PANEL

Beyond Pills:
Tackling polypharmacy in an ageing population

whole-person health CONFERENCE 26







Chair: **Dr Simon Opher**
GP / Labour MP - Stroud / UK

Dr Lucy Pollock
Geriatrician / Author / UK

Dr Hussain Al-Zubaidi
Lifestyle GP / TV Doctor / Public Speaker / Health Coach / Personal Trainer / Triathlete / UK

Prof Deborah Swinglehurst
Professor of Primary Care, Wolfson Institute of Population Health, Queen Mary University of London / UK

Dr Bogdan Chiva Giurca
Clinical and Global Lead, College of Medicine / UK

Clare Howard
Pharmacist / Clinical Lead, Medicines Optimisation, Health Innovation Wessex / UK

Dr Sion Scott
Associate Professor - Behavioural and Implementation Sciences, University of East Anglia / Pharmacist, Norfolk and Norwich University Hospitals NHS Foundation Trust, UK

BEYOND PILLS

COLLEGE OF MEDICINE BEYOND PILLS 2026

Panel discussion:

Tackling Polypharmacy in an Ageing Population

#beyondpills #polypharmacy
#ipmcongress2026 #collegeofmedicine

BEYOND PILLS

Chair: Dr Simon Opher MP

Chair of the Beyond Pills All-Party Parliamentary Group

Polypharmacy in an ageing population

A public health emergency

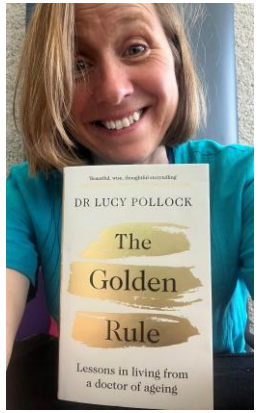
Dr Lucy Pollock

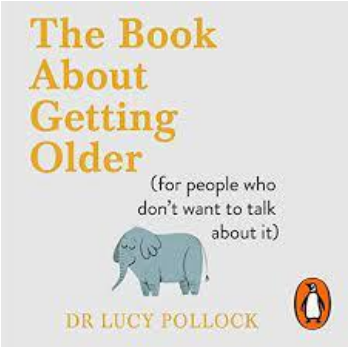
Consultant Geriatrician, Somerset Foundation Trust

I have the following interest or relationship/s to disclose regarding the subject matter of this presentation:

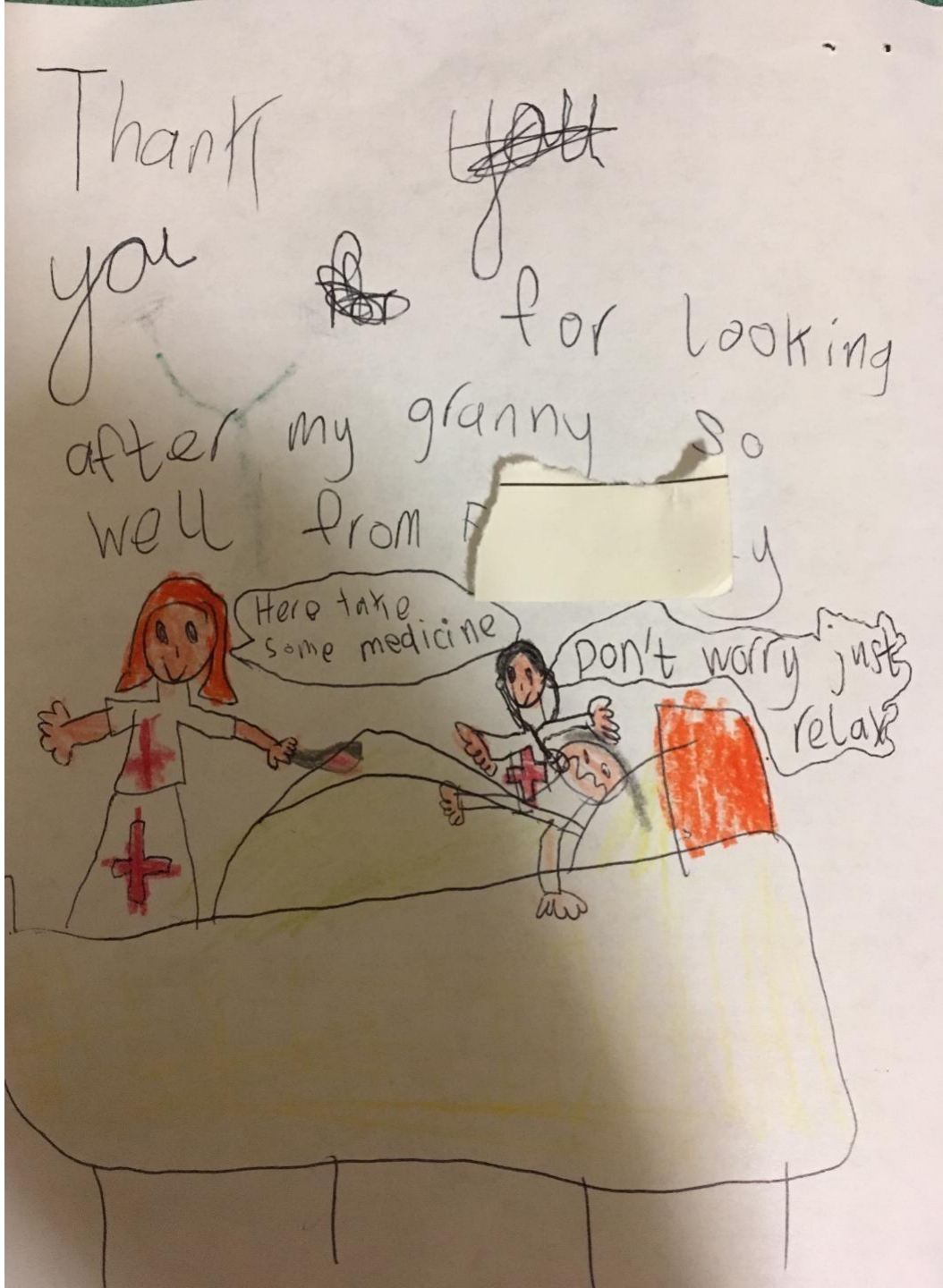
I'm an NHS doctor and have no private practice

I'm a patron of Age UK Somerset and an honorary member of the National Federation of Women's Institutes





The number of people in England taking 10 or more medications has grown, exceeding 1.1 million in January 2025



Medication-related admissions account for

10-20%

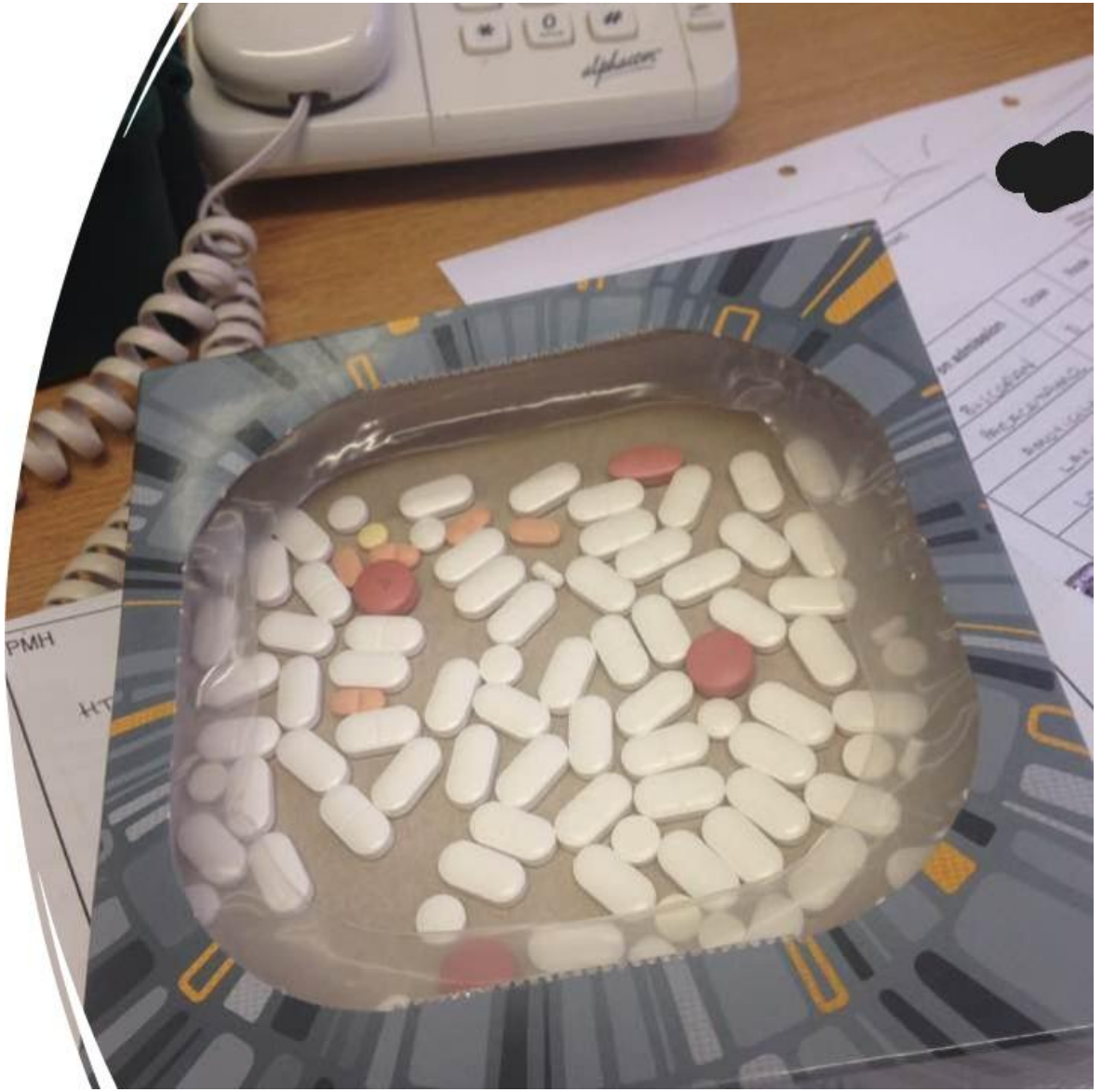
of admissions of people over 65

[Polypharmacy: Getting our medicines right (rpharms.com)]

[Good for you, good for us, good for everybody: a plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions]

- 1 in 10 readmissions are also medication-related

- Prevalence of and Risk Factors for Drug-Related Readmissions in Older Adults: A Systematic Review and Meta-Analysis | Drugs & Aging (springer.com)

