Health Innovation Network National Polypharmacy Programme: Getting the balance right Review

Health Innovation Network South London
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Health Innovation Network South London

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1. Executive summary

1.2. Programme background

As people live longer with multiple long-term conditions, many patients find themselves taking increasing numbers of medicines. As patients get older, some of these medicines or combinations of medicines may no longer be clinically appropriate and in some cases can cause harm. The National Over Prescribing review reports the challenges facing the NHS in England around this issue and made 20 recommendations.

Building on work already developed by the Health Innovation Wessex, the Health Innovation Network Polypharmacy Programme: Getting the balance right was launched in April 2022. Originally launched as a national programme, the programme transitioned to a regional 'cluster programme' in March 2023 until its completion in June 2025. This enabled participating HINs to have greater ownership of local design and delivery and develop localised metrics.

Aims of the programme

The programme aimed to support local systems and primary care to identify patients at potential risk of harm from problematic polypharmacy and support both clinicians and patients to have better conversations about medicines by promoting shared decision making. Specifically, the programme was designed to change the behaviour of clinicians and patients through the following core objectives:

1) **Encourage routine use of the NHSBSA Polypharmacy Prescribing Comparators** to identify and prioritise patients for a shared decision-making structured medication review.
2) **Increase confidence amongst the primary care prescribing workforce** to safely stop medicines identified to be inappropriate or unnecessary.
3) **Support a change in patient expectations** to anticipate having a shared decision-making conversation about their medicines regularly, especially as they get older.
4) **Establish a national network of Polypharmacy Communities of Practice**, all working to address the system-wide challenges of problematic polypharmacy in their geographies.
5) **Contribute to the evidence base** around how to help patients to feel more empowered, to open up about their medicine issues, and clinician understanding around how to tackle problematic polypharmacy.

Programme structure

The programme is based on three core pillars to drive behaviour change:

Pillar 1: Population health management	Pillar 2: Education and training	Pillar 3: Public behaviour change
This pillar included delivering webinars focused on encouraging use of the NHS Business Services Authority (NHSBSA) ePACT2 Polypharmacy Prescribing Comparators dashboard to help primary care staff identify patients at risk from harm from problematic polypharmacy and prioritise them for a Structured Medication Review (SMR).	This pillar included delivering the Polypharmacy Action Learning Sets (ALS) and Polypharmacy Masterclasses to upskill the primary care clinical workforce to be more confident about stopping unnecessary medicines and better equipped to deliver high quality SMRs. A Train the Trainer model was developed to accredit regional Polypharmacy Educators to deliver local bespoke education and learning.	This pillar focused on supporting a change in patient expectations around medication reviews by testing and promoting patient-facing materials designed to: - help patients to understand the purpose and importance of a SMR - help patients make the most of the appointment - support shared decision-making during the SMR consultation.

Communities of Practice (CoP)
Pillars 1-3 were underpinned by Polypharmacy Communities of Practice (CoP) in each local Health Innovation Network (HIN) area, with the objective of bringing together cross-sector stakeholders with an interest in reducing problematic polypharmacy.

In terms of the roles and responsibilities of the programme:

- The National Polypharmacy Programme Team coordinated design and delivery of educational activity within Pillars 1-2 and led on the development and roll-out of Pillar 3 nationally.
- Local HINs were responsible for promoting the national offers to drive local system attendance, the development of localised education and learning offers delivered by accredited Polypharmacy Educators, and for local engagement in Pillar 3.

1.3. Programme review

The Health Innovation Network South London (HIN South London) was commissioned by the National Polypharmacy Programme Team to produce a **learning-focused review** for the programme (April 2022 to June 2025).

Review objectives

The review focus is to report on programme delivery, understand implementation facilitators, challenges and lessons learnt specific to the Polypharmacy Programme and relevant future Network-wide programmes. A separate health economic analysis of the programme will be published.

The Primary objectives of the review are:

- To **understand participant experiences** of programme pillar activities and CoPs, including satisfaction levels, self-reported learning and behaviour change outcomes, and suggestions for improvement.
- To **review programme delivery** at national and local levels, including local adaptation of the national programme structure, barriers, challenges, learning, and steps taken towards embedding the programme in local systems to achieve longer term sustainability.

Data sources

This review is predominantly based on the analysis of secondary data provided by the National Polypharmacy Programme Team, derived from quantitative and qualitative methods (including programme participant feedback forms, public datasets, semi-structured interviews and focus groups). This secondary data has been supplemented with primary qualitative data captured by HIN South London in the form of semi-structured interviews and focus groups with local HINs and the National Polypharmacy Programme Team.

1.4. Key review insights and recommendations

The following presents key review insights by each core programme activity area. Learnings shared by local HIN and national stakeholders have been formulated into Pillar specific recommendations.

Pillar 1: Population Health Management – Polypharmacy Comparator Data Webinars

Pillar 1 successfully raised awareness and knowledge of the NHSBSA Polypharmacy Prescribing Comparators, which saw a 90% increase in weekly unique users of the dashboard from 2021 to 2025. Many webinar participants reported the utility of the data and their intentions to integrate into future practice.

- 18 webinars were delivered to **1,529** delegates. **Webinars were well-received**, with 97% of feedback form respondents stating the sessions met or exceeded their expectations. There was an **increase in self-reported knowledge** of the polypharmacy prescribing comparator data following webinar participation, with 91% of feedback form respondents indicating learning could be applied in practice.
- **Use of the NHSBSA Polypharmacy prescribing comparators increased over the programme duration** with the average number of weekly unique users almost doubling from a baseline of 30 in 2021 to 57 in early 2025 (however, direct causation cannot be verified). Some regions successfully used the data as a "hook" for engagement, creating "case for change" packs that were valuable for securing buy-in from Integrated Care Board (ICB) leads.
- Despite increased usage, the average number of **requests for patient NHS numbers from the dashboard remained relatively low**. This could suggest a gap between awareness and practical application or could mean that local systems are using their own local data to identify patients at risk from harm.
- Local HINs reported that some clinicians found the dashboard complex, requiring dedicated time and expertise to use effectively. **Some local HINs developed their own bespoke data dashboards** using platforms familiar to local systems, such as Power BI, to improve accessibility and encourage use of comparator data within their local system. This learning will be shared with the NHSBSA as they develop their new data offer to primary care.

Pillar 1 Recommendations

- **Leverage data for strategic engagement.** Continue to use localised data to create tailored "case for change" packs for ICB and system leaders, as this was deemed a highly effective strategy for securing strategic buy-in and demonstrating the value of the work.
- **Provide targeted data support.** To bridge the gap between awareness and application, future programming should provide targeted, continued, and practical support to primary care staff and programme support institutions on how to interpret the comparator data and integrate it into their patient prioritisation workflows.
- **Support development of accessible data tools.** To overcome the complexity of the national dashboard and encourage broader use, support the development and use of more accessible local tools, such as the bespoke Power BI dashboards created by some HINs, which provide a more familiar interface for local system stakeholders.

Pillar 2: Education and Training – Action Learning Sets and Masterclasses

Pillar 2 activities were highly rated by programme participants. Both the National Polypharmacy Action Learning Sets (ALS) and the Polypharmacy Masterclass series reached thousands of clinicians and received consistently positive participant feedback. A large majority of Polypharmacy ALS feedback form respondents (83%) reported making changes to practice, including increased shared decision-making and greater confidence in deprescribing.

- **Both the Polypharmacy Action learning Sets and the Polypharmacy Masterclasses engaged large numbers of the target audience**. Over 4,000 people attended the Masterclasses. Over 1,300 clinicians completed the Polypharmacy ALS, which were consistently oversubscribed. Participant satisfaction was high, with 99% of the 765 ALS survey respondents stating they would recommend the course to colleagues.
- **ALS participants valued the interactive aspects of the course**, which enabled peer-peer learning and networking. The involvement of specialists, notably geriatricians, was also highly valued.
- **The training led to self-reported changes in practice**, with 83% of ALS feedback form respondents reporting making changes including increased shared decision-making, greater confidence in deprescribing, and actively stopping inappropriate medicines. Similarly, 99% of Masterclass respondents felt they could apply their learning, citing intentions to change prescribing habits and improve patient communication due to their participation.
- **The programme's 'Train the trainer' approach led to the accreditation of 40 local trainers** to support local implementation of the National Polypharmacy ALS.
- **Some local HINs developed their own bespoke, shorter, and inclusive local education sessions to meet system needs**. These sessions attempted to mirror certain aspects of the National Polypharmacy ALS in terms of design and content, however, were designed with shorter session durations to increase accessibility for busy senior clinicians. Locally adapted education offers typically enabled and encouraged participation from junior prescribers.
- Additionally, **some local HINs developed local educational sessions** mirroring the format of national Masterclass sessions but focusing on priority topic areas of local systems. Local HINs reported delivering local and national Masterclasses in tandem was an effective approach to provide a breadth and depth of educational content.

Pillar 2 Recommendations

- **Continue National Polypharmacy ALS and Polypharmacy Masterclass series as core components of future programming.** Future programmes should continue to offer evidence-based educational models like the Polypharmacy ALS and polypharmacy Masterclasses, retaining the key success factors of specialist input (particularly from geriatricians), peer-to-peer discussion, and a focus on practical tools.
- **Expand the national training offer to provide formalised training for junior staff.** Given local HIN calls for structured training to incorporate junior staff, the National Polypharmacy Programme training offer could consider formally integrating the established Polypharmacy ALS Foundation Course* into future national programming. This could help address the call for formal junior staff education, whilst retaining fidelity of existing National Polypharmacy ALS models targeting senior clinicians.

*In response to feedback calling for inclusion of junior staff in National ALS, Health Innovation Wessex developed, delivered, and evaluated the Polypharmacy Action Learning Set Foundation Course, aimed at junior prescribers and pharmacy technicians.

Pillar 3: Public Behaviour Change

Pillar 3 demonstrated that patient-facing materials can empower patients and improve shared decision-making in Structured Medication Reviews (SMRs). The **adoption of materials was inconsistent** and highly dependent on local system capacity to engage, and proactive, hands-on support from local HINs to help embed the materials into clinical workflows. Over 9,000 unique users downloaded the resources, however simply making resources available was not enough to ensure uptake, and the lack of a systematic monitoring mechanism made it difficult to track the scale of adoption and resulting outcomes and impact.

- Prior to the programme, no patient resources relating to structured medication reviews existed. **Through the programme, a suite of resources was co-developed with academia, local innovators, and patients to support shared decision-making**. Within programme Year 1, local HINs piloted materials with local populations, helping capture patient and clinician feedback to refine materials further prior to adoption. Materials were then rolled out nationally from Year 2.
- **Where the materials were implemented and their use monitored, clinician and patient feedback highlighted positive experiences and outcomes**, with some clinicians reporting that patients were arriving at appointments better prepared and "feeling empowered to bring the questions they feel much more involved".
- **Some local HINs developed the materials to better suit local populations.** For example, HIN East Midlands adapted the 'Me and My Medicines' materials so that the original QR code linked to non-English audio translations to improve accessibility for non-English speaking local populations.
- **However, the adoption of Pillar 3 materials was varied across the country**. A primary barrier to adoption was the lack of time and capacity within primary care to embed the new materials into workflows. Simply promoting resources is not enough; local HINs needed to provide proactive, hands-on support to help practices integrate the materials, and a key challenge was the inability to systematically monitor their uptake and use.
- **The availability of targeted funding (albeit small), particularly through the CORE20Plus5 initiative, was seen by HINs to drive engagement.** This funding incentivised PCN buy-in and was reported to be a key success criterion for increasing engagement with seldom-heard communities.
- Local HIN and PCN generated **case studies indicate areas of self-reported prescribing behaviour change** associated with the programme. Participating PCNs reported outcomes including successfully utilising ePACT2 comparator data to prioritise patients in seldom heard groups and at the highest risk of problematic polypharmacy, a reduction in did not attend ('DNA') rates, an increase in SMR activity, and that both clinicians and patients reported improved discussions around medicines enabled my programme materials.

Pillar 3 Recommendations

- **Provide dedicated funding and support for adoption.** To ensure patient-facing materials are used more consistently, initiatives must provide practical, hands-on support and, where possible, funding, to help busy primary care teams integrate them into their existing workflows.
- **Build and publicise the evidence base early.** As appropriate, develop and share testimonials and evidence of the effectiveness of programme resources and approaches early in a programme's lifecycle to help secure buy-in from clinicians, practice managers, and patients. Leverage programme champions at a system level to generate and promote evidence.
- **Develop mechanisms for monitoring uptake.** Future programmes should establish simple mechanisms from the outset to monitor the uptake and use of patient materials, which would allow for a better understanding of their impact and help target support more effectively.

Communities of Practice (CoPs)

Across the programme's duration, local HINs delivered 124 CoPs with 3954 attendances. The Polypharmacy CoPs showed successes in creating spaces for networking and enhancing collaboration, particularly in bringing together primary and secondary care colleagues who would not normally interact. However, the intended "hands-off" theoretical model of CoPs proved difficult to implement and sustain at local HIN levels, as busy clinicians indicated preference for a more structured, educational format.

- **CoPs improved system confidence and enhanced networking and collaboration**, particularly in bringing together primary and secondary care. They were seen to provide a vital "finger on the pulse" of the real-life challenges across local systems.
- **However, many local HINs struggled to implement a true "hands-off" CoP model** due to low engagement and ownership across the system, a lack of capacity and technical expertise, and system workforce pressures. One local HIN retained fidelity to the original intended delivery model, including delivering sessions face-to-face and promoting system led control over content.
- **Consistent engagement was a challenge, especially from GPs**, due to workload pressures. The sustainability of the CoPs was highly variable and depended almost entirely on securing ownership from a local system partner. While some HINs successfully handed their CoPs over to universities or ICB teams, others were not set to continue because "no one wants to own it". This highlights the fragility of such networks without dedicated funding and a clear local host.
- **Most local HINs adapted delivery to a more structured educational session** with guest speakers, which significantly increased participation and perceived benefit.

CoP Recommendations

- **Review the acceptability and feasibility of Polypharmacy CoPs.** Prior to future programming, assess the appropriateness of CoPs given programme objectives, local contextual factors, and type of commitment required for successful delivery. As appropriate, consider revising the approach to retain aspects of CoPs that are feasible to, and are deemed to provide value for, local systems.
- **Prioritise local ownership from the outset.** To ensure buy-in, ownership, and sustainability, CoPs should be co-designed with local systems. This might include establishing core planning groups with diverse local stakeholders, confirming commitment and accountability, and encouraging system leads to chair and facilitate sessions to foster a true sense of community ownership.

1.5. Programme implementation

National and local stakeholders were asked to share their experience of implementing the National Polypharmacy Programme, including factors that supported and hindered implementation, and views on programme sustainability.

Factors supporting implementation

Successful implementation was driven by a combination of strong local engagement, robust national support, and programme flexibility.

- **System buy-in and leadership**. Strong relationships with and support from local systems, particularly Integrated Care Boards (ICBs), were cited as a critical facilitator. This was achieved by aligning the programme with ICB priorities, leveraging existing local system networks, and empowering dedicated system champions who advocated for the programme peer-to-peer.
- **National coordination and resources**. Local HINs viewed the national programme's support as a major asset. Centralised resources, a clear three-pillar structure (data, education, public awareness), and the profile of national leaders helped local HINs focus on engagement and delivery. Accessible

and accurate polypharmacy data from NHSBSA was a vital underpinning for the entire programme.

- **Enabling flexibility at local HIN level.** The ability for local HINs to adapt their localised programme offer around aspects of the national programme to meet the specific contexts, capacity, and needs of local systems was key to increasing local HIN and local system buy-in, engagement and reach.
- **Financial incentives and no-cost programme access.** No-cost access to educational training and resources facilitated participation across local systems. Even small financial incentives provided significant incentive for practices and Primary Care Networks (PCNs) to engage in Pillar 3 material adoption and behaviour change.
- **Effective communication and collaboration**. A multi-channel communication strategy using digital platforms, established local system newsletters, and direct engagement was an important underpinning to programme promotion and engagement. Furthermore, collaboration between local HINs provided a valuable platform for sharing best practices and overcoming common challenges.

