Dementia: Reducing use of antipsychotics in patients with behavioural and psychological symptoms of dementia (BPSD)

National & London Context

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Defining dementia

The term dementia describes a set of symptoms including memory loss, mood changes, and problems with communication and reasoning.

Dementia is not a natural part of growing old. It is caused by diseases of the brain, the most common being Alzheimer’s.
The size of the challenge

The breakdown of the population with dementia across the UK.

**UK total**
800,000

- N. Ireland: 18,286
- England: 648,895
- Wales: 43,614

Dementia is most common in older people but younger people (under 65) can get it too.

- 40–64 years: 1 in 1,400
- 65–69 years: 1 in 100
- 70–79 years: 1 in 25
- 80+ years: 1 in 6

Two thirds of people with dementia are women

One in three people over 65 will develop dementia

Alzheimer’s Society, March, 2012
**Future projections**

The number of people in the UK with dementia will double in the next 40 years.

- **2012**: 800,000 people with dementia
- **2021**: 1,000,000 people with dementia
- **2051**: 1,700,000 people with dementia

[@Alzheimer’s Society](http://www.alzheimers.org.uk)
Future Projections of dementia - Graph

[Graph showing projected number of people with dementia by age group from 2005 to 2051.]

Professor Martin Knapp, Dementia UK (2007)
London context

- **64,600** people currently have dementia, with numbers set to rise by 16% from 2009 to 2021
- The rate of growth will then **double** in the following decade, as the population grows older
- Tower Hamlets, Brent and Greenwich will see **30%** increases by 2021
- Rates amongst BME groups set to **double** over next 12 years
Dementia; rising up the public agenda

• Pre 2007 – reports by National Audit Office, etc. highlighting the need for focused work on dementia
• February, 2009 – National Dementia Strategy published, jointly authored by Professor Sube Banerjee
• October, 2009 – Healthcare for London Dementia Services Guide published
• Operating Framework 2012/13 – Dementia included as an area requiring particular attention (10 clear action points)
• 26th March, 2012 – Prime Minister David Cameron announces “challenge on dementia”, to deliver major improvements in dementia care and research by 2015
• 26th July, 2012 - Dementia announced as one of the Mandated Strategic Clinical Networks of the National Commissioning Board (together with Mental Health and Neurological Conditions)

“So my argument today is that we’ve got to treat this like the national crisis it is. We need an all-out fight-back against this disease… “We did it with cancer in the 70s. With HIV in the 80s and 90s… Now we’ve got to do the same with dementia.”
London wide work on dementia – March 2011 – September, 2012

• NHS London - clinical team (5 GPs, 1 pharmacist, 1 lead acute trust nurse) working since March 2011:
  – Reducing antipsychotic prescribing
  – Improving quality of care in acute hospitals
  – Supporting improvements in commissioning
  – Improving diagnosis rates through improvements in coding
  – GPs working locally to improve dementia care
  – Developing joint working relationship with social care on a pan-London level
The use of antipsychotic medication for people with dementia:

Time for action

The report “Time for Action” by Professor Sube Banerjee highlighted the problem of overprescribing of antipsychotics in order to manage BPSD.

Ministerial Mandate to reduce this prescribing – Care Services Minister Paul Burstow committed to 66% reduction by late 2010; renewed in NHS Operating Framework 2012/13.

National project initiated to reduce prescribing.
Why is antipsychotic prescribing a problem? – The clinical evidence

• There are an estimated 180,000 people with dementia on antipsychotic drugs.
• In only about one third of these cases do the drugs have a beneficial effect.
• Estimated 1800 excess deaths and 1620 severe cerebrovascular adverse events per year from prescribing.
• Side-effects are common and can be severe ⇒ Sedation, extrapyramidal symptoms, worsening cognition, gait disturbance leading to falls/fractures and increased risk of stroke.

