NHS England

NHS Bury Clinical Commissioning Group

Reviewing the antipsychotic medicines taken by people with a learning disability in Bury

In Bury, Greater Manchester, pharmacists worked across primary and secondary care to review everyone with a learning disability, autism or both who were prescribed antipsychotic drugs.

This review has helped Bury to deliver NHS England's Stopping Over-Medication of People (STOMP) campaign which pledges to reduce the over-medication of people with a learning disability, autism or both.

What they did

The CCG's Clinical Lead for Medicines Optimisation and Learning Disabilities, Nigget Saleem, worked with Bury's Clinical Commissioning Group (CCG), 30 GP practices and Pennine Care NHS Foundation Trust (PCFT).

- The CCG's medicines optimisation team used the learning disability register to identify which patients with a learning disability, autism or both were prescribed antipsychotics.
- The trust's mental health pharmacist was commissioned by the CCG to support the work one day a week for six months.
- They reviewed each person's antipsychotic medication, in particular dosage (including whether it was in British National Formulary limits) and rationale.
- Patient's notes were reviewed in their GP practice to determine whether the prescriptions had been for a relevant diagnosis or 'challenging behaviour.' The notes were reviewed to clarify if the appropriate health checks and blood tests had taken place.
- The mental health pharmacist made prescribing recommendations and worked with the consultant and a GP in each practice to agree an action plan.

The results

- 998 patients were on the learning disability register, of whom 195 (20%) were prescribed an antipsychotic.
- Of those, only 68 (35%) were prescribed antipsychotics with a relevant indication. 127 (65%) patients were prescribed this medication for challenging behaviour.
- 39 (20%) of those prescribed an antipsychotic were receiving more than one drug in this class, and 13 (7%) were on high dose antipsychotic therapy (HDAT) that exceeded the recommended maximum.

The review also found that some people had not had a physical health check to monitor the side effects of these drugs, and some people were taking high dosages in combinations of medication with no clear rationale. Reduction plans could take longer for patients under the care of a consultant than those under the care of their GP, possibly because the former patients were more complex.

Action-planning

The mental health pharmacist's recommendations were followed up by the medicine optimisation technicians (MOT) and practice-based pharmacists across the town.

They contacted the person or their carer to given them advice on reducing their medication and call back each month to check how things were going. The monthly calls provide support and reassurance and make sure recommendations have been followed up.

The team worked closely with each practice's lead GP to amend reduction plans if the person needed more support to manage their symptoms. If they needed behavioural support, they were referred to the community learning disability team.

Recommendations for individual patients included:

- Reducing and stopping their antipsychotic
- Reviewing their physical health to include blood tests and ECGs where indicated
- Annual reviews of their antipsychotics against NICE guidance
- Behavioural support from the learning disability team

Nigget says: "There is evidence that people with a learning disability, autism or both are being prescribed medication to treat behaviour that can often be an expression of distress or a form of communication rather than any underlying mental health disorder. As health professionals it is our duty to ensure that these medications are used appropriately. I have seen how involving people in making decisions and supporting them to follow a steady reduction plan can give them much happier lives."

Nigget also made recommendations for primary and secondary care colleagues:

- All correspondence about patients on high dose antipsychotic therapy should include the length of time on this therapy and a clear rationale for continued use. The trust should set up systems to share information with primary care.
- The trust should make sure it meets its guidelines for the initiation and monitoring of high dose antipsychotic therapy.
- Clinicians should make sure all relevant patients have a physical health check.
- The trust should review all patients who are on clinical combinations which are not recommended or on high dose antipsychotic therapy. They should work with the mental health pharmacist to ensure appropriate changes are made to medication.
- The trust and CCG should actively promote alternatives to medication – such as active support from the learning disability team, intensive interaction and positive behaviour support.

- The trust and CCG should work together to make sure everyone with a learning disability, autism or both who are prescribed antipsychotics for challenging behaviour are actively reviewed against NICE guidance and are given a clinically appropriate reduction plan.
- The quality of patient care, especially patient safety should be paramount.

Next steps

- The clinical lead from the CCG and mental health pharmacist from the trust are working together to see how they can support GP practices to prevent inappropriate referrals to secondary care.
- An audit in April 2018 will compare prescribing figures to baseline data from April 2017.
- Nigget is developing a local CQUIN (Commissioning for Quality and Innovation). This can make around 2.5% of the trust's income dependent on demonstrating improvements in quality and innovation.

Read more about STOMP:

- **www.england.nhs.uk/stomp**
- **www.vodg.org.uk/publications/preparing-to-visit-a-doctor-to-talk-about-psychotropic-medication/**

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