Implementation challenges

Stakeholders noted implementation challenges from funding uncertainty, capacity constraints, and challenges monitoring programme behaviour change components.

- **Funding uncertainty and resource gaps**. Continuous funding uncertainty for the programme at a national level diverted programme management resources towards fund-seeking activities and away from other programme implementation support functions. The programme was expected to deliver from the outset without a pre-implementation planning phase factored in. Local HINs were not provided formal programme implementation guidance from the outset and limited administrative support at the national level to prepare implementation guidance caused delays, which impacted local HIN programme implementation.
- **System capacity and competing priorities.** A frequently cited barrier by local HINs was the significant pressure on clinician time and programme objectives competing with other system priorities, especially those with direct financial incentives. The removal of national incentives for Structured Medication Reviews (SMRs) led in some instances to the programme being de-prioritised locally and made buy-in and engagement from GPs and PCNs challenging.
- **Programme acceptability and fidelity.** Certain aspects of the programme, notably CoPs and the 'Train the Trainer' model, encountered notable implementation challenges. The 'train the trainer' model struggled to attract senior staff with the capacity to lead sessions, and the CoP model was generally not applied with fidelity to the intended approach due to system commitment and capacity challenges.
- **Difficulty measuring and communicating outcomes and impact.** Programme indicators and metrics were co-developed by the National Polypharmacy Programme team and participating local HINs. In reflection, some local HINs felt the programme measurement approach had too much focus on process-level metrics that did not provide insight into system level outcomes and impact.

Programme sustainability

While strategies have been put in place to secure the programme's sustainability, the picture is varied across the national landscape. Long-term sustainability is threatened by a lack of secure funding and system ownership.

- **Dependence on HIN support and funding** was noted as a primary risk to sustainability. Some teams reported a significant drop-off in engagement as the programme entered its closing phases as local HIN involvement decreased, highlighting a lack of embedded ownership within local systems. Many felt the programme was ending just as it was gaining significant traction.
- **Strategies for continuation.** Strategic efforts to ensure sustainability include formally handing over educational components to ICBs and academic institutions, and embedding programme

resources into permanent structures like university curricula and new staff inductions. The ongoing enthusiasm of programme champions is also a key driver.

- **Future needs for national programme success.** The national programme team identified key factors required to underpin programme sustainability:
    1) **A national deprescribing network (as established in Canada, Australia and the USA)** to provide a central hub for research, tools, and materials, keeping polypharmacy on the national agenda;
    2) **Continued, easy access to resources**, ideally by embedding them directly into GP clinical IT systems to integrate with workflows, and;
    3) **Ongoing funding for education**, particularly the Polypharmacy Action Learning Sets, described as the "glue" that holds the programme's impact together.

Programme Recommendations

Learnings shared by local HIN and national stakeholders have been formulated into a set of recommendations, applicable to future national programmes

Funding and metrics

- **Secure long-term funding.** The lack of secure, long-term funding created significant uncertainty for the programme team and participating HINs. Future national programmes should seek to understand from the outset which criteria must be satisfied to secure future funding and/or sustainability into usual practice to allow for confident and effective planning and delivery at national and local levels.
- **Develop a comprehensive mixed-methods measurement framework that includes process and outcome measures.** A co-developed MEAL (monitoring, evaluation, accountability and learning) framework that should be embedded into future national programmes from the outset. Future programme measurement and evaluation approaches should be mixed methods, formative, and underpinned by established implementation frameworks (e.g., RE-AIM). A plan for how behaviour change and health outcomes will be objectively and robustly measured to determine impact (including Value for Money, 'VfM') should be established.

Programme design and structure

- **Dedicated pre-implementation phase.** Future national programmes should be designed with an appropriate pre-implementation phase and testing to allow for the development of a clearly defined package of interventions, strategies to support implementation and scale-up, local level planning and relationship building, and relevant outcome and impact measures (including VfM).
- **Programme duration.** Programmes should be designed to allow appropriate time for implementation to achieve desired outcomes and impact, including development and implementation of strategies focused on long term sustainability.
- **Balance flexibility and fidelity.** Relevant future national programmes should adopt the design flexibility seen in the current programme, whereby national support, products, and assets are delivered with high fidelity alongside provisions and support for local adaptation.

Increased breadth and depth of programme participation

- **Embed a systems approach to programme design.** Future programmes should continue the systems approach adopted by the current programme, enhancing the support provided to local HINs for effective and consistent system engagement approaches. Additional support is required for local HINs with limited capacity to implement strategies for broad system engagement.
- **Increase integration of the patient voice.** The patient voice should be consistently involved throughout the entire programme lifecycle, to add validity, encourage stakeholder buy-in, to ensure the programme is fit-for-purpose and effective, and to monitor outcomes and impact.

2. Background

2.2. The National Polypharmacy Programme

In England, the NHS primary care system dispenses over 1 billion prescription items every year. As more people live longer with multiple long-term health conditions, the number of medicines they take often increases, which can create a significant burden for the patient and in some cases can cause harm. Problematic polypharmacy adds a cost to the healthcare system and diminishes quality care for the patient, and most of this is preventable.

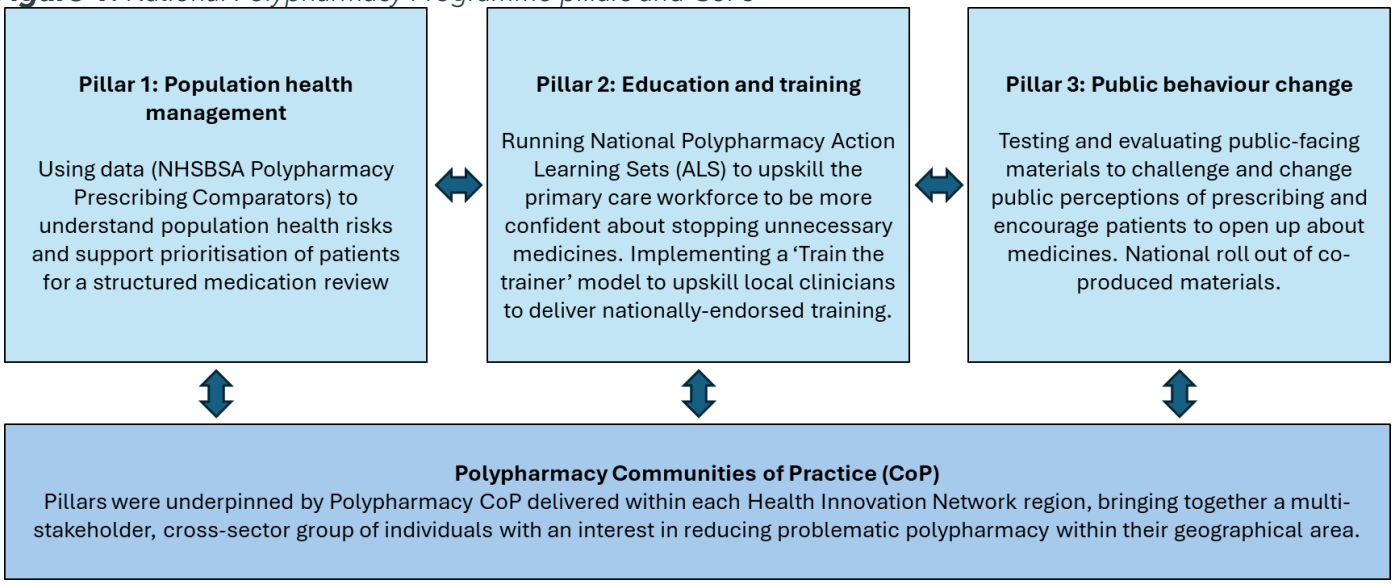
Launched in April 2022, the Health Innovation Network (HIN) National Polypharmacy Programme aimed to support local systems and primary care practitioners to identify patients at potential risk of harm from problematic polypharmacy, and support better conversations about medicines by promoting shared decision making. Originally launched as a National Programme, in March 2023 the Network's commissioners requested that the programme move to a regional 'cluster programme'.

This enabled HINs to have greater ownership of local design, delivery and develop localised metrics. The National Programme team remained in place to lead on the national delivery offer, oversight and reporting. Reduced national metrics were agreed with participating HINs to support national delivery. Specifically, the programme was designed to change behaviour of clinicians and patients by:

- **Encourage routine use of the NHSBSA Polypharmacy Prescribing Comparators** to identify and prioritise patients for a shared decision-making structured medication review.
- **Increase confidence amongst the primary care prescribing workforce** to safely stop medicines identified to be inappropriate or unnecessary.
- **Support a change in patient expectations** to anticipate having a shared decision-making conversation about their medicines regularly, especially as they get older.
- **Establish a national network of Polypharmacy Communities of Practice**, all working to address the system-wide challenges of problematic polypharmacy in their geographies.
- **Contribute to the evidence base** around how to help patients to feel more empowered, to open up about their medicine's issues, and clinician understanding around how to tackle problematic polypharmacy.

The programme was designed with three core 'pillars' driving activity, outlined in **Figure 1**.

Figure 1. *National Polypharmacy Programme pillars and CoPs*



The National Polypharmacy Programme Team coordinated delivery of educational activity within Pillars 1and 2 and led on the development and roll-out of pillar 3 nationally. Local HINs were responsible for promotion of the national offers to drive local system attendance, were responsible for the development of localised education and learning offers delivered by their accredited Polypharmacy Educators and local engagement in pillar 3. Pillars were underpinned by **Polypharmacy Communities of Practice (CoP)** in each local Health Innovation Network (HIN) area, bringing together cross-sector stakeholders with an interest in reducing problematic polypharmacy.

2.3. About this review

2.3.1. Purpose

The Health Innovation Network South London (HIN South London) delivered an evaluation of Year 1 of the National Polypharmacy Programme (April 2022 – April 2023). With the programme closing in July 2025, the National Polypharmacy Programme commissioned the HIN South London to review the full three-year programme, focusing on reviewing programme implementation processes and identifying learning for future programme delivery.

This review is not intended to make an independent determination on the programme's effectiveness regarding prescribing behaviour change outcomes and corresponding clinical impact.

The scope of this review includes activity undertaken from April 2022 – May 2025.

Figure 2 outlines the review questions for each core programme area.

***Figure 2**. Review questions*

Pillar 1: Population health management	• Does programme participation correlate with increased access to the NHSBSA Polypharmacy Comparators? • What did regional Pillar 1 activity look like, and what effect did this have on engagement and practice? • What were participant experiences and learning and behavioural outcomes of Polypharmacy Comparator Webinar participation?
Pillar 2: Education and training	• What did adoption of Pillar 2 activities look like at a regional HIN level, and to what extent did this result in knowledge and behaviour change? • What are participant experiences and learning and behavioural outcomes of attending Action Learning Sets and Masterclass Sessions? • What suggestions for improvement do attendees offer?
Pillar 3: Public behaviour change	• What has use of materials looked like across HIN regions? • Has there been variance in implementation and use across HIN regions, and what lessons can be learned to improve implementation? • What outcomes have been reported by HINs adopting materials in practice, including those working with CORE20Plus communities?
Polypharmacy Communities of Practice (CoP)	• What barriers and facilitators to implementation have stakeholders experienced? • Are there differences in CoP implementation across regional HINs? • What are participant experiences and learning and behavioural outcomes of attending CoPs? • To what extent are CoPs sustainable?

2.3.2. Design and methods

This review is based primarily on analysis of secondary data provided by the National Polypharmacy Programme Team, derived from quantitative methods (programme participant feedback forms and public data sets), and qualitative methods (semi-structured interviews and focus groups).

This secondary data has been supplemented with primary qualitative data captured by HIN South London in the form of semi-structured interviews and focus groups with local HIN and national programme teams.

Review questions provided a broad framework for structuring analysis and insights. Qualitative data relating to each question was thematically analysed using an inductive approach to allow for identification of relevant emergent themes.

Feedback form data were analysed using descriptive statistics and frequency analysis for closed questions, and content analysis for open ended questions.
Table 1 provides an overview of review data sources for each programme area.

Table 1. *Review data sources.*

Programme area	Data source	Collected by
Pillar 1	Data webinar participant feedback form NHSBSA Polypharmacy Comparator Data usage analytics Local HIN programme team focus groups	National Programme Team NHSBSA HIN SL
Pillar 2	ALS participant feedback form Masterclass participant feedback form Local HIN programme team focus groups	National Programme Team National Programme Team HIN SL
Pillar 3	Local HIN Case Studies Core20PLUS5 Case Studies Local HIN programme team focus groups	National Programme Team National Programme Team HIN SL
Communities of Practice	CoP participant feedback form CoP lead interviews Local HIN programme team focus groups	National Programme Team National Programme Team HIN SL

3. Pillar 1: Population health management

The NHS Business Services Authority (NHSBSA) Polypharmacy Prescribing Comparators were designed to help primary care networks (PCNs) and GP practices identify and prioritise patients who may be at risk of harm from problematic polypharmacy. They help benchmark prescribing patterns and identify patients taking a high number of medications or specific combinations of medications known to increase risk.

The polypharmacy prescribing comparators were created to supplement local clinical system searchers and provide the **only source of data that includes all medicines prescribed *and* dispensed by NHS primary care**. They are accessible via the NHSBSA ePACT2 dashboard, which allows for comparison between national and local averages.

The National Polypharmacy Programme, in collaboration with the NHSBSA ran 18, one-hour online webinars between March 2022 and May 2025 on the use of the NHSBSA Polypharmacy Prescribing Comparators dashboard.

Webinars were open to all NHS staff but were aimed to help primary care staff to use the data to understand population health risks and support prioritisation of patients for a structured medication review (SMR). Local Health Innovation Networks (HINs) promoted the webinars and encouraged attendance across local systems.

3.2. Webinar attendee feedback

This section presents an analysis of data collected by the National Polypharmacy team on webinar attendee details, pre-webinar data on attendee knowledge of the NHSBSA comparators, and a post-webinar feedback form.

In total, **1,529 people attended one of 18 webinars** run between March 2022 and May 2025. A further 1,306 people registered and did not attend. The webinar attendee feedback form received 235 responses, representing 15% of attendees. Figure 3 and Figure **4** show a breakdown of webinar attendees by organisation and profession, respectively.

