City & Hackney GP Confederation
A community interest company

# Audit of Anti-psychotic Prescribing in City and Hackney Primary Care

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**July 2019**

## 1 Purpose

1.1 This report provides a summary of a detailed audit of GP practices' interventions and activity with regards to best practice for the monitoring and review of patients prescribed anti-psychotic medication, in the absence of a psychotic diagnosis provided by specialist secondary care mental health services.

## 2 Introduction

2.1 Antipsychotics have known adverse drug effects that can affect the physical health of patients, including weight gain, hyperlipidaemia, hyperglycaemia and diabetes. Monitoring of patients for these effects following initiation of treatment can help improve physical health outcomes.

2.2 Antipsychotic medication is licensed in treatment of patients with severe mental illness (schizophrenia and bipolar affective disorder)[1] and in patients with psychotic symptoms. Some antipsychotics are also licensed for agitation and disturbed behaviour, anxiety, vertigo, nausea and vomiting, Tourette's and for distress and pain in palliative care.[2]They are also recommended for treatment resistant cases of depression, anxiety and obsessive compulsive disorder (OCD). Patients with other mental health diagnoses are also prescribed antipsychotic medication although there are not clear guidelines in place and there is little evidence of effectiveness or the evidence demonstrates that harms outweigh benefits. They are often prescribed for their sedative effects or for challenging behaviour in conditions including; insomnia, personality disorder, depression, post-traumatic stress disorder (PTSD), OCD, anxiety, learning disability, attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder.[3] There is a particular concern over side effect profiles and increased mortality when antipsychotics are prescribed to patients with dementia (for treatment of behavioural and psychological symptoms of dementia - BPSD)[4]

2.3 The National institute for Clinical Excellence (NICE) provides guidelines in the UK for prescribing antipsychotic medication for different illnesses.[5-7] The British National Formulary (BNF) provides information on dosages, monitoring and interactions. The BNF details if a medication is licenced for a particular indication or is prescribed, 'off licence'.[8]

## 3 Background

3.1 Data analysis of the Primary Care Mental Health Dashboard in April 2016 identified that approximately 1200 patients were prescribed anti-psychotic medication without a recorded diagnosis of a psychotic disorder. This prompted an audit of a representative sample of patient within this cohort, conducted by GPs and ELFT psychiatrists at selected practices,

and documented by Dr Helen Drew, General Practitioner and CCG Primary Care Mental Health Clinical Lead.

3.2 The initial audit found that most patients were not receiving regular physical health checks:

- Less than 50% of patients in the cohort had had a blood pressure reading done in the past year
- Less than a third of patients had their lipids checked
- Less than 1 in 5 had had their BP, lipids and Hba1c done that year.
- Many patients have been on antipsychotics for many years (average 6 years, with some over 20 years) and with most starting medication in secondary care, abroad or in the private sector.

It was concluded that a significant number of patients may benefit from having their medication reduced or coming off medication.

In view of these findings the Primary Care Mental Health Alliance, which includes the City and Hackney GP Confederation, the Clinical Effectiveness Group, City and Hackney CCG and East London NHS Foundation Trust (ELFT), developed and approved this draft proposal for review and comment.

## 4 Aims

4.1 The aims of the audit were:

a) For patients on anti-psychotics without an anti-psychotic diagnosis, to have increased access to annual physical health checks.
b) Utilise secondary care psychiatric expertise in the review of medication.
c) Where clinically appropriate, reduce or stop the use of anti-psychotic medication, creating a clinical benefit to the patient in terms of reduced side effects.
d) Improve referrals to interventions that improve physical and mental health wellbeing.
e) Set out new protocols for anti-psychotic medication covering both secondary care and primary care.

## 5 Method

5.1 Practices were sent lists of their patients, identified by the Clinical Effectiveness Group as being prescribed anti-psychotic medication without a coded psychotic diagnosis.

5.2 GPs were asked to complete a review of each patient on the list, in terms of the prescribed anti-psychotic medication and psychiatric diagnosis. The review included the following:

a) A discussion between the GP and the ELFT Primary Care Liaison psychiatrist linked to the practice at an MDT meeting or through an individual meeting or telephone conversation, about the patient's medication.
b) Checking the diagnosis was correctly coded.
c) A GP face to face meeting with the patient, where indicated, to discuss their medication and informed by the prior discussion with the psychiatrist. The discussion should cover potential changes to the patient's medication and other non-pharmacological interventions such as lifestyle or wellbeing interventions, psychological therapies etc.
d) The completion of the medication review template, including the physical health check. N.B.: the physical health check could be completed by an HCA or practice nurse.
e) Recording any changes to medication, diagnosis and the offer and acceptance of non-pharmacological interventions in the patient's notes.

