NATIONAL ASSEMBLY FOR WALES: Health, Social Care and Sports Committee - Inquiry into antipsychotic medication in care homes.

Date: 17 January 2018
Venue: Senedd, National Assembly for Wales

Title: Use of antipsychotic medication in care homes

Purpose: To provide supporting information in relation to the inquiry into the use of antipsychotic medication in care home settings, and the ways in which its inappropriate use could be reduced.

1. The availability of data on the prescribing of antipsychotics in care homes, to understand prevalence and patterns of use.

Currently available prescribing and dispensing data

The NHS Wales Shared Services Partnership (NWSSP) collates a range of prescribing and dispensing data. This data are limited to the name, form, strength and quantity of medicines prescribed and is used primarily for the purpose of remunerating dispensing contractors. Data are attributable to GP practices, primary care clusters and Local Health Boards and changes in prescribing and dispensing patterns can be tracked over time. Restrictions on the processing of prescribing and dispensing data preclude the linking of medicines' data to patient characteristics such as age or postcode.

Whilst relatively good data are available regarding the name, form, strength and quantity of medicines prescribed, prescriptions do not contain any information about patients' diagnoses or the reasons they might be prescribed a medicine. This means that whilst data for the number of prescriptions for antipsychotics over time is available it cannot be linked to patients' age, gender, postcode or diagnosis.

Data that subject to necessary approvals could be derived from prescription barcodes in future

We understand there are clear benefits to population health in respect to linking patient/demographic data to prescribed medicines however in order to do so requires formal approval as it is technically processing personal data. The NWSSP is currently undertaking the formal approval processes required to link this information. Subject to the necessary approvals these data will available from April 2018.

Whilst linking details of medicines prescribed to patient age, gender and partial post code area will improve understanding of how medicines are used it will not allow prescribing to be analysed either by residence in a care home or by the reason for prescribing or diagnosis.

National Prescribing Indicators and the use of Audit+

Annually, the All Wales Medicines Strategy Group (AWMSG) endorses a suite of national prescribing indicators used to highlight therapeutic priorities for NHS Wales

and compare the way in which different prescribers and organisations use particular medicines or groups of medicines, thereby promoting rational prescribing. Traditionally national prescribing indicators have utilised the prescribing and dispensing data collated by NWSSP to make comparisons between health boards, primary care clusters and individual GP practices. In 2017-2018, AWMSG endorsed a new approach to developing prescribing indicators, for the first-time utilising data extracted directly from GP practice IT systems using Audit+ software and aggregated at the primary care cluster level.

One of two new prescribing indicators introduced looked at reviewing patients prescribed medicines with anticholinergic effect (which include antipsychotic medicines), defined as an Anticholinergic Effect on Cognition (AEC) score of 3 or more, with the aim of reducing inappropriate anticholinergic use. Audit+ provides a means of linking prescribing data to other data, such as diagnosis and age, contained in GP clinical systems[1].

Anticholinergic burden prescribing indicator

An increasing number of studies report that medicines with anticholinergic effects, including antipsychotic medicines, are associated with an increased risk of cognitive impairment, heart disease, stroke, dementia and falls in older people, with research also suggesting a link to increased mortality with the number and potency of anticholinergic agents prescribed.[2,3,4,5]

This indicator will measure the number of patients aged 65 and over with an AEC of 3 or more for medicines on active repeat prescription, as a percentage of all patients aged 65 and over. Data will be available later in 2017-18.

Future prescribing indicators

Work is currently underway to define additional national prescribing indicators for 2018-19 utilising linked data captured through the Audit+ software. Current proposals include a prescribing safety indicator which comprises several high risk prescribing scenarios, one of which is the number of patients aged 65 and over prescribed an antipsychotic medicine on active repeat prescription, as a percentage of all patients aged 65 and over.[6]

---

[1] AMWSG, National Prescribing Indicators 2016-17. 2017. Available at: http://www.awmsg.org/docs/awmsg/medman/National%20Prescribing%20Indicators%202016-2017.pdf. Accessed October 2017.

[2] PrescQIPP. Bulletin 140 - Anticholinergic drugs. 2016. Available at: https://www.prescqipp.info/resources/send/294-anticholinergic-drugs/2864-bulletin-140-anticholinergics-drugs. Accessed October 2017.