Figure 3

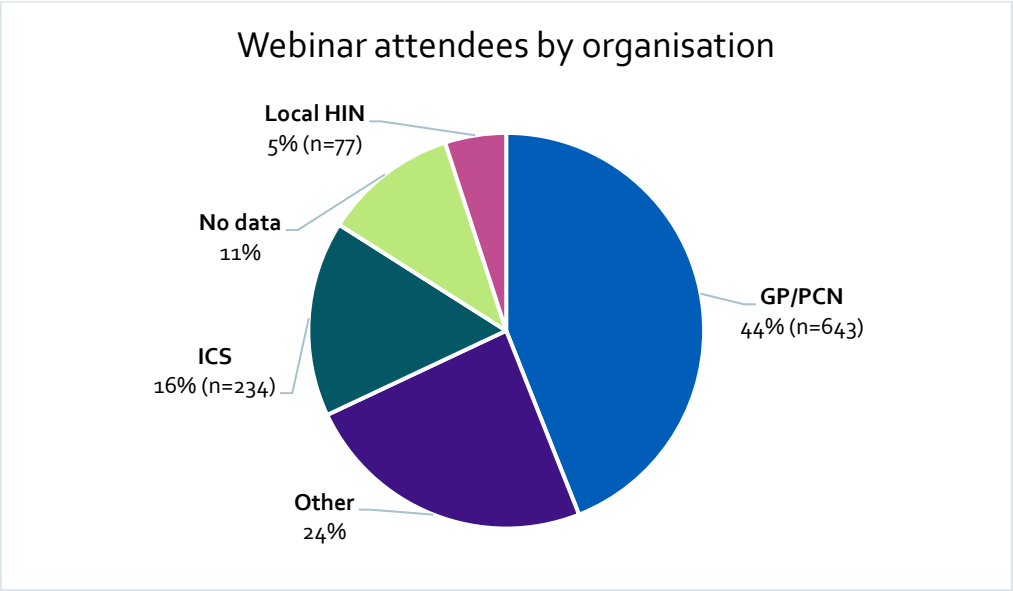
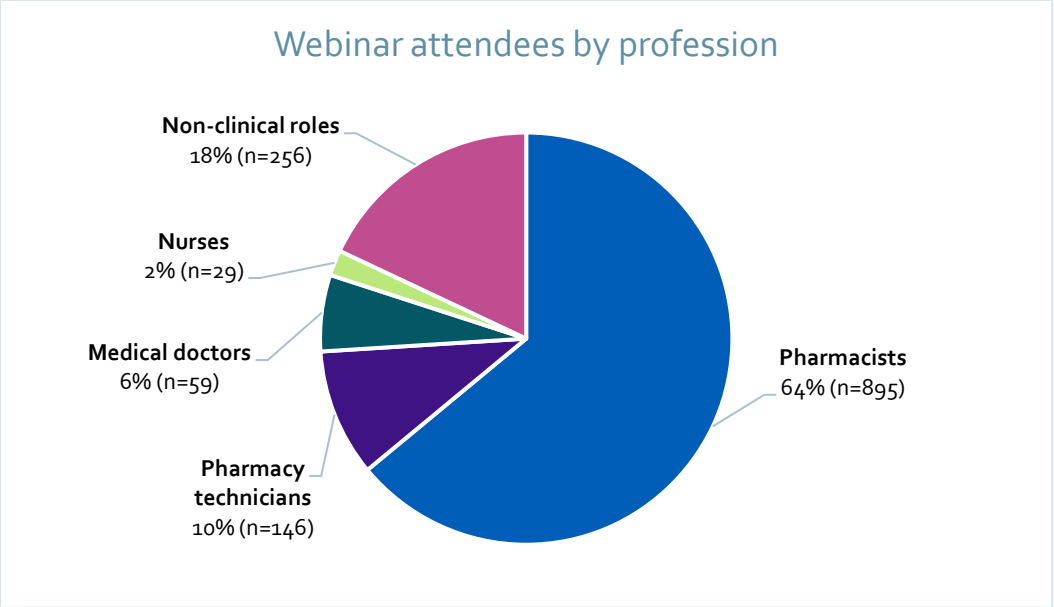


Figure 4



Attendee experience of the webinars

The large majority of feedback form respondents **(75%, n=173) stated that the webinar session met their expectations**, and a further **22% (n= 50) that it exceeded their expectations**. Respondents generally commented that the session was well delivered, informative and that they found the walkthrough of the ePACT2 system – the system that houses NHS BSA comparator data – very helpful.

A great session and I especially liked the practical aspect of showing how to use the dashboard.
Participant, September 2024

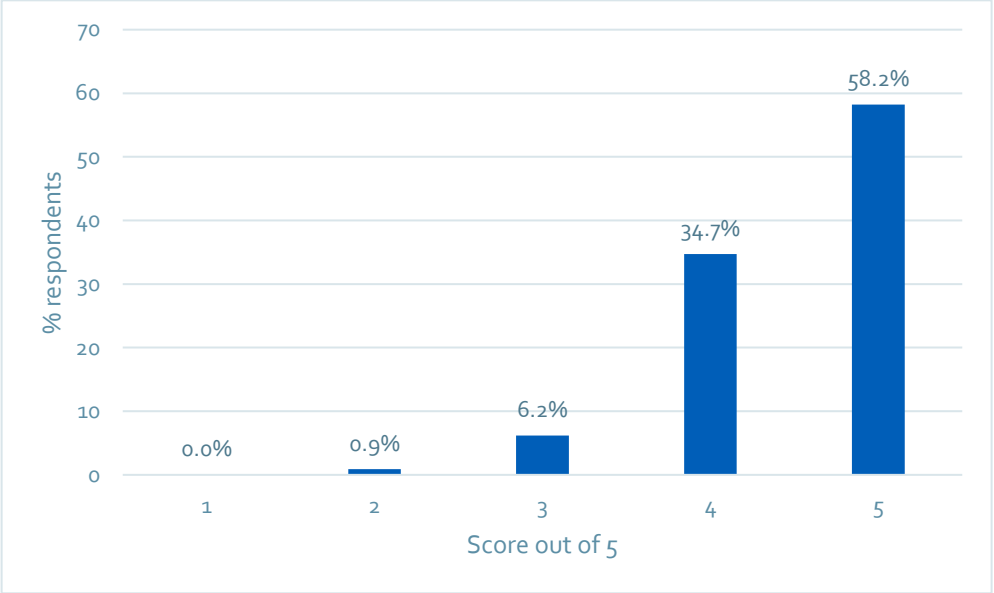
Some respondents expected more information or tips about recognising and addressing polypharmacy in patients and deprescribing. A few mentioned it would have been helpful to receive information and links to the database ahead of the session to improve familiarity and usefulness of the webinar.

Most respondents **(91%, n=210) reported they would be able to apply webinar information into practice**. Some reported they already used the dashboard, and others said they planned to do so. Some highlighted that gaining access would be challenging or time-consuming, whilst others felt they would need more practice or training prior to integrating it within practice. A few highlighted the need to identify a designated person to access and use the data within their practice or PCN.

I think that we could apply the information within our PCN. However, we would need a designated person to gather and collate the information. **Participant, April 2022**

Over half of respondents **(58%, n=132) scored the quality of the webinar presentation 5 out of 5**, with 93% giving either 4 or 5 (Figure 5).

Figure 5 *Respondents' rating of the quality of webinar presentations (n=225)*



Almost all **(99%, n= 222) of respondents felt that the online format worked well.** However, a few noted the one-hour session being 'too long for online', and that Zoom as a platform is not supported by some organisations.

The majority (97%, n= 225) of **respondents felt that they had enough time to ask questions**. Among the small percentage that felt that they needed more time, a few noted that questions were answered 'very quickly'. A few suggested circulating 'frequently asked questions' following the webinars.

Further **comments highlighted some challenges to using ePACT2,** including the need for time to become familiar with the dashboard and identify how and what the data would be used for within the specific context of work. Others felt they needed more training on how to use the dashboard. Some noted that whilst they could see the value of the dashboard and data, it presented a 'cumbersome tool' to use. Others highlighted their confidence and high levels of enthusiasm for using the dashboard in future.

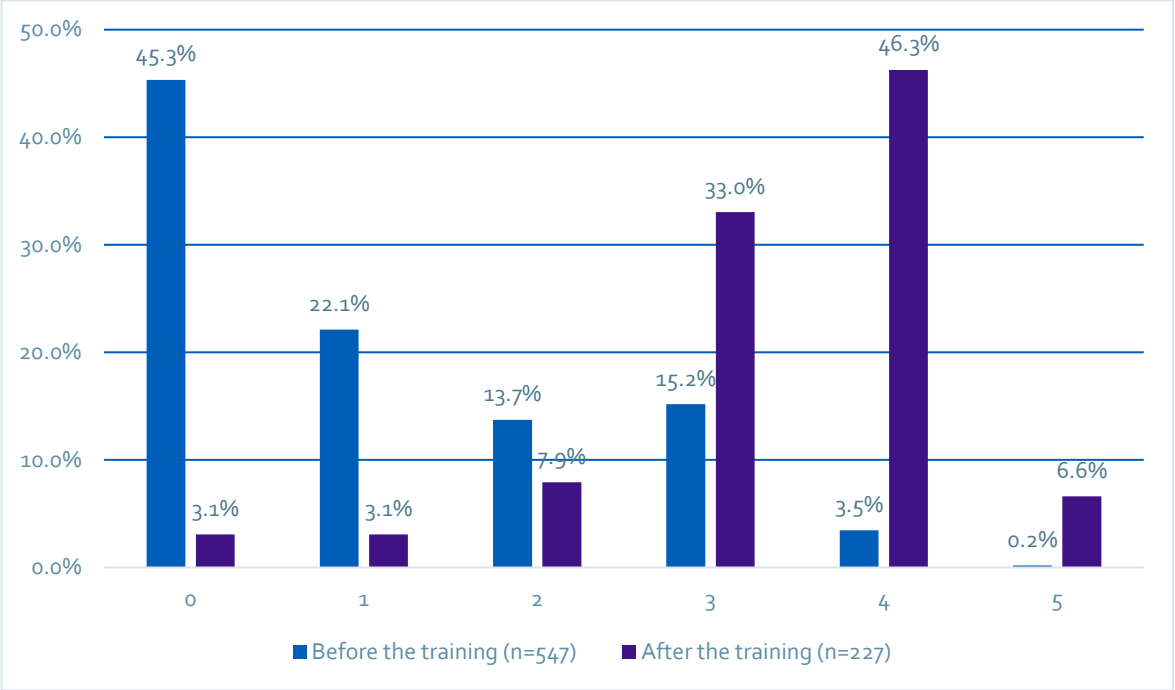
"Really excellent resource, I have been worrying about polypharmacy and prescribing safety in my surgery, and this will help analyse the problems and identify those most at risk". ***Participant, Sep 2024***

Attendee awareness of the NHSBSA Polypharmacy Prescribing Comparators

Webinar participants were asked to rate their knowledge of the NHSBSA Polypharmacy Prescribing Comparators on a scale of 0 (no knowledge) to 5, (expert) both before and following the training webinar. Responses were almost twice as high for the pre-webinar poll (n=547) compared to the post-webinar poll (n=227). Due to the large variance in volume of pre-post data, responses are presented as percentages.

Figure 6 indicates an **increase in self-reported knowledge of the comparator data following webinar participation**. Approximately two-thirds of attendees (67.3%) rated their pre-webinar knowledge as 0 or 1 compared to over half (53%) rating their post-webinar knowledge as 4 or 5.

Figure 6 *Webinar attendee pre- and post-webinar knowledge of NHSBSA Polypharmacy Comparators*



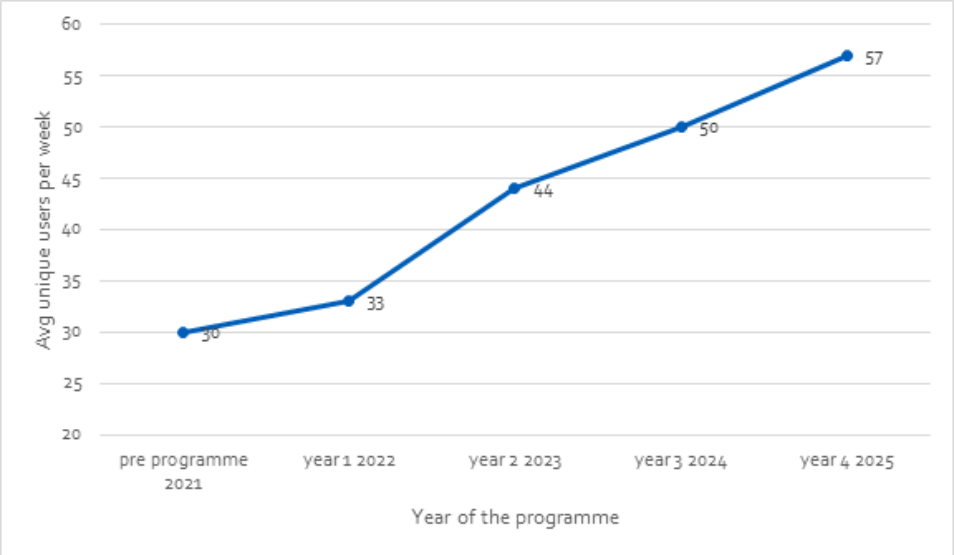
3.3. Accessing the polypharmacy metrics and requesting NHS numbers of patients from ePACT2

Data on usage of the NHSBSA Polypharmacy Prescribing Comparators was provided by the NHS Business Services Authority (BSA). This included weekly number of unique users, and weekly number of requests for NHS numbers. Dashboard usage data were analysed to compare activity levels before and after the webinars took place.

Unique users

The average usage increased from 30 unique weekly users in 2021 prior to the programme starting to 57 unique weekly users in the within the first quarter of 2025, which represents the final stages of the national programme (Figure 7). This change represents an increase of 90% from baseline.

Figure 7 *Average number of weekly unique users of the NHSBSA Polypharmacy Prescribing Comparators dashboard by year*



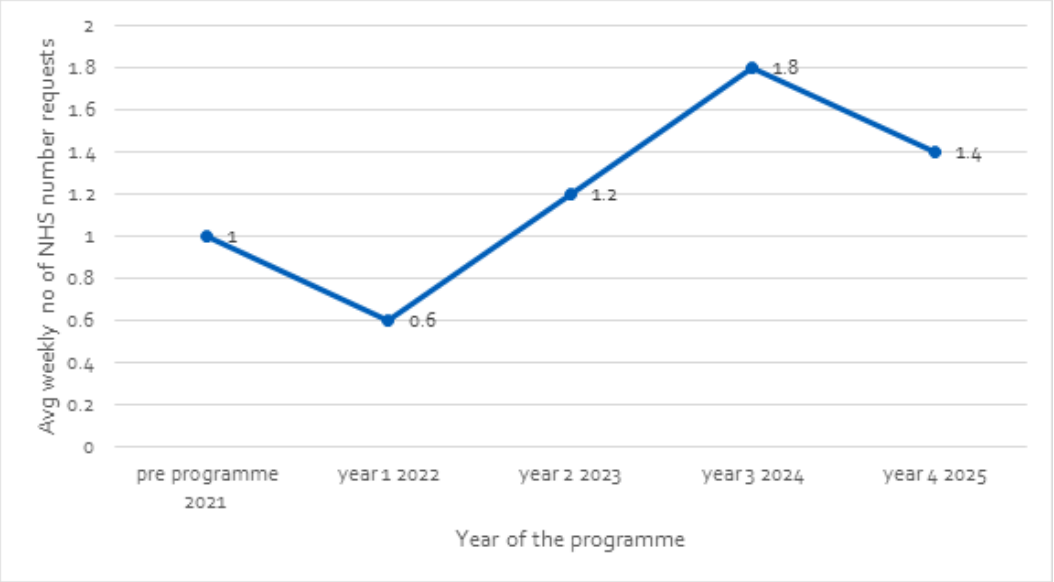
NHS BSA data presents Polypharmacy Prescribing Comparators usage at a weekly level. Usage over the course of the programme was assessed. There was no clear pattern in terms of usage following a webinar, rather, weekly usage levels fluctuated throughout each year. See Figure Figure **12** in Appendix 10.1.

NHS number requests

The number of requests from GP practices for the NHS numbers of patients taking multiple medications was tracked over time to see if this had increased following the webinars. The below analysis excludes requests from GP practices in the Health Innovation Wessex area, as they were actively encouraging the usage of the dashboard prior to the webinars starting.

The weekly average number of NHS number requests remained consistently low throughout the programme (Figure 6), with no clear relationship between the webinar dates and the number of requests for NHS numbers coming through (see Figure 12 and Figure 13 in Appendix 10.1). Appendix 10.1 provides an overview of NHS number requests by each local HIN.

Figure 8 *Average number of weekly requests for NHS numbers by year*



3.4. Implementing Pillar 1 – activities and lessons

The following section presents insights from interviews and focus groups with local HIN programme teams about approaches to supporting national Pillar 1 activity, perspectives on outcomes achieved, and lessons learned.

Approaches and activity to support Pillar 1 implementation

Local HINs adopted a range of approaches to implement Pillar 1, from cascading national information to developing their own bespoke data tools and dashboards:

- **Promoting and disseminating national information and resources.** Most HINs focused on promoting the national webinars by 'cascading' centrally provided resources and webinar details to local systems. This was done primarily by leveraging existing relationships, networks, and communication channels. In most cases, ICBs acted as the gatekeeper to local systems, and therefore HINs felt required to gain their consent and direct support for system engagement.
- **Providing targeted data support.** Some local HINs supplemented the data webinars by providing direct data support to practices and PCNs. For example, Health Innovation East Midlands developed bespoke data packs for every practice that had delegate representation in programme courses. These packs were intended to provide localised data without the need for practices or PCNs to navigate the ePACT2 system directly.
- **Developing bespoke dashboards.** Some HINs developed integrated dashboards, with the aim of

making the comparator data more accessible for local systems. One local HIN developed a Power BI dashboard that provided a more familiar interface and offered prescribing trend data. Another commissioned a health inequalities dashboard to *"overlay the ePACT2 data with specific health inequalities metrics"*.