5.3 Prescribing Support Pharmacists were asked to assist GPs by:

a) Summarising key details from the patient's records such as length of time on medication, dosage etc.
b) Identifying reviews, which GP's should consider prioritising, based on dosage and length of time on medication, length of time since last review
c) Attending MDT meetings and scheduling in patient discussions within these meetings
d) Checking that patient outcomes were recorded in the patient's notes in terms of changes to dosage, stopping medication, non-pharmacological interventions etc.
e) Collating the patient outcomes into a practice-based report

5.4 The GP Confederation was responsible for the following:

a) Managing the completion of the audit by practices.
b) Payments to GPs and practice pharmacists based on evidence of activity.
c) Providing an audit report.

5.5 East London NHS Foundation Trust (ELFT) provided psychiatry time within MDT team meetings and telephone-based support as part of the Primary Care Liaison service. It also advised on a new set of protocols to support GPs and psychiatrists with the management of patients who are prescribed anti-psychotics in the absences of a psychotic diagnosis and are primarily supported in primary care.

5.6 <u>Timescales and Stages</u>

5.6.1 The original timetable of one year was extended due to staff changes and reorganisation of project which required the GPs to have more input to the audit. The audit has taken approximately two years to complete.

5.6.2 There audit was carried out in four stages (four steps):

Step 1: Patient's notes are reviewed by the pharmacist
Step 2: Patient's notes are discussed by GP and pharmacist
Step 3: Patient is discussed by the GP and psychiatrist
Step 4: GP and patient meet for a face to face review, where necessary

5.7 <u>Roles and Responsibilities</u>

5.7.1 The Prescribing Support Pharmacists (PSP) assisted the GPs by:

- Summarising key details from the patient's record such as length of time on medication and dosage
- Meeting with the GP to review the pre-assessed list
- Collating the patient outcomes and producing a practice based final report and GP sample survey

5.7.2 The GP were required to:

- Meet with the PSPs to review the pre-assessed list
- Check that the diagnosis was correctly coded
- Participate in a 2 way MDT meeting(s) with the ELFT psychiatrist
- Undertake a GP face to face review with the patient (where this is deemed necessary).

5.7.3 East London NHS Foundation Trust (ELFT) was required to:

- Provide psychiatry time within MDT team meetings or telephone-based support. Also to advise on a new set of protocols that support GPs and psychiatrists to more effectively monitor and manage anti-psychotic medication.[9]

- Provide training at a Friday Education Session on the use of anti-psychotic medication and how to reduce dosages. This training was not mandatory, but practices were encouraged to attend.

5.8 Midway Review: GP Focus Group

5.8.1 A small focus group with GPs was held on 19th June 2018 to answer the following questions:

1) What did you think the aims were for the project?

2) How did you the find the relationship and involvement from the practice pharmacist?

3) Did the practice pharmacist save you additional work and was their input useful?

4) Did you understand the AP specification and its aims?

5) What was your personal experience and the experience from your patient?

6) Can you suggest any methods or improvements to reduce or stop the prescribing of anti-psychotic medication for patients without a diagnosis of Psychosis?

7) Can you help develop protocols for patients on AP meds for Secondary Care to add to the letter in which they explain that they are starting the medication to help primary care?

5.8.2 Conclusions of the GP Focus group:

- All attendees reflected on the benefits of the project and all felt that it has been a useful tool to identify this patient cohort, who often are not on the SMI register. This is a group of patients who often fall between the cracks of QoF and contracts.
- Collaboration with the sleep service would be of benefit as often these drugs are given to patients for sleep disorders making patients reluctant to having them removed.
- The Project provided the GPs with a valuable platform to open the discussions about medication reduction/removal and also as a way of looking again at the physical health of these patients as well as their mental health.

## 6 Data Quality

6.1 All GP practices returned the audit. 7 of the 42 returns were partially completed and did not detail all 4 steps.

6.2 There was a standard spreadsheet provided to pharmacists and practices to complete the data collection. Step 1 was completed thoroughly by pharmacists. Step 2 was blank in some submissions suggesting a conversation between GP and pharmacist had not taken place or the detail of the discussion was not clear. Step 3 was also not completed in some submissions and it was unclear if this was due to difficulties meeting with the psychiatrist or problems completing the spreadsheet. Step 4 was not completed by all practices but most added details of the discussion and outcomes.

