Understanding the deprescribing landscape

A perceptions survey of NHS stakeholders

ENTER



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Forewords



Richard Condon
Chief Executive Officer,
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At Aspire Pharma, we believe medicines optimisation must always begin with the patient. The right medicine, at the right time, can transform lives. Equally, stopping a medicine that no longer benefits a patient can be just as important to their safety, dignity and quality of life.

Deprescribing is not about doing less. It is about doing what is right for each patient. It means listening to patients, understanding their treatment burden, supporting shared decisions, and giving healthcare professionals the confidence, tools and time to act when medicines may no longer be appropriate.

This type of work is exactly why Aspire created the Medicines Optimisation Centricity programme: to bring stakeholders together, challenge assumptions and turn patient-centred principles into practical action. Through our collaboration with HSJ Information, NHS leaders, healthcare professionals and wider partners, we want to help ensure medicines optimisation is recognised not simply as a process, but as a meaningful, patient-focused mission.

This report highlights both the urgency and the opportunity. While the NHS recognises the risks of problematic polypharmacy, deprescribing remains too variable and too dependent on local enthusiasm. To change this, we need clear pathways, protected time, multidisciplinary leadership and practical tools that make patient-centred reviews part of everyday care.

Aspire is proud to support this important work and remains committed to helping turn insight into action — so every medicine decision reflects what matters most: the patient.



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Across England, more than 718,000 people aged 65 years and over are taking 10 or more medicines. If current trends continue, that figure will exceed 1.1 million by 2035. The evidence is clear: polypharmacy-related harm is common, costly, and largely preventable. The case for deprescribing has never been stronger.

Yet this report reveals a system that recognises the problem but continues to struggle to act at scale. Of the 39 NHS pharmacy stakeholders surveyed, only 5% report truly embedded, system-wide deprescribing programmes. Time, training, and unclear ownership remain the dominant barriers. Cultural and behavioural challenges, including clinicians' reluctance to stop medicines initiated by others, further compound the issue.

The question is no longer whether deprescribing works. It is why our systems are not consistently enabling clinicians to deliver it. This report sets out those reasons clearly and candidly and highlights what effective practice looks like when leadership, pathways, workforce capability, and governance are aligned.

This report is intended to provide a clear-eyed assessment of current practice and to serve as a credible, evidence-based reference for NHS leaders committed to advancing safe, systematic deprescribing at scale.

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Executive summary

Deprescribing is becoming a critical test of medicines optimisation maturity across the NHS. Problematic polypharmacy creates avoidable harm for patients and significant operational and financial pressure for services. An estimated £2.21 billion is spent annually on hospital admissions resulting from adverse drug reactions, underlining the scale of the opportunity for systems to reduce medication-related harm through safer, more proactive medicines optimisation. This report finds that while system leaders increasingly recognise the risks, deprescribing remains inconsistent, under-resourced and often dependent on local enthusiasm rather than embedded operating models.

The survey of 39 NHS pharmacy stakeholders highlights a significant implementation gap. Only 5% of respondents reported embedded, system-wide deprescribing with governance and measures, while 23% described established activity across several pathways or settings. Most activity remains developing, limited in scale or *ad hoc*, and 31% of respondents had no current plans for a formal deprescribing programme or workstream. Although deprescribing was rated as a moderate-to-high system priority, with an average score of 6.74 out of 10, it is frequently loosely defined, inconsistently owned, and insufficiently supported by incentives, digital infrastructure or data.

Summary of findings

Deprescribing is recognised as important, but delivery varies significantly between systems, organisations and care settings.

Current activity is strongest when it is embedded into structured medication reviews, frailty pathways, falls services, care home reviews, discharge processes and multidisciplinary team working.

The highest-priority patient groups include people with frailty, those with high falls risk, care home residents, people taking 10 or more medicines, and those exposed to high-risk medicines.

Key medicine groups include opioids, sedatives, antidepressants, anticholinergics, antihypertensives, anticoagulants and long-term proton pump inhibitors.

The main barriers are lack of time and capacity, insufficient training and confidence, unclear ownership across primary and secondary care, limited follow-up capacity and medico-legal concerns.

Cultural barriers remain key, particularly reluctance to stop medicines initiated by another clinician or specialty.

Patients and carers are generally willing to engage when deprescribing is explained clearly as a safety-focused, patient-centred intervention.

Recommendations for system leaders

Formalise deprescribing as a governed workstream within medicines optimisation, frailty and patient safety strategies.

Establish named leadership, clear accountability, agreed pathways and routine outcome reporting.

Protect time for structured medication reviews and ensure capacity for follow-up and monitoring.

Scale pharmacist-led multidisciplinary models across primary, secondary, mental health, frailty, care home and community settings.

Embed practical tools into workflows, including structured medicine review templates, anticholinergic burden scoring, electronic prompts, post-fall reviews and risk-stratification searches.

Invest in training on shared decision-making, risk communication and safe deprescribing.

Align incentives, data dashboards and performance measures with medicines safety outcomes.

The full report provides practical examples, stakeholder insights and implementation priorities to help system leaders make deprescribing routine, scalable and sustainable.

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Background



Introduction to polypharmacy

Polypharmacy, commonly defined as the use of five or more medicines, and increasingly 10 or more medicines, is now a widespread and growing challenge across health systems.

In England alone, more than 718,000 people aged 65 years and older were taking ≥10 medicines in 2025, representing more than 9% of the older population.[1]

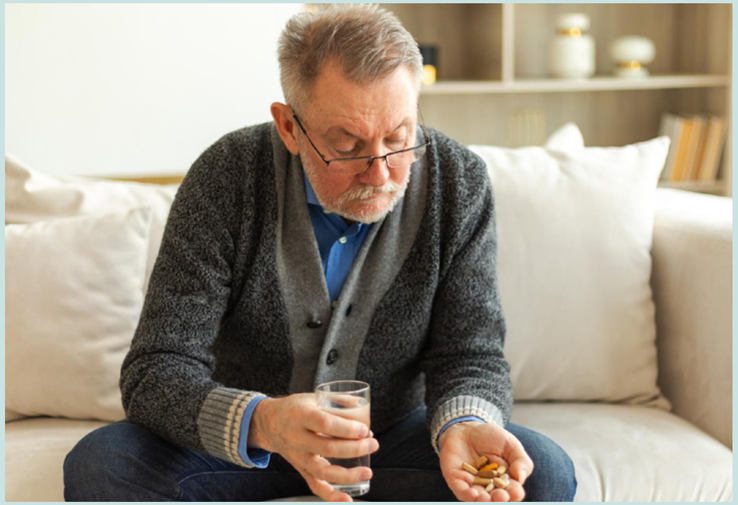
If current trends continue, this figure is forecast to exceed 1.1 million by 2035, driven by population ageing and rising multimorbidity. Reducing prescription costs can reduce the clinical, operational, financial and environmental burden placed on society.[1,2]