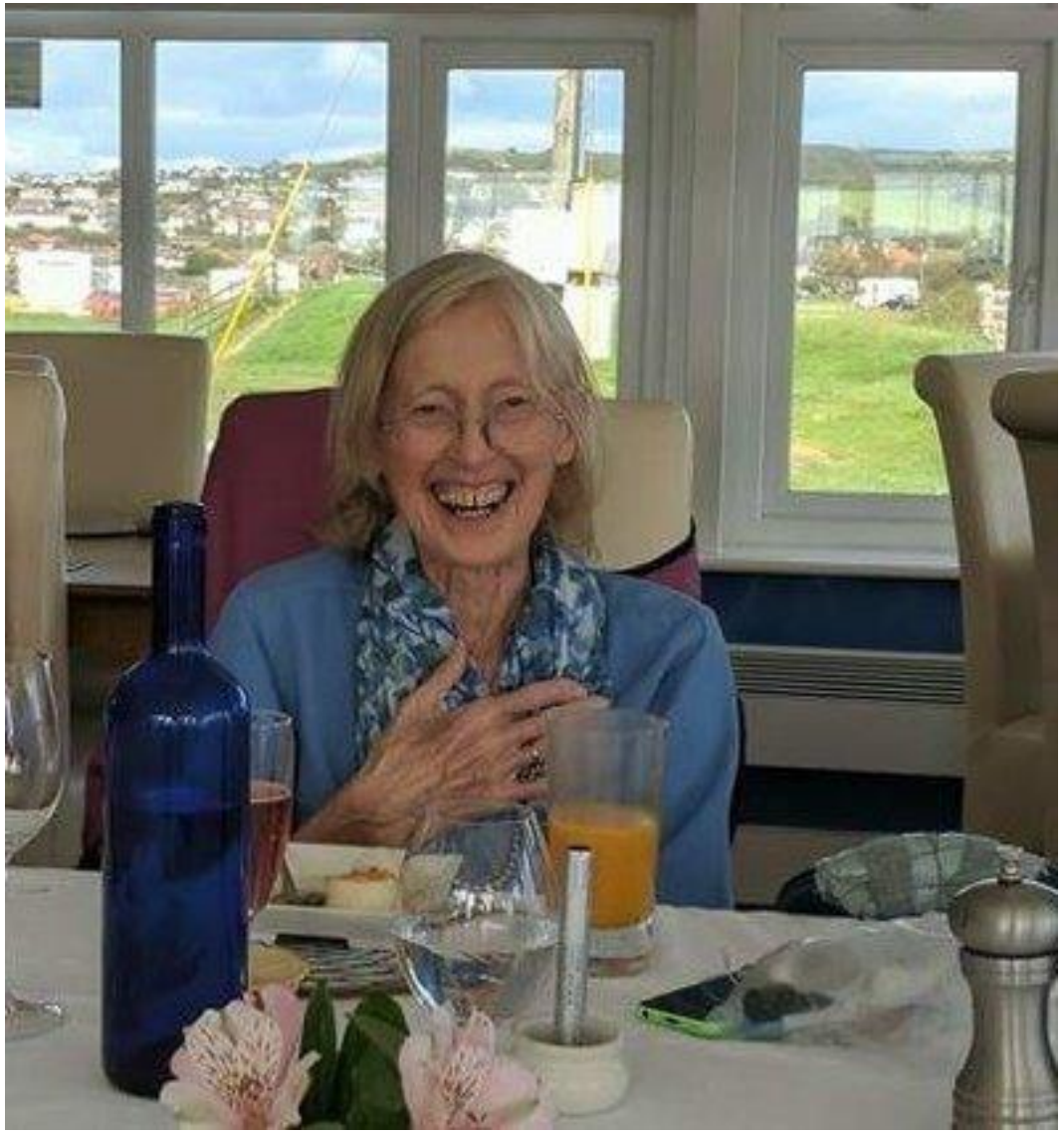


Older people with frailty deserve access to effective medicines

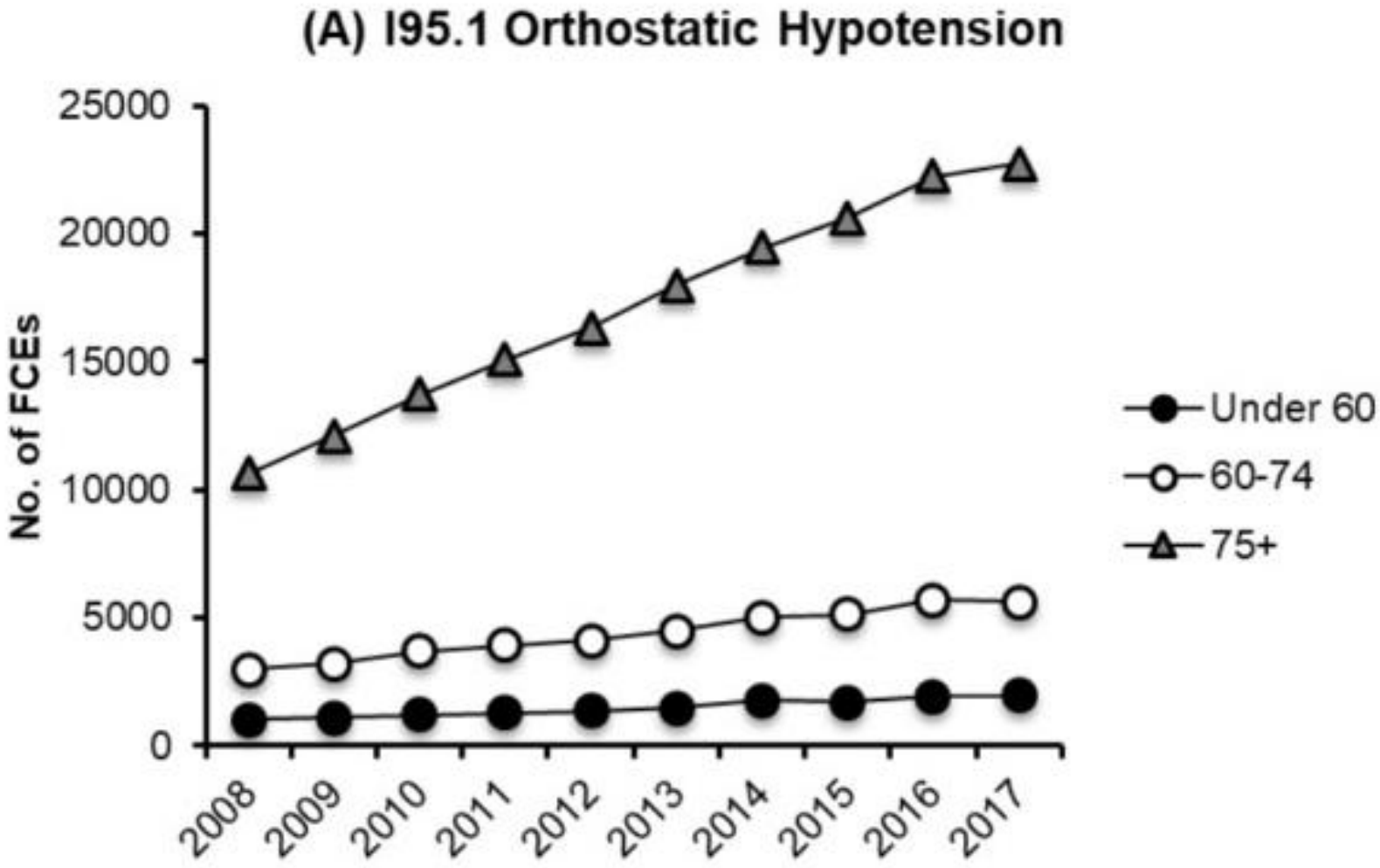
But they are more prone to adverse drug reactions

And these ADRs have more significant consequences

National Surveillance of Emergency Department Visits for Outpatient Adverse Drug Events | Clinical Pharmacy and Pharmacology | JAMA | JAMA Network



- [Admissions for orthostatic hypotension: an analysis of NHS England Hospital Episode Statistics data - PMC]



Hidden harms of polypharmacy – many examples eg

Bladder anticholinergic drug use is associated with a 10-20% increase in incidence of dementia

[Risk of dementia associated with bladder anticholinergic drugs: a case-control study of older adults in UK primary care – PMC]

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

The Evidence Gap

Older people with moderate/ severe frailty tend not to be represented in trials

A serious issue with how frailty is measured in trials:
How to make a validated Frailty Index

Choose some variables (bad things) eg 36 across different domains

Add up how many variables your patient has eg 12

Divide patient's variables by total variables eg 12/36 =0.33

Check that your FI predicts bad stuff: mortality, hospital or care home admission, new home care package

Variables included in validated indices eg eFI2: polypharmacy, cognitive decline, needing care, falls, poor mobility etc

Frailty Indices used in drug trials ignore key deficits

People with ‘most severe frailty’ in drug trials are NOT the people with most severe frailty IRL

Extrapolating data from one population to another is a high-risk activity

Comorbidities	
5	Myocardial infarction
6	PCI or CABG
7	Unstable angina pectoris
8	Peripheral artery disease
9	Atrial fibrillation/flutter*
10	Left bundle branch block
11	Pacemaker

31	Bilirubin, mg/dL
32	Alkaline phosphatase, U/L

35	Total cholesterol, mmol/L
36	HDL cholesterol, mmol/L

Medication related harm

Limited evidence base

Burden of medicines management for patients and families/carers

Poor understanding by medics and patients of how well medicines work

Not meeting patients' individual goals

Costs and waste –unwanted/ unhelpful/untrusted meds

1 in 4 patients not taking meds as prescribed 'Show me your meds, please': the impact of home-based medicines assessments - The Pharmaceutical Journal

Environmental damage

And now for the good news!

Somerset ageUK

Health Innovation Network
Local change, national impact

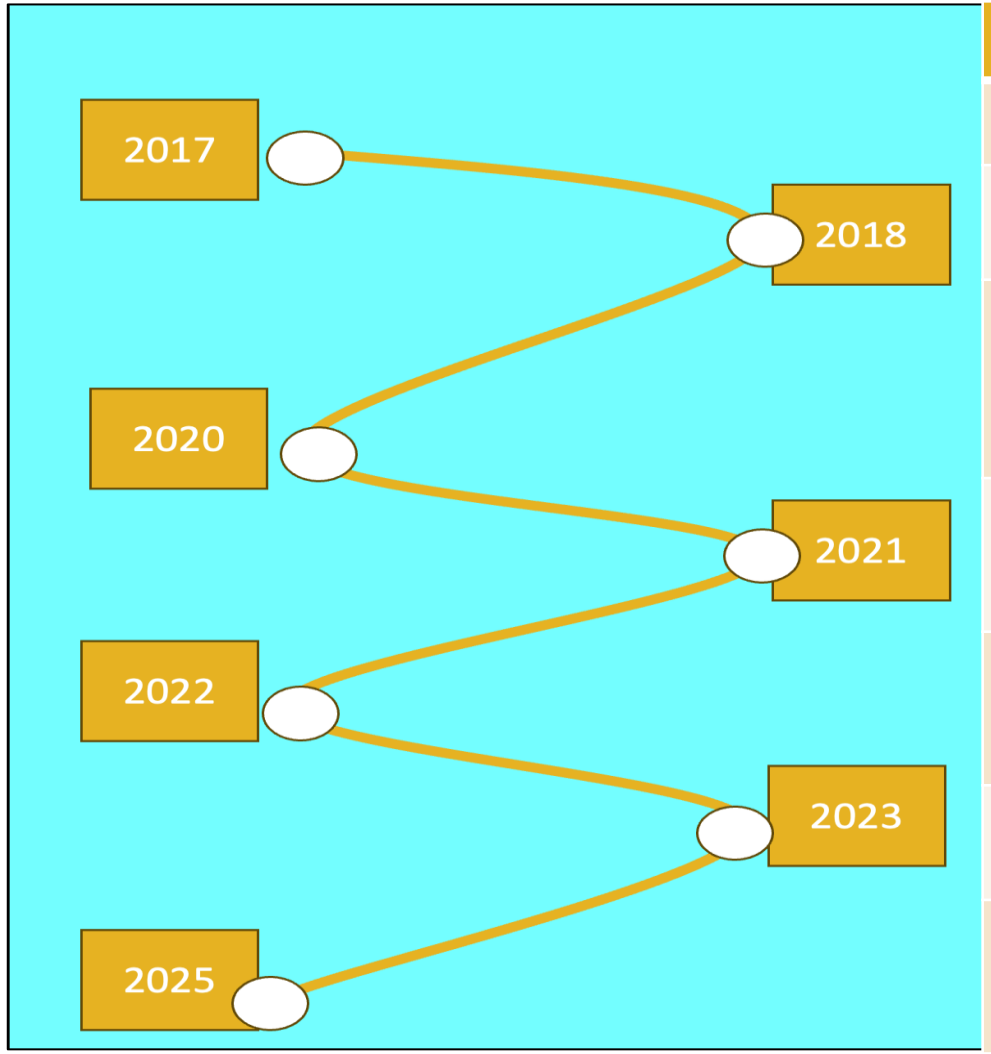
Preventing Problematic Polypharmacy
Getting the balance right in frail and older people

Preventing Problematic Polypharmacy: Getting the balance right in frail and older people