NICE Clinical Guideline 042 (2006)
Consider antipsychotics for non-cognitive symptoms only if there is severe distress and a risk of harm to the person or others.
Reducing antipsychotics for dementia patients in primary care

- Repeat prescriptions largely issued by GPs ⇒ GPs are the gatekeepers in the community
- Perceived barriers to discontinuation by GPs
  - Not enough information about target symptoms, monitoring & discontinuation criteria
  - Concerns regarding lack of specialist knowledge
  - Let sleeping dogs lie’ – concerns regarding problems upon discontinuation
  - Lack of continuity of care of these patients
  - Time constraints
<table>
<thead>
<tr>
<th>Percentages</th>
<th>Borough 1</th>
<th>Borough 2</th>
<th>Borough 3</th>
<th>Borough 4</th>
<th>Borough 5</th>
<th>Borough 6 (remaining practices completing this year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients on an antipsychotic*</td>
<td>10%</td>
<td>6%</td>
<td>6%</td>
<td>16%</td>
<td>13%</td>
<td>6%</td>
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<tr>
<td>Percentage of patients on an antipsychotic living in a care home</td>
<td>62%</td>
<td>74%</td>
<td></td>
<td>95%</td>
<td></td>
<td>Not advised</td>
</tr>
<tr>
<td>Percentage of patients noted as reason for prescribing being symptoms causing severe distress/risk of harm</td>
<td>81%</td>
<td>82%</td>
<td>100%</td>
<td>68%</td>
<td>84%</td>
<td>88%</td>
</tr>
<tr>
<td>Percentage of patients with medication initiated in secondary care</td>
<td>80%</td>
<td>79%</td>
<td>80%</td>
<td>63%</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>Percentage of patients with medication reviewed in the past 3 months</td>
<td>70%</td>
<td>84%</td>
<td></td>
<td>51%</td>
<td>35%</td>
<td>Not advised</td>
</tr>
</tbody>
</table>
Role of hospital pharmacists

- Highly regarded healthcare professional
- Multidisciplinary team
- Seeing and interacting with patients
- Role model
- Safety net
Important role of ward pharmacists in reducing AP prescribing

- **Need for review of APs before discharge and improved communication with GPs**
- **Full clinical reviews should be undertaken by geriatrician/neurologist or specialist liaison**
- **If patients are not under care of geri/neuro or liaison, review of prescriptions should be undertaken by ward pharmacist:**
  1. Highlighting that the patient is on antipsychotic/s and identifying the type of antipsychotic/s and dose
  2. Highlighting the timescale for review to the GP in accordance with NICE guidance
  3. Highlighting the DoH guidance "Optimising the care and treatment for people with dementia & NHS London guidance document; Guidance 1; Guidelines for discontinuation/reduction of antipsychotics in dementia patients in the community"
Holistic approach

“it is clear that it (antipsychotic prescribing) is a specific symptom of a general cumulative failure over the years in our health and social care systems to develop an effective response to the challenges posed by dementia”

(Professor Sube Banerjee, Time for Action, 2009; 2)
Acute Trust Training Programme

AIM: to strengthen the provision of dementia training across London’s hospitals in 2012/13

WHY? National Audit of Dementia:

• Less than a third of respondents in London said that their training and development in dementia care was sufficient.
• 48% of London staff felt they had not received sufficient training in communication skills specific to people with dementia.
• 54% felt they had not received sufficient training in dealing with challenging or aggressive behaviour.

WHAT HAVE WE DONE?