Evidence consistently shows that increasing medication burden is associated with higher risks of adverse drug reactions (ADRs), falls, delirium, cognitive impairment, emergency admissions and mortality.[3] People taking 10 or more medicines are far more likely to be admitted to hospital than those on fewer medicines.[4]

Much of this harm is avoidable, arising from prescribing cascades, failure to review ongoing need, duplication, and poor coordination across care settings.[2,3]

One study found adverse drug reactions (ADRs) in 18.4% of hospital admissions.[5]

Extrapolated nationally, admissions resulting from ADRs have a projected annual cost of **£2.21 billion** to the NHS.[5]



The evidence base for deprescribing is strong and growing. Polypharmacy-related harm is common, costly and largely preventable.

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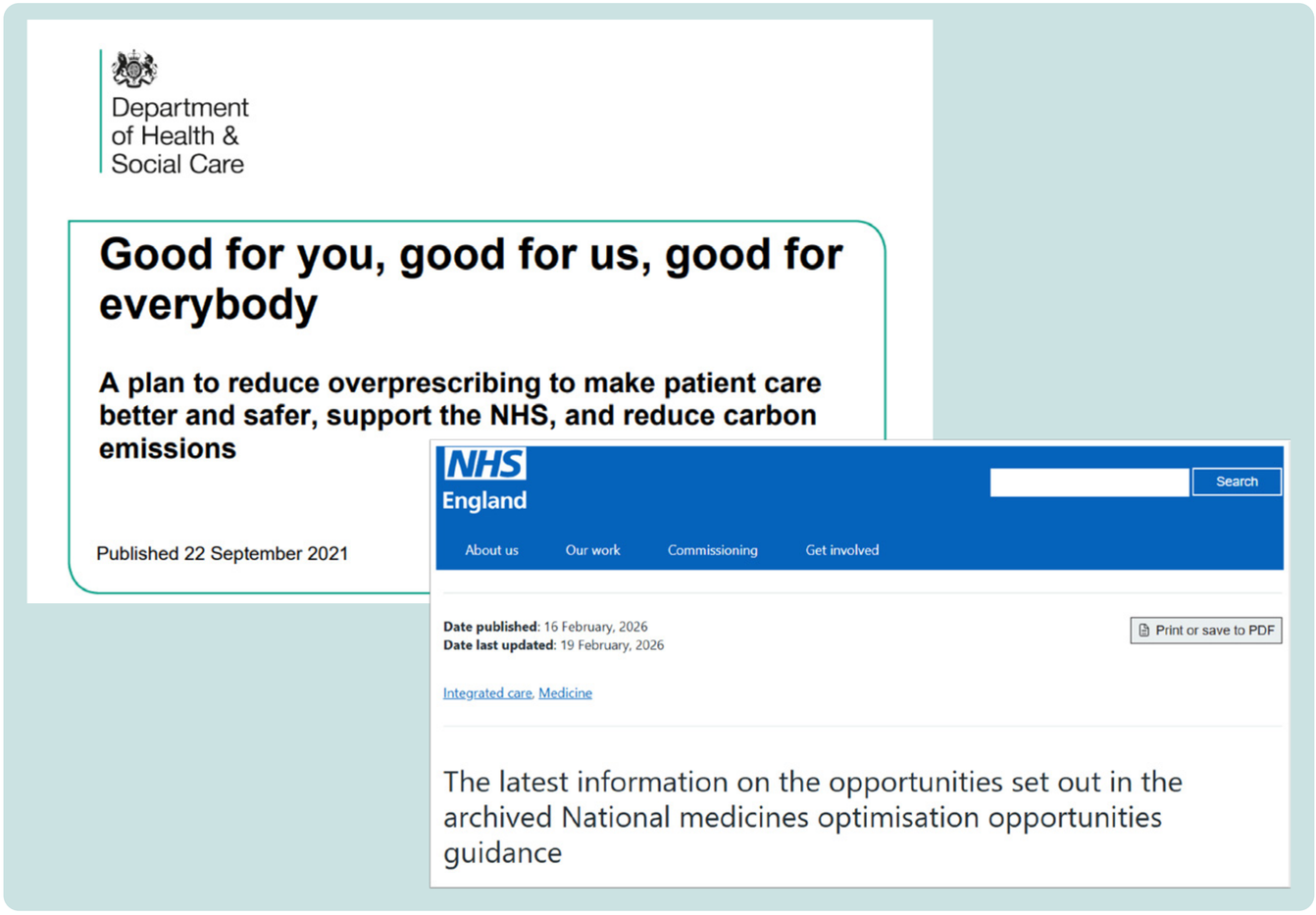
National strategies and guidance are in place to address problematic polypharmacy

Guidance and national strategies are in place to address problematic polypharmacy and focus on reducing avoidable patient harm.

- NHS England's national medicines optimisation objectives outline 16 key prescribing priorities, the first of which is addressing problematic polypharmacy.[6]
- The Department of Health & Social Care review '*Good for you, good for us, good for everybody*' outlines recommendations to reduce overprescribing.[2]



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Deprescribing is a critical component of patient safety and medicines optimisation

Deprescribing, defined as the systematic process of identifying and stopping medicines where harms outweigh benefits in the context of an individual's goals of care, is increasingly recognised as a critical patient safety intervention.

High-quality reviews consistently demonstrate that deprescribing is safe when undertaken in a structured, patient-centred and monitored way, particularly for older adults with frailty, multimorbidity or limited life expectancy.[6,7]

Recent systematic reviews show that deprescribing preventive medicines in frail or palliative patients is not associated with worse outcomes.

Beyond safety, the evidence shows real benefits: more appropriate prescribing, fewer potentially harmful medicines, and reduced medication burden.[7-9] These gains translate directly into less harm and better quality of life.

Deprescribing works best when embedded in routine clinical pathways, supported by training, protected time, senior endorsement and clear accountability across the primary–secondary care interface.[3,8,10]

Tools from the British Geriatrics Society[10] and PrescQIPP[11] are available to support implementation of deprescribing activities.