Health Innovation Network

Clare Howard FFRPS FRPharmS, Clinical Lead

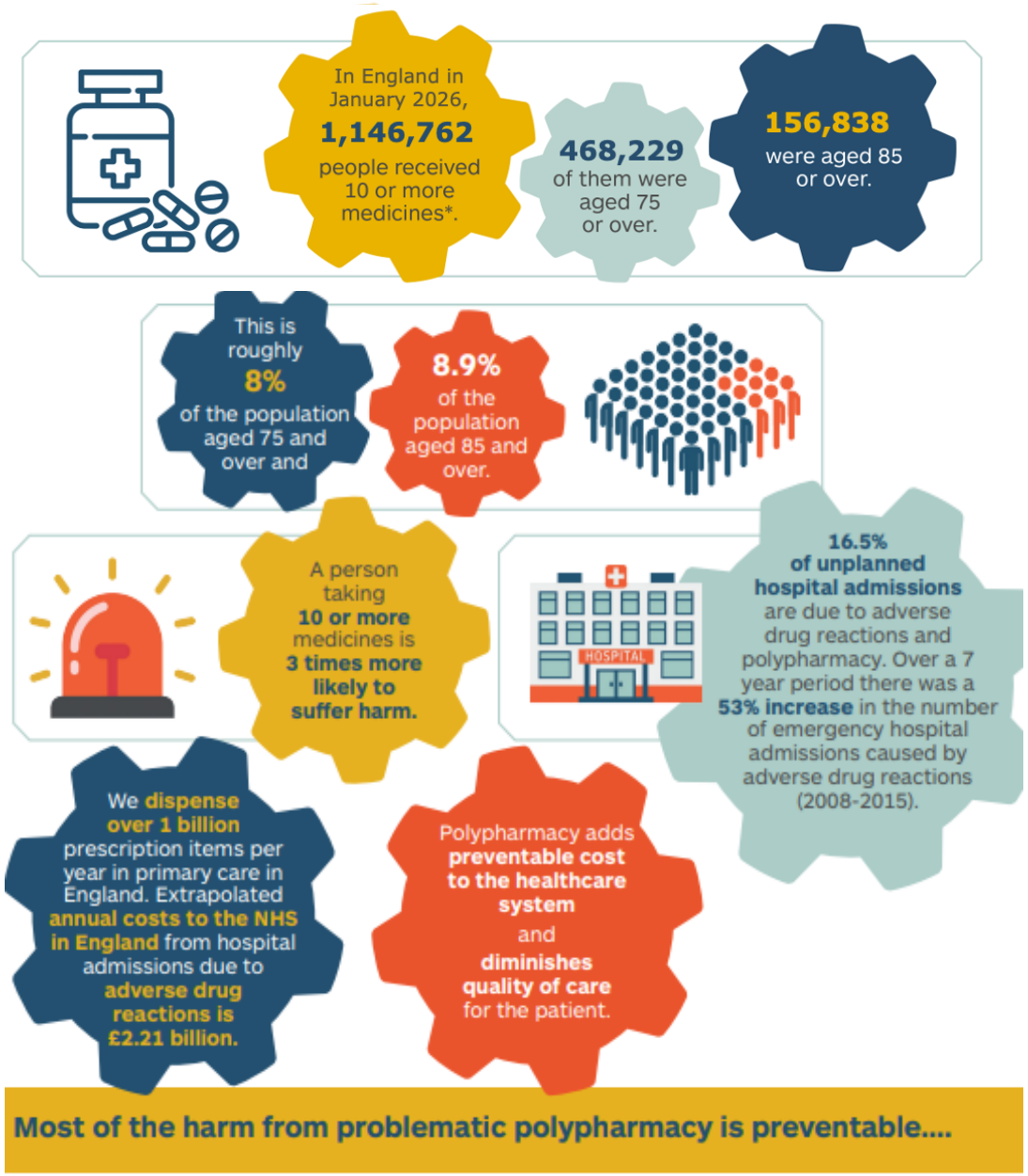
The Polypharmacy Programme Journey

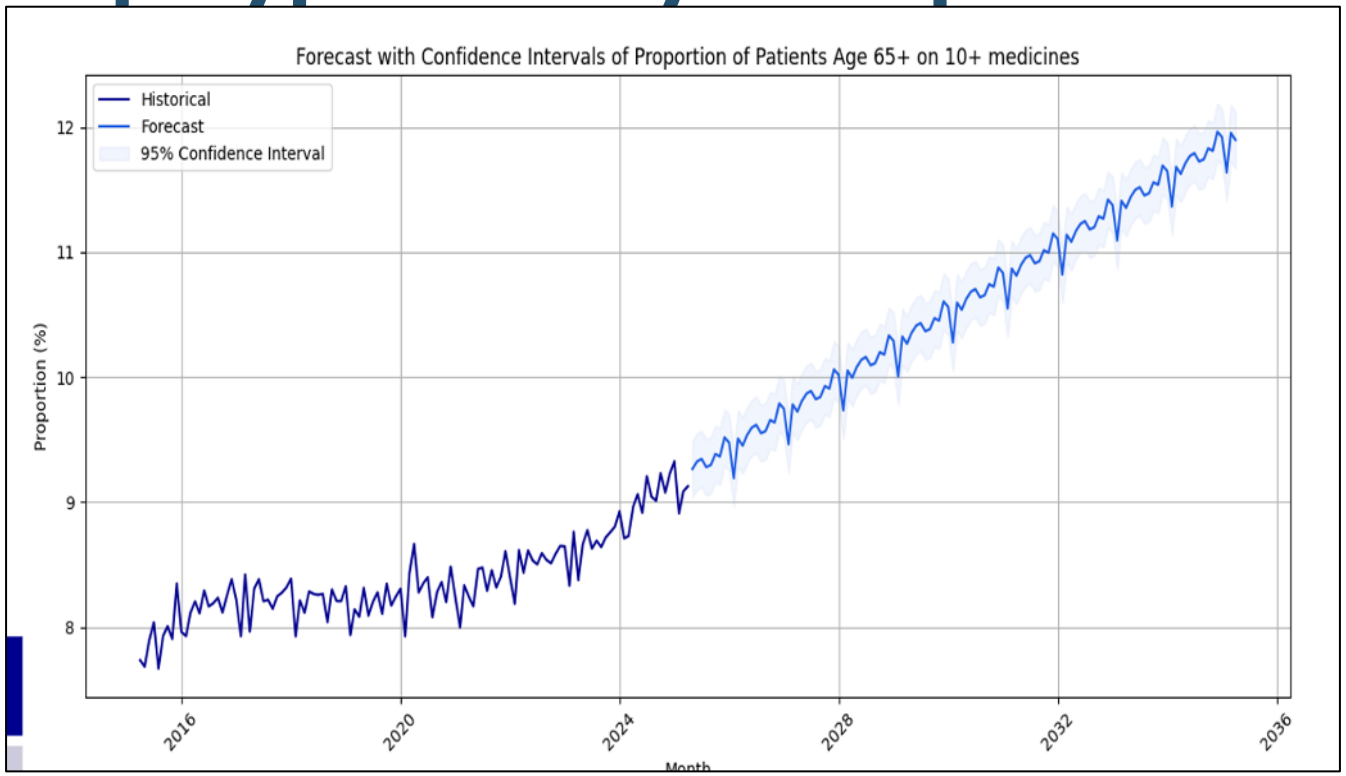


Year	Activity
2017	Publish NHS BSA Polypharmacy Prescribing Comparators
2018	Adapt Health Foundation model: 2 pilots **POLYPHARMACY ACTION LEARNING SET** cohorts in Southampton.
2019	Review and retest: 2 cohorts in Dorset University of Southampton Evaluation NHS BSA polypharmacy comparators win HSJ award for patient safety.
2020	HEE South fund 9 cohorts across Wessex, Oxford, Southwest and West of England. COVID-19 move to virtual delivery.
2021	6 virtual cohorts: feedback shows positivity and outcomes maintained. Harder to deliver for facilitators but reach increased.
2022	HIN National Polypharmacy Programme: scale up ALS Findings published in *BMC Medical Education 2022*
2023	Develop and test the SMR patient facing materials. Publish Polypharmacy ALS 5 Year Synopsis and present at the BGS conference.
2024/5	Scale it all up nationally Publish The Mechanics of Tackling Overprescribing and Problematic Polypharmacy. Publish final programme evaluation

Health Innovation Wessex

Why addressing problematic polypharmacy is important



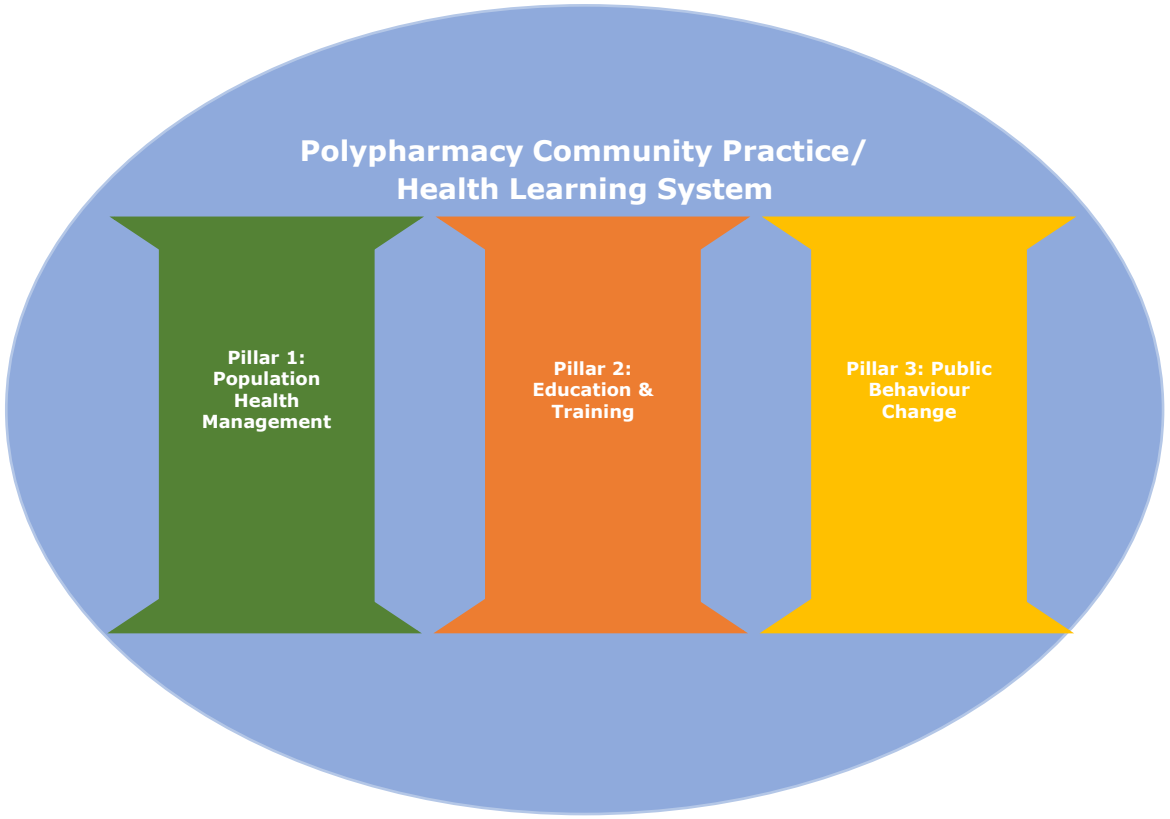


- Data from the NHS BSA Polypharmacy Prescribing Comparators for March 2025 - **718,577 patients aged 65** and over were identified to be prescribed 10 or more medicines, equal to 9.1% of the population.
- If the current trend continues, an estimated **1,148,279 patients aged 65 and over will be prescribed 10 or more medicines by 2036**, an additional 415,722 patients.
- Current studies suggest that this might drive an additional **77.7k unplanned hospital admissions (adults) annually**.

The HIN Polypharmacy Programme: Getting the Balance Right

Launched April 2022 – September 2025

The core principle of **Polypharmacy** is to support local systems address problematic polypharmacy through setting up local learning systems and adoption of a 'three pillar' approach:



Pillar 1: Population Health Management

Using data (NHS BSA Polypharmacy Comparators) to understand PCN risks and identify patients for prioritisation for a Structured Medication Review

Pillar 2: Education & Training

Running local **Polypharmacy** Action Learning Sets (ALSs) to upskill the primary care workforce to be more confident about stopping unnecessary medicines. ALS model originally developed and piloted by HI Wessex and supported by Health Education England (HEE)

Delivery of local education and learning through our Polypharmacy Train the Trainer Model.

Pillar 3: Public Behaviour Change

Pilot and roll out of public-facing campaigns to change public perceptions of a "pill for every ill" and encourage patients to open up about medicines. e.g., Me + My Medicines, Are Your Medicines Working For You?

Programme delivery impact (Sept 2025)

Polypharmacy: getting the balance right

All 42 ICBs engaged in all or part of the programme

124 Communities of Practice attended by **3,954** stakeholders

21 ICBs show evidence of a **decline or flattening of the 'line'** in 1 or more of the NHSBSA therapeutic polypharmacy prescribing comparators locally *(against baseline forecast data)*

1,535 stakeholders attended **18 NHSBSA Polypharmacy Prescribing Comparators: Understanding the Data webinars**

12,891 completed **polypharmacy education and learning.**
1,397 completed **National Polypharmacy Action Learning Set** training
4,630 participated in **local education events** facilitated by **40 regional polypharmacy educators** accredited through HIN Polypharmacy Train the Trainer programme
6,901 participated in **HIN National Polypharmacy Masterclass Series** (**8** Webinars)
59 Junior prescribers piloted HI Wessex **Action Learning Set Foundation** course

9,621 downloaded **HIN Patients Structured Medication Review resources** to support better conversations about medicines. **21.6K views**

CORE20 PLUS 5

Health & Justice Prescribers Action Learning Set Pilot and **Learning Report**
Improving access to SMRs in seldom-heard communities 27 PCNs funded + Evaluation
Patient resources translated into 12 community languages including **Easy Read** and **Audio**

Economic Impact & ROI of SMRs: ISYMPATHY Project

iSIMPATHY Evaluation Report

Table 15: Summary of costs and benefits per 100 cases

Summary costs, cost avoidance and patient benefits (numbers / '£) for one year per 100 cases in each region	Region				Total / Average
	ROI		NI	Scotland	
Staff cost for 100 cases, excl. data collection		-£12,400 (-€14,526)	-£3,200 (-€3,748)	-£6,700 (-€7,848)	-£7,500 (-€8,785)
Staff cost for 100 cases, incl. data collection		-£13,500 (-€15,812)	-£4,000 (-€4,685)	-£7,900 (-€9,254)	-£8,500 (-€9,956)
Net medication change: total cost reduction / increase (100 cases)		£24,700 (€28,927)	£0	£14,400 (€16,863)	£13,000 (€15,223)
Bottom-up: Eadon score avoided cost, QALY gain					
Total QALY gain (100 cases)		7.0	7.8	8.3	7.4
Monetary equivalent of QALY gain (£ per QALY)	£15,000	£105,000 (€122,955)	£116,900 (€136,890)	£124,500 (€145,790)	£111,200 (€130,215)
	£70,000[1]	£489,800 (€573,854)	£545,600 (€638,923)	£581,200 (€680,646)	£518,900 (€607,686)
Healthcare resource cost avoidance (100 cases)		£172,300 (€201,779)	£176,600 (€206,802)	£146,600 (€171,672)	£168,800 (€197,669)
Top-down: avoided admissions					
ADR admissions avoidable by 100 med reviews		0.9	1.1	0.8	0.9
Inpatient bed days avoidable by 100 med reviews		7.1	9.6	8.3	8.1
Inpatient cost avoidance (100 cases)		£5,900 (€6,909)	£8,100 (€9,485)	£6,100 (€7,143)	£6,600 (€7,729)
	[1] The Green Book 2022 gov.uk[80]				

The data here clearly illustrates the benefits to the patients and across the whole health and care system of undertaking the reviews.