6.3 It was particularly difficult to establish if a code had been added for SMI diagnosis for some patients, as the diagnosis may have been SMI but was unclear from the data entered. Some practices were able to add the specific read code (e.g. Schizophrenia)

## 7 Summary of the findings

7.1 42 GP practices submitted audit data. This can be seen in Appendix 1.

7.1.1 All 42 GP practices completed Step 1 (Pharmacist review) and returned their data.

7.1.2 41 GP practices then proceeded to Step 2 (Pharmacist and GP review).

7.1.3 37 GP practices completed Step 3 (Psychiatrist and GP discussion)

7.1.4 35 GP practices completed Step 4 (Face to Face review between GP and patient)

7.1.5 5 GP practices did not complete Step 3 (discussion between GP and psychiatrist). Of these 5 practices, 1 practice was still able to proceed with Step 4 despite not having a discussion with the psychiatrist.

7.2 835 patient records in total had been identified and reviewed.

7.2.1 All patients (835) had step 1 completed

7.2.2 97% of all patients (807) had step 2 completed

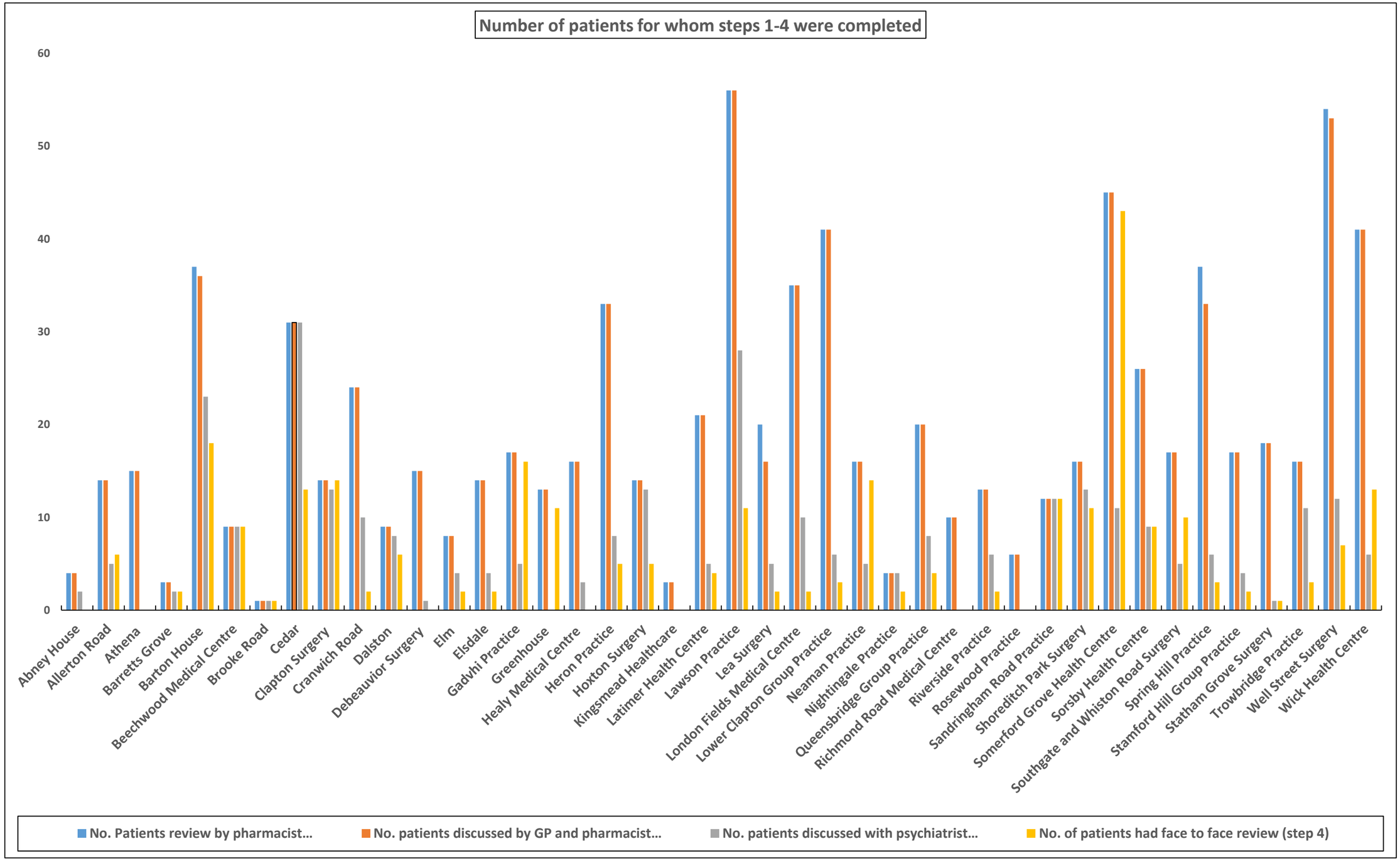
7.2.3 37% of patients (309) had step 3 completed