A key challenge is no longer whether deprescribing works, but how consistently and confidently systems enable clinicians to deliver it at scale.



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Partnership working to transform patient care

HSJ Information and Aspire Pharma are working in partnership to drive transformative change in patient care by:

- placing patients at the core of every decision, ensuring their voices shape Aspire's mission and actions
- developing and supplying innovative products and medicines throughout the world
- deeply understanding the real-world experiences of patients and the healthcare professionals (HCPs) who support them
- partnering with healthcare systems like the NHS to implement practical, outcomes-focused solutions that elevate health across communities.

2023 Two roundtable events on the way forward for medicines optimisation

2024 Roundtable event on whether medicines optimisation is creating health inequalities

2025 Roundtable event on the value of medicines in the patient pathway

2026 Survey to understand the deprescribing landscape









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About this report

Medicines deprescribing emerged as a topic of interest with pharmacy stakeholders at the HSJ Medicines Forum in October 2025. During a panel discussion, Richard Condon, Chief Executive Officer of Aspire Pharma Ltd, emphasised that the company considers deprescribing to be a central and core part of its work in medicines optimisation.

There was interest around the Forum in further understanding how industry can work with system leaders to explore:

- how effective deprescribing can be achieved
- how industry can support with appropriate tools to help support managing patients off medications that may not be benefiting them.

Despite the existence of national guidance and sustained interest among pharmacy stakeholders, anecdotal evidence suggests that progress on deprescribing has been relatively slow. Against this backdrop, Aspire Pharma Ltd commissioned HSJ Information to conduct a system-wide survey exploring the national deprescribing landscape. The objectives were to:

- assess the extent of deprescribing activity across systems and trusts
- understand where deprescribing sits within local priorities and agendas
- identify cultural, behavioural, and operational factors influencing progress
- characterise the challenges faced at system level and identify key enablers of change.



The survey ran in March 2026 and was completed by a total of **39 NHS pharmacy stakeholders.**



Respondents represented a mix of primary and secondary care settings including **acute trusts/providers (46%), primary care organisations/commissioning functions (21%), and integrated care boards/systems (10%)**, with local footprints spanning general practice, primary care networks (PCNs), acute hospitals, mental health, care homes, and community services.



The vast majority of respondents were pharmacists in a range of roles, including **chief pharmacists, deputy/assistant chief pharmacists,** and those specialising in **frailty, hospital, medicines optimisation, and primary care.**



This report summarises the findings of this research survey

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Current deprescribing activity and maturity



Current deprescribing activities

Despite national guidance on deprescribing, medicines optimisation and patient safety – such as the National Overprescribing Review report, the NHS Network Contract directed enhanced service (DES) policy, and the NHS Patient Safety Strategy[2,12,13] – only 28% of our survey respondents report embedded (5%) or established (23%) deprescribing activities across their systems.

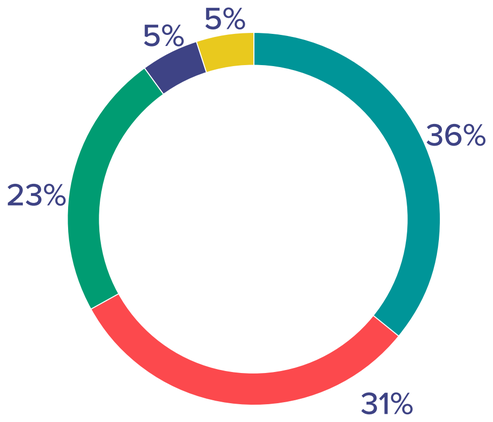
Around two-thirds of respondents had either minimal (31%) or developing (36%) deprescribing activities.

Formal deprescribing programmes or workstreams were established and active in 26% of respondents' systems/trusts, with development/planning in a further 18% and discussions underway in 10%. However, 31% of respondents had no current plans in place, with 15% unsure about plans.

> *"What is needed? Dedicated, highly trained pharmacists provided with sufficient time to build therapeutic relationships and actively manage patients' medications and conditions."*

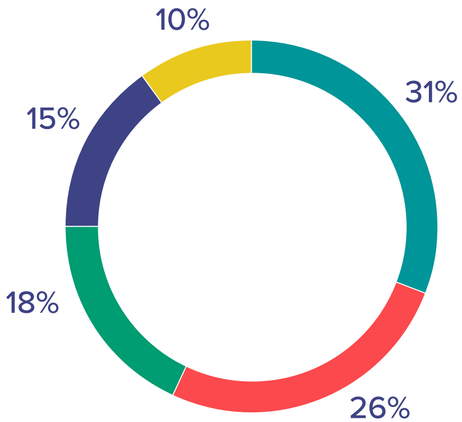
Most deprescribing activities are developing or minimal

	n
Developing (some structured activity; limited scale)	14
Minimal (*ad hoc*; dependent on individual clinicians)	12
Established (routine in several pathways/settings)	9
Embedded (system-wide approach with governance and measures)	2
Not sure	2



Almost a third of respondents have no current plans for a formal deprescribing programme or workstream

	n
No – no current plans	12
Yes – established and active	10
Yes – in development/planning	7
Unsure	6
No – but discussions are underway	4



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Availability of deprescribing systems and local use

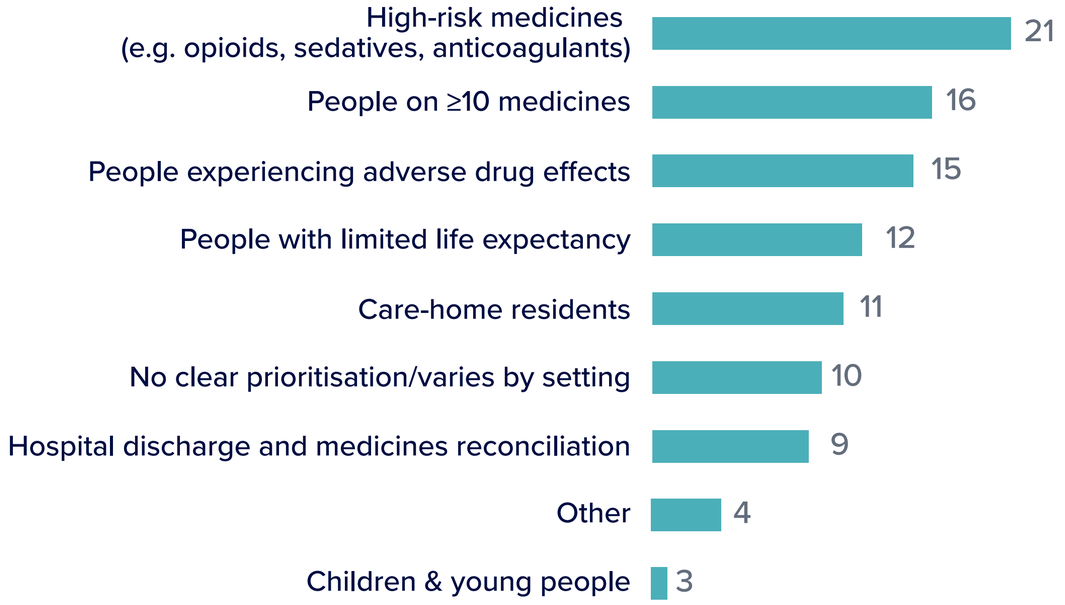
Formal deprescribing programmes or workstreams, where they exist, typically target patients who are frail or are at high risk of falls, those taking high-risk medicines such as opioids, sedatives or anticoagulants, or people on ≥10 medicines.