Economic savings: Per 100 cases (SMRs):

- healthcare utiisation: £169K
- 0.9 avoided admissions
- 8 days avoided inpatient costs
- £13,000 direct medicines savings costs.

SMR medicines cost saving per person: £131.

iSYMPATHY study estimates

£36 million cost savings for Scotland if SMRs provided to all patients 65 years and over on 5 or more medicines .

Interventions costs £7,500 per 100 cases.

READ THE FULL ECONOMIC BREAKDOWN: Appendix D: Health Economics Analysis of Polypharmacy Reviews | Right Decisions

Since the ALS, I have been more proactive around inappropriate medications and negotiated more with the patient.

Pharmacist, Cohort 14

I found the group discussions where we discussed actual cases particularly helpful. Getting support on my own cases and also hearing how others have managed theirs. [It was] also reassuring to know that many of the reasons I struggle.

Pharmacist cohort 12

58% made changes to their practice around decision making with colleagues. 42% intended to make relevant changes in future.

- **Increased shared decision-making** involving clinical colleagues and MDT meetings.
- **Increased confidence to deprescribe**, and to talk to colleagues openly about deprescribing.
- **Sharing learning using ALS resources** and delivering targeted education session to colleagues.
- Undertaking QI projects, utilising data and systems (such as EPACT2) to help identify priority patients.
- Applying **evidence based practices to aid decision making** e.g. use of tools and medicolegal processes.
- **Actively stopping or reducing medications**, e.g. diuretics, laxatives, creams, sleep aids, Cetirizine and Fesoterodine, Statins, Aspirins, and Opioids.

I have found the Geriatrician view point invaluable, reinforcing that every patient is an individual and guidelines are exactly what they say – 'guidelines' rather than tramways.

Pharmacist, Cohort 6

The course has given me more confidence to stand my ground. Confidence to individualise treatment, to step outside what might be standard practise.

GP, South London

This will change my practice more than any learning event I have ever done.

GP, Cohort 18

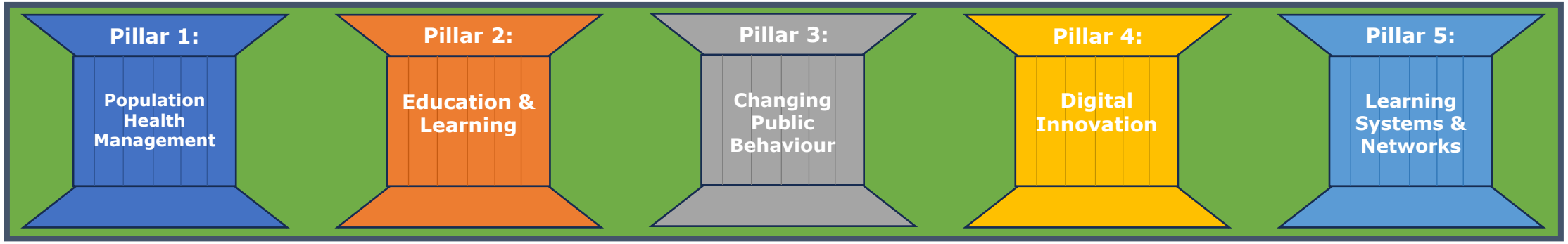
Attending the polypharmacy ALS has reignited my passion for doing good medicine in older people.

GP Cohort 24

Phase 2 Programme (2026/2027)

Preventing Problematic Polypharmacy
Getting the balance right in older people and those with frailty

The core principle the programme is to support local systems address problematic polypharmacy through setting up local learning systems and adoption of a 'five pillar' approach underpinned by policy and guidance:



Pillar 1: Population Health Management

Using data (NHS BSA Polypharmacy Comparators) to understand PCN risks and identify patients for prioritisation for a Structured Medication Review. Using data (NHSBSA Oversupply Dashboard) and the RCGP RPS Repeat Prescribing Toolkit to improve the safety and efficiency of repeat prescribing processes

Pillar 2: Education & Learning

Delivery of **Polypharmacy Action Learning Sets (ALSs)** and **Masterclasses** to upskill the primary care workforce to be more confident about stopping unnecessary medicines. Optional local education and learning offers led by regional teams. In Year 2 a focus on educational offers to secondary care and community pharmacy.

Pillar 3: Changing Public Behaviour

Embedding our co-designed suite of patient resources to prepare and support patients attending Structured Medication Reviews in primary care systems and the NHS App. Working with VCSE on a public awareness campaign.

Pillar 4: Digital Innovation

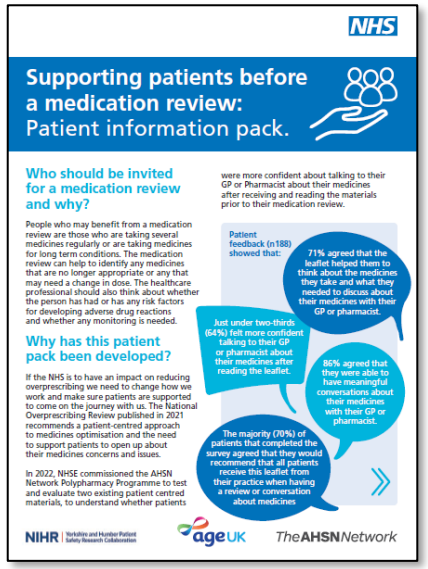
Identification of digital, AI, and technology solutions that help tackle problematic polypharmacy by using horizon scanning and innovator calls to showcase robust products to primary and secondary care.

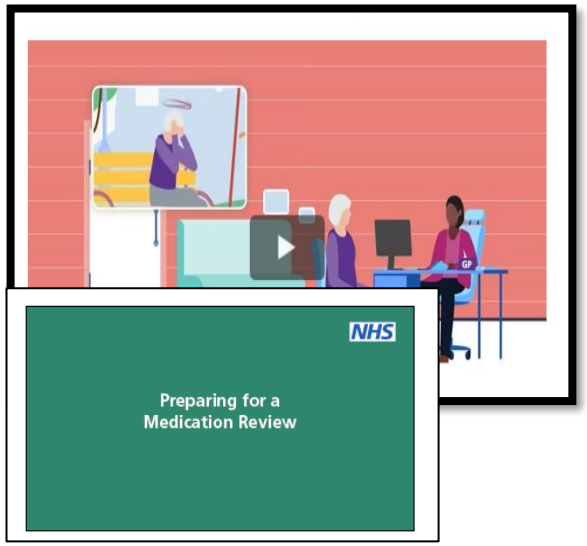
Pillar 5: Learning Systems & Networks

A national and international learning ecosystem that strengthens shared learning on preventing problematic polypharmacy, from ICB-led learning systems and national networks to global partnerships that scale our work and generate new opportunities.

NHS branded and fully evaluated resources to help patients think about their medicines and to prepare for a Structured Medication Review.

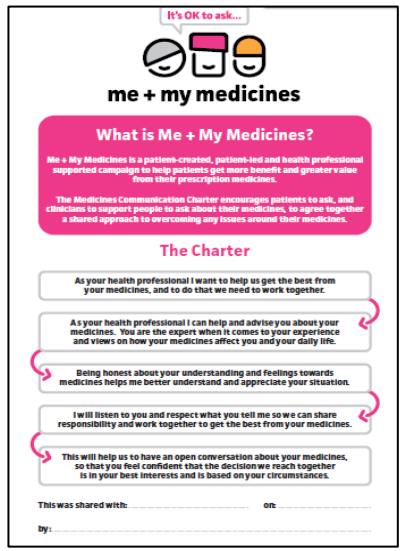
Shown to be effective especially in vulnerable patient groups

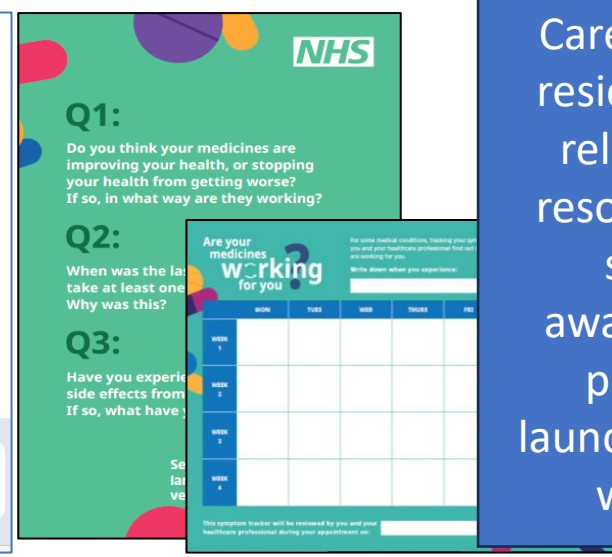




Available languages

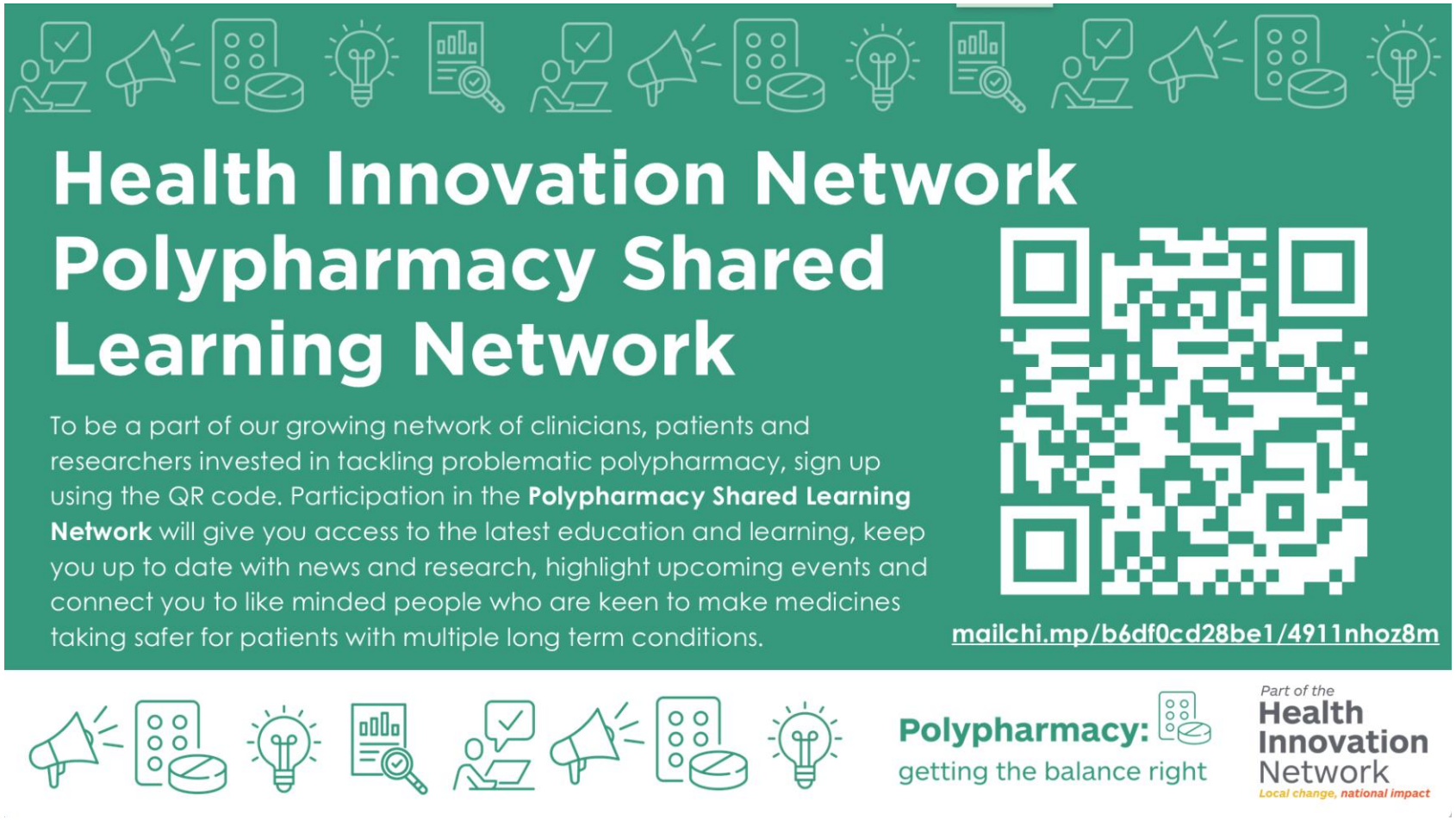
- English
- Arabic
- Bengali
- Chinese Traditional
- Chinese Simplified
- Gujarati
- Polish
- Punjabi Gurmukhi
- Punjabi Shanmukhi
- Romanian
- Urdu
- Somali