- **Using data as a "hook" for engagement.** Some HINs adopted a strategy to use the data as a "hook" to engage with local systems and drive the conversation around polypharmacy. Some reported the data had a significant effect on stakeholder buy-in and support. One local HIN created 'Case for change' packs at the ICB level, which were understood to be "*absolutely fundamental at getting in the room with ICB leads*".
- **Alignment with ICB strategy.** Embedding the programme's data metrics into local strategy was a powerful facilitator for Health Innovation North East and North Cumbria, where the ePACT2 comparators have been integrated into ICB strategy as key performance indicator (KPI) metrics, which helped to promote active use of the data.

Pillar 1 implementation challenges

Local HIN programme leads identified the following barriers specific to implementing programme Pillar 1:

- **Low engagement with data and webinars**. Despite promotional efforts, several HINs reported low engagement from clinicians with the national webinars. One HIN reported that Pillar 1 was the "*least engaged pillar*" and that "*engagement remained low*" despite active promotion.
- **Accessibility of the data and expertise required to use it**. Local HINs described receiving feedback from system stakeholders related to the complexity of the data and the expertise required to use it effectively. One HIN team felt the dashboard "*could be a bit overwhelming for anybody to try and work their way through*" and that you "*need somebody with expertise in its use and application*" to use it effectively.
- **Internal local HIN capacity.** Some organisations faced their own internal challenges with capacity in delivering Pillar 1 activities, which related to the expertise required to navigate the dashboard and interpret and present the data. This was particularly the case for HINs that did not have a pharmacist – or other related clinical lead – on the programme team. One HIN lead referenced the *'lack of insights support locally for primary care to be able to access and understand the data'*.

Pillar 1 Outcomes

Local HIN programme leads discussed a range of outcomes for Pillar 1, indicating notable variation between regions. Key outcomes included:

- **Positive reception for ePACT2 dashboard and bespoke data tools**. Several HINs reported positive system reception of comparator data, with many stakeholders highlighting the clear value of the data to their local systems. HINs that developed their own dashboards and translated the comparator data into existing local systems reported instances of uptake.
- **Variable adoption of comparator data.** Despite positive signals from many local stakeholders, adoption of EPACT2 was reportedly variable. Whilst some system feedback highlighted use of EPACT2 amongst primary care teams, many HINs noted that adoption remained low. This is further underpinned by analysis of NHSBSA data presented in section.

Lessons learned

The key learnings identified by local HIN programme leads about Pillar 1 activity were:

- **Data can be used proactively as an effective tool for engagement**.
- The **need for data expertise** to interpret and communicate the data.
- The efficacy of **leveraging existing data systems** staff have familiarity with.

4. Pillar 2: Education and training

Pillar 2 involved delivery of National Polypharmacy Action Learning Sets (ALS) and National Polypharmacy Masterclass series. This section presents findings from analysis of primary and secondary qualitative and quantitative data relating to Pillar 2 delivery, including data from a focus group and interviews with Health & Justice sector participants who participated in the ALS[1]. It also provides insights from qualitative data relating to local-level implementation of Pillar 2 activity.

4.2. Pillar 2 National Polypharmacy Action Learning Sets

The Polypharmacy Action Learning Set (ALS) is an evidence-based learning model developed by Health Innovation Wessex. The aim of the Polypharmacy ALS is to help GPs, pharmacists and other primary care prescribers who carry out medication reviews and de-prescribing on a regular basis, to address the complexity of polypharmacy and improve clinician confidence surrounding stopping inappropriate medicines safely.

Health Innovation Wessex piloted the original Polypharmacy ALSs in October 2018 which were independently evaluated by the University of Southampton. Health Education England South funded a wider roll out in November 2019 to include Health Innovation Oxford, Health Innovation South West, and Health Innovation West of England. In April 2022, the Polypharmacy ALS was selected for national roll-out as part of the wider National Polypharmacy Programme.

GPs and prescribers with a minimum of 12 months' experience were eligible to take part. Prior to the national programme, the ALS format had been tested with a wider delegate criterion to include more junior prescribers, however this was found to not meet the needs of more experienced clinicians.

A total of 23 ALS cohorts were delivered during the programme, with 1,301 delegates competing the ALS. Each Polypharmacy ALS cohort consisted of a series of three, half day action learning sessions over a one-month period, involving taught content, group discussions led by expert facilitators (e.g. pharmacists, GPs and geriatricians) and individual 'homework' to complete between sessions. More detail about the aims and content of the ALS sessions can be found in Appendix 10.2.

In addition to the National Polypharmacy ALS, Health Innovation Wessex (HIW) developed a Polypharmacy ALS Foundation Course as part of the National Polypharmacy Programme in response to an identified gap in polypharmacy education available to junior prescribers. The course is designed to enhance the confidence and capability of more junior pharmacists and pharmacy technicians or those not yet qualified as prescribers. The Polypharmacy ALS Foundation Course has been evaluated by HIW and has not been included the current review.

This section describes Polypharmacy ALS participant profile, provides an overview of findings from participant feedback forms, and outlines insights related to implementing the Polypharmacy ALS.

4.2.1. National Polypharmacy Action Learning Set insights from course feedback form.

In total, 753 participants completed a National Polypharmacy ALS feedback form. The breakdown of feedback form respondents is as follows:

- **Pharmacists** were the largest and most diverse group (464 responses, **61%).**
- **General Practitioners (GPs)** were the second largest group (155 responses, **21%)**.
- **Advanced Practitioners** (77 responses, **10%)**, including Advanced Clinical Practitioners (ACP) and Advanced Nurse Practitioners (ANP).

[1] See section 4.2.3. for further detail.

- **Nurses** (41 responses**, 5%)**.

Other respondent groupings included geriatricians (n=8), paramedics (n=4), 'Other clinical' (n=4) included mental health lead, physiotherapist, clinical pharmacologist, and frailty practitioner.

Most feedback form respondents (95%, n=718) attended all three Polypharmacy ALS sessions. A total of 23 respondents (3%), attended only one of the three sessions.

Did the Polypharmacy Action Learning Sets meet attendee expectations?

Cohorts 1-12 were asked to rate the extent to which the Polypharmacy ALS met their expectations using a 5 point numerical scale[2]. Of 391 responses, the large majority indicating the ALS strongly met expectations, with **344 (88%) selected either 4 (n=151) or 5 (n=193) (i.e. fully met or exceeded expectations)**.

Cohorts 13 – 23 were asked to rate the extent to which ALS met their expectations using a qualitative scale (i.e. expectations were exceeded, fully met or somewhat met). Of attendees that responded to this question, **83% (n=302) felt the ALS 'exceeded' (30%, n=110) or felt it 'fully met' (53%, n=192) expectations**.

For all 23 cohorts, analysis of the results by job category showed that 86% of pharmacists, 79% of GPs, 86% of Advanced Practitioners, and 98% of nurses state the ALS either 'Fully Met' (score 4) or 'Exceeded' expectations' (score 5).

Across all 765 respondents, **99% (n=746) said they would recommend the ALS to colleagues.**

Aspects of the Polypharmacy Action Learning Sets participants found helpful

Cohorts 1-4 were asked *"Which elements of the Action Learning Set were the most helpful?"* using an open-text format. Cohorts 5-23 were asked to answer the same question using a multiple-choice selection with pre-determined components of the ALS.

The overall sentiment of the responses was positive. Participants frequently used words such as "excellent," "really useful," "brilliant," and "invaluable" to describe their experience, indicating a high level of satisfaction with the course content and delivery.

Thematic analysis of open-ended responses identified the following key themes as being most helpful to participants:

- **Discussions, group work, and collaboration**. The most helpful aspect of the ALS was that it provided a space for open discussion with peers. Many noted specifically they valued discussing approaches to structured medication reviews (SMRs), sharing challenges, and discussing views on best and poor practice.

"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."

- **Specialist input**. Many respondents found the provision of specialist input helpful, notably from geriatricians, who were able to share insights and best practice on language to support discussion with patients and provide tips on approaches and methods of deprescribing.

[2] The descriptors of the scale categories were not given. This analysis assumes that '1' was interpreted by all respondents as expectations not being met, and '5' as expectations being fully met or exceeded, however individual respondent interpretation of the scale may have differed.

"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."

- **Resources and tools**. Respondents appreciated receiving slides, information on data utilisation (such as ePACT2 data), links to deprescribing tools, and evidence-based reports.
- **Peer support and shared experience**. Many respondents expressed a sense of reassurance and validation from hearing about the experiences of their colleagues. Realising that others face similar challenges in their practice was a powerful and affirming aspect of the course.
- **Practical skills and application**. Attendees valued learning how to deliver structured medication reviews, the language to use in shared decision-making with patients, and practical tips for optimising polypharmacy in their daily work.

"The training was good mixture of breakout group, discussion, pre-work/assignment and real life scenarios."

- **Evidence-based practice**. The emphasis on an evidence-based approach to polypharmacy and medication reviews was also a valued component.

For cohorts 5-23, 612 participants answered the question about what aspects were most helpful from the ALS. Participants were able to select as many options as relevant to their experience. A frequency analysis of the data was conducted, identifying the following aspects of the course were identified by participants:

1. **Geriatrician involvement Day 3** = 504 selections (82% of respondents).
2. **Breakout room discussions** = 392 selections (64%).
3. **Practical tools and resources Day 2** = 382 selections (62%).
4. **Shared decision-making Day 2** = 283 selections (56%).
5. **Facilitators discussion and guidance** = 298 selections (49%).

Appendix 10.2 provides further detail on other aspects deemed helpful.

Participant suggestions for improving the Polypharmacy Action Learning Set

Attendees were asked if there was anything they would like to change about the Polypharmacy ALS. There was a total of 243 responses (32% of total responses) suggesting areas for improvement. A further 165 (22%) proactively commented that no changes were necessary. Thematic analysis of open-text responses identified five key themes for potential improvement:

- **Course pacing, duration, and timing.** This was the most frequent area for suggested improvement (n=64). Respondents suggested lengthening sessions to allow for in-depth discussion and networking, condensing the Polypharmacy ALS to improve accessibility, slowing the pace of delivery of technical content, and reducing the frequency of sessions to allow more time for learning and application.
- **Enhanced specialist and geriatrician involvement.** Almost one in five (n=45) signalled a strong preference for more time and direct interaction with course specialists, particularly geriatricians. Several made suggestions for increased time for Q&A.
- **Increased practical application.** Some respondents (n=41) noted a desire for more learning through case studies and real-world examples, with some of these noting it would enable them to better apply the tools and principles discussed in practice.
- **More timely and consolidated resource provision.** Almost one in ten (n=22) of those that suggested improvements felt that resources could have been shared earlier, and in a more consolidated format.
- **Improved breakout room dynamics.** While many valued the discussions, some respondents (n=21) suggested breakout group structure and dynamics could be improved by rotating group members between sessions to allow for wider networking, making groups smaller to encourage wider

participation, and standardising group moderation approaches.

- **Content-related suggestions.** While the course content was generally praised, some participants (n=18) wished for more specific, "hard" clinical information to supplement the discussions on process and soft skills. For example, sessions focused on deprescribing specific high-risk drugs or drug classes (e.g., anticholinergics, proton pump inhibitors (PPIs), opioids).

Other less frequently mentioned suggestions included opening sessions to non-prescribers, having an ongoing forum to continue discussions related to polypharmacy, increasing capacity of the ALS to enable more staff to attend, delivering sessions face-to-face, and integrating more visualisations and graphics to breakdown complex information and increase accessibility.

Participant changes made around stopping medicines

A **large majority of respondents (n=627, 83%) reported making changes in their practice**, compared to 15% (n=111) who answered 'No'. By profession, **82% of pharmacists, 88% of GPs, and 88% of nurses noted they had made at least one change to their practice involving decision-making with patients.**

Of those that reported making a change, 415 provided further information. Open-ended responses were analysed and categorised into themes[3]. The six most noted changes were:

1. **Increased shared decision-making** (n=73).
2. **Improved overall patient communication**, including adopting a more patient-centred approach to consultations (n=64).
3. **Actively deprescribed medication(s)** in consultation with patients (n=52).
4. **Greater confidence in conducting mediation reviews** and deprescribing (n=43).
5. **Increased confidence stopping or amending medications** (n=31).
6. **Utilising new phrases and language in medication reviews** (n=30).

Other themes that emerged from the data included adopting use of decision aides in SMRs, proactively identifying priority patients for SMRs, reviewing the process and increasing time designated for polypharmacy reviews, and continued learning based on ALS resources.

Respondents reported using patient facing materials to support decision making with patients, including (in order of frequency), *'Are your medicines working for you?'* (n=132), *'Me and My Medicines'* (n=116), *'Benefits, Risks, Alternatives, Do nothing, or BRAN'* (n=83), and *'WHO 5 Moments of Medication Safety'* (n=50). 'Other' tools used included NICE patient decision aids and implementation tools, NO TEARS tool, QRISK3, GP Evidence, NHSE Decision aids,, TO Rand Dr Chris Cates' EBM Website.

Over half of respondents **(58%, n=303) indicated that they had made a change to their practice around decision making with colleagues.** Of the remaining 42% (n=215), some noted they intended to make relevant changes in future, some mentioned that no change had been made but the Polypharmacy ALS reinforced good practice. Not all open-ended responses clearly identified changes linked to direct interaction with colleagues, possibly due to different interpretations of the question. Open-ended responses were analysed and categorised into representative themes as follows:

1. **Increased shared decision-making involving clinical colleague** (n= 120). Several respondents referenced Multi-Disciplinary Teams (MDT) and MDT Meetings as the source of shared decision-making with colleagues. Others referenced ad-hoc sense-checking decisions and debriefing with

[3] A limitation of the data and this analysis is the inability to assess the *extent* of a large proportion of reported behavioural change. For example, a response noting 'Shared decision making' is indicative that SDM has become more prominent in the respondent's approach to SMR and polypharmacy more generally, however the nature of this cannot be inferred from the data. A response such as this was still allocated to the appropriate behavioural change category.

colleagues around medications decisions.

2. **Increased confidence** (n= 35). In some instances, it was not possible to infer the nature or implication of reported increase in self-confidence, however some responses indicated increased confidence to deprescribe, and to talk to colleagues openly about deprescribing.
3. **Sharing learning based on ALS resources** (n=33 respondents). This included sharing resources accessed via the training, as well as delivering targeted education session to colleagues.
4. **Steps taken to increase workforce capacity** (n=22 respondents), including initiating a PCN-wide Quality Improvement project, utilising data and systems (such as EPACT2) to help identify priority patients, and delivering ongoing training for pharmacy teams.
5. **Able to better evidence decision-making** (n=17 respondents), including being more aware of medicolegal processes and requirements, of evidencing decision making in writing, and taking a greater evidenced-based approach to decision-making.
6. **Actively deprescribed medication(s)** (n=14 attendees). Some reported more generally that they had stopped medications, and others specifically reported reducing or stopping medications such as diuretics, laxatives, creams, sleep aids, Cetirizine and Fesoterodine, Statins, Aspirin, and Opioids.

Other themes that emerged from the data included increased ability to better evidence decision-making and utilising new approaches in medication reviews (including using new phrases/language, pictorial discussion guides and decision-making aides).

Participant experiences of support in making decisions about stopping medicines

Of 111 responses, the **majority (n=69, 62%) reported that they felt supported** in their work. The reasons provided were thematically analysed and grouped into four primary themes:

1) Supportive colleagues and team culture (n=30),
2) Formal MDT structures and specialist access (n=14),
3) Personal confidence and autonomy (n=10), and
4) Access to resources and evidence (n=7).

A further **42 respondents (38%) reported not feeling supported** or identified significant barriers. The reasons fall into five main themes:

1. **Lack of time and workforce capacity** (n=17), citing that they, or colleagues they needed support from, were too overwhelmed with high workloads, "fire-fighting," and reactive work.
2. **Lack of MDT and collaboration** (n=13). Many felt unsupported due to working in isolation, having insufficient MDT opportunities, or limited communication with other clinicians.
3. **Resistance or lack of support from colleagues** (n=10). Some pointed directly to a lack of support or resistance from other clinicians (often GPs) who were perceived as being stuck in their ways, not confident with frailty, or unappreciative of the pharmacist's role.
4. **Lack of expertise or clear guidance** (n=5), including a perceived lack of mentorship, specialist knowledge within the team, or clear evidence particularly for complex patient groups.
5. **Systemic pressures** (n=4 mentions). A few identified system-level issues like Quality and Outcomes Framework (QOF) targets or a general lack of focus on proactive care as barriers to feeling supported in deprescribing.