Current deprescribing activities are largely through structured medication or polypharmacy reviews, with other common settings for deprescribing being frailty services, hospital discharge and medicines reconciliation and care home medication reviews.

Responses to current activities for local prescribing prioritisation



Responses to patient prioritisation for medication reviews



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Common themes among effective deprescribing systems reported in survey

Better targeting of high-risk patient cohorts

Focus on:

- frail
- older
- high-risk patients.

Particularly those with:

- falls
- polypharmacy (10–15 or more medicines)
- low blood pressure
- high anticholinergic burdens.

Medication target areas

Commonly utilised deprescribing activities or focus areas by respondents were:

- antihypertensive
- opioids
- antidepressants
- proton pump inhibitors (PPIs)
- anticholinergic drugs.

Safer prescribing

Pharmacist-led and multidisciplinary team (MDT) models were key enablers:

- structured medication reviews (SMRs)
- frailty pharmacists in emergency departments (EDs)/virtual wards
- ward-based pharmacists with authority to stop medicines
- dedicated pharmacists embedded in chronic pain, mental health, orthopaedic, and care-home teams.

Improved sustainability

Pathways and prioritisation improved consistency and impact; tools cited included:

- frailty pathways
- risk-stratification searches
- British Geriatrics Society tools
- post-fall “swarm” reviews (e.g. safety-focused, ward-based, action-orientated, rapid, multidisciplinary review)
- formal service-level agreement (SLA)-supported programmes.

Despite these advances, many respondents noted work was still *ad hoc* or absent in some areas.



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Current effective deprescribing work

"We offer SMRs to all people over 65 on ≥10 medicines, but a subgroup who are 80 years and over with moderate/ severe frailty taking antihypertensives and a systolic of <120 mmHg is a particularly beneficial group for preventing falls and unplanned admissions, given the observational evidence of increased mortality with low blood pressures in this cohort."

"Pharmacy-led comprehensive falls medication review on all acute trust frailty wards. Project has been embedded over several years and is achieving 78% comprehensive reviews across the frailty bed base."

"Opioid deprescribing – a pharmacist within chronic pain service. Dedicated, highly trained pharmacist provided with sufficient time to build therapeutic relationships and actively manage patients' medications and conditions."

"Use of British Geriatrics Society pragmatic prescribing tool to look at patients with frailty score of 7 and above. Work on medicines reconciliation and communication to GP. Communication to pharmacies via Discharge Medicines Service."

"Acute frailty team actively identifying people in the ED, frailty specialist pharmacist on virtual wards actively reviewing medication, and frailty inpatient services reviewing medications for patients following falls and those on complex medication regimens."

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Priority and place in local agendas

> “The single change that would have the greatest impact in making deprescribing a clearer system priority would be the introduction of a structured, organisation-wide medication review pathway with defined targets and governance oversight.
>
> This could include embedding routine deprescribing reviews for high-risk patient groups, such as older adults and patients with polypharmacy, with pharmacists and prescribers working collaboratively to review ongoing medicine appropriateness.”



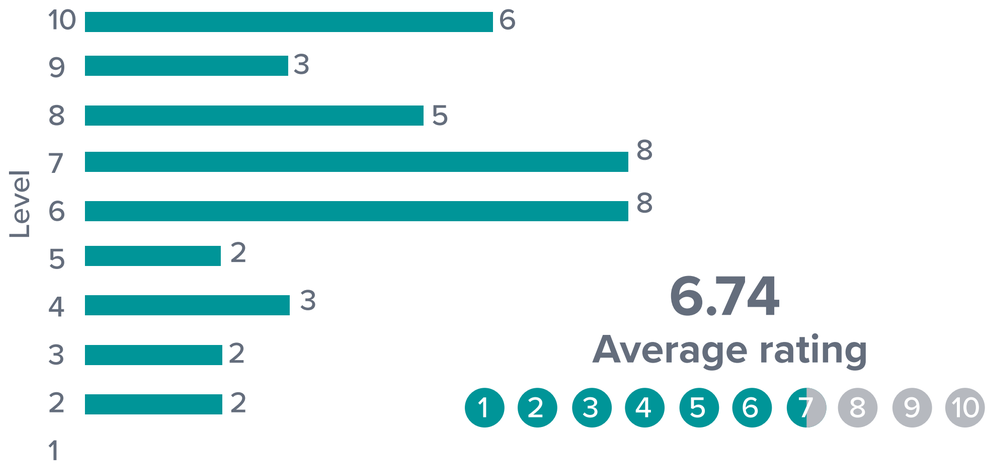
How important is deprescribing as a system priority?

When asked to rate the importance of deprescribing as a system priority on a scale of 1 to 10 (with 10 being a top-tier priority), the average score for the 39 respondents was 6.74. While six respondents rated this as a level 10 (top-tier) priority, two respondents each rated it as level 2 and 3, indicating it is not a uniform priority across all systems.