Care Home residents & relatives' resources + staff awareness poster launched last week

Polypharmacy Shared Learning Network



Queen Mary University of London
Medicine and Dentistry

Funded by NIHR | National Institute for Health and Care Research

Funded by barts CHARITY

Let's Talk Differently About Medicines:

empowering patients and public to address polypharmacy

Professor Deborah Swinglehurst

Wolfson Institute of Population Health, Queen Mary University of London.

d.swinglehurst@qmul.ac.uk

medicinestalk.co.uk

June 2026

Polypharmacy: What's the Problem?

Illustrations: Camille Aubrey

- Global patient safety concern
- An ESCALATING problem
- Older people at high risk
  - >1/3 of over-80s on 8+ medicines
- Many prescribed medicines not taken
- Carbon 'hotspot'
- Overprescribing (10%; £300m)

Let’s Talk Differently About Medicines

“Improving quality of life in older age sometimes means less medicine, not more. It is essential that all patients, but especially those in later old age, are able to have realistic discussions with their doctors”

Chris Whitty, CMO report 2023

How was *Let's Talk Differently About Medicines* developed?

Patients' homes

RD2 0405

NHS

REPEAT DISPENSING

A new way to get repeat prescriptions

Do you get the same medicines regularly? Do you often use the same pharmacy?

Would you like to get your repeat prescriptions direct from your pharmacy, rather than getting them from the surgery each time?

See inside for more informa
repeat dispensing and how i
you.

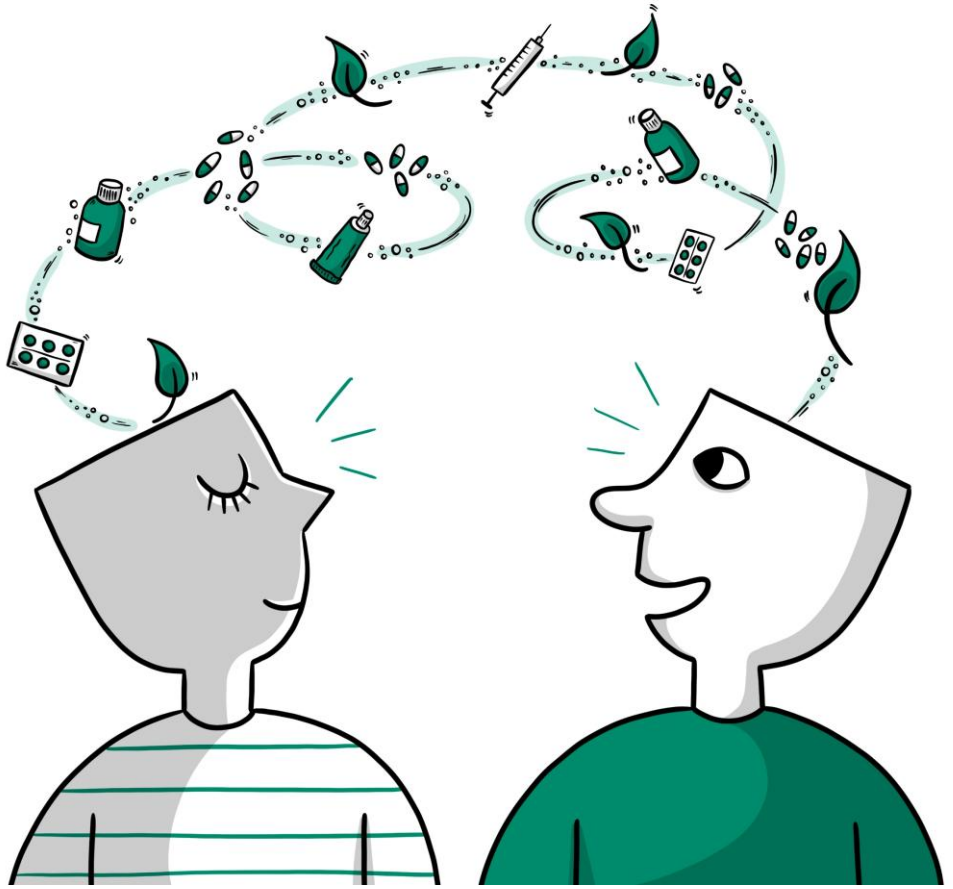
NHS

Electronic Prescription Service

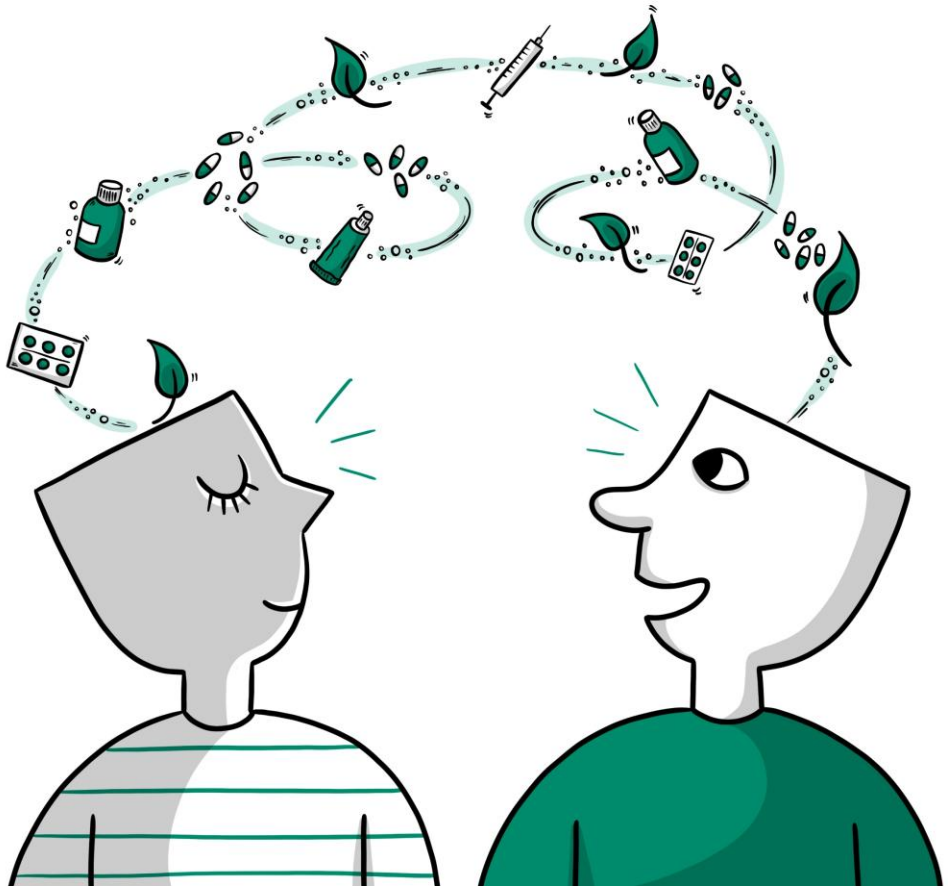
General Practice

Community pharmacy

Polypharmacy is difficult to talk about



Illustrations: Camille Aubrey



Illustrations: Camille Aubrey

Polypharmacy really IS difficult to talk about


STORY 2
STORY 4
'KEEPING GO
A HELP OR A
STORY 5
I LOOK AF
STORY 6
IS THERE ANYT
LET'S
TALK
DIFFER
ABOUT
MEDICI


LET'S
DIFFERENT
ABOUT
MEDICINES

LET'S TALK DIFFERENTLY ABOUT MEDICINES

Are you Based in North East London?

Are you over 65?

Are you prescribed medicines or caring for someone who is?

As people age, they can be prescribed more and more medicines. If this sounds like you, you are not alone. Many others are in your position and it's not something we often talk about, is it?

We want everyone to have better conversations with healthcare professionals about their medicines and regularly review what medicines are right for us.

GET INVOLVED

We are inviting you to a free workshop to look at what others have done and hear about your situation.

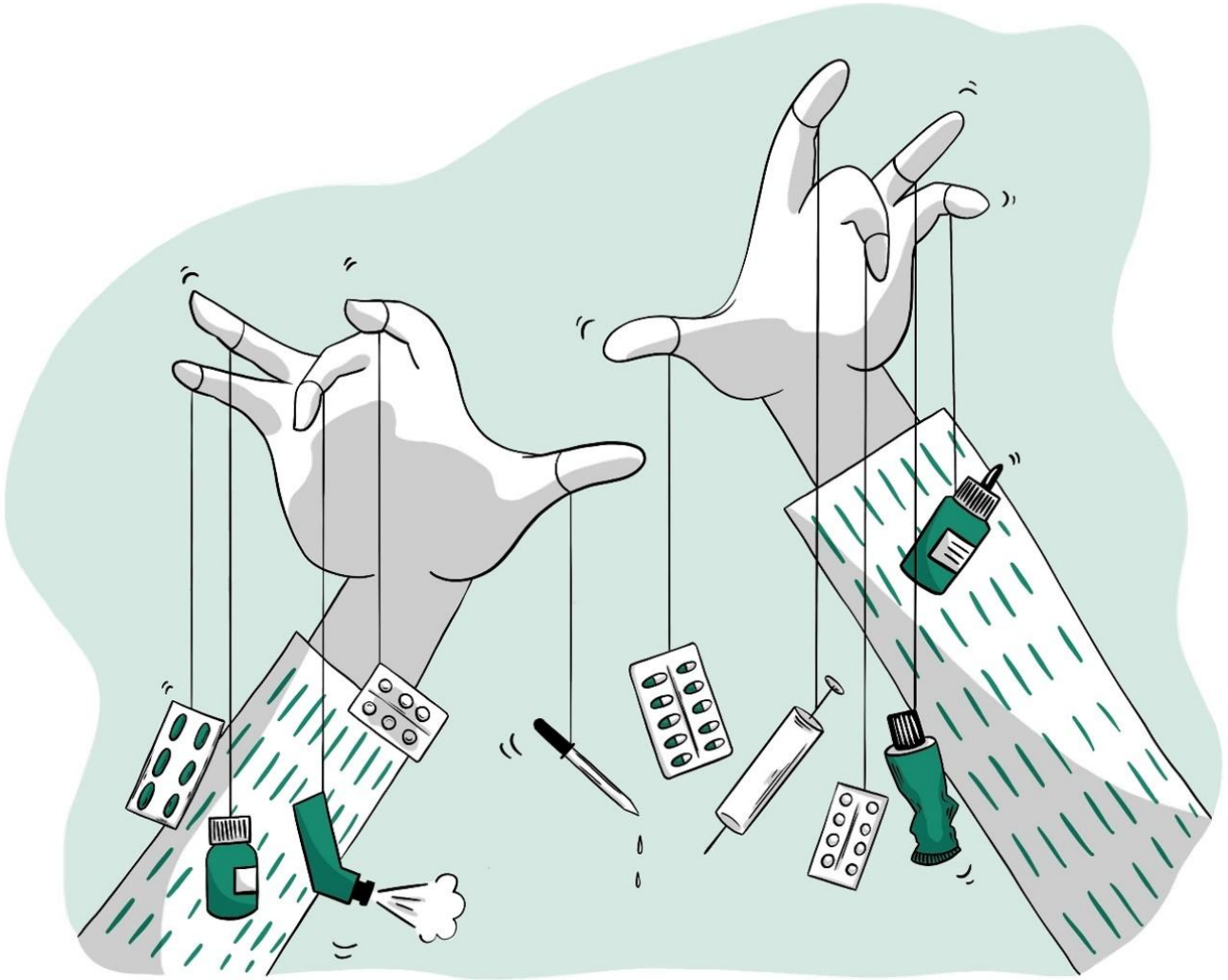
Date and time:
Thursday 22nd May 2025
10.30am – 12.30pm

