nwadiugwu, M. 2020. Frailty and the Risk of Polypharmacy in the Older Person: Enabling and Preventative Approaches. [Online]. *Journal of Aging*. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC7341397.



Desert island desks: **Marjory Warren**

‘On the shoulders of giants’ is a well used phrase, and readers of this publication will be familiar with Prof Bernard Isaacs’s ‘geriatric giants’. For 30 years, much of my working life as a consultant has been based at the desk of a true giant of geriatrics.

Above is my drawing of Marjory Warren’s desk as it looked in 2016. When I started my consultant post in 1992 at West Middlesex University Hospital the desk was used by our unit manager Ann Higginson, formerly a ward sister in the acute geriatric ward at Charing Cross Hospital where I’d started as a registrar in geriatrics. She told me the provenance of the desk.

I joined Dr Binoy Bhattacharyya after the retirement of his colleague Dr Jimmy Andrews who had succeeded Marjory Warren following her death on 5 September 1960 in a road accident in France. Dr Warren had worked at the hospital site since 1926, initially as an assistant resident medical officer at Isleworth Infirmary, rising to become Deputy Medical Superintendent in 1931. She was recognised as a consultant physician in the new NHS from 1949.

During the earlier years of my job I would occasionally encounter, as patients, retired nurses who worked with Dr Warren. I encouraged them to send me their memories.

John Carver, who was attached to her wards as a student remembered ‘the tall auburn haired lady’ in a white coat standing at the top of a stairway encouraging a patient to walk up towards her. He recalled how she was strict and formidable but she cared well for her staff and would leave a vase of flowers on the nursing station and take staff out to the theatre as a treat. He wrote about her seeking surgical help for a frail patient only to get the indignant response from the surgeon "Who do you think I am? God?"

When Ann left her management post in the mid 1990s, she arranged for the desk to be moved into my neighbouring office for my use and safekeeping, replacing my more mundane and flimsy NHS desk. The desk is very heavy and solid, possibly made of oak. It has nine drawers.

‘The desk is very heavy and solid, possibly made of oak. It has nine drawers. It is robust, having endured decades of labour with no sign of fracture or instability. It shows no signs of frailty. ’

It is robust, having endured decades of labour with no sign of fracture or instability. It shows no signs of frailty. Its skin is a pleasant smooth green leather surface, only slightly battered and blemished with ink stains. I don’t know its age or when Dr Warren acquired it, and I am no expert on antique furniture, but it has the look of a desk from the 1930s.

I started work in the days when a consultant had personal office, a dedicated secretary and a named parking space. Connie, the first secretary, well into her eighth decade, used to sit by the desk, efficiently jotting down my dictation in shorthand. She was reluctant to use a word processor or tape player. This was a new experience for me.

During a period of annual leave my next secretary, Maria, conscious of the importance of correct posture, arranged for the desk it to be raised a few inches with wooden blocks to allow more knee room as the desk, despite its grandeur, was not designed for my six foot four frame. She also arranged the provision of a particularly massive desk chair on wheels which, though beneficial for comfort and posture revealed its sinister side when it tipped backwards as I bent to arrange acetates for a presentation which I’d laid on the floor. Its weighty steel base smashed into my back resulting in what later turned out to be a fractured rib. The desk witnessed my combination of agony and laughter as I writhed on the floor before struggling up to start that morning’s ward round, apparently ashen faced.

On several occasions the desk has been admired by visitors to the unit, medical pilgrims, who tend to gently place a hand on it as if it was a shrine. A visiting geriatrician from Spain touched the desk with reverence then brought his son so that I could photograph both of them next to it. The desk has tolerated decades of hoarding. It has housed supplies of ibuprofen for migraines, ageing Lemsips, a ready box of tissues to wipe away tears of staff and patients’ relatives, an outfit for a hospital show and balloons awaiting birthday celebrations. Before a recent clear out it was a museum of the pre-digital era, its drawers containing entangled treasury tags, staples, batteries, drawing pins, paper clips and spare plastic fasteners for bloated medical notes. Over three decades numerous trainees, many now consultant geriatricians or local GPs, will remember ponderous appraisals by this desk.

At times of pressure I have stared down at the green surface of the desk thinking about its past use and seeking inspiration from my illustrious predecessor. The result is usually just a sense of humility before carrying on trying to meet the daily demands. My consultant colleagues, who have increased from one to seven during my tenure, are aware of this precious symbol and our managers have pledged to preserve it in our Marjory Warren Unit.

I wish Dr Warren’s desk a continuing long and useful life in the service of geriatric medicine long after I retire.

John Platt
Geriatrician and Stroke Physician
@john_splatt

NIHR Evidence Alert: How to reduce medications for people with multiple long-term conditions

The National Institute for Health and Care Research (NIHR) has published recommendations based on the latest research evidence on reducing medications for people with multiple long-term conditions.

NIHR Evidence produces find plain language summaries of health and care research that’s funded by the NIHR. These summaries can assist in informed decisions about health and care – whether you’re a member of the public, a health or care professional, commissioner or policy maker.