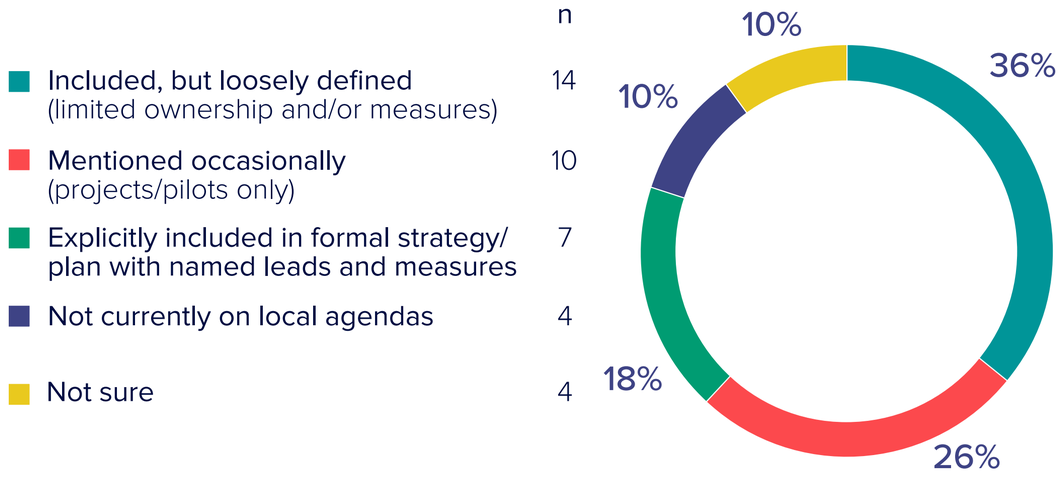
In local agendas, deprescribing is explicitly included in formal strategy/ plan for 18% of respondents, included but loosely defined with limited ownership and/or measures for 36% of respondents, or mentioned occasionally as part of a specific project or pilot (26%).

However, 10% of respondents reported that deprescribing was not currently on local agendas.

Deprescribing is an important system priority



Inclusion of deprescribing in local system agendas



> *Deprescribing would become a clearer system priority if it were embedded as a formal, measured, and governed component of the frailty and medicines optimisation agenda rather than an optional activity delivered variably across services.*

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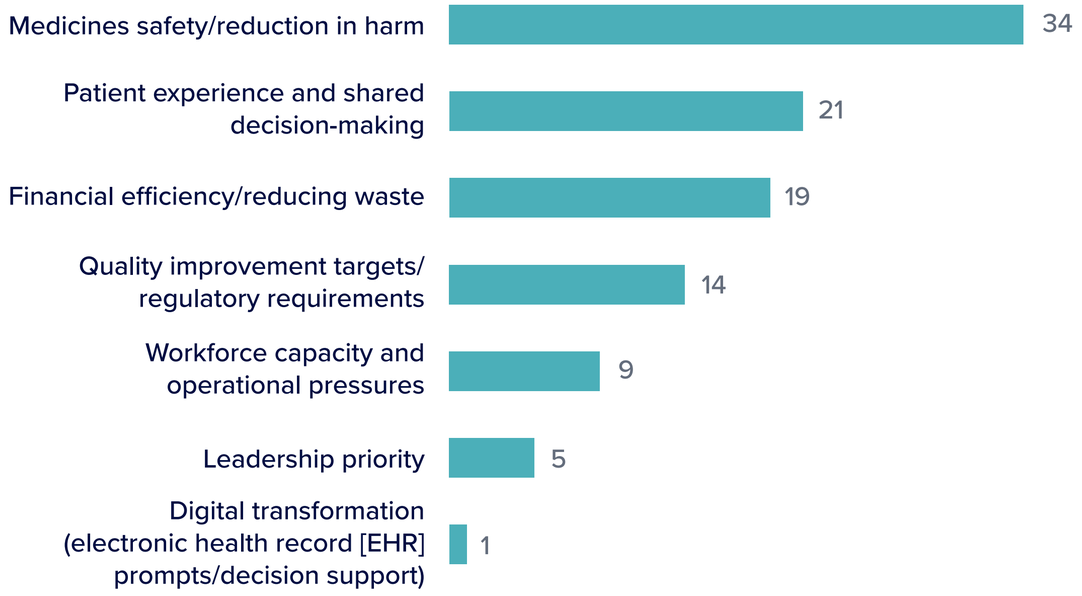
Pathway design, education and funding are key aspects that would make deprescribing a clearer system priority

Respondents considered the most important drivers for elevating deprescribing locally were medicine safety/ reduction in harm followed by patient experience and shared decision making, and financial efficiency/ reducing waste.

When asked what would make deprescribing a clearer system priority over the next 12 months, respondents identified a set of key enablers, including:

- pathway design
- education
- funding
- leadership and governance
- clear, achievable targets.

Influential drivers for deprescribing



> "Funding, pathway design. Targets are difficult as they can be used punitively and don't account for the fact that deprescribing done correctly is a slow process and SHOULD be patient-centred with shared-decision making."

> "Governance, embedded within policy – incentive to deprescribe."

> "Embedding routine deprescribing reviews for high-risk patient groups... with clear metrics monitored through regular reporting."

> "Funding and support for pharmacists around polypharmacy for long-term conditions."

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What is needed to lead the deprescribing agenda?

Respondents described the following key aspects as being required to lead the deprescribing agenda and make it a clearer system priority in the next 12 months.

Visible leadership and governance

- Senior leadership sponsorship (trust/integrated care board [ICB]/health board)
- Deprescribing embedded within medicines optimisation, frailty and safety governance
- Clear accountability and oversight

Risk if not addressed

- Deprescribing remains optional, fragmented and inconsistent
- Work depends on individual enthusiasts rather than system design

Clear pathways with sensible targets and measures

- Organisation-wide deprescribing pathways
- Clear but clinically appropriate measures (e.g. high-risk medicines, polypharmacy)
- Focus on learning and improvement, not punitive reduction

Risk if not addressed

- Ongoing variation in practice
- Fear of deprescribing, or superficial "tick-box" reductions that undermine patient-centred care

Education, confidence and culture change

- Deprescribing taught as a core prescribing skill
- Cultural shift so stopping medicines is seen as good clinical practice
- Support for shared decision-making with patients

Risk if not addressed

- Prescribers remain risk-averse and reluctant to stop medicines
- Medication burden continues to grow unchecked

Workforce model that enables proactive deprescribing

- Adequate pharmacist capacity and funding
- Multidisciplinary ownership – not "pharmacists alone"
- Time and skills for proactive review of high-risk patients

Risk if not addressed

- Deprescribing becomes reactive, patchy and unsustainable
- Complex patients remain over-medicated despite repeated contacts with services

Systems, tools and incentives

- Clinical system prompts and patient identification tools
- Better primary–secondary care interface
- Contractual, national or ICB-level levers to legitimise the work

Risk if not addressed

- Clinicians lack prompts, data and permission to act
- Deprescribing is continually deprioritised in pressured clinical environments

Deprescribing will not succeed through isolated initiatives. Without aligned leadership, pathways, workforce, education and system incentives, medication harm and polypharmacy will continue to grow despite best intentions.