4.2.2. Implementing National Polypharmacy Action Learning Sets

The following section presents insights from interviews and focus groups with local HIN programme teams. Insights cover approaches to supporting national Pillar 2 activity including implementation facilitators and

challenges, perspectives on outcomes achieved, and lessons learned.

Approaches to implementing National Polypharmacy Action Learning Sets

Local HINs adopted a range of approaches to implement the Polypharmacy Action Learning Sets (ALS), with most supporting the national programme while also developing their own bespoke local training to meet system needs.

Supporting the National ALS Programme
As with Pillar 1, local HINs supported the national Polypharmacy ALS offer by, promoting and disseminating Polypharmacy ALS information within local systems. Some local HINs provided logistical support for participants including following up with individuals who had completed one or two of the sessions to ensure they were able to complete the course and providing support with booking onto appropriate cohorts.

Developing bespoke local education
Several HINs created their own local education training sessions delivered by their accredited Polypharmacy Educators in response to feedback from local systems, who felt the national Polypharmacy ALS offer was 'too restrictive' or difficult to access for some. In particular, the national Polypharmacy ALS criteria, which required participants to be prescribers for 12 or more months, were seen as too "strict" and "too high a bar", excluding many staff who conduct or contribute directly to medication reviews[4].

The time commitment for the national Polypharmacy ALS (i.e. three half-day sessions) was understood by some local HIN programme leads to present a barrier for some busy clinicians. The morning timing of national sessions was also seen as a "challenge for attendance" for some prescribers working in clinics.

Responding to local stakeholder feedback, local HINs adapted ALS content or developed new training content to meet local learning requirements. Common adaptations to included:

- **Shortening ALS sessions for bespoke learning.** For example, one local HIN condensed some of the key content into two educational sessions instead of three, while another offered shorter, 90-minute to two-hour sessions.
- **Adapting content.** Some HINs adapted content from the national Polypharmacy ALS, combining it with local priorities, case studies, and for one HIN, a "'golden thread of QI methodology'". One local HIN developed an additional session focused on presenting and discussing case studies.
- **Expanding eligibility for attendance.** Local sessions were commonly opened to a wider range of professionals, including junior prescribers, "non-prescribing pharmacists", pharmacy technicians, nurses, and staff from secondary care and mental health.
- **Using local trainers.** Local HINs utilised local Polypharmacy Educators under the national programme's 'train the trainer' offer to deliver the bespoke sessions.

"We had secondary care people attending the [locally adapted] training, so it was obviously needed. We tried to respond to the local needs more than just sticking purely with the national team way of doing it and I think it's worked. We've been able to get to a lot more people by adapting." ***HIN Clinical Lead***

One local HIN explicitly framed offering national and local education offers as a dual approach to provide more choice to their system. The national Polypharmacy ALS was "*pitched as the gold standard*" while their own local workshops provided a more accessible "*tier of training*".

Additionally, a few local HINs highlighted that the fact the national Polypharmacy ALS sessions were free

[4] Prior to the national programme, the ALS format had been tested with a wider delegate criterion and was found to not meet the needs of more experienced clinicians. Therefore, the original attendee criteria of requiring at least 12 months prescribing experience were applied in the national programme. Local HINs were able to develop their own educational offers to meet system needs.

to attend helped participation levels.

Implementation challenges

Local HIN leads identified challenges and barriers specific to implementing the Pillar 2 Polypharmacy ALS.

- **Restrictive eligibility criteria**. As noted above, the requirement for participants to be prescribers for 12 or more months was seen as "*too restrictive*", "*too stringent*", and "*too high a bar*" by several local HINs. One HIN considered it a missed opportunity to engage and promote positive behaviours amongst more junior prescribers.
- **Time commitment** of the national sessions presented significant challenges. The three half-day sessions were seen as a significant time commitment for busy staff, particularly for those with regular clinics that cannot be moved.
- **Challenges with attendance and completion** primarily due to scheduling challenges. Some HINs also mentioned the registration period for some cohorts was short, making it challenging for busy clinicians to plan ahead and schedule ALS attendance.

- **Challenges with engaging local trainers** due to their limited capacity. One HIN reflected that their 'most engaged trainer' was the most junior, as this individual had more time to dedicate to the role. More senior accredited trainers found it difficult to commit time to deliver sessions.

Outcomes

Local HIN programme leads discussed several outcomes related to the national ALS, including system-level commitments and increased confidence, however also highlighted challenges regarding visibility of outcomes.

- **Increased clinician confidence.** Some HINs reported anecdotally that those attending the ALS expressed increased levels of confidence to conduct structured medications reviews and deprescribe where appropriate.
- **System-level commitment and sustainability.** In one region, the polypharmacy ALS model led to system-level change, with one ICB having framed their entire prescribing incentive scheme around over prescribing and polypharmacy.
- **Peer-to-peer learning.** The national sessions were seen as facilitating learning between colleagues. One local HIN noted that some participants participated in the Polypharmacy ALS on the proviso that they would report back to their local teams and share learning. Some highlighted the value of national delivery for sharing and learning from diverse practice across the country.

Several local HIN programme teams noted challenges in measuring outcomes due to focus on monitoring and reporting on process-level metrics, rather than changes in practice. A key challenge was understanding what participants did with their learning after the course ended. It was also noted that the impact of the Polypharmacy ALS training would not be immediate, making short-term measurement challenging.

Lessons learned

HIN programme leads identified several key lessons from implementing the Pillar 2 polypharmacy ALS:

- **The need for flexible and adapted training**. A recurring lesson was that a rigid, one-size-fits-all approach to training is not effective. Rather, training requiring significant time commitment should respond and adapt to local system characteristics and needs, and consideration needs to be given to provision of a multi-tiered education offer to include all relevant health professionals. The National Polypharmacy Programme Team have already taken steps to address this gap, through

development of the ALS Foundation, aimed at junior prescribers. An evaluation of the ALS Foundation was undertaken by Health Innovation Wessex.

- **Integrate Quality Improvement (QI) training**. Some felt that the ALS assumed a level of QI knowledge that participants often lacked, and as a result some participants struggled to understand how best to implement changes to working practices.
- **Provide delivery teams with more information**: A lesson for national programmes was to give local delivery teams better insight into the training they are being asked to promote. This would have supported some HINs to promote ALS more effectively to local systems.

4.2.3. Polypharmacy Action Learning Sets Health and Justice

The NHS England Health and Justice Lead Pharmacist requested a small pilot to understand the benefits of Polypharmacy ALS participation by clinicians working within the Health and Justice sector responsible for prescribing medicines for prison populations. Given the unique prescribing context compared to community primary and secondary settings, three interviews and a focus groups were conducted by the national programme team with health and justice Polypharmacy ALS participants to understand the relevance and applicability of the Polypharmacy ALS to their prescribing contexts. Participants included mental health prescribing nurses, nurses, pharmacists, and five GPs (including a Lead and Regional Lead GP).

The following presents a summary of insights derived from data analysis.

Usefulness and applicability of the ALS to attendees

Participants described several elements of the Polypharmacy action learning set (ALS) that were useful, which can be grouped into core themes:

- **Peer learning.** Participants frequently cited the opportunity to learn from the experiences of others, particularly those outside their immediate specialism, as a key benefit. Participants appreciated hearing the perspectives of clinicians from different sectors and learning how their challenges and practices differ.

"It was just good to hear other people's perspectives working in different sectors as to how they manage other medicines to give us that confidence, because we often get bogged down." ***H&J Polypharmacy ALS Delegate***

- **Practical resources.** Participants found the practical tools and resources provided during the course to be valuable for their practice. The course also prompted reflection on how to better use data. One pharmacist was prompted to conduct an audit on PPI prescribing after the course.

"I found really useful when we went through the whole selection of tools that are available, like the 'quality of life index', especially with older adults I could use those tools in my consultation." ***H&J Polypharmacy ALS Delegate***

- **Session content.** Participants appreciated that the course covered polypharmacy beyond just dependence-forming medications, which can dominate their work in prisons. It served as a "*good reminder*" that their patients have other physical and mental health needs and increasingly live with multiple long-term conditions. The variation of specialists was well-received.

Attendee learning and behavioural outcomes

The polypharmacy ALS **encouraged participants to reflect on their own clinical habits and thinking**. Some noted it provided space to reflect on prescribing mindset and approach. The ALS acted as a "nice reminder" to question the reasons for prescribing and to be mindful of the "righting reflex" or feeling pressured to give a patient a prescription.

"The geriatrician talked about being mindful of, 'does this person need this medication, and why are we prescribing it?'. We do quite often feel quite pressured. Just being aware of that, and are we doing it for the right reasons? Is it appropriate prescribing?" ***Health and Justice Polypharmacy ALS participant***

A key takeaway for some was the importance of providing patients with knowledge, exploring non-pharmaceutical alternatives, and empowering them to make their own choices about their health. Participating alongside and learning from other professionals gave participants confidence in their own decision-making.

Several participants reported making tangible changes to their clinical practice and mindset around shared decision-making and stopping medicines since attending the polypharmacy ALS.

For some, the training prompted changes in clinical and prescribing practices among participants, including proactively auditing specific, high-risk medications to identify patients for deprescribing reviews, clearer documentation of medicines decision-making within care plans, and using topics from the course to help standardize prescribing practices at their local medicines optimisation board meeting.

For some participants who had only just finished the course, it was too soon to have implemented specific changes. However, they noted that it had reinforced good practice and changed their thinking.

Participants identified barriers that prevent shared decision-making with patients in the prison setting. This included patient mindset and resistance to medication changes, limited patient interaction due to time constraints linked to short sentences, fragmented care between prison and community settings, and a lack of data and IT infrastructure compared to community settings.

Participant suggestions for adapting ALS for roles within the health and justice sector

Participants identified a need for the training to be tailored to the unique challenges of the prison setting, suggesting it should include sessions on the environmental and social factors that complicate prescribing and medication management. For instance, clinicians noted that significant issues like the trading and concealment of medication were not covered. They also felt the training could better address the "emotional weight" of working with a cohort prone to self-harm and who have complex personality disorders.

Those in mental health roles specifically suggested including more on the complex overlap between mental health, physical health, and substance use, with a greater focus on younger people and relevant medications like Gabapentintoids. A further recommendation was to cover the systemic barriers between prison and community care, as clinicians working exclusively in prisons found some content aimed at community GPs less relevant.

These suggestions led to a discussion about whether to adapt the current Polypharmacy ALS or develop a new, bespoke programme. While some advocated for creating a course specifically for the secure environment or grouping Health and Justice practitioners together to reduce isolation, others highlighted the value of maintaining cross-learning opportunities between prison and community prescribers.

4.3. Pillar 2: Polypharmacy Masterclasses

The National Polypharmacy Masterclass series was developed by the Polypharmacy Programme Team in response to feedback gathered during the Polypharmacy Action Learning Sets (ALS), where participants consistently raised common areas of prescribing where they lacked confidence and competence. Building on a local "Polypharmacy Masterclass" model from Health Innovation Wessex, the national series was created to address these concerns.

Sessions featured a national subject matter expert who conducted a 'deep dive' into a therapeutic topic as it relates to polypharmacy. Polypharmacy Masterclass sessions typically lasted an hour and a half and involved an introduction with prescribing data, expert presentation, real-life patient case studies, and a final panel Question and Answer session.

Nine Polypharmacy masterclass sessions were delivered between May 2024 and June 2025. In total, 6,359 people registered for the nine masterclass sessions, with 4,058 attending. A further 2,843 have since watched the recorded webinar online (as of September 2025). Appendix 10.3 provides details of masterclass session topics and delivery dates.

4.3.1. National Masterclass feedback

The National Polypharmacy Programme team implemented a Masterclass post-session feedback form, receiving 354 responses. Over half respondents (n=183, 53%) were pharmacists, with most of those describing themselves as clinical pharmacists. A total of 34 (10%) were GPs, and 19 (6%) respondents indicated that they were nurses.

Participant experiences of Masterclass sessions

Feedback forms asked participants, *'Did the session meet your expectations?'*, providing a scale of 1-5[5]. Overall, ratings were very high when taking ratings 4 and 5 together, with no individual session returning less than a 94% response.

Open-ended comments were invited on each of the webinars. Feedback was overwhelmingly positive with respondents drawing attention to the content being informative, evidence-based, thought-provoking. and deeply insightful, with several noting that the content challenged existing assumptions and broadened their understanding.

Feedback also highlighted the practicality and immediate applicability of the content, particularly in clinical settings. Case studies and discussions of tapering strategies were especially valued. Respondents appreciated the clarity, passion, and knowledge of the presenters, mentioning of their ability to connect with the audience and include diverse perspectives.

There was a small amount of negative feedback where it was felt that the presentation has been too fast or that terminology was not understood.

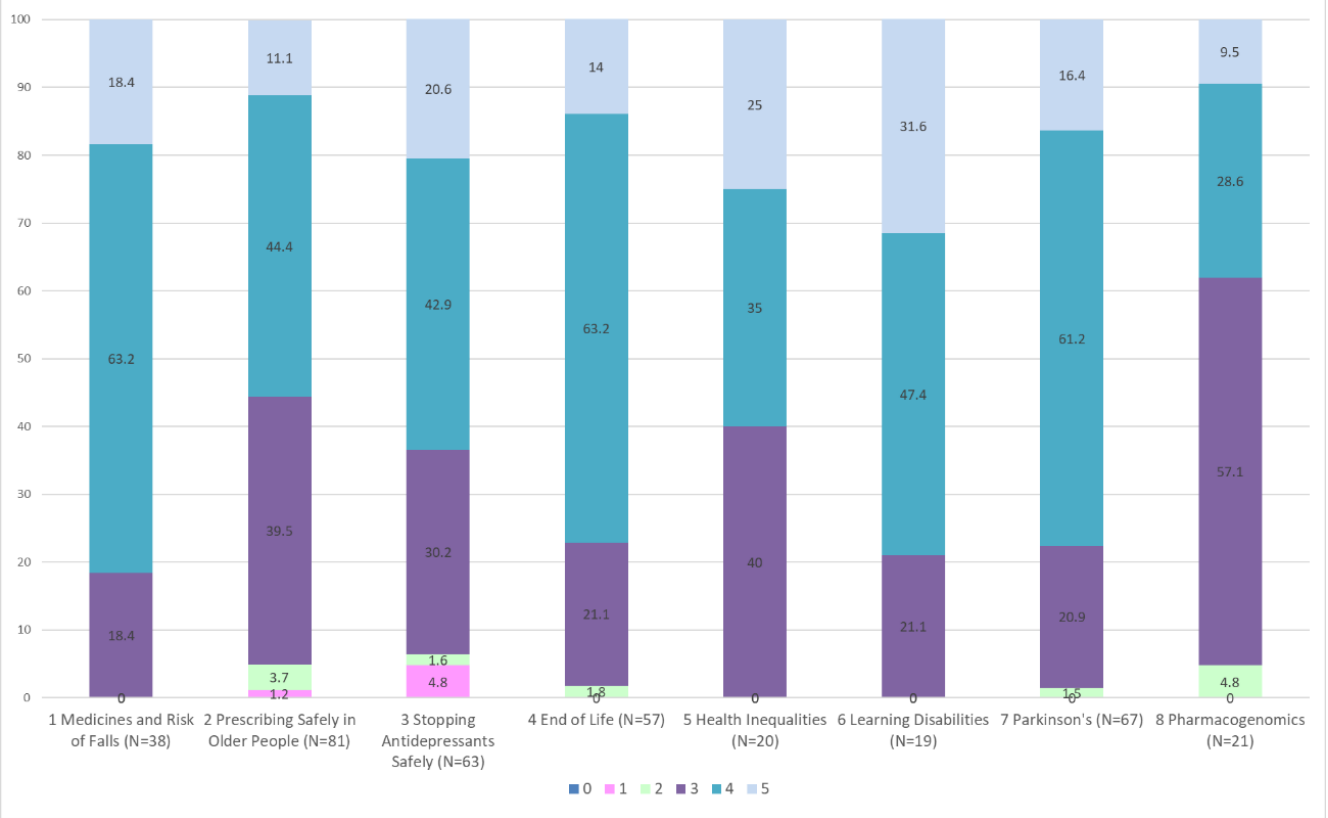
Attendee confidence

Polypharmacy Masterclass feedback form respondents were asked to rate their level of confidence regarding each respective polypharmacy masterclass topic on a scale of 0-5. There was considerable variation across the sessions in the proportion of respondents rating their confidence as 4 or 5[6], ranging from 38.1% for the Pharmacogenomics masterclass, to 81.6% for Medicines and the Risk of Falls. Analysis identified no direct relationship between confidence and the rating of the quality of the session. Figure *9* shows the variation in self-reported participant confidence levels associated with each masterclass session.