How to reduce medications for people with multiple long-term conditions

Most treatment guidelines are written for people with single conditions; a recommended treatment might therefore not be right for people with multiple conditions. But clinicians have little guidance to help them decide how and when to stop or reduce medications (a process called deprescribing).

In the NIHR-funded TAILOR study, a review of previous research found that deprescribing is generally safe and acceptable if done in a structured way. The researchers then carried out a realist review of papers that explored how deprescribing happens in practice. From this, they identified factors that help clinicians deprescribe. These include:

- Clarity about caring outside of guidelines.
- Access to relevant patient data.
- Discussing plans to stop a medicine when it is first prescribed.
- Trust.

To find out more and to read the evidence alert in full, please visit https://evidence.nihr.ac.uk/alert/how-to-safely-deprescribe-medications-for-people-with-multiple-long-term-conditions.

As part of a blog series to celebrate Nurses Day 2023 in May, Lyndsey Dunn, Vice Chair of the BGS Nurse & Allied Health Professionals (AHP) Council, reflected on how she is inspired by the words of her late Gran to always remember that time is precious.

My passion for achieving a person-centred approach to discharge planning comes from the time my Gran was a patient in hospital 10 years ago and I was a student nurse. She had fallen at home, which unfortunately required her to be admitted to hospital with a period of rehabilitation.

Our conversations at visiting time would often revolve around her overwhelming desire to return home and whether she should pick leather or fabric for her new recliner chair. My Gran had always been a very independent lady who loved driving, taking weekly trips to the garden centre, and ensuring we always had a holiday every year, no matter how far she had to drive: all fond memories that we would find ourselves reminiscing about when she was in hospital.

However, as time passed, I remember the struggle on her face, trying to stay motivated and positive as she was told she was making good progress and would hopefully return home soon.

Despite the daily, weekly and then monthly reassurances that this was good news, it became increasingly difficult to watch my Gran's brightness slip from her face with each passing day.

On the day she finally returned home, she mentioned how extremely grateful she was for the excellent care she received. However she wanted me to understand that every day she spent in hospital, she felt like time was slipping away. "Wouldn't it be great if time could be prescribed?" she said. "When you get to my age, that's all you want."

'Behind every patient delayed in hospital and unable to return home (or to a homely setting), there is a person for whom time is passing.'

My Gran died two years ago at the amazing age of 92; however, her words have stayed with me throughout my nursing and management journey.

In my new role as Service Manager for a Community Flow & Integrated Discharge Hub, I am mindful that behind every patient delayed in hospital and unable to return home, or to a homely setting, there is a person for whom time is passing.

While we have seen a hugely challenging time nationally for our health and social care systems, we have also witnessed significant and beneficial change in our discharge process.

The Discharge Without Delay Initiative has delivered improvements in the discharge process, especially in ensuring a person-centred approach to discharge planning where the patient's voice is always heard.

Effective person-centred discharge planning and joint integrated working between services will minimise delays in transfer of care and unnecessary length of stay in hospital for our patients.

Over the past six months my Gran's words have never been more significant as I understand the importance of my new role as manager for the integrated and community discharge hubs.

Remembering that time is not ours to prescribe and making every day count for our patients is why I am proud to be part of a team that ensures this remains a top priority.

Lyndsey Dunn
Vice Chair, BGS Nurse & AHP Council; Service Manager, Community Flow & Integrated Discharge Hub, Fife Health & Social Care Partnership
@Lyndseydunn7

The full Nurses Day 2023 blog series can be accessed at www.bgs.org.uk/ND23

Obituary:
Dr Roberto Kaplan

Dr Roberto Kaplan, friend, mentor and esteemed geriatrician, passed away on 15 May 2023, aged 91.

Dr Roberto Kaplan, a renowned geriatrician and a leading figure in the field of Geriatric Medicine in Argentina, passed away on 15 May 2023. He died peacefully after battling almost a decade with dementia, leaving behind a legacy of compassionate care, academic involvement, and tireless dedication to improving the lives of older adults.

Born in Rosario (Santa Fé Province, Argentina) on 11 April 1932 into a Jewish family that immigrated from Poland, Roberto devoted his career to the care of older adults and academic geriatric medicine. He earned his medical degree from University of Buenos Aires in 1964 and after obtaining a scholarship from the Joint Distribution Committee, a philanthropic American institution, in 1971 he went on to specialize in Geriatrics in England and Scotland under the supervision of Professor Bernard Isaacs and Prof Sir Ferguson Anderson, respectively. With Bernard Isaacs he cultivated a strong friendship that lasted until Prof Isaacs passed in 1995. In 1975, he embarked to Israel, to receive further training.

Throughout his career, Roberto championed the rights and well-being of older adults in Argentina. He was instrumental in establishing geriatric care programs in the Italian Hospital of Buenos Aires, considered one of the leading academic teaching hospitals in Latin America. Roberto was one of the founders of the University of Buenos Aires Geriatric Fellowship and the first Program Director at the Italian Hospital 'Carrera de Especialista en Medicina Geriatrica.'