Location:
Carecity, 50 Cambridge Road, Barking IG11 8FG

To book a place:
www.carecity.org/participate,
scan the QR code,
email: theteam@carecity.org
or call 020 8064 1996.

carecity.org

Care City



Care City

Illustrations: Camille Aubrey

medicinestalk.co.uk

Thank you

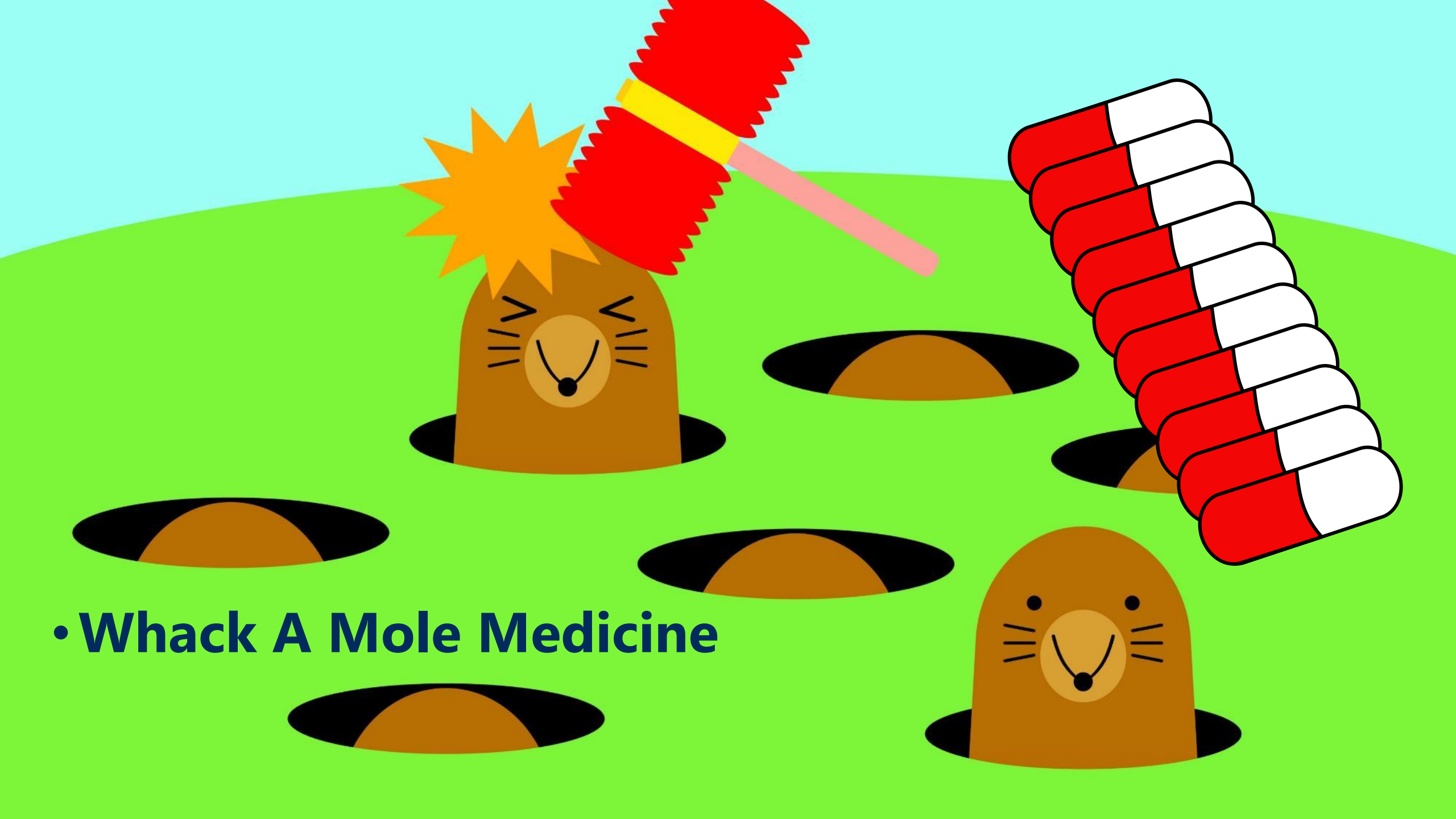
Queen Mary
University of London
Medicine and Dentistry

•Lifestyle Medicine in Primary Care

Dr Hussain Al-Zubaidi
@irondoctorhaz

• Headlines:

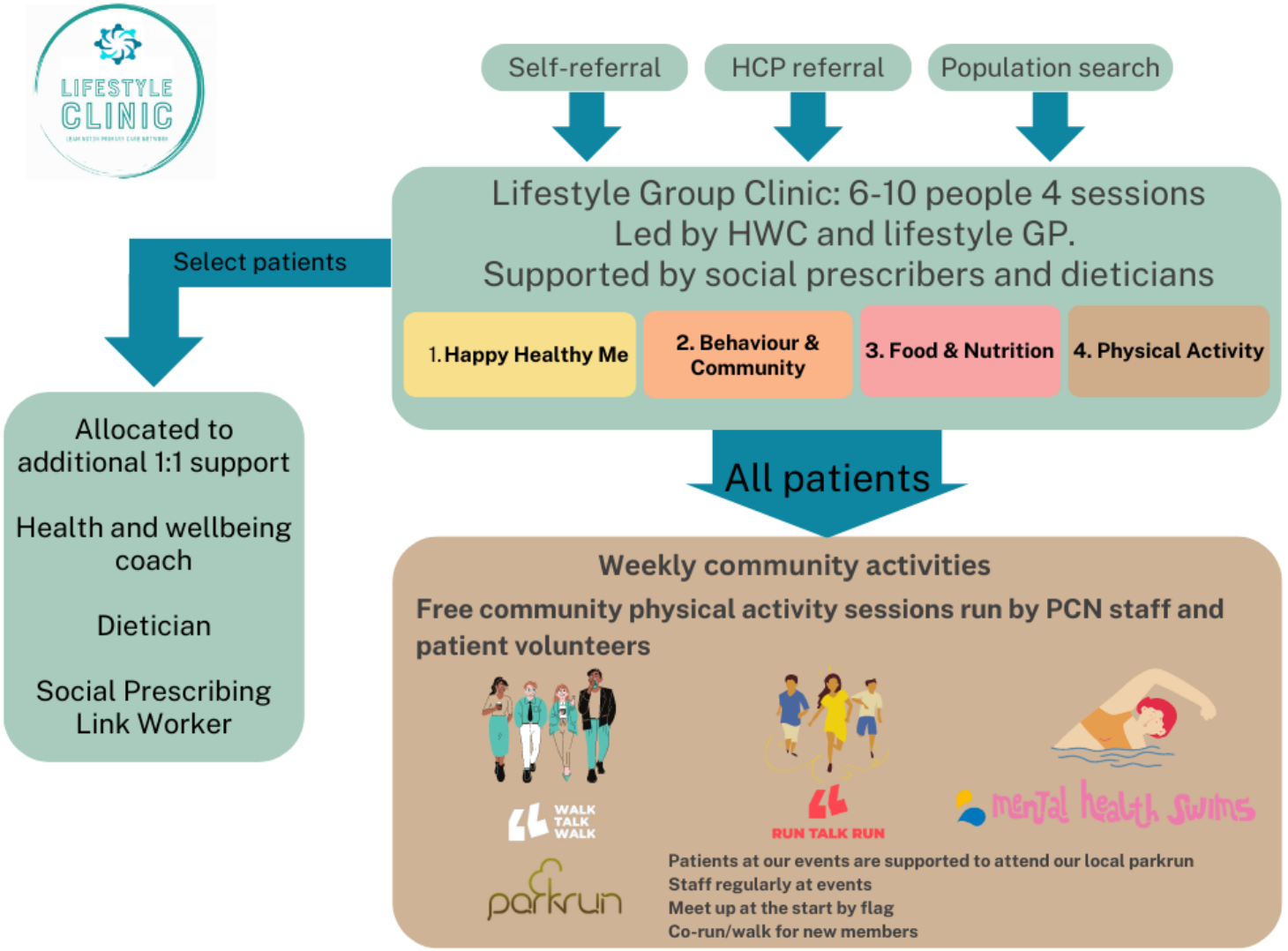
- In the UK, 75% of people over 75y have more than one long-term health condition
- 11% of unplanned admissions to hospital are a result of harms from medication – and 70% of these are in older people on multiple medications
- Only 50% of medications are taken as prescribed, and this costs the UK £200million a year (2007 data)
- For healthcare professionals and patients to feel confident when deprescribing/overprescribing they need **knowledge, confidence** and **skills** to consider alternatives

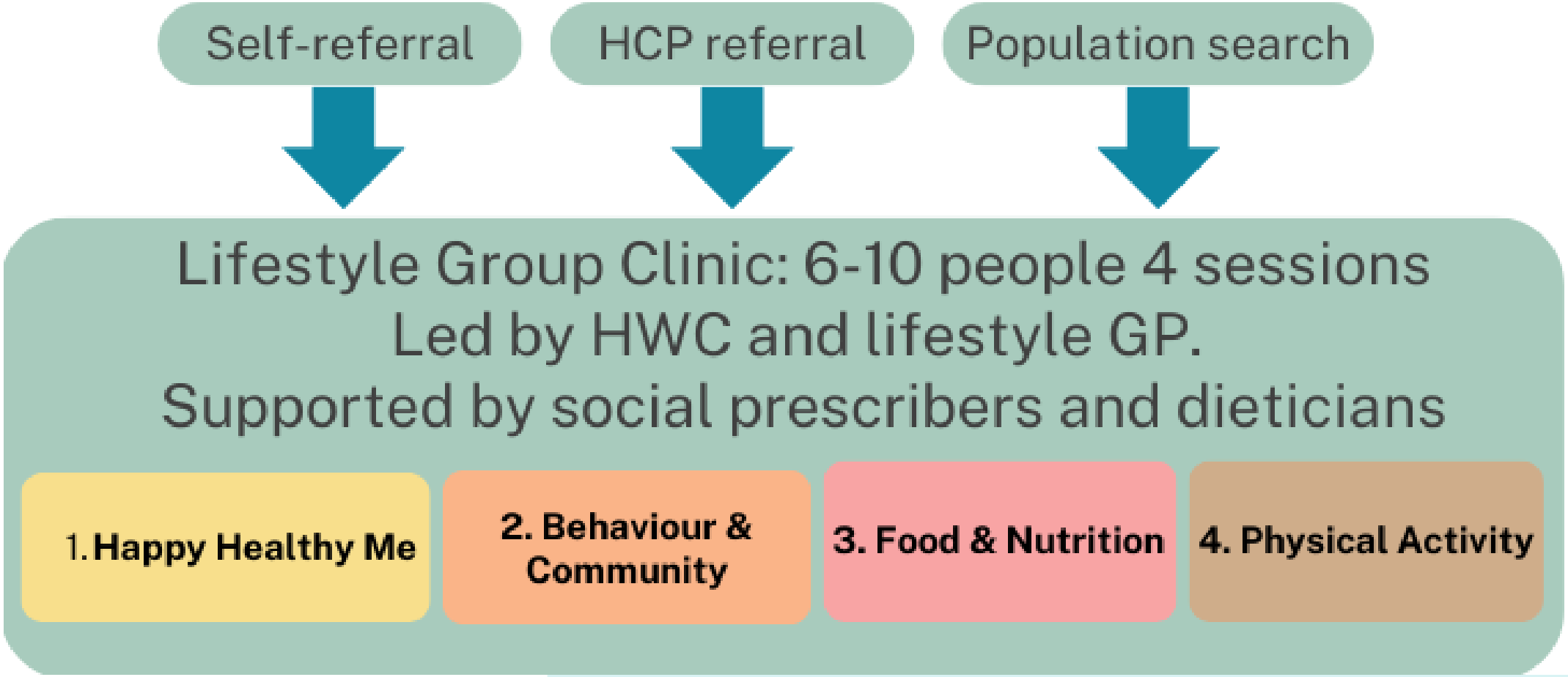


- **Whack A Mole Medicine**

- The Potential

• Leamington Spa Model



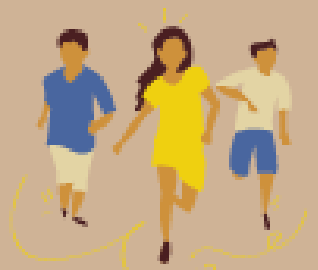

Self-referral
HCP referral
Population search
Lifestyle Group Clinic: 6-10 people 4 sessions
Led by HWC and lifestyle GP.
Supported by social prescribers and dieticians
1. Happy Healthy Me
2. Behaviour & Community
3. Food & Nutrition
4. Physical Activity