7.2.4 32% of patients (270) had step 4 completed

7.2.5 207 patients were recommended a face to face review following discussion with a psychiatrist but 270 had a review documented.

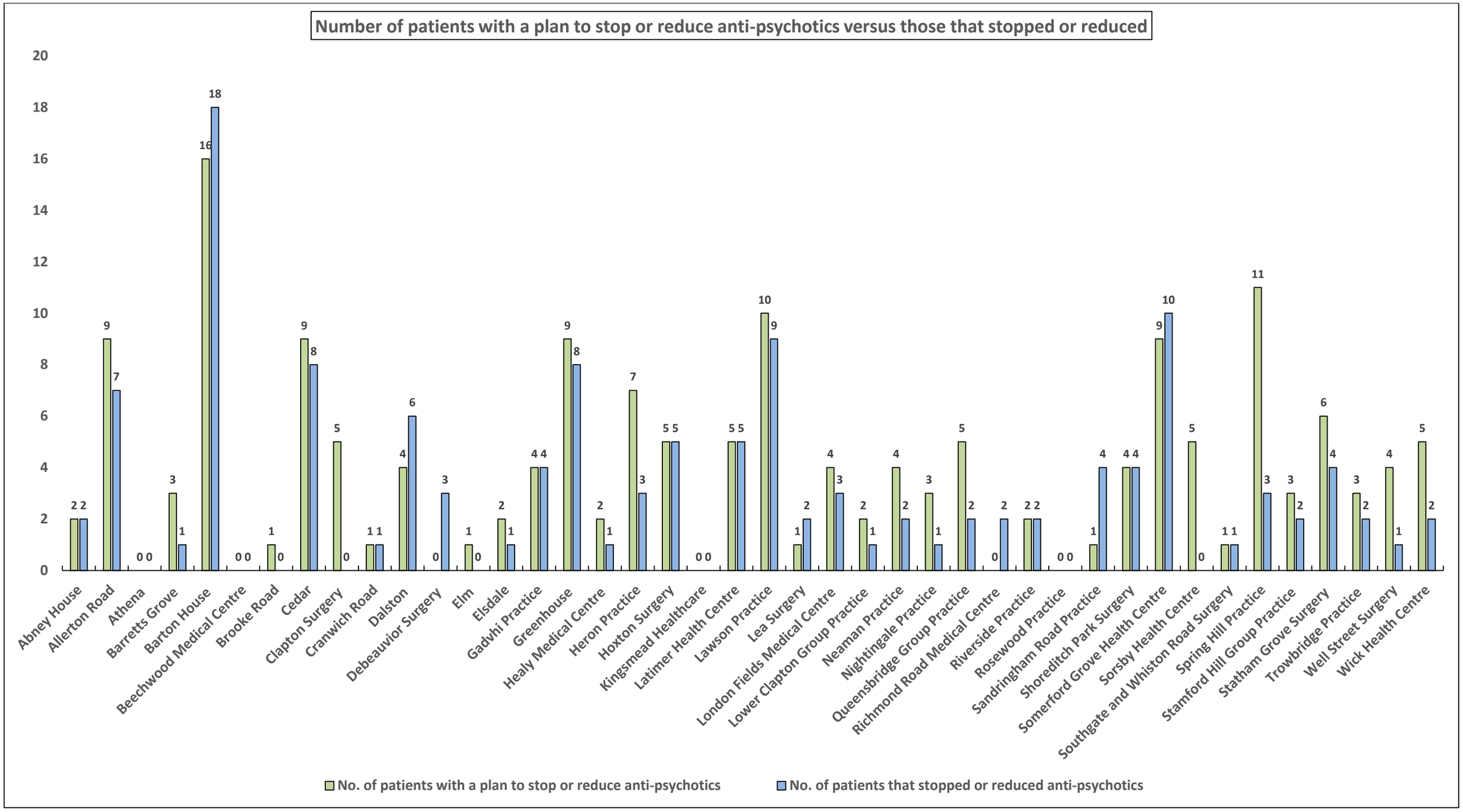
7.3 **Chart 1** below shows how each practice completed the steps and moved through the process. Step 1 and 2 are fairly equal for most practices but some practices discussed the majority of their patients in steps 3 and 4 whereas others had far fewer face to face reviews than review of notes and discussion.