[3] National Institute for Health and Care Excellence. Drugs with anticholinergic effects and risk of cognitive impairment, falls and all-cause mortality. Eyes on Evidence 2015(77). Available at: https://www.nice.org.uk/Media/Default/newsletter/eyes-on-evidence-october- 2015.pdf. Accessed October 2017.

[4] Fox C, Richardson K, Maidment I et al. Anticholinergic medication use and cognitive impairment in the older population: the medical research council cognitive function and ageing study. J Am Geriatr Soc. 2011;59(8):1477-1483. Available at: https://www.ncbi.nlm.nih.gov/pubmed/21707557. Accessed October 2017.

[5] Gray S, Anderson M, Dublin S et al. Cumulative Use of Strong Anticholinergics and Incident Dementia. A Prospective Cohort Study. JAMA Intern Med. 2015;175(3):401-407. Available at: https://www.ncbi.nlm.nih.gov/pubmed/25621434. Accessed October 2017.

[6] All Wales Prescribing Advisory Group papers September 2017.

2. Prescribing practices, including implementation of clinical guidance and medication reviews.

It is estimated that between 40,000-50,000 people in Wales are currently living with dementia. The Welsh Government routinely publishes data of the numbers of people in Wales diagnosed with dementia, derived from dementia disease registers maintained by general practices alongside health board level estimates of the number of undiagnosed dementia cases calculated using prevalence rates published in the CFAS II (Cognitive Function and Ageing Study) study.[7]

Prescribing antipsychotics to people with dementia

It has been estimated that 46% of new admissions to care homes are for reasons of dementia and 36.5% of people with dementia live in a care home. There is evidence and concern that antipsychotic medicines, originally developed for the treatment of schizophrenia or psychosis, are used for the management of behavioural and psychological symptoms in dementia (BPSD). Antipsychotic medicines should not routinely be prescribed in patients with dementia since they may be associated with an increased risk of stroke and all-cause mortality[8].

Clinical guidelines

The National Institute for Health and Care Excellence (NICE) has produced a clinical guideline on the management of dementia (*Dementia: supporting people with dementia and their carers in health and social care*)[9] which includes guidance on pharmacological interventions. The Welsh Government expects all clinicians, and NHS bodies to follow the NICE guidance. NHS bodies are expected to have processes in place to monitor and assure themselves that NICE guidance is followed.

The guidance from NICE is clear that people with dementia who develop behaviour that challenges should only be offered pharmacological intervention if they are severely distressed or there is an immediate risk of harm to themselves or others. For people with dementia whose distress is less severe, non-pharmacological interventions, e.g. behavioural interventions, should be tried before pharmacological intervention is considered.

People with Alzheimer's disease, vascular dementia, mixed dementias or dementia with Lewy bodies (DLB) with severe non‑cognitive symptoms (psychosis and/or agitated behaviour causing significant distress) may be offered treatment with an antipsychotic drug only where there has been a full discussion with the person with dementia and/or carers about the possible benefits and risks of treatment, where

[7] Welsh Government 2017. General Medical Services Contract: Quality and Outcomes Framework Statistics for Wales, 2016-17. Available at http://gov.wales/docs/statistics/2017/170927-general-medical-services-contract-quality-outcomes-framework-2016-17-en.pdf. Accessed October 2017.
[8] Szczepura A. et al Antipsychotic prescribing in care homes before and after launch of a national dementia strategy: an observational study in English institutions over a 4-year period. *BMJ Open* 2016; **6**: e009882
[9] The National Institute for Health and Care Excellence. Dementia: supporting people with dementia and their carers in health and social care. 2016. Available at:https://www.nice.org.uk/guidance/cg42. Accessed October 2017.

treatment goals are clearly understood and monitored regularly, and where co-morbidities such as depression are identified and addressed. The prescription of an antipsychotic medicine in these cases should be time limited and regularly reviewed.

In all cases where an antipsychotic is prescribed, the choice of agent should be made after an individual risk–benefit analysis and the dose should be low initially and then titrated upwards only if symptoms are not ameliorated.

Polypharmacy: Guidance for Prescribing

In 2014, AWMSG published guidance entitled *Polypharmacy: Guidance for Prescribing* which supports prescribers and other professionals caring for frail elderly patients prescribed multiple medicines, to address problems associated with polypharmacy. AWMSG's guidance provides specific considerations for prescribing for people with dementia which identifies priority groups in which prescribing should be reduced. This includes providing advice on how antipsychotic medicines may be reduced safely.[10]

Use of off-label medicines

In practice a range of antipsychotic medicines are used to treat behavioural and psychological symptoms in people with dementia. The risks and benefits of treatment will differ between antipsychotic medicines.