All patients

Weekly community activities

Free community physical activity sessions run by PCN staff and patient volunteers

WALK TALK WALK



RUN TALK RUN

mental health swims

parkrun

- Patients at our events are supported to attend our local parkrun
- Staff regularly at events
- Meet up at the start by flag
- Co-run/walk for new members

LIFESTYLE CLINIC

Self-referral | HCP referral | Population search

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Supported by social prescribers and dieticians

1. Happy Healthy Me | 2. Behaviour & Community | 3. Food & Nutrition | 4. Physical Activity

Select patients

Allocated to additional 1:1 support

Health and wellbeing coach

Dietician

Social Prescribing Link Worker

All patients

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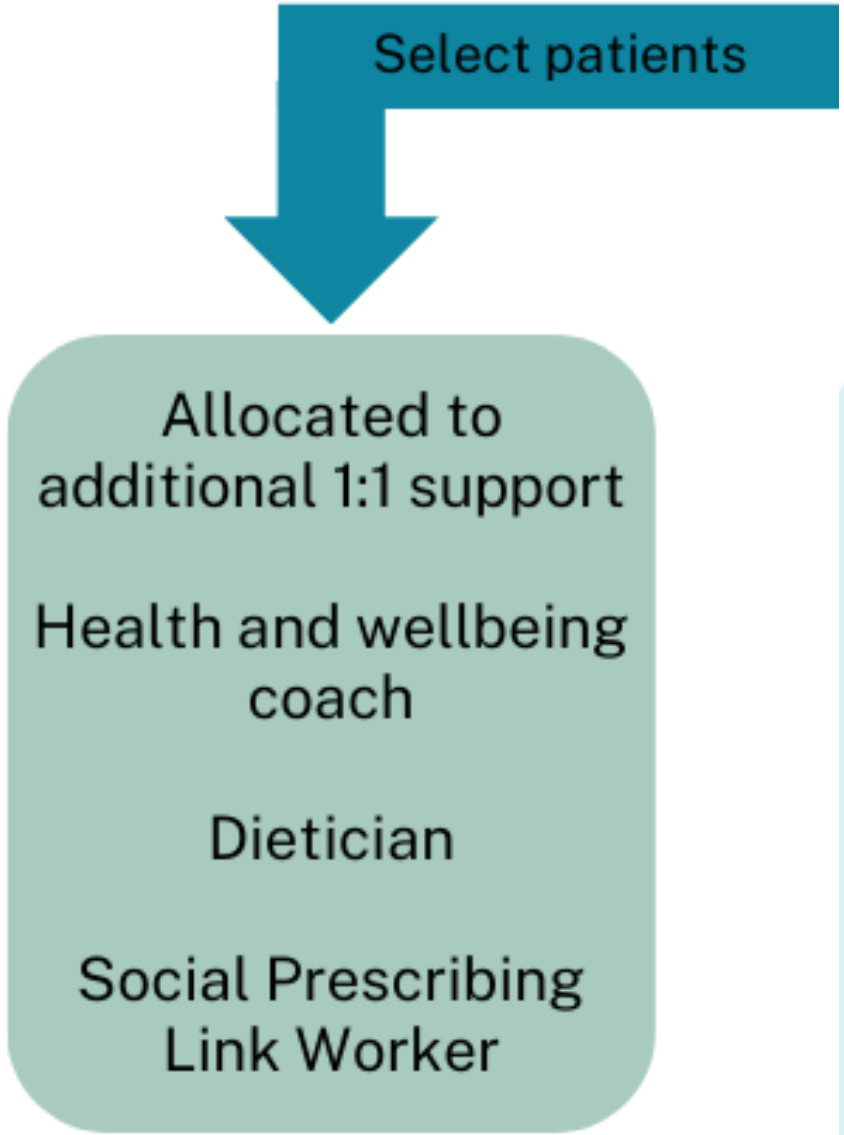
RC GP


Select patients
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LIFESTYLE CLINIC

WE ARE UNDEFEATABLE

Self-referral | HCP referral | Population search

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ageUK Act Now, Age Better.

INDULGDANCE FITNESS

MEGABOX FITNESS FOR REAL LIFE

bbx

SYDNI

BHLC

WARWICK DISTRICT COUNCIL

RCGP

- Extended role in Lifestyle Medicine (GPwERLM)

•Key Take Homes

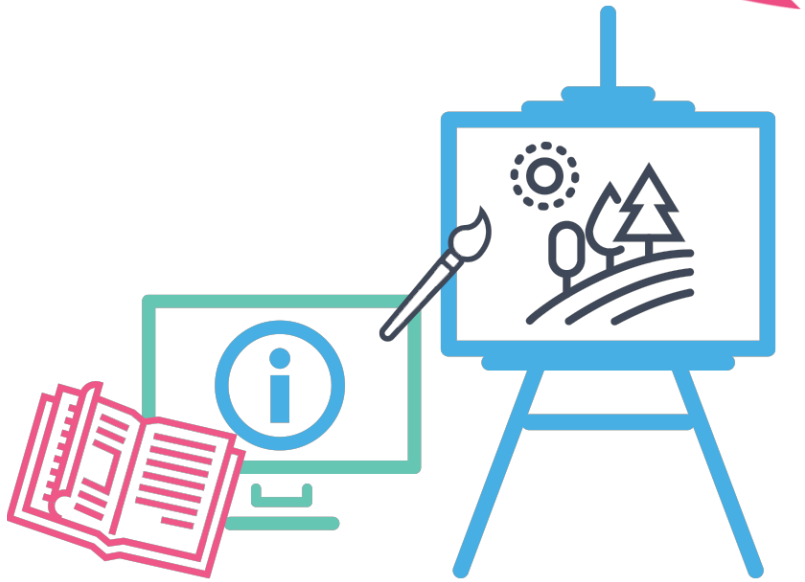
- Healthy professionals make healthy patients
- There is a strong need to incorporate lifestyle medicine into primary care
- Building knowledge, confidence and skills is required
- Evolution over time with patient involvement (preferably co-creation) is key
- Evaluation and coding needs to be built in from the start

National Academy for Social Prescribing

Rethinking Professional Health Education: Culture Change for a New Era of Care

Dr Bogdan Chiva Giurca
Director, WHO CC for SP Policy and Development
Clinical Lead and Global Director for Social Prescribing
National Academy for Social Prescribing (UK)
Honorary Lecturer, University College London
Bogdan.Giurca@nasp.info

WHO Collaborating Centre for Social Prescribing Policy and Development



National Academy for Social Prescribing

WHO Collaborating Centre for Social Prescribing Policy and Development

Healthcare systems were built to treat disease.

The challenge of our century is learning how to create health in our homes, our communities, and everyday lives.

The problem

We are training health professionals for yesterday's epidemiology.

- Medical education was designed for a different era of healthcare
- Training remains heavily hospital-centred despite care shifting into communities
- Most curricula still prioritise acute episodic illness over multimorbidity and frailty
- Polypharmacy, chronic disease and social complexity are now the norm
- Prevention, behaviour change and anticipatory care remain peripheral in assessment and identity formation

But… where does it all begin?

Hope for the Future

Social Movements and Change Agents

Case Study:

NHS Social Prescribing Student Champion Scheme (2016-2023)

Programme Highlights: 7 Years On

782
student champions recruited to date

20,000+
healthcare trainees and students engaged

1,500+
teaching sessions delivered across UK universities

50+
Conferences and published multiple peer-reviewed publications presented by Champions

3x
National Conferences with over 500 attendees

83
Universities involved

Launched world's first **#SocialPrescribingDay** awareness campaign (2018)

Social prescribing is now being taught at **all UK-based medical schools**

Social Movements and Change Agents

Case Study:

NHS Social Prescribing Student Champion Scheme (2016-2023)

"Embarking on my journey with the Social Prescribing Student Scheme right from the start in 2016 was a decision that profoundly shaped my medical career. Over five transformative years, the programme ingrained in me a deep appreciation for holistic healthcare approaches, emphasising the human side of medicine beyond diagnosis and treatment. Now, as a junior doctor, this approach is integral to my clinical work. It's not just about treating conditions but understanding patients' unique stories and environments, which has become a cornerstone of my daily clinical practice."

Dr Daisy Kirtley
(Junior Doctor)

"I became the AHP coordinator for the scheme in November 2021 when I started my MSc in Occupational Therapy at UEA and have been a member since! I have loved raising awareness of the usefulness of social prescribing for AHPs by delivering lectures, speaking at the national social prescribing conference, and publishing research on best practice for teaching AHP students about social prescribing."

Kirstie Goodchild
(Occupational Therapy Student)

"The champion scheme introduced to an extraordinary facet of healthcare that forever changed my approach to medicine. It unfolded a world where care extends beyond mere medical prescriptions to touch the very lives and wellbeing of individuals, considering their social realities. Now, as a newly qualified doctor, these experiences serve as my compass. They inform every consultation, guiding me to practice medicine with an open heart and a broad mind."

Dr Wentin Chen
(Junior Doctor)

"Engaging with the SP champion scheme at medical school shaped my perspective on being a doctor. I became more aware of the social determinants and my role in tackling health inequalities. It encouraged me to approach healthcare with empathy, compassion, and aiming to address the root cause of health issues. Witnessing the empowering impact of social prescribing on individual patients, but also the shift within professions and institutions towards a more comprehensive model of care was inspiring."

Dr Aimee Dowek
(Junior Doctor)

Rethinking Health: Hope for the Future Campaign

Hosted by NHS Charities Together

Campaign position statement

Refocusing health education to better meet the challenges of the future by championing health creation and disease prevention alongside health services and care.

Campaign mission

To empower and educate the next generation of health care workers on disease prevention and health creation principles.

Campaign vision

To establish a standard of clinical culture prioritising disease prevention, health creation, and patient-centred biopsychosocial approaches to wellbeing.

NHS CHARITIES TOGETHER

To find out more get in touch at rethinkinghealth@hotmail.com

Rethinking Health.

The campaign's strategic advisory group includes world-renowned key health leaders with a diverse background and extensive expertise

Strategic Advisory Group

- Lord Nigel Crisp (co-chair)
- Dame Donna Kinnair (co-chair)
- Alf Collins
- Sir David Haslam
- Dame Robina Shah
- Sir Keith Willett
- Sir Norman Lamb
- Katie Petty Saphon MBE
- Prof Kamran Abbasi

Hope for the Future

Ongoing opportunities

A new era for professional health education

1) General Medical Council: Redrafting Graduate Outcomes

2) Postgraduate Training Review (currently led by Dame Jane Dacre)

3) University and medical school curricula changes

4) Postgraduate body representatives (e.g. Royal Colleges, Medical School Council, etc)

Hope for the Future

National Academy for Social Prescribing

WHO Collaborating Centre for Social Prescribing Policy and Development

If we want a different health system tomorrow…

We must train differently today.

National Academy for Social Prescribing

Thank you, for questions or queries

Bogdan.Giurca@nasp.info

Dr Bogdan Chiva Giurca
Director, WHO CC for SP Policy and Development
Clinical Lead and Global Director for Social Prescribing
National Academy for Social Prescribing
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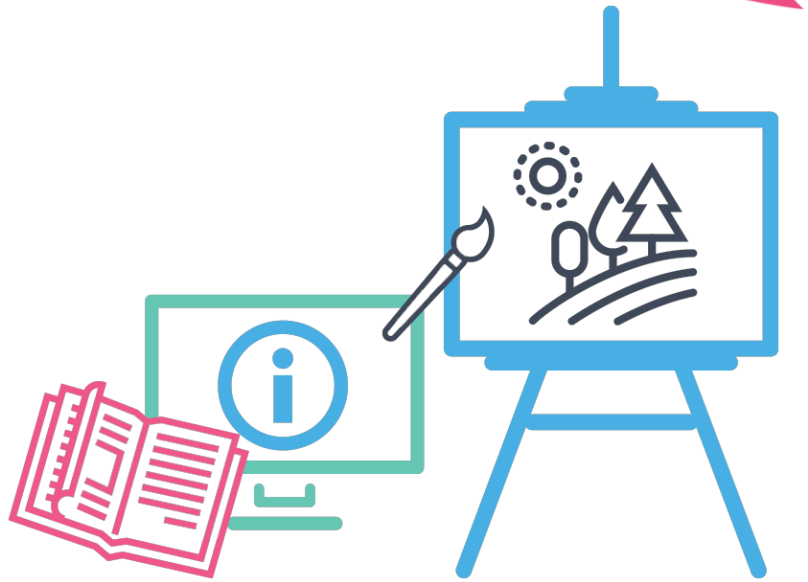

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

CHARMER
COMPREHENSIVE GERIATRICIAN-LED MEDICATION REVIEW

UEA University of East Anglia Norwich

Funded by
NIHR | National Institute for Health and Care Research

Dr Sion Scott

Associate Professor of Behavioural & Implementation Sciences
Hospital Pharmacist
CHARMER hospital deprescribing intervention developer
charmerstudy.org

The research evidence

SENATOR trial
N=1,537 patients
p>0.05 (no effect)

O'Mahony D, Gudmundsson A, Soiza RL, Petrovic M, Cruz-Jentoft AJ, Cherubini A, Fordham R, Byrne S, Dahly D, Gallagher P, Lavan A. Prevention of adverse drug reactions in hospitalized older patients with multi-morbidity and polypharmacy: the SENATOR* randomized controlled clinical trial. Age and ageing. 2020 Jul;49(4):605-14.