**Chart 1**



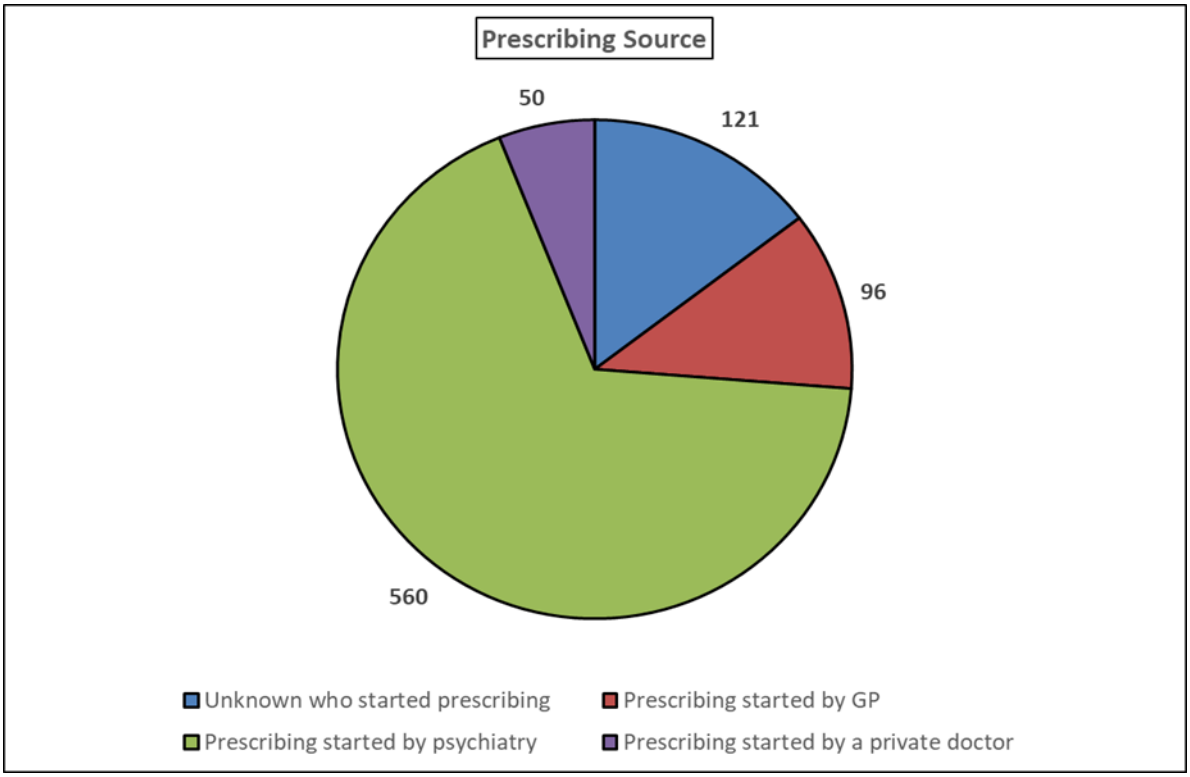
7.4 Chart 2 below shows the numbers of patients, by practice, who had a plan to stop or reduce antipsychotics and were subsequently able to stop or reduce anti-psychotics. Overall, 77 patients stopped antipsychotics (9%) and 53 patients reduced antipsychotics (6%). More were recommended to reduce or stop but were unable to.

**Chart 2**



7.5 Data was collected on who initiated antipsychotic medication as shown in **Chart 3** below.

**Chart 3**




7.5.1 As expected the majority of antipsychotic prescriptions were initiated by psychiatry (67%). GPs initiated fewer antipsychotics (14%) and private initiation was the lowest (5%). For many patients it was unknown who initiated the medication (14%) and this is a significant gap in the data.