It was at the Italian Hospital when I first met him in 1990, when I was as a first year medical resident in internal medicine. I was immediately struck by his persona and impeccable dress code, always with a tie. From then, we started a lasting friendship. He was my first mentor in the field of geriatrics, an excellent role model who instilled in me the passion for the care of older adults and catalysed my curiosity to better understand geriatric syndromes. From the thousands of moments we shared in those early days of my career, one it is as still alive in my mind as if it was yesterday - when Roberto gave me a copy of *The Naked Ape*, a Desmod Morris book, in order to help me to better understand the evolution of bipedalism in humans and the complexity of gait and balance decline in aging.

Roberto served in different Societies with different responsibilities that are too many to mention here, but two worth highlighting are serving as President of the Argentinean Geriatrics and Gerontology Society (SAGG), twice; and an active delegate of the International Association of Gerontology & Geriatrics (IAGG).

Dr Roberto Kaplan (left) pictured with Professor Manuel Montero-Odasso (right) in 2014

Roberto received several accolades during his career but I will mention only one, that I know was very close to his heart: the British Geriatrics Society's Anniversary Medal for Services to Age Research and Geriatric Medicine. This was a medal that was given during the 50th anniversary year of the BGS on 8 October 1997. Roberto was proud member of the BGS, joining the membership during the 1970s, while training England. Aligned with these honours, I was privileged to have been asked to give a special lecture during the 2022 World IAGG Scientific Meeting entitled the 'Professor Robert Kaplan Lecture' to acknowledge and pay tribute to his legacy.

Roberto had a remarkable ability to connect with his patients on a personal level, providing comfort and reassurance during challenging times. In interpersonal relationships, he was a truly gentleman, very well known by a myriad of colleagues worldwide. For those of us who had the privilege to know him and work with him, we will remember his superb manners, encyclopedic knowledge of art and literature, and passion for academic geriatric medicine. He used to say to me, "if you want to provide good care for older adults, you will first need to 'academise' Geriatric Medicine" highlighting the challenge of this specialty when care of the elderly was provided in some countries by physicians without specialised training. Above is one of the last photos I took with him, in 2014, during a relaxed lunch in a restaurant in Buenos Aires.

Roberto leaves behind a profound void in the field of Geriatric Medicine in Latin America, but his legacy continues to shine with an excellent cadre of colleagues in Argentina that he mentored and who are now leading the way. They will inspire future generations under his legacy to provide compassionate and comprehensive care for older adults. Roberto's contributions to geriatric medicine will be remembered and cherished for generations to come, as one of the founders of Geriatric Medicine in Latin America.

Sympathies go to his two children who have lost a mainstay of their lives.

Professor Manuel Montero-Odasso
Western University, Ontario, Canada

BGS AGENDA

Vacancies *and notices*

BGS vacancies and notices View all current BGS opportunities online at **www.bgs.org.uk/BGSvacancies**

Abstract submission deadlines

We are currently accepting abstract submissions for the following BGS conferences:

- **2023 Autumn Meeting**
  EXTENDED - Closes: 1 September 2023
- **2023 Wales Autumn Meeting**
  Closes: 25 August 2023
- **2023 Scotland Autumn Meeting**
  Closes: 25 August 2023
- **2023 Joint BGS and Northern Ireland Frailty Network Meeting**
  Closes: 1 September 2023
- **2023 G 4 Everyone**
  Closes: 1 September 2023

For all current abstract submission dates, including links to submission guidelines and our abstract submission portal, please visit: **www.bgs.org.uk/abstracts.**

Notice of election

We will be holding elections shortly for the role of BGS Deputy Honorary Secretary. Members will be notified via email with a link to cast their vote.

William Farr Medal

BGS President Elect, Professor Jugdeep Dhesi, has been awarded the prestigious William Farr Medal 2022 by the Worshipful Society of Apothecaries.

The Worshipful Society of Apothecaries' William Farr Medal is presented annually to recognise the significant contribution by a UK healthcare professional to improving care for older people.

Professor Dhesi (pictured with BGS President Professor Adam Gordon) was presented with her medal at the Galen & Farr Awards Ceremony and Dinner on Wednesday 24 May.

Previous award winners include Professor Adam Gordon, Professor Gillian Mead, Professor Alasdair MacLullich, Professor Miles Witham and Professor Simon Conroy.

British Geriatrics Society
Improving healthcare for older people

BGS

Autumn Meeting 2023

22-24 November
Vox Birmingham & Online

GRANTS AVAILABLE
CATEGORY B, C & D MEMBERS

FLEXIBLE ATTENDANCE OPTIONS
IN PERSON, ONLINE & ON DEMAND

EARLYBIRD DISCOUNT
UNTIL 24 SEPT

Programme highlights:

- OncoGeriatrics (in association with The Royal College of Radiologists and The International Society of Geriatric Oncology)
- Primary and community care
- Urgent care of older people
- Orthogeriatrics
- Safe prescribing

www.bgs.org.uk/events