[5] It is not clear whether feedback forms qualified the scale, e.g., '1= expectations not met at all, 5=expectations exceeded'. For the purpose of analysis, '1' has been interpreted as the lowest score (i.e., expectations not met in any way), and '5' has been interpreted as the highest score (i.e., 'expectations fully met/exceeded').

[6] Again, it is not clear whether feedback forms qualified the scale. For the purpose of analysis, '1' has been interpreted as the lowest score (e.g., not at all confident), and '5' as the highest score (i.e., 'fully confident').

Figure 9 *Participant reported confidence levels on each polypharmacy masterclass session*



Open-ended responses regarding confidence levels

Although many respondents indicated that their confidence had increased, the strongest theme emerging from the data was that more learning and information was required. Only a small number felt their confidence had decreased and there were a considerable number of responses indicating that the question was not applicable (e.g. because they are not a clinician) or 'don't know' responses.

Around 15 respondents suggested their confidence (in relation to the masterclass topic) had increased.

"Much more comfortable in justifying lower doses and also starting a discussion about why a drug that patient been on for many years, WAS useful and helpful when younger, but now is more uncertain/dangerous now." ***GP***

Several respondents suggested they had more to learn before they would feel confident, with some noting a need to revisit the course material or do further related reading. Several respondents referred to the complexity of the topic and the need to get more experience or practice.

"I think I just need to develop my experience despite the impact of the webinar." ***PCN Clinical Pharmacist***

A small number of respondents suggested their confidence had decreased because of the polypharmacy masterclass, and this was because they had become more awa re of complexities and risks.

Applying Masterclass learning into practice

Almost all (n=343, 99%) of respondents felt they would be able to apply masterclass learning into practice. Further comment through open-text responses provided the following themes.

- **Changing prescribing and deprescribing habits.** Several noted their intention to change their approach to prescribing certain drugs, notably antidepressants. This included being more cautious about "*not initiating as many SSRIs [Selective Seretonin Reuptake Inhibitors]*", planning to "*withdraw ADs [anti-depressants] more slowly using liquids*", and generally amending their "*tapering plans*

and counselling".

- **Improved confidence** to undertake structured conversations with patients around their medications, including having "*More confidence in some of the conversations to be had*". The sessions provided a "*robust scientific background to support tacit knowledge and gut feelings*".

"Having more confidence to plan conversion to patches in future. This has been delayed in a lot of my end-of-life patients." ***Senior Specialist Practitioner District Nurse***

- **Improving patient communication.** Many respondents focused on how the learning would change their interactions with patients and their families. A key takeaway was the value of communication techniques, including framing discussions and language used. A recurring point was the intention to focus more on what is important to the patient.
- **Sharing Learning and Influencing Colleagues.** Participants frequently mentioned their intention to disseminate the information to their wider teams, to "*share the learning and encourage others to attend such sessions*".

"I will be sharing this with my team. I chair a PD [Parkinsons Disease [MDT [Multi-Disciplinary Team] with PD CNS [Clinical Nurse Specialist] and Hospice community colleagues. This is very useful to help refresh and inform my knowledge further." ***Consultant in Palliative Medicine***

- **Need for Further Learning.** A subset of responses indicated that the masterclass was the beginning of a learning process, not the end. Several participants expressed sentiment that "*There was so much information, that I feel that I will need to watch again to embed some elements*".

4.3.2. Approaches to implementation

Local HINs primarily supported the implementation of Pillar 2 national masterclasses through promotion to local systems. Whilst overall engagement with national Masterclasses was notably high, some HINs reported challenges generating significant engagement within local systems, which led them to focus efforts on developing bespoke local educational offers instead.

Local Polypharmacy Masterclass development
Local polypharmacy masterclass sessions were developed to address challenges specific to local conditions, and to address specific gaps in clinician confidence. Local HINs chose local masterclass topics based on discussions with ICB leads, by engaging with ICB Medicines Optimisation task and finish groups, and in response to direct clinician feedback.

Local Polypharmacy Masterclasses covered a range of specific clinical and practical topics identified by the local systems, including:

- Anticholinergic burden (ACB)
- Deprescribing cardiac medications
- Reducing medications linked to diabetes
- Deprescribing opioids
- Mental health, frailty, and oral nutritional supplements
- Quality Improvement and falls-inducing medications

5. Pillar 3: Public behaviour change

Prior to the HIN Polypharmacy Programme, there was no readily available resources to help patients understand what a structured medication review was or how to prepare for a discussion about their medicines with health professionals. In Year 1, the programme team identified early-stage developed patient resources and worked with 11 local Health Innovation Networks (HINs) to participate in a nationally coordinated effort to test the acceptability of these materials designed to support Structured Medication Reviews (SMRs) with patients.

Local HINs ran a series of focus groups in summer 2022 with patients and prescribing clinicians to collect feedback on which of three pre-established materials were preferred by local stakeholders. The three materials tested were: Are your medicines working for you?, Me and My Medicines, and 5 Moments for Medication Safety The Health Innovation Network South London conducted an evaluation of programme Year 1, which includes patient and clinician insights gathered through the process of testing materials.

Each local HIN was encouraged to adopt the preferred material and promote its use within SMRs across the local system as part of a local pilot. The aim of this pilot was to capture both patient and clinician feedback to inform further refinement and scale-up of materials across the system. Evaluation showed that overall, the materials were well received by patients and most clinicians. Improvement recommendations were implemented and in September 2023 a suite of patient materials, developed in partnership with patients, clinicians and academia were made available in 12 community languages including audio and launched for national roll-out. In 2024, Easy Read versions were added, co-created and tested by Mencap Liverpool and Sefton.

In summer 2024, the national Polypharmacy programme opened a funding call for Core20 PCNs to utilise the patient facing materials in groups of patients known to have low engagement. There was significant interest in participating in the project with100 bids received across each of the participating10 HIN regions. National funding was available for one PCN per HIN region only, resulting in seven local HINs identifying local funding to support a further 17 PCNs.

This section provides insights from focus groups with local HIN programme teams and local HIN generated case studies, to provide examples of how materials were integrated into practice. The review is unable to comment on the breadth and depth of adoption of SMRs and shared decision-making materials at local and national levels, and cannot provide a determination regarding the programme's efficacy in achieving intended outcomes and impact relating to prescribing behaviours and corresponding rates of polypharmacy. However, case studies indicate that utilising ePACT2 comparator data and shared decision-making materials can lead to improved patient and clinician experience, and medicines optimisation through deprescribing and altering existing prescriptions.

The section identifies approaches to implementing the materials, implementation facilitators and barriers, and reflections on sustainability and learning for future delivery.

5.2. Implementing Pillar 3 behaviour change

The extent to which local HINs committed time and resource to encouraging the adoption and use of SMR support materials across their local systems varied. Some dedicated staff resource to engaging proactively with and supporting select sites within their system, such as individual practices and PCNs, where there was buy-in and interest to trial materials.

Others decided to prioritise other programme pillars and therefore diverted limited resource to this aspect of the programme. Some local HINs and local system stakeholders adapted existing materials based on system feedback and the requirements of local populations.

Local adaptations and additions

Some local HINs developed the established materials to better suit their local systems and populations. In many cases, where funding allowed, the adaptations were then incorporated into newer iterations of the resources. Examples included:

- **Improving accessibility for non-English languages**. HIN East Midlands adapted the 'Me and My Medicines' materials so that the original QR code linked to non-English audio translations to improve accessibility for non-English speaking local populations. To ensure equity in access, additional funding was secured from NHS England by the National Team to enable QR codes to be made available across all patient resources as part of the Phase 2 National roll-out.
- **Targeting specific community groups**. A few local HINs encouraged practices to adapt materials to local needs. One example of this was a practice that publicised translated materials on their website to reach ethnic minority groups within the population they served.
- **Developing supplementary video resources**. A local HIN created its own films to explain the SMR process to both clinicians and patients, which helped with understanding and buy-in for both audiences. The films were incorporated into the national programme resources and promoted in the Polypharmacy Action Learning Sets.

Factors supporting adoption of materials

Local HINs identified several factors that facilitated the implementation of Pillar 3.

- **Targeted funding for adoption**. The availability of funding pots was a significant driver of engagement. Some HINs noted they only saw significant uptake of materials when funding was released via CORE20Plus bids. This funding was seen as a crucial enabler, as it gave clinicians a "*way into their practice managers to be able to be given the go ahead*" and "*brought in PCNs that the HIN hadn't previously engaged with*".
- **Peer-to-peer advocacy through system 'champions'**. Working collaboratively with clinicians who were early adopters to champion the materials was a highly effective strategy for some HINs.
- **Proactive HIN support**. Direct, hands-on support from local HIN teams was a key facilitator in some areas. A few HINs did a *"lot of the legwork"* to engage practices, which included briefing pharmacists on the materials, and setting up local working groups to discuss and support use.
- **Availability of an evidence base**. As the programme progressed, the growing evidence base and testimonials highlighting efficacy of the materials made it easier to get buy-in from practices.
- **Local adaptation of materials**. Adapting the national materials to suit local population needs was another facilitator seen to encourage the use of materials at a local level. This was particularly important for local populations with diverse language requirements.

Challenges to material adoption

Local HIN programme teams identified barriers to the adoption of SMR materials, however all HINs noted difficulty in understanding fully what practical barriers were experienced at more local levels (i.e., practice and PCN) due to a lack of system feedback. Key barriers highlighted were:

- **Lack of system capacity and time.** A primary barrier HINs reported hearing from local stakeholders was the lack of time and capacity within GP practices to conduct SMRs using the materials. The process of coordinating materials, delivering SMRs, and collecting feedback was understood as time and labour intensive, presenting a barrier to adoption. One HIN highlighted a "*very difficult dynamic*" where the areas with the biggest polypharmacy challenges "*also have the biggest challenges in being able to release the resources*" to adopt materials as intended.

- **Integration into workflows.** Several practical issues made it difficult to embed the materials into practice workflows, for example, adapting the process for in-person versus remote consultations, and integrating materials into clinical systems like Ardens or EMIS.

From the perspective of local HINs themselves, supporting the adoption of materials within local systems was also time and resource intensive. Some HINs chose to dedicate resource to supporting local adoption, which required proactive and targeted support of local systems over a significant period. Others did not have internal resource to commit to this level of support and therefore focused mainly on promoting the use of materials through established communication channels.

Pillar 3 Outcomes

Some local HINs noted areas of clear positive outcome where the materials were successfully implemented but also highlighted significant challenges in systematically measuring these outcomes. Where the materials were adopted, the feedback was positive:

- **Improved patient empowerment and engagement.** One local HIN reported receiving "*almost immediate*" feedback that the materials worked well. Patients were "*turning up knowing what they want to talk about*" and "*feeling empowered to bring the questions they feel much more involved*".
- **Success in seldom-heard communities.** Several HINs noted that the CORE20Plus funding significantly increased engagement with seldom heard communities.
- **Broader use of materials beyond polypharmacy**: In one region, the patient-facing materials were adopted for use in a wider range of reviews, not just those focused on polypharmacy, as a result of their effectiveness in supporting shared decision-making during consultations.

"Some localities used the materials for different reviews, not just for polypharmacy, because they were felt effective in supporting patient empowerment and shared decision-making". **Local HIN programme lead**

Lessons learned

Participants identified learnings specific to implementing Pillar 3:

- **Provide practical guidance on workflow integration**. A key learning was that more support was needed on the practicalities of embedding new materials into existing clinical systems and practice workflows.
- **Building and publicising an evidence base early can help secure interest, buy-in and adoption**. It can be easier to get buy-in from practices and other stakeholders once there is clear evidence of the materials' wider use and effectiveness.
- **Develop mechanisms for monitoring uptake and outcomes.** A significant challenge was the inability to track the extent and nature of material use across local systems. Established approaches and support from the outset may have made understanding outcomes, and providing targeted support, more feasible.
- **Recognise the need for proactive HIN support.** Simply making resources available and promoting use is not enough to encourage wide-scale adoption. Rather, active and at times technical support is required to encourage and support adoption on a wider scale.

6. Polypharmacy Case studies

6.2. Local HIN Polypharmacy Case Studies

Local HINs generated polypharmacy case studies, focusing on a self-selected aspect(s) of programme delivery. Table 2 provides an overview of selected case studies, including the area of focus, activity, and outcomes and learning. All submitted case studies can be found on the National Polypharmacy Programme Website.

Table 2 *Overview of local HIN case studies*

Case Study Overview			
Local HIN	**Area of focus**	**Activity**	**Outcomes and Learning**
Wessex	Developing National Polypharmacy Programme Pillar 2 assets	• Wessex led the development of the Polypharmacy Action Learning Set (ALS) model and Masterclass series utilised by the National Programme. • In addition, an ALS Foundation course targeting junior prescribers was developed.	• The ALS and ALS foundation course increased confidence for many participants, lead to changes in practice, and improved workplace collaboration. • Masterclass Series successfully engaged and educated large volumes of national workforce.
HIN South London	Communities of Practice (CoP)	• Established and delivered two self-governing CoPs, with SEL ICB and SWL ICB. • CoPs focused on locally derived priorities, facilitating open multi-stakeholder communication and collaboration. • CoPs were held face-to-face.	• Building on and optimising existing resources supports spread and adoption. • Buy-in from medical directors and senior leaders is critical to system change and alignment with strategic priorities. • Highlighting shared benefits builds consensus and drives sustained collaboration.
West of England	Local ALS adaptation and adoption	• Building on success of national ALS, developed local ALS offer open to trainees and newly qualified prescribers. • Sessions were shorter than national ALS (three lunch-time sessions) and had smaller cohorts to encourage personalised networking between participants. 613 participants.	• A clear offer adaptable to local system needs effectively engages target stakeholders. • Localised training can boost participant engagement and long-term support. • Very positive participant and trainer feedback.
Kent Surrey Sussex	Implementing local changes through local training and CoPs	• Accredited ALS trainer co-delivered two polypharmacy training sessions and co-chaired several CoPs.	• Training has led to changes in practice. E.g., using PrescQIPP guidance and Anticholinergic Burden calculator led to revising medications to produce a lower ACB and relieve symptoms, to the patient's improved satisfaction.
Yorkshire and Humber	Reducing no. patients at risk of Anticholinergic Burden (ACB).	• Joined SMR task and finish groups. Produced data packs at PCN, sub-ICB, and ICB level to highlight ACB trends. • Delivered two local ACB focused Masterclasses. • Provided support direct to PCNs to embed patient SMR resources. Developed ACB educational videos and produced ACB guidance documents for clinicians and leaflet for patients.	• Steady decrease in no. >65yrs at ACB risk. Increased use of comparator data and changes to SMR practice. • Almost 200 clinicians attended the local ACB Masterclasses, with positive participant feedback. • Educational videos viewed over 1,600 times, with positive feedback. • Patients report use of SMR resources gave confidence to ask questions.

6.3. Core20PLUS5 Case Studies

The National Polypharmacy Programme provided funding for PCNs to run pilot projects implementing SMR materials within Core20PLUS5 populations. Participating PCNs submitted case studies showcasing their pilot projects.

Table 3 below provides an overview of selected Core20PLUS5 case studies. Data relating to case studies has not been analysed or independently verified by the review team. All submitted case studies can be found on the National Polypharmacy Programme Website.