Whilst research in the UK demonstrates that a range of antipsychotic medicines are used in the management of behavioural and psychological symptoms in people with dementia,[11] risperidone is the only antipsychotic medicine that is licensed for the short term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others.[12]

Other antipsychotic medicines prescribed for people with dementia are prescribed 'off-label'. This means that whilst they are licensed as medicines in the UK they are not being used in a way which is covered by the license; this can happen for example, when medicines are found to be effective for a particular condition but its manufacturer has not chosen not to seek an extension to the license.
All doctors, along with some nurses and pharmacists can prescribe medicines off-label if they have good reason to do so, and provided they follow rules set out by the General Medical Council or their professional body.

Clinical and medication review

Since 2004, the Quality and Outcomes Framework (QoF) of the General Medical Services (GMS) contract in Wales has rewarded GP practices for the provision of

[10] AMWSG. 2014. Polypharmacy: Guidance for Prescribing. Available at http://www.awmsg.org/docs/awmsg/medman/Polypharmacy%20-%20Guidance%20for%20Prescribing.pdf. Accessed October 2017.
[11] Marston L et al. Prescribing of antipsychotics in UK primary care: a cohort study. *BMJ Open* 2014; **4**: e006135. Available at: http://bmjopen.bmj.com/content/4/12/e006135. Accessed October 2017.
[12] Risperdal Film-coated Tablets summary of product characteristics. Available at: http://www.medicines.org.uk/emc/medicine/30433. Accessed October 2017.

quality care and helped to standardise improvements in the delivery of primary medical services.

The Medicines Management domain of QoF rewards practices where a medication review is recorded in the notes in the preceding 15 months for at least 80% of patients being prescribed four or more repeat medicines. The underlying principles of the medication review are:

1. All patients should have the chance to raise questions and highlight problems about their medicines;
2. Medication review seeks to improve or optimise impact of treatment for an individual patient;
3. The review is undertaken in a systematic way by a competent person;
4. Any changes resulting from the review are agreed with the patient;
5. The review is documented in the patient's notes; and
6. The impact of any change is monitored.

The dementia domain rewards practices where the care of patients diagnosed with dementia has been reviewed in a face-to-face review in the preceding 15 months.[13]

In 2017-18, the Welsh Government agreed a GMS directed enhanced service (DES) for care homes which aims to enhance the care provided for residents in care homes through a proactive, holistic coordinated model of care. There is a strong emphasis on prudent healthcare principles where the clinical skills and abilities of all members of the primary care team are maximised. In particular, the DES seeks to (a) deliver best-evidenced treatment and services to the most appropriate level based on individual need; maximise the continuity of care; (b) minimise unplanned transitions of care; (c) minimise the risk of poly pharmacy and (d) ensure the most appropriate professional is available to deliver care.

GP practices participating in the DES are required to undertake at least one medication review with particular reference to polypharmacy, antipsychotic prescribing and other high risk medicines, for each resident in the care home.

3. Provision of alternative (non-pharmacological) treatment options.

There is a body of knowledge that shows that using a range of evidence based interventions have positive outcomes on the wellbeing of people living with dementia. The use of antipsychotics is linked directly to behavioural distress, agitation and challenging behaviour therefore the use of therapies that address these aspects of dementia and related conditions, will over time lead to a reduction in the use of antipsychotics.

Delivering therapeutic approaches to the care of people living with dementia and behavioural distress requires a culture to support implementation and cultural change is a process that takes time to achieve.

[13] BMA Cymru Wales and Welsh Government. Quality And Outcomes Framework Guidance for the GMS Contract Wales 2017/18, 2017. Available at: http://www.wales.nhs.uk/sites3/Documents/480/QOF%20Guidance%202017-18%20updated.pdf. Accessed October 2017

For therapies to be successful it is important that people living in care homes are involved in some form of activity every day, these can be simple activities and can be individual or group. This overall approach to providing activities should be part of the culture and environment in the care home. Adopting such an approach is a positive way of preventing behavioural distress in some people. In addition to this there are people who due to their behavioural distress require a highly individualised plan of care with some specialist therapeutic interventions to support them with their behaviours, agitation and restlessness.

The staff who work in care homes need to be skilled in delivering activities and therapies to people living with dementia and sometimes they lack these skills. Many of the most effective interventions rely heavily on communication skills, and development of these is an important part of workforce development. It is also important that homes have access to specialist input for support.