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Culture and readiness to change

> “Deprescribing needs to be considered more – at routine reviews of medication, on hospital ward rounds and in clinics. It is easy to start new drugs, but many prescribers seem reluctant to change/stop them, especially where they did not initiate that drug.”



There is willingness for deprescribing among clinicians and patients

82% of respondents agree or strongly agree that patients and carers understand and are willing to accept deprescribing when it is explained well. However, there is overall disagreement that clinicians feel psychologically safe to stop a medicine started by others, with 53.9% of respondents disagreeing or strongly disagreeing.

While respondents' answers were mixed in response to the statement 'Deprescribing is viewed as "everyone's business" across our system', there was general agreement that shared decision-making is used consistently for stopping medicines and that deprescribing is supported by senior leaders.

There was a trend to disagreement (15.4% strongly disagreeing) that deprescribing is supported by incentives or performance reviews. Respondents' answers leaned neither one way nor the other when asked if deprescribing has leadership support or accountability from senior leadership.

Digital tools are not routinely used when deprescribing, with 56% of respondents either disagreeing or strongly disagreeing that digital tools are being used to support deprescribing.

The majority of respondents said that systems were at some level of readiness (87%), with 10% 'very ready' to scale up deprescribing in routine care in the next 6–12 months, while 13% of respondents stated that their system was not ready to scale up.

Readiness to scale up deprescribing in the next 6–12 months

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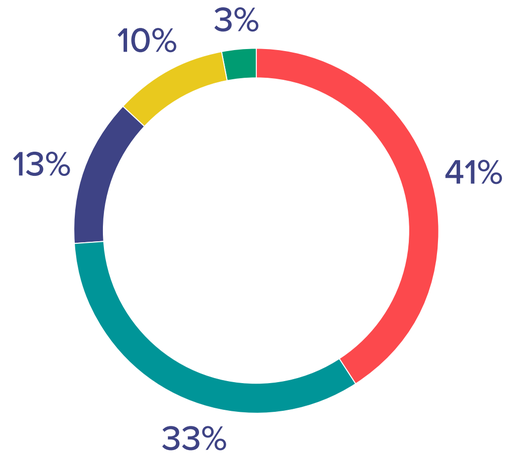
Slightly ready	16
Moderately ready	13
Not ready	5
Very ready	4
Fully ready (able to scale now)	1



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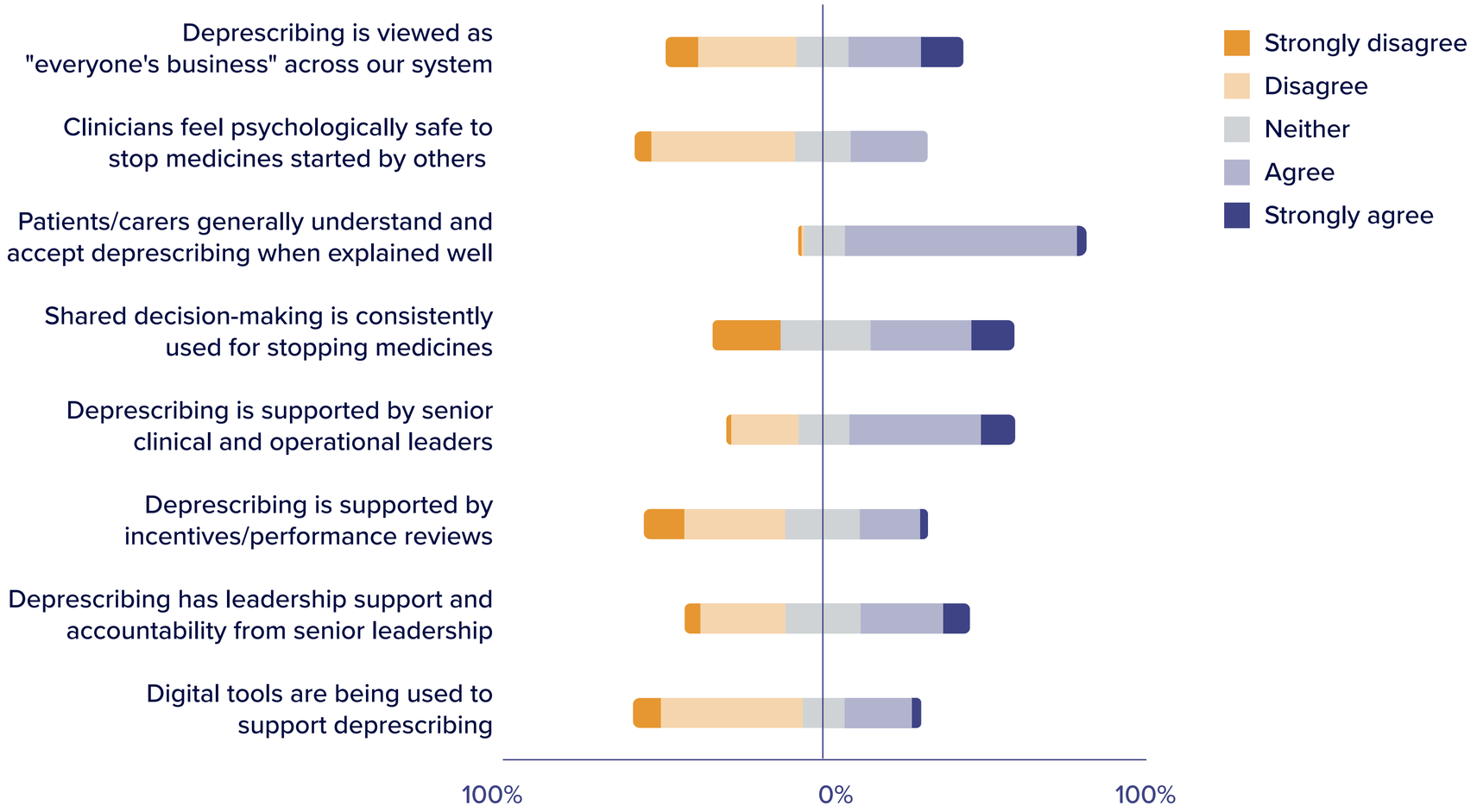
There is willingness for deprescribing among clinicians and patients