7.6 388 patients had been under psychiatry within the last year (46% of patients).

## 8 Themes

8.1 Several themes were identified as recurring in the data.

8.2 **Engagement** was a very significant theme, it was documented that patients were invited in to discuss medication but did not attend or did not attend psychiatric follow-up after initiation of medications. Some patients were under private psychiatry and were reluctant to attend for GP monitoring. 16 of the 42 practices documented problems with patients not engaging with the reviews.

8.3 **Coding** identified within the submissions and also in the later analysis. It was difficult to establish from the submissions who had an SMI code added to their medical record but some patients were picked up in the audit as non-SMI who were later identified to have schizophrenia or bipolar. It was difficult to establish a clear diagnosis in some patients but psychotic features to their illness or past psychotic episodes were identified in many records. 4 practices had coding identified as an issue.

8.4 The difficulties of working with a **transient population** fed into the above 2 themes. Patients were often newly registered and receiving antipsychotic medication without their diagnosis being documented and coded or there was a delay in receiving records and transfer of psychiatric care. Patients often moved out of the area before they were reviewed which led to problems with engagement. 8 practices demonstrated this theme.

8.5 Some patients had a **change in diagnosis** in the past but had remained on their antipsychotic medication. This was often the case when psychosis or schizophrenia was changed to personality disorder. There was some evidence they had been identified to stop medications before but had not been able to. There was also some diagnostic uncertainty for some patients and they returned to secondary care for review. A few patients had also been lost to secondary care follow-up and were re-referred.

8.6 Many practices documented within their review that the patient had a **fear of deteriorating;** indeed some patients came off their medications but felt worse and requested to restart.

## 9 Conclusion

9.1 There was variation in the number of patients reviewed in Step 4, some practices reviewed relatively few (or none) of their patients in the final face to face step. There were some practices that had reviewed the notes of all patients at the end of the process and documented outcomes and changes in medication. This was beneficial in terms of the analysis to identify who had stopped or reduced and the themes.

9.2 One area of concern was that antipsychotic prescribing may be high in patients with dementia or learning disability which are groups where there have been concerns about increased mortality and morbidity. In fact the numbers were relatively low (appendix 1), 28 patients with dementia and 39 with learning disability. There was no indication in this audit that GPs have particularly high rates of prescribing in these groups and therefore are following NICE guidelines appropriately.[10,11]It was also demonstrated in the submissions that many of these patients were under regular review with elderly psychiatry and learning disability teams.

9.3 There was considerable variation in GP initiation rates. This was not related to practice size and although numbers were small, there were significant differences. This may be an area which needs further consideration.

9.4 For private initiation it was hard to draw clear conclusions about the appropriateness of prescribing. Often the communication was poor or delayed between the GP and private doctor and requests for information were unanswered. This was even more limited when private opinions were sought abroad and the patient returned requesting an ongoing prescription. The narrative comments suggest patients under private care were less likely to engage with the GP requests for reviews.

9.5 Where the initiator was unknown this may be due to lack of information in the record, particularly new patients to the surgery when records had not yet been received.

## 10 Recommendations

10.1 It is difficult to judge how reviews should be performed in terms of frequency and detail as NICE issues recommendations by condition and many of the conditions where antipsychotics were prescribed in this audit, are not covered. An annual review is recommended in local guidelines, particularly for the GP to monitor physical health.[9]There may need to be more focus on exploring the indication for the anti-psychotic, whether the diagnosis is clear or has changed and whether it can be safely reduced or stopped at each review.

10.2 When patients are discharged from psychiatric follow-up but remain on antipsychotic medication it would be useful to know the expected duration of treatment, the recommended time interval for a review and under what circumstances stopping the medication may be considered. This could be incorporated into a protocol for practices to follow or refer to.

10.3 Whilst a review of this size may not be possible to repeat, it would be useful for individual practices to focus on reducing and stopping antipsychotics when doing regular 6 monthly or annual medication reviews. This could be targeted by providing a list of patients on antipsychotics without an SMI diagnosis to practices. This list could then be reviewed with the psychiatric team where they are under ongoing follow-up or utilising existing quarterly mental health MDT meetings once or twice a year to review this cohort of patients. This would ensure psychiatric opinions were sought and a regular process of review was ongoing. This process would be quicker when patients were well known to the GP or psychiatric team and also identify those who are not engaging with services who may represent a vulnerable group.

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