Table 3 *Overview of selected Core20PLUS5 case studies*

Coer20PLUS5 Case Study Overview			
PCN	**Area of focus**	**Activity**	**Outcomes and Learning**
Northern Arc PCN	Patients with hyper-polypharmacy and moderate to high ACB	• ePACT2 identified priority patients for SMR. • NHS numbers were requested, and patients were invited to SMR. • Information and resources shared with patients prior to SMR via text message and printed versions. • 200 SMRs conducted of 263 invited.	• Through SMRs, non-compliance issues were identified, side-effects and ACB scores discussed with patients, inappropriate medicines identified and stopped. • Notable reduction in polypharmacy related parameters related to project focus. • Rates of hyper polypharmacy and ACB scores reduced. *"I didn't realise some of my issues were medicine related; My colleagues have noticed such an improvement in me since stopping these medications."* **Patient**
Reading Holybrook PCN	Improve safety and reduce prescribing burden in high-risk patients where English is a second language	• Targeted seldom heard groups with high do not attend rates, with aim to improve engagement through SMR materials. • 70 individuals invited to SMR via telephone, text message, mailed letter. 52 appointments scheduled, 50% in person vs telephone consultation.	• 23 SMRs completed (44% of scheduled) with previously unreached patients. • SMR shared-decision-making resources were well received. Invitation letter in primary (non-English) language supported patients to have a clear understanding of and prepare for appointment. • PPIs and over the counter medicines most deprescribed. *"These are patients we haven't seen in a long time, who are now accessing services through the practice."* **Clinical Pharmacist**
Hammersmith and Fulham North PCN	Increasing SMR uptake in high-risk patients	• Pilot targeted patients aged >75yrs on 10+ medicines who hadn't had an SMR within 12 months. • Patients sent an invitation letter and received a follow-up phone call or text message offering a 30 minute face-to-face or telephone appointment with clinical pharmacist. • A weekly SMR clinic was set up over a three-week period to review patients.	• All 20 invited patients attended their appointment and completed the feedback form. • 75% of patients noted receiving materials prior to their appointment, reporting they helped to understand the reason for the appointment, and prepare for discussing medicines and what was important to them. *"I was waiting for this type of appointment as there was a specific query which I wanted clarification on but did not want to impose on the surgery."* **Patient**

7. Communities of Practice (CoP)

Programme Pillars 1-3 were underpinned by Polypharmacy Communities of Practice (CoP) delivered within each local HIN geography, bringing together a multi-stakeholder, cross sector group of individuals with an interest in reducing problematic polypharmacy within their geographical area. CoPs are networks of professionals that share common goals or interests. CoPs can be sources of knowledge, learning and support.

Local HINs received training and support from the Health Innovation Network South London on the theory, purpose, and approach of CoPs. Thereafter, local HINs were given autonomy on how they delivered CoPs within their systems.

7.2. Implementing Polypharmacy CoPs

This section provides an overview of key insights regarding implementation of CoPs from interviews with CoP leads conducted by the National Polypharmacy Team, and from focus groups with local HIN programme teams conducted by the review team.

Polypharmacy CoP delivery

Local HIN CoP leads delivered CoPs with the objectives to provide platforms for

- **Sharing experiences and practical learning**
- **Enabling networking**
- Providing a **psychologically safe space** to discuss challenges related to polypharmacy
- **Raising awareness** of polypharmacy issues and **empowering clinicians** to address these

"It was to create a psychologically safe space for people to come together to discuss polypharmacy and create a learning space to discuss challenges, share experiences and learning in an open forum to get to the bottom of challenges and improve going forward." ***CoP Lead***

Those involved in the set up and delivery of CoPs at the local level varied between HINs. **Project managers and senior improvement leads** from the local HINs were often central to setting up and delivering CoPs within their regions. In some regions, **clinical advisors** and leads played an important role, often leveraging their existing networks to secure speakers and using their clinical expertise to shape CoP content.

Core planning groups, or similar, with diverse clinical and non-clinical backgrounds were established in some regions to represent local systems and help develop ideas and content that would most benefit system stakeholders and needs.

Polypharmacy CoPs attendance

Local HINs encouraged participation from a broad range of system stakeholders relevant to polypharmacy, which was established to greater or lesser extents. **Pharmacists** were the most represented group, including primary care, secondary care, and community pharmacists. While most CoPs sought to engage **general practitioners (GPs),** many regions struggled due to workload pressures and prioritisation.

Efforts were made to include **secondary care** clinicians and consultants, though this was also noted as a challenging area for consistent engagement. Some CoPs had consistent representation from **universities and pharmacy schools**, who often presented in the sessions. Some regions tried to involve **patient and Voluntary Community and Social Enterprise (VCSE) sector representatives** but found it challenging to maintain and manage their involvement due to the clinical and candid nature of discussions.

Approaches to delivering Polypharmacy CoPs

The **frequency** of CoPs varied across regions. Most held CoPs every three or four months. One CoP had only one session throughout the course of the programme. CoPs were run **online** across all the regions, with the exception of one local HIN that ran two CoPs face-to-face. Some noted preference to run CoPs in person, however this was not possible due to practical and logistical reasons.

Most HIN regions ran **separate CoPs for individual ICBs** within their region, which was viewed as generating greater local ownership, relevance, and sustainability, as well as to support more candid discussions within CoPs. One HIN region opted to run a **single CoP across three ICBs** with the aim of fostering greater awareness, learning, and networking across a larger and more diverse group of people.

Many regions struggled to implement a "true" or "hands-off" CoP model as promoted in training, citing system pressures and lower-than-expected engagement as significant barriers. This led most to adapt their delivery towards more structured educational, information-sharing sessions.

Facilitators to delivering CoPs

While most local HINs adapted activity so that it no longer reflected a CoP in theory, local HIN teams offered aspects of delivery that they felt successfully responded to local system needs, ultimately increasing relevance and engagement:

- **Creating relevant, educational content based on community feedback** was felt to be an important factor leading to increased engagement. Shifting to shorter, more frequent, and less interactive online sessions was also understood to be more targeted and accessible to busy clinicians.
- **Fostering community ownership and trust**. For some HINs, an important element of success was shifting ownership to the system stakeholders. However, a 'hands-off' approach was not successful in all regions, and some HINs felt obliged to retain overall control over CoP.
- **Effective communication and feedback loops**. Promoting CoPs through social media, newsletters, and direct mailing lists was key to raising awareness and engagement. Feedback systems via surveys and polls directly informed agendas and a sense of ownership and buy-in.

Challenges to delivering CoPs

HIN CoP leads identified common themes relating to CoP delivery challenges:

- **Participant engagement and attendance,** particularly secondary care staff and GPs, was a consistent challenge, which was understood to be a result of workload pressures. **Facilitating participant interaction** was a major hurdle. Attendees were often reluctant to speak up or turn on their cameras and participate in breakout room discussions.
- **Difficulty in finding local "champions" willing to lead CoPs** was a common issue. Furthermore, ICB restructures and staff turnover made it hard to identify the "right" people to engage with and maintain consistent system-level support.
- **Uncertainty around national programme funding and duration** led to "stop-start" delivery, which made it difficult to maintain participant engagement. HINs and host organisations also faced their own resource constraints, limiting administrative and technical support dedicated to delivering CoPs.
- **Measuring impact and outcomes** was challenging for CoP leads, who found it hard to gather feedback beyond attendance and satisfaction ratings, specifically on what attendees did differently in practice.

Polypharmacy CoP outcomes

CoP leads identified outcomes stemming from CoP delivery, although many noted challenges in consistently capturing measurable, direct outcomes and impact on practice.

CoPs effectively **increased knowledge and awareness of polypharmacy and related issues**, and provided a vital "*finger on the pulse*" of real-life experiences and challenges across local systems.

"It's given us direction. Where we know that we're doing well, which I think has been useful, and it where we're not." **CoP Lead**

Some noted that CoPs **increased practical knowledge** by providing educational content in an accessible format that clinicians within their system needed and appreciated, and in an accessible format for 'busy clinicians'.

"90 Plus percent said they learnt something that they could apply in practise from the session." **CoP Lead**

It was also felt that CoPs **improved system confidence and empowered participating clinicians** by increasing confidence to discuss medicines with patients and change prescribing behaviour. Another reported benefit and outcome of CoP was they **enhanced networking and collaboration within local systems.** Specifically, some CoP leads reported better relationships with ICBs, improved links between primary and secondary care, resulted in closer collaboration and learning between pharmacists and pharmacologists, and between frontline services and academic institutions.

"By biggest observation is that it's bringing together primary and secondary care, those two groups that would not normally talk to each other." **CoP Lead**

Development of new tools and resources, was also noted as an important outcome that would also help support sustainability. These ranged from the creation of a user-centred communications package for SMRs and a new primary care 'intervention tool', to the wide dissemination of best practices like "top tips for greener prescribing" and SMR guidance.

Polypharmacy CoPs sustainability

The extent to which Polypharmacy CoPs were felt to be sustainable was highly variable and depended almost entirely on securing ownership from a local system partner. Many leads expressed concerns about long-term sustainability due to factors outside their direct control, such as ongoing resource constraints, shifting ICB priorities, and the inherent time pressures on busy clinicians. Despite this, some CoP leads adopted approaches to sustainability.

A few CoPs were successful in **embedding CoPs within existing system structures**, such as ICB Medicines Optimisation Team (MOT) meetings, existing programmes, and the polypharmacy schools of academic institutions.

From the outset, some HINs developed **CoP planning and steering groups** consisting of multiple local stakeholders, with the aim of fostering local ownership. This was understood to provide effective foundations for CoP sustainability. Some local HINs created **toolkits and handover documents** to make the transition easier for future hosts. Some have made **resources easily accessible on online platforms** (e.g., pain management resources hub, NHS Futures pages) to allow for continued access to learning in the scenario live sessions change or cease.

Learning to inform future Polypharmacy CoP delivery

CoP leads identified key learnings for future CoP delivery. **Having a core planning group** consisting of a

breadth of relevant system stakeholders can help foster ownership, guide strategic direction, and enhance relevance of the CoP. **Planning for sustainability from the outset** by identifying and preparing future hosts organisations and leaders for the CoP is crucial for its sustainability.

Responding to members' needs by actively soliciting and incorporating feedback from members on desired topics and questions can ensure relevance and engagement. **Considering the feasibility of the CoP approach**, in terms of local stakeholder capacity and needs, and the technical ability and capacity of those leading the initiative, is important to understand likelihood of successful CoP delivery.

Maintaining psychological safety creates a safe space for open and honest conversations, fostering trust and candid sharing among attendees. **Balancing education with interaction** is important to provide the most valuable and attractive proposition for local systems.

7.3. CoP Participant Feedback

The National Polypharmacy Team implemented a CoP participant feedback form for completion by participants across all HIN regions. The feedback form was sent to all local HIN CoP leads for sharing to respective CoP participants. The following section presents findings from the feedback form.

Feeback was received from a total of 48 responded from eight of the 17 established CoPs, representing seven of the 12 participating local HINs. More than half of responses (n=25, 52%) were affiliated with South West London (SWL) CoP. Yorkshire & Humber CoP represented eight responses (17% of total), and South East London (SEL) CoP represented six responses (13%). The other five CoPs returned three or fewer responses.

Most respondents were Pharmacists (n=29, 60%). The second most cited role was 'Service user, Patient or Expert by Experience (n=6, 13%). Other professional roles included GPs (n=2), Nurses (n=2), and social prescribers (n=2).

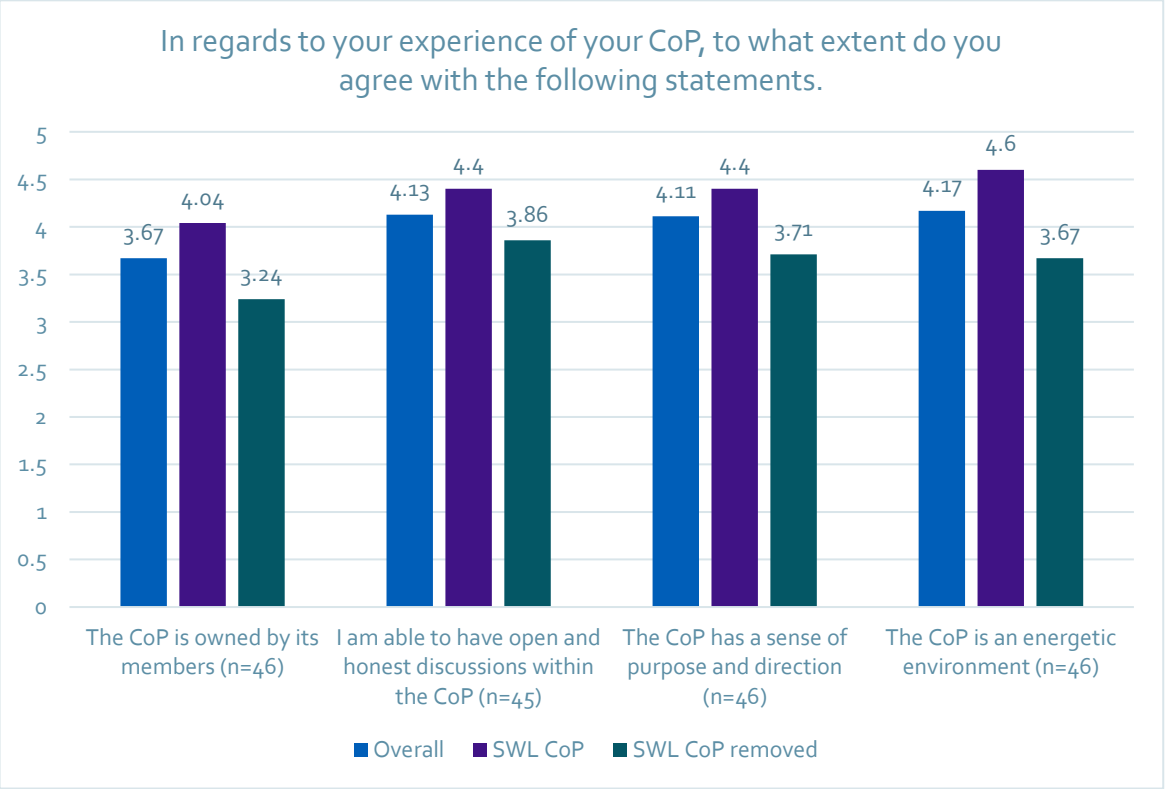
Experience of participating in the Polypharmacy CoP

Respondents were asked to rate their extent of agreement on a series of questions relating to their experience of participating in CoPs using a five-point scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

Overall, most respondents agreed that they felt able to have open and honest discussions within the CoP (n= 39, 87%), that the CoPs have a sense of purpose and direction (n=37, 80%), and the CoP is an energetic environment (n=38, 83%) (Figure 10). Whilst most agreed that the CoP was owned by its members (n=27, 59%), a notable proportion (n=18, 35%) expressed neutral sentiment.

Given the disproportionately large number of responses from SWL CoP (n=25, 52%), SWL responses were analysed separately to identify variation from overall responses. As shown in Figure 10, SWL responses were higher for each question compared to the average.

Figure 10. *Respondent extent of agreement regarding experiences of Polypharmacy CoP participation*



Outcomes of participating in the Polypharmacy CoP

Respondents were asked their extent of agreement on a series of questions relating to outcomes due to participating in CoPs. Respondents were provided a five-point scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

Overall, most respondents positively to all questions (Figure 9). Most agreed (i.e., selected either 4 or 5) that they had access to new resources and tools that are being used in practice (n=36, 67%), that their understanding of the challenges of polypharmacy has improved (n=33, 78%), that they felt inspired to resolve problematic polypharmacy (n=34, 85%), that they shared learning with colleagues (n=33, 78%).

When accounting for SWL CoP responses, overall responses are less positive. The decrease in average response between SWL and other participants was most notable for the question relating to using connections made at the CoP to make improvements in how polypharmacy is managed (SWL average = 4.32, non SLW average =3.07).

Open-ended responses

Respondents were asked to comment generally on their chosen answers regarding CoP outcomes. Ten responses were received which were varied in nature. Feedback included content being pharmacist-centric and feeling a lack of connection to CoP members due to physical work locations being dispersed. Others noted that CoPs supported delivery of the broader Polypharmacy Programme and provided an important platform to network.