Drivers and barriers to deprescribing



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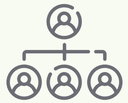
Normalising deprescribing through change

	Current perceptions	Future ideal
	• Deprescribing seen as *optional,* specialist-led or someone else's role • Adding medicines prioritised over reviewing or stopping them • "If they came in on it, leave it" mindset, especially in hospitals	• Reviewing and stopping medicines seen as core to good prescribing • Deprescribing considered at every ward round, clinic and review • Stopping medicines viewed as a marker of high-quality, patient-centred care
	• High fear of complaints, litigation or "rocking the boat" • Perception that deprescribing is riskier than continuing medicines • Formulaic prescribing applied without adjustment for frailty or prognosis	• Shared understanding that not deprescribing carries equal or greater risk • Greater confidence supported by leadership, governance and guidance • Consideration of deprescribing in frail patients where benefits are limited
	• Fragmented ownership between primary and secondary care • Reluctance to change medicines started by another clinician or specialty • Responsibility often falls to GPs or pharmacists after initiation elsewhere	• Shared accountability across the full care pathway • Prescribers who initiate medicines also own review and follow-up • Clear expectations that deprescribing is everyone's responsibility
	• Variable trust in pharmacy-led recommendations • Hierarchical decision-making, especially in non-frailty specialties • Deprescribing driven by individuals rather than teams	• Strong MDT working with pharmacists empowered to act • Consistent uptake of pharmacy recommendations across specialties • Deprescribing embedded as everyone's business
	• Medicines framed as "lifelong", with no discussion of stopping • Patients often expect continuation of specialist-initiated medicines • Limited time to explain risks, benefits and medication burden	• Expectations that medicines may be stopped set at the point of initiation • Shared decision-making normalised, including deprescribing conversations • Patients and families see stopping medicines as safe and appropriate
	• Insufficient time, funding and workforce capacity • Limited training in how to deprescribe safely • Competing incentives drive initiation rather than review	• Protected time for medication review and follow-up • Clear guidance, training and audit to build confidence • Incentives and systems that support sustainable deprescribing

Normalising deprescribing requires a shift from fear, fragmentation and individual effort to shared accountability, support for clinicians, and routine multidisciplinary practice.

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Challenges, enablers and priorities

> “Deprescribing will not get anywhere while we are thinking in terms of programmes…it must become a priority of all clinicians treating the patient – whether in secondary care or primary care.”



Challenges and enablers in deprescribing

Challenges to deprescribing



Time was identified as both a challenge and a major enabler for deprescribing. A lack of time/capacity in appointments and reviews was respondents' most commonly selected challenge to deprescribing (90% selecting), while protected time for SMRs was ranked second highest out of a list of enablers that would most support deprescribing at scale.

Other pressing challenges were identified as insufficient training/skills/ confidence (by 59% of respondents) and unclear responsibility/ownership across settings (54% of respondents).

Respondents' rankings of the most supportive enablers for deprescribing at scale

1. Clear system-wide deprescribing policy and governance
2. Protected time for SMRs
3. Shared care pathways across primary/secondary/community
4. Training in shared decision-making and risk communication
5. Access to pharmacy/MDT support
6. Decision support tools/deprescribing guidance embedded in EHR
7. Patient-facing education materials and campaigns
8. Better data (polypharmacy dashboards, outcomes, variation)
9. Funding/incentives aligned to deprescribing outcomes
10. Follow-up and monitoring infrastructure

Survey respondents were invited to rank 10 enablers of deprescribing at scale – from most supportive (1) to least supportive (10) – and the list above shows the averaged rankings of all respondents.

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Priorities for increasing deprescribing

High-risk patients and medicines

1

- Frailty, falls risk, care homes, end of life, severe mental illness, learning disabilities
- Polypharmacy (≥10 medicines)
- PPIs, anticholinergics, opioids, benzodiazepines, gabapentinoids, antidepressants, Z-drugs (non-benzodiazepine drugs)

Requires

- Increased number of SMRs in high-risk groups
- Reduced anticholinergic burden (ACB) scores and high-risk prescribing
- Reduced falls, readmissions, and medicine-related harm

Embed deprescribing into routine care

2

- Shared primary–secondary care pathways
- Deprescribing built into ward rounds, clinics and discharge
- Clear accountability for medicines initiated and reviewed

Requires

- Less variation across settings
- Fewer medicines started without a review plan
- Improved clinician confidence and smoother interface working

Workforce, capacity, and incentives

3

- Protected time and funding for reviews
- Training in deprescribing and risk communication
- Pharmacists and non-medical prescribers (NMPs) enabled to lead MDT discussions
- Alignment with Quality and Outcomes Framework (QOF)/ICB priorities

Requires

- More staff trained and actively deprescribing
- More documented deprescribing conversations
- Better-informed patients, reduced medication burden

Reducing harm requires focus, routine practice and capability – deprescribing will succeed when it targets the highest risks, is embedded into everyday care, and is properly resourced.

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Best practice examples in deprescribing

The topic boxes below describe examples of best practice in deprescribing from survey respondents.

Falls, frailty, and high-risk patients



Pharmacist-led and MDT-based deprescribing



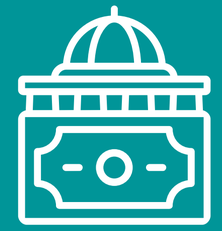
Tools, frameworks, and digital decision support



Training, education, and cultural change



Governance, incentives and system-wide programmes



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Falls, frailty, and high-risk patients

"In the pharmacy falls team, a comprehensive assessment includes a postural hypotension check. A patient is then referred to the pharmacist for a medication review that may result in deprescribing."

"SWARM huddles post-falls, multi-factorial analysis of reasons for fall and review of fall risk-increasing drugs (FRIDs) for the prevention of future falls."

"Pharmacy-led comprehensive falls medication review across all frailty wards in large acute trust. Achieving 78% comprehensive falls review."

"For post-myocardial infarction patients, all admission medications reviewed and rationalised to ensure they are evidence based and prognostic, and patient given full counselling on discharge."

"In-patient falls review by pharmacist. Discharge prescription validation."

"Care homes training – giving carers confidence to ask for a medication review in a deteriorating patient."

"Geriatric review in orthopaedic patients."

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Pharmacist-led and MDT-based deprescribing

> "Pharmacists need to be given the time during reviews to make these decisions."

> "Working together and with the patient."