There is a range of evidence based non pharmacological interventions used within dementia care - examples of which being used in the care home sector in Wales include social therapies, life story work, behavioural therapies (use of positive behavioural support), reminiscence therapies, Cognitive behavioural therapy (CBT) and assessment / management of pain to enable undiagnosed health needs to be recognised and treated. We need to ensure that this practice is consistent and will be a theme within the forthcoming dementia strategic action plan. We will also work with Social Care Wales whose current priorities include supporting people with dementia in relation to both workforce development and service improvement.

4. Training for health and care staff to support the provision of person-centred care for care home residents living with dementia.

Good Work: A Dementia Learning and Development Framework for Wales was launched by the Welsh Government in 2016. Good Work is the result of collaboration between what was then the Care Council for Wales (now Social Care Wales) NHS Wales, Public Health Wales and the Welsh Government.

It was recognised that there are a large number of education and training providers undertaking a range of programmes and courses and some standardisation into a framework that sets out minimum standards for the delivery of person centred care supported by quality training was needed. Therefore anyone delivering education and training to health and social care staff in Wales must meet the criteria and the outcomes/ competencies in Good work. Good work sets a framework for education and training based on best practice and has a strong person centred and ethical values base. The framework describes three layers of education and training:

- Informed people – what everyone needs to know and understand
- Skilled people – those who work with people living with dementia on a daily or regular basis; and
- Influencers- those who manage or commission services

Within Good Work there are also outcomes / competencies that specifically relate to addressing the overuse of anti-psychotic medication in people with dementia. For instance at the informed level it states that everyone working in health and social

care should be able to demonstrate good communication and provision of meaningful activities. Also within the skilled people section, which describes the competencies for care home staff, includes explicit requirements for both medicines management and therapeutic interventions.

For influencers, who will be senior care home staff, managers and liaison nurses there is an expectation that they will be trained to use evaluation and quality assurance; that they will demonstrate leadership and set the tone of the culture and support and supervise staff in delivering person centred and therapeutic care. Further roll out of Good Work will also be a requirement of the forthcoming dementia plan and its uptake will be monitored throughout.

5. Identifying best practice, and the effectiveness of initiatives introduced so far to reduce inappropriate prescribing of antipsychotics.

There are a number of examples of notable practice across Wales which cover both the monitoring of antipsychotics use and the use of therapeutic interventions. For instance, care home in-reach teams, mostly nurses, who support the care homes in developing practice, providing training and supporting complex care.

As part of the consultation in developing the Dementia Action Plan we have captured a number of practice examples which will be published following the launch of the strategic plan. We will also use existing mechanisms through Social Care Wales and the older person's community of practice established by Public Health Wales in 2015 to further identify and disseminate good practice.

The Welsh Government has also invested in the Bradford model of dementia mapping with plans to further roll this out. This is an intervention which is an established approach to achieving and embedding person-centered care for people with dementia, recognized by NICE.

6. Use of antipsychotic medication for people with dementia in other types of care settings.

The limitations of prescribing and dispensing data in primary care are set out previously. Given those limitations it is not possible to identify the care setting of patients prescribed antipsychotics in primary care.

Previous studies in the UK have evidenced the levels of use of antipsychotic medicines in people with dementia in secondary care. A study of 54 mental health service trusts in 2012 identified that 15.9% of patients in mental health services were prescribed antipsychotics for the management of Behavioural and Psychological Symptoms of Dementia (BPSD) (when patients with a comorbid psychotic illness were excluded). The study also found that a range of antipsychotic medicines were prescribed.[14] We are not aware of any study which has measured the prevalence of antipsychotic prescribing in mental health services in Wales.

[14] Barnes T.R.E. et al. Antipsychotics in dementia: prevalence and quality of antipsychotic drug prescribing in UK mental health services The British Journal of Psychiatry (2012) 201, 221–226.

As with primary care, secondary care prescribing data are not linked to patients' age, gender, postcode or diagnosis. In some respects secondary care data is more limited since medicines may be supplied to wards/services either as items for specific patients or as stock items. In the case of the latter this means they might be administered to more than one patient. Medicines supplied in secondary care may be coded to directorates on the basis of the prescribing consultant or team or directly to wards. This means where a patient is prescribed a medicine, including an antipsychotic medicine, it will not necessarily relate to the ward or unit on which they are an inpatient.