The research evidence

University of East Anglia Norwich

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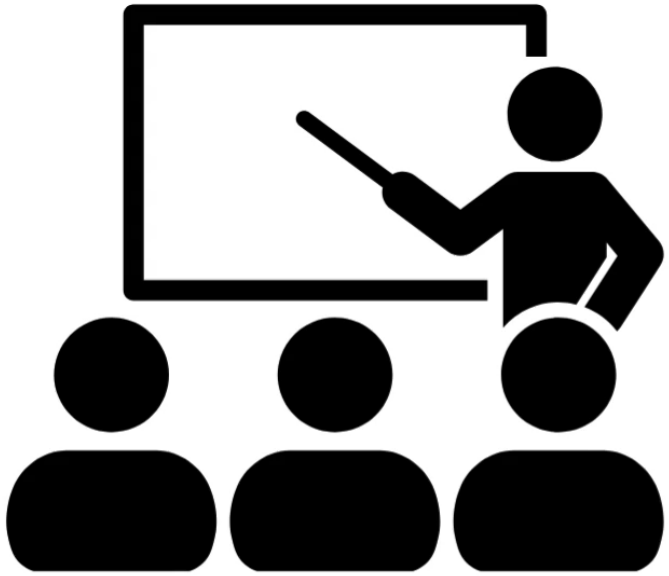


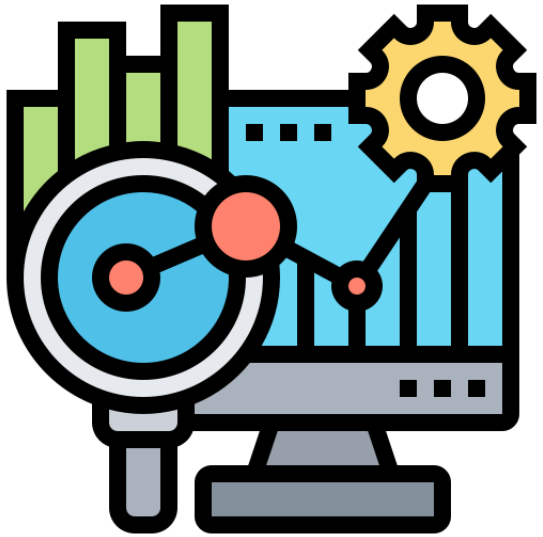
OPTIMIZE trial
N=3,012 patients
p>0.05 (no effect)

O'Mahony D, Gudmundsson A, Soiza RL, Petrovic M, Cruz-Jentoft AJ, Cherubini A, Fordham R, Byrne S, Dahly D, Gallagher P, Lavan A. Prevention of adverse drug reactions in hospitalized older patients with multi-morbidity and polypharmacy: the SENATOR* randomized controlled clinical trial. Age and ageing. 2020 Jul;49(4):605-14.
Bayliss EA, Shetterly SM, Drace ML, Norton JD, Maiyani M, Gleason KS, Sawyer JK, Weffald LA, Green AR, Reeve E, Maciejewski ML. Deprescribing education vs usual care for patients with cognitive impairment and primary care clinicians: the OPTIMIZE pragmatic cluster randomized trial. JAMA internal medicine. 2022 May;182(5):534-42.

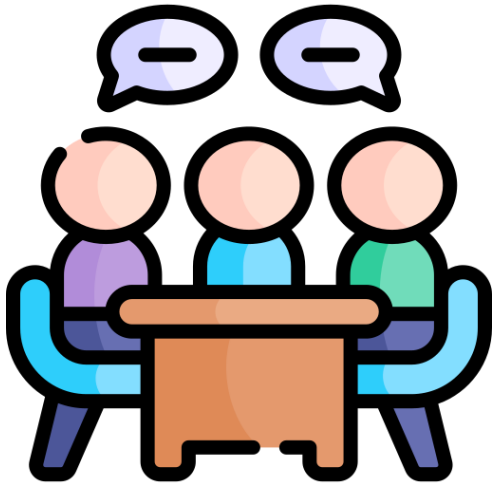
The CHARMER deprescribing intervention

COMPREHENSIVE GERIATRICIAN-LED MEDICATION REVIEW

University of East Anglia Norwich



Analysis of hospital deprescribing activity (n=24,552)



Focus groups with NHS staff (n=56 staff, 4 hospitals)

Co-design workshops with NHS staff and patients (n=42 staff, 6 hospitals)

Scott S, Clark A, Farrow C, May H, Patel M, Twigg MJ, Wright DJ, Bhattacharya D. Deprescribing admission medication at a UK teaching hospital; a report on quantity and nature of activity. International journal of clinical pharmacy. 2018 Oct;40(5):991-6.

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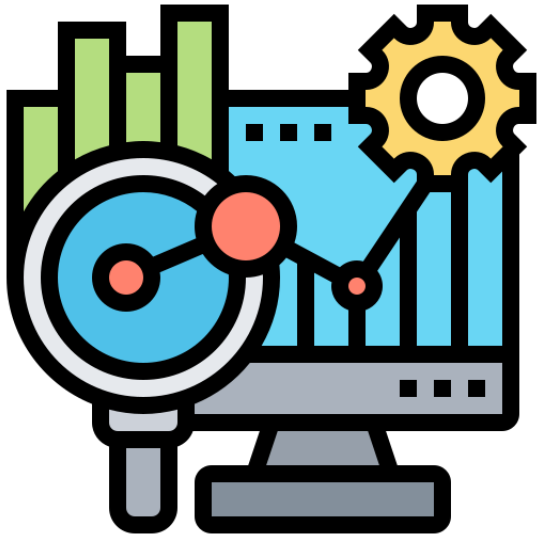

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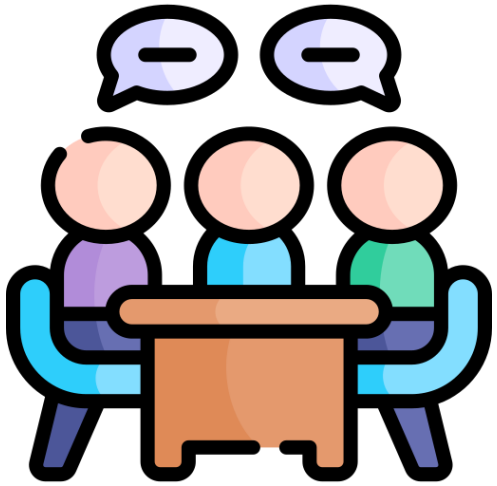

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Behavioural Science

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The CHARMER deprescribing intervention

COMPREHENSIVE GERIATRICIAN-LED MEDICATION REVIEW

University of East Anglia Norwich

1. Hospital action plan for proactive deprescribing

2. Workshop for pharmacists with patient case studies & pros and cons activities

3. Workshop for geriatricians with deprescribing consultation case studies

4. Benchmarking reports on proactive deprescribing activities

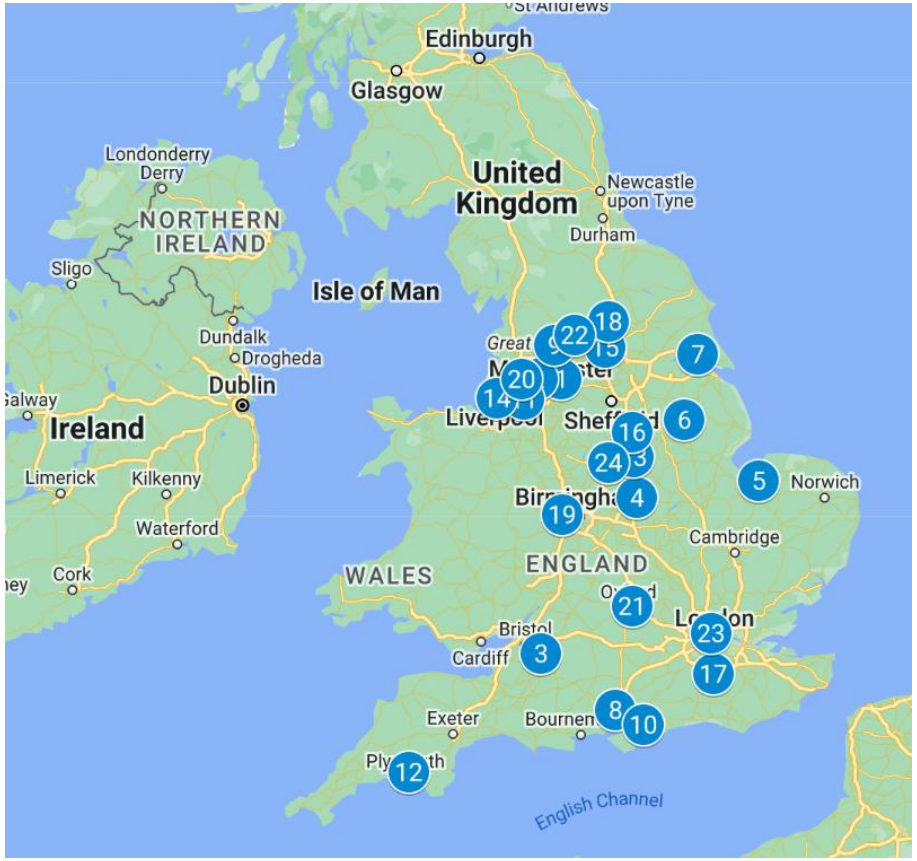
5. Weekly briefings between pharmacists and geriatricians

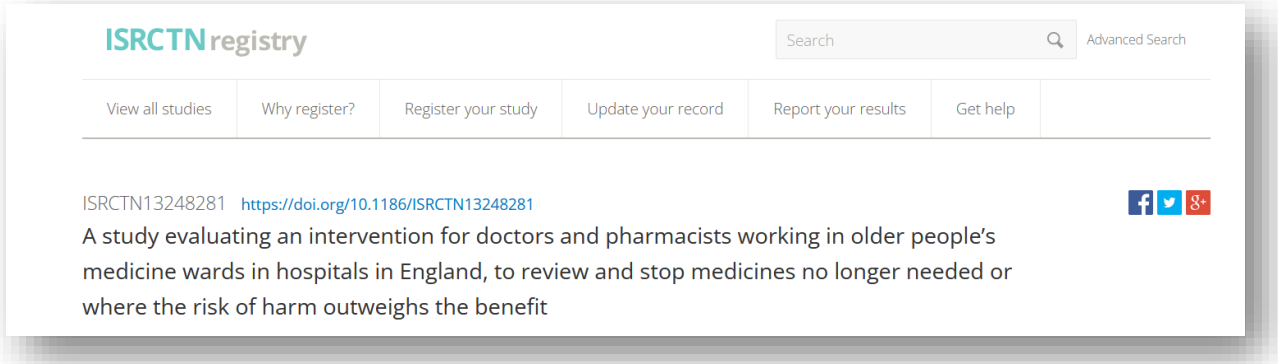
The CHARMER deprescribing trial

COMPREHENSIVE GERIATRICIAN-LED MEDICATION REVIEW

University of East Anglia Norwich

- February 2024 – September 2026
- 24 hospitals
- 150 geriatricians and pharmacists
- 42,000 patients
- Primary outcome measure: 90-day hospital readmission (powered for a 3%↓)





Funded by NIHR | National Institute for Health and Care Research

The CHARMER deprescribing trial

COMPREHENSIVE GERIATRICIAN-LED MEDICATION REVIEW

University of East Anglia Norwich

Headline deprescribing activity results

- Intervention group patients were **30% more likely** to have at least one medication stopped compared to the control (OR = 1.31, p=0.001)
- Intervention group patients had a **22% higher number** of medications stopped compared to the control (IRR = 1.22, p<0.001)
- Difference increased as number of medicines stopped increased

Funded by NIHR | National Institute for Health and Care Research

Norfolk and Norwich University Hospitals NHS Foundation Trust

CHARMER
COMPREHENSIVE GERIATRICIAN-LED MEDICATION REVIEW

University of East Anglia Norwich

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Main trial results: Autumn 2026

sion.scott@uea.ac.uk

charmerstudy.org