> "MDTs incorporating pharmacists, with a discussion around risks versus benefits and prognostic benefit, etc."

> "Pharmacist-led polypharmacy medication reviews. Structured medication reviews led by pharmacists for patients with multiple long-term medicines, particularly older adults and those at higher risk of medicine-related harm. These reviews assess ongoing need, safety, and duplication of therapy, with recommendations made collaboratively with the prescribing clinician. Best practice elements include:
>
> 1. Use of a structured medication review template and documentation of deprescribing decisions, ensuring consistent practice and clear communication across the MDT.
> 2. Use of deprescribing guidelines and decision-support tools, implementation of recognised deprescribing tools or checklists to support clinicians when reviewing medicines. These tools help identify high-risk or potentially inappropriate medicines and provide guidance on how to safely taper or stop treatment.
>
> *Best practice: Embed these tools into prescribing systems or medication review processes to support safe and evidence-based decision-making.*
>
> 3. Education and awareness sessions for clinical staff. Providing training for pharmacists, doctors, and nursing staff on deprescribing principles, high-risk medicines, and safe medication reduction strategies.
>
> *Best practice: Regular teaching sessions and case-based discussions that build clinician confidence in deprescribing and promote a culture where reviewing and stopping medicines is considered part of good prescribing practice."*

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Tools, frameworks, and digital decision support

"Use of deprescribing guidelines and decision-support tools."

"Anticholinergic burden (ACB) framework (Australia), All Wales Medicines Strategy Group (AWMSG) PPI audit tool, and Canadian deprescribing algorithms, patient leaflets from https://www.choiceandmedication.org/nhswales/."

"Practices in Greater Manchester have access to the SMASH dashboard (medication safety dashboard), which identifies patients with potential medication safety problems, and its use has been incentivised."

"Use of open prescribing data."

"Use of Johns Hopkins tool to risk stratify and identify patients for MDT review."

"The deprescribing organisation ThinkCascades has developed a tool for identifying clinically important prescribing cascades affecting older people."

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Training, education, and cultural change

> "Education and awareness sessions for clinical staff...case-based discussions that build clinician confidence in deprescribing."

> "Health Innovation Network polypharmacy training programme, SMR support training and care home targeted SMRs."

> "Training and guidance produced for deprescribing antidepressants as well as co-produced videos."

> "Health Innovation West Midlands ran polypharmacy webinars, which were helpful for developing skills."

> "Use of morphine opiate training."

> "Care homes training – giving carers confidence to ask for a medication review in a deteriorating patient."

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Governance, incentives and system-wide programmes

> “Staffordshire and Stoke-on-Trent ICB Medicines Optimisation PCN service-level agreement – annual workstream focusing on different medication priorities. Training webinars provided online during the year.”

> “We incentivised education for problematic polypharmacy in our system to change the capability and culture. We have incentivised the SMRs for 3 years and it is self-funding.”

> “Use of medical students to undertake audits to highlight and then implement changes.”

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Conclusions/ call to action



Conclusions

Deprescribing is recognised as important, but delivery is highly variable

- Respondents widely rated deprescribing as a high priority, yet activity ranges from embedded, system-wide programmes to entirely *ad hoc* or absent, depending on organisation, setting, and leadership.

Effective deprescribing examples focus on frailty, falls, and polypharmacy

- The strongest examples from respondents targeted older adults with frailty, people with high falls risk, and those on 10–15 or more medicines, with emphasis on antihypertensives, opioids, antidepressants, PPIs, sedatives, and anticholinergic medicines.

Pharmacist-led and MDT models drive success

- Effective initiatives relied on embedded clinical pharmacists with protected time, prescribing authority, and MDT support (e.g. frailty wards, ED, virtual wards, chronic pain, mental health, and care homes).
- Where pharmacists were in advisory only roles, deprescribing was weaker.

Structured pathways outperform *ad-hoc* reviews

- Programmes using SMRs, ACB scoring, frailty pathways, post-fall swarm reviews, and risk-stratification searches were more consistent, safer, and scalable than individual clinician-led efforts.

Cultural and behavioural barriers remain the biggest obstacles

- Common challenges included fear of medico–legal risk, reluctance to stop medicines started by others, lack of inter-professional trust, and patient expectations that medicines are "lifelong".
- There was sometimes limited confidence in shared decision-making processes.

Commissioned, SLA-supported work is more sustainable and measurable

- Deprescribing embedded within formal strategies, SLAs, or ICB-led programmes (with governance, funding, and reporting) showed clearer ownership, better uptake, and demonstrable outcomes, compared with unfunded goodwill activity.

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Call to action

Objective

Formalise deprescribing as a system workstream



Establish deprescribing within ICB/health board strategies, supported by governance, named clinical leadership, agreed pathways, and outcome reporting (e.g. falls, admissions, high-risk medicine use).

Prioritise high-risk populations and medicines



Focus system effort on severe/moderate frailty, post-fall patients, polypharmacy (10–15 or more medicines), high ACB scores, opioids, antidepressants, sedatives, and long-term PPIs, where benefit–risk is most favourable.

Scale pharmacist-led MDT models



Invest in advanced pharmacist roles across primary, secondary, mental health, frailty, and care-home settings, with prescribing authority, protected time, and clear accountability for deprescribing.

Standardise tools and triggers



Embed SMR templates, ACB scoring, electronic prompts, post-fall SWARM reviews, and risk-stratification searches into routine workflows to normalise deprescribing.

Address culture, confidence, and patient expectations



Deliver training in shared decision-making, risk communication, and deprescribing guidance, and introduce patient-facing education that reframes stopping medicines as safe, proactive care, not cost cutting.

Align incentives and data with deprescribing goals



Shift incentives away from prescribing volume toward medicines safety outcomes, and improve access to polypharmacy dashboards, audit data, and cross-system information sharing to support follow-up and monitoring.

How can this be achieved?

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Appendices



Abbreviations

ACB	anticholinergic burden
ADR	adverse drug reaction
AWMSG	All Wales Medicines Strategy Group
DES	directed enhanced service
ED	emergency department
EHR	electronic health record
FRIDs	fall-risk-increasing drugs
GP	general practitioner
HCP	healthcare professional
HIN	Health Innovation Network
ICB	integrated care board
MDT	multidisciplinary team
NMP	non-medical prescriber
PCN	primary care network
PPI	proton pump inhibitor
QOF	Quality and Outcomes Framework
SLA	service-level agreement
SMR	structured medication review

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