• Freely available interactive training resources developed for London acute trusts -25 modules
• 99 trainers undertaking “Train the Trainer” programme across all 27 London Acute Trusts that care for older people (including all specialist hospitals) and LAS
<table>
<thead>
<tr>
<th>Module</th>
<th>Title</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>THE EXPERIENCE OF DEMENTIA</td>
<td>30 minutes</td>
</tr>
<tr>
<td>1.2</td>
<td>SOME POSSIBLE DIFFICULTIES OF DEMENTIA AND YOUR CONTRIBUTION TO IMPROVING THE EXPERIENCE OF DEMENTIA</td>
<td>1 hour</td>
</tr>
<tr>
<td>1.3</td>
<td>COMMUNICATION WITH PEOPLE WITH DEMENTIA</td>
<td>1 hour</td>
</tr>
<tr>
<td>1.4</td>
<td>UNDERSTANDING THE INDIVIDUAL WITH DEMENTIA</td>
<td>45 minutes</td>
</tr>
<tr>
<td>1.5</td>
<td>FACTORS WHICH CAN CAUSE OR CONTRIBUTE TO DIFFICULTIES IN DEMENTIA</td>
<td>45 minutes</td>
</tr>
<tr>
<td>2.1</td>
<td>WHY FOCUS ON DEMENTIA?</td>
<td>30 minutes</td>
</tr>
<tr>
<td>2.2</td>
<td>MEDICATION AND DEMENTIA</td>
<td>30 minutes</td>
</tr>
<tr>
<td>2.3</td>
<td>GOOD PRACTICE IN ANTIPSYCHOTIC PRESCRIBING</td>
<td>1 hour</td>
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<tr>
<td>2.4</td>
<td>DELIRIUM</td>
<td>1 hour</td>
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<tr>
<td>2.5</td>
<td>MANAGING PAIN</td>
<td>1 hour</td>
</tr>
<tr>
<td>2.6</td>
<td>GOOD PRACTICE IN DEMENTIA DIAGNOSIS</td>
<td>45 minutes</td>
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<tr>
<td>3.1</td>
<td>BEHAVIOURS THAT CHALLENGE</td>
<td>1 hour</td>
</tr>
<tr>
<td>3.2</td>
<td>RESPONDING TO DIFFERENT REALITIES</td>
<td>1 hour</td>
</tr>
<tr>
<td>3.3</td>
<td>UNDERSTANDING AND RESPONDING TO BEHAVIOURS THAT CHALLENGE: AGGRESSION</td>
<td>1 hour</td>
</tr>
<tr>
<td>3.4</td>
<td>UNDERSTANDING AND RESPONDING TO BEHAVIOURS THAT CHALLENGE: WALKING</td>
<td>45 minutes</td>
</tr>
<tr>
<td>3.5</td>
<td>ASSESSING AND MANAGING RISK</td>
<td>30 minutes</td>
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<tr>
<td>4.1</td>
<td>EFFECTIVE DISCHARGE PLANNING FOR SOMEONE WITH DEMENTIA</td>
<td>30 minutes</td>
</tr>
<tr>
<td>4.2</td>
<td>END OF LIFE CARE FOR PEOPLE WITH DEMENTIA</td>
<td>1 hour</td>
</tr>
<tr>
<td>4.3</td>
<td>COMMUNICATION WITH FRIENDS AND FAMILY</td>
<td>30 minutes</td>
</tr>
<tr>
<td>4.4</td>
<td>PROMOTING MOBILITY</td>
<td>30 minutes</td>
</tr>
<tr>
<td>4.5</td>
<td>NUTRITION, HYDRATION AND DEMENTIA</td>
<td>1 hour</td>
</tr>
<tr>
<td>5.1</td>
<td>CORPORATE INDUCTION (CAN BE USED FOR CQUIN)</td>
<td>1 hour</td>
</tr>
<tr>
<td>5.2</td>
<td>TRAINING SESSION NON CLINICAL STAFF (CAN BE USED FOR CQUIN)</td>
<td>30 minutes</td>
</tr>
<tr>
<td>5.3</td>
<td>1-HOUR SESSION FOR DOCTORS: KEY ISSUES IN DEMENTIA CARE IN THE ACUTE HOSPITAL (CAN BE USED FOR CQUIN)</td>
<td>1 hour</td>
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Workstreams 2012/13

1. Finalising antipsychotic reductions work
2. Continuing to develop acute hospital network and maximise legacy of training project
3. Raising diagnosis rates through improving coding
4. Strengthening commissioning for dementia
5. Community Services Train the Trainer and network development
6. GP Dementia Leadership Development Programme
7. Knowledge and skills framework for GPs with extended roles in dementia (follow on from GPwSI)
8. Updating Dementia Needs Assessment to support CCGs
9. Supporting work of Integrated Commissioning Network
QUESTIONS?