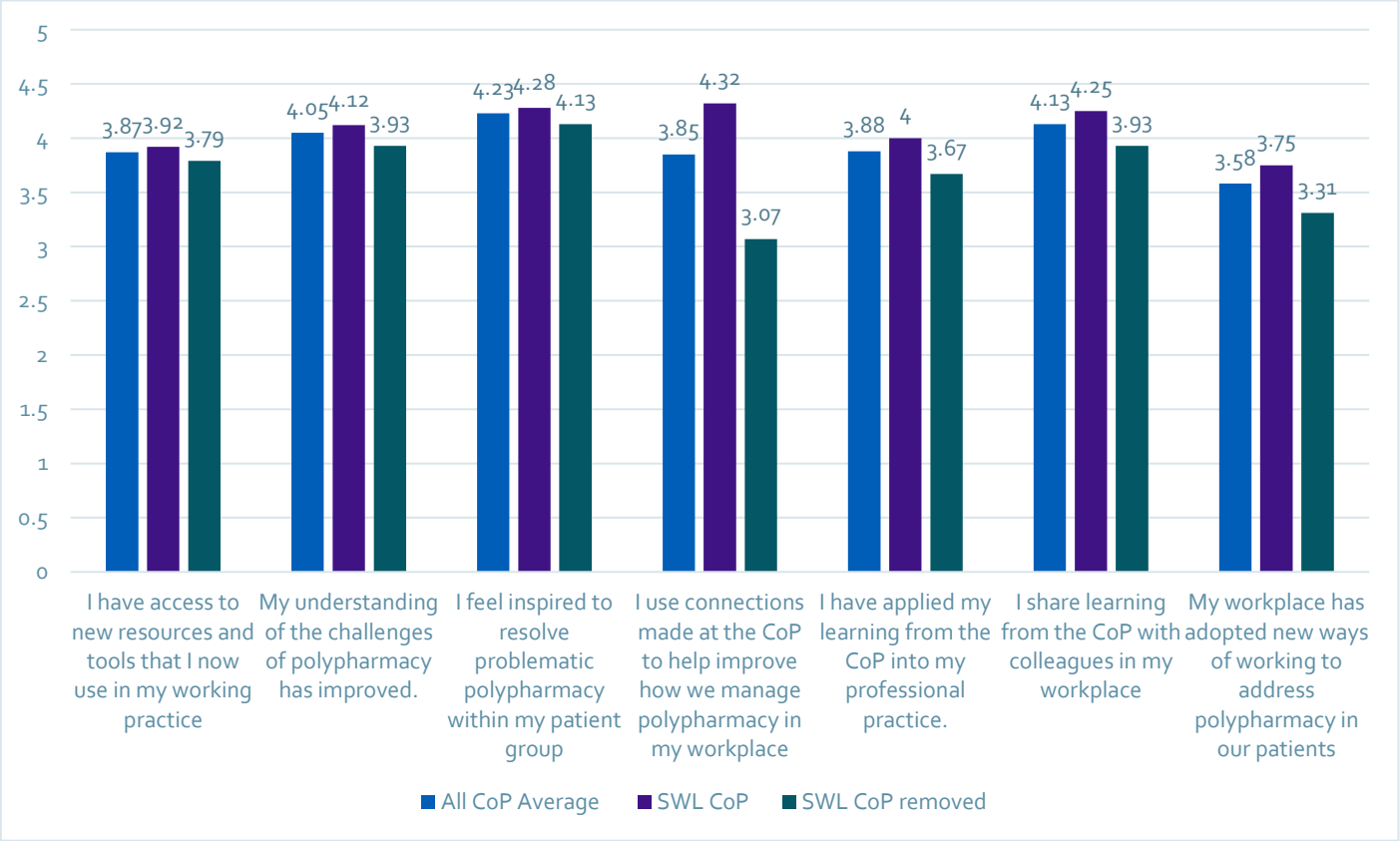
"I don't really feel connected to anyone from the CoP as they are mostly not in my area - I'm in [region] and we don't really have those links. The topic areas were interesting though, and I may well go and read some more about motivational interviewing." ***Pharmacist***

Respondents were asked **'Do you feel there are any barriers to the success of the CoP?'**. Of the 18 responses received, respondents highlighted time commitment and competing priorities as a challenge, the scale of the task CoPs attempt to address, logistical challenges of attending face-to-face sessions (although these are preferable to online), time required to build an effective 'community', and difficulty

attracting continued involvement.

Respondents were asked **which organisation they thought would be best placed to host the Polypharmacy CoP when the HIN Polypharmacy programme eventually closes**. Of the 22 responses, the most commonly cited response (n=10) was 'ICB'. A few noted GPs or a GP network, and a few others generally noted 'NHS'. Others felt unable to comment.

***Figure 11**: Respondent extent of agreement regarding outcomes of CoP participation.*



8. Programme Implementation

To support learning and inform future programme delivery, local HIN teams and the National Programme team were asked to reflect on programme implementation at the local and national level, respectively. Insights shared have been separated by local and national perspectives given the different nature of implementing the programme at these levels. In some cases, local and national teams have identified common factors.

At the local HIN level, insights relate to delivery of the polypharmacy programme in full, including as they relate to local-adaptations of national pillars, rather than pillar-specific learning (which is presented within each relevant section of the report).

Insights have been structured into the following themes: implementation facilitators, implementation challenges, perspectives on sustainability, and learning.

8.2. Factors supporting implementation

8.2.1. Factors supporting local implementation

Local HINs identified the following implementation successes and facilitators:

- **Engaging with ICB structures to facilitate buy-in and support implementation.** Many HINs used established links with ICBs to share information, for example by presenting programme activities and updates at regular system meetings such as Medicines Optimisation working groups. Established ICB communication channels such as primary care bulletins were also used to disseminate information.
- **Building and using existing networks.** Local HINs built and used existing stakeholder networks to disseminate information and materials, including networks built through other related medicines programmes.
- **Digital and direct communications for system engagement.** HINs used various digital platforms to promote the programme, including publishing information and resources on dedicated websites (e.g., sites on NHS Futures), within established and popular clinical newsletters, local HIN social media channels, physical flyers and posters within primary care settings, and targeted communications to gatekeepers and champions within local systems (e.g., clinical directors of care, or care home matrons).
- **System buy-in and support.** Strong relationships with, and buy-in from, local healthcare systems and leaders was consistently cited by local HIN teams as the most important facilitator to programme delivery.
    - **ICB buy-in.** All HINs highlighted buy-in and support from ICBs as 'mission critical'. Alignment between the programme and ICB priorities significantly increased HINs' ability to engage and receive buy-in from system partners. One HIN noted that their early "groundwork" to align with ICB priorities "*paid off because then they have committed their resource for the full three years [of the programme]*".
    - **System champions.** Having dedicated and respected champions within the local system was seen as instrumental by many HINs. Peer-to-peer advocacy and support for the programme helped increase engagement and active participation, particularly when it came to implementing Pillar 3, behaviour change materials.
    - **Engaging existing networks.** Local HINs leveraged established networks related to polypharmacy to build early programme engagement and participation. Conversely, those that had not delivered similar programmes (i.e., those related to medicines optimisation and safety) required significantly

more time and resource to engage local system stakeholders.

- **National programme coordination and support.** The structure and resources provided by the national programme team were seen as a major asset by regional HINs.
    - **Centralised resources.** Having pre-established resources and activities enabled local HINs to focus on engagement and promotion within their local systems. Additionally, the existing evidence base for several aspects of the programme facilitated stakeholder engagement and buy-in.
    - **Programme structure.** The programme having a clear 'pillar' structure organised around core objectives made communicating the programme approach, purpose, and activities to system stakeholders easier and more effective.
    - **National profile and leadership.** The involvement of "*big name speakers*" and influential national leaders like Dr. Lucy Pollock was seen to raise the programme's profile and "*pull people into the conversation*". Local HINs also highlighted the proactive and helpful support provided by the National Polypharmacy Team.

- **Flexibility and Local Adaptation.** The ability to adapt the national programme to local needs was understood to be a key element of success, enabling local HINs to adapt and innovate corresponding to local capacity, needs, and levels of expertise. This was understood to increase engagement, reach, and knowledge generation and application across local systems.
- **Financial incentives.** Even small amounts of funding were highlighted as significant facilitators for engagement. Several HINs noted that the CORE20Plus funding call was particularly successful at engaging practices and PCNs and encouraging uptake of Pillar 3 materials. Some highlighted the fact national Polypharmacy Action Learning Sets were free for delegates to attend helped get buy in and increase participation.
- **Local HIN team structure.** Teams with clinical expertise, particularly within pharmacy, saw this as a significant asset, improving their ability to engage with and understand programme content, and then actively promote it across local systems.
- **Cross-HIN collaboration.** Several HINs were part of local groups designed to share learning based on experiences of programme delivery. Due to the local variance in programme adoption and adaption, these forums were seen as valuable in highlighting best practice and challenges in delivery.
- **Alignment with Other Internal Programmes**. Running the programme in tandem with other related work was seen as a facilitator. One local HIN delivered the programme alongside the Medicines Safety Improvement Programme (MedSIP), finding that the approaches and relationships developed in one programme helped to inform the other, making delivery overall more efficient and effective.
- **Positive feedback and patient stories**. Receiving positive feedback from patients and clinicians helped to build momentum and validate the programme's work. Health Innovation West of England highlighted the power of patient stories, filming testimonials to be used as resources to "inspire other patients" and "promote the good work". These videos were shared with other local HINs.

8.2.2. Factors supporting national implementation

The national programme team identified the following implementation successes and facilitators:

- **Accessible and accurate polypharmacy data**. Underpinning the programme was robust, accurate, and accessible polypharmacy data in the form of the NHSBSA Polypharmacy Prescribing Comparators. Local systems at all levels were able to leverage this data to inform understanding of local population needs and build strategic approaches to patient engagement for structured medication reviews.
- **The three-pillar programme structure.** As with local HINs, the national programme team understood the three-pillar structure of the programme to enable effective and accessible communication and adoption of a complex, multi-faceted programme. Focusing on data, education, and public awareness was also an approach understood to be underpinned by sound evidence and was generally respected and supported by national stakeholders as well as local systems.

- **Programme leadership.** The importance of having an experienced and consistent clinical lead with a deep history of the programme was understood to be critical for navigating early challenges. Consistent programme management was also integral to maintain institutional knowledge and overcome challenges linked to funding.
- **Enabling adaptation to local contexts and other emergent needs.** The programme pivoted and flexed to meet HIN and stakeholder requests. Mirroring aspects of the National Polypharmacy ALS and national Masterclass sessions into a local education offers expanded the reach of programme related education.
- **Developing positive relationships with influential national stakeholders** is understood to have strengthened the programme's profile and supported funding decisions and legacy planning.
- **A focus on health inequalities** through translation of Pillar 3 resources into 12 widely spoken non-English languages, easy read and audio versions, and a patient animation was understood to increase the programme's spread and adoption, enabling PCNs to engage patients from seldom heard communities.

8.3. Implementation challenges

8.3.1. Local implementation challenges

Local HIN teams identified barriers to implementing the programme:

- **System capacity and competing priorities.** A frequently cited barrier was a lack of clinician time to participate in programme activities, and the need to compete with other system priorities, particularly those with direct financial incentives. Particularly related to Pillar 3 activity**, removal of national incentives** (Investment and Impact Fund and Quality and Outcomes Framework) for Structured Medication Reviews (SMRs) led to the programme being de-prioritised at a local level.
- **Varied ICB prioritisation**. A recurring theme was that engagement and levels of ICB prioritisation varied significantly. Often this was due to competing priorities, limited capacity, and uncontrolled events such as restructures. In areas with limited ICB engagement and support, system stakeholder engagement and programme implementation were felt to be significantly hampered.
- **Stakeholder engagement.** Gaining buy-in from local systems, particularly ICBs and PCNs, was a major challenge. Some regions struggled for over a year to connect with the 'right' stakeholders, and a lack of an ICB champion made engagement resource-intensive.
- **Difficulty measuring impact.** Local HINs highlighted the inability to demonstrate programme success through outcome and impact data due to a lack of systematic monitoring systems, the difficulty of tracking prescribing trends for complex patients, and the time lag associated with observing impact.
- **Financial instability and resource barriers.** Local programme delivery was hindered by funding uncertainty and high staff turnover within HINs and local ICBs. Practical barriers also existed, such as the lack of physical space in GP practices for face-to-face reviews and the logistical challenges of embedding programme materials into clinical IT systems.

8.3.2. National implementation challenges

The national programme team identified barriers to implementing the programme:

- **Lack of pre-implementation phase.** The programme was expected to deliver from day one without a dedicated planning or setup phase. The national programme team felt a six-month lead time for setup and relationship building, without pressure to collect metrics, was needed.

- **Funding uncertainty and fundraising challenges.** Continuous funding uncertainty required ongoing fund-seeking activity which diverted the small programme resource away from programme development and delivery. This uncertainty was also felt by local HINs, which in some instances undermined confidence in, and commitment to, the programme.
- **Limited administrative support.** The national programme team operated without a Programme Support Officer (PSO) for the first six months, which impacted programme set up in critical early stages (for example by limiting the team's ability to write implementation guidance).
- **Adapting from a national to a local programme** in April 2023, added a layer of complexity and uncertainty, requiring balance between enabling local adaptability and retaining programme integrity. Supporting local HINs through this transition, particularly in helping shape their local offers appropriately, presented an additional challenge to a national team with limited capacity.
- **Community of Practice (CoP).** The intended "hands-off" CoP model did not work well in some regions, where clinicians preferred a more structured, educational offer with keynote speakers over a "nebulous thing where you talk about an issue".
- **The 'train the trainer' model** encountered challenges around the eligibility of applicants. This resulted in a limited pool of accredited trainers able to carry out high quality training at local and local levels. HINs reported that the desired levels of seniority amongst trainers was incompatible with the time and resources required to become an accredited trainer and then lead sessions.
- **Incorporating the patient voice** was a challenge, despite a 'patient innovator' working with the national team. From a local HIN level, this challenge was underpinned by difficulties obtaining patient feedback and engagement at practice level. The CORE20 funding introduced latterly strengthened this element in terms of capturing patient experience and voice, but in terms of public and patient involvement at national level this remained a challenging gap.
- **Setting and communicating appropriate outcome metrics** proved challenging, where it was felt that too heavy a focus on quantitative process-level metrics distracted local teams from qualitative measures of delivery. Local HINs felt there to be too heavy a focus on process-level metrics, at the expense of establishing an approach to understanding system level outcomes and impact.

8.4. Perspectives on sustainability

8.4.1. Local programme sustainability

Local HINs identified strategies aimed at supporting the continuation of the programme's work. However, most also noted significant challenges to sustaining programme activities locally:

- **Handover to system partners**. Some HINs successfully secured host institutions for local education and CoPs, including within local academic institutions and schools of polypharmacy, and within ICBs. However, with the future ICB landscape due to change significantly, the sustainability of embedding activity within their own systems and structures might encounter limitations.
- **Embedding resources and training**. Some HINs have embedded programme resources into ongoing processes and structures. For example, programme resources have been integrated into the induction process for new pharmacy staff across the system in one HIN region. Another local HIN has arranged for universities to adopt their local education materials for their undergraduate schools of pharmacy.
- **The role of programme champions**. The enthusiasm and commitment of 'programme champions' was seen as a key driver for continuing the work.
- **Dependence on HIN support and funding**. A risk highlighted was the reliance on local HINs for coordination and funding. Some local HINs had already started to experience significant 'drop-offs' in engagement and activity during the initial closing phases of the programme.
- **Lack of system ownership**. Whilst some HINs successfully identified host organisations for ongoing

delivery, others have found this challenging, encountering a lack of interest and commitment across their systems.

- **Programme length and premature closure.** Some HINs felt the programme was ending just as it was gaining significant traction, and that an additional 6–12-month period would enable significant progress in embedding programme activities across local systems sustainably.

8.4.2. National programme sustainability

The national programme team identified key factors that underpinned the programme's sustainability:

- **A national de-prescribing network** is a necessary component of sustainability, representing a long-term national commitment to addressing problematic polypharmacy. Such a national polypharmacy/ deprescribing network (as seen in countries like Canada and Australia) would provide a "one-stop shop" for clinicians and potentially patients, combining research, practical implementation tools, and patient materials, thereby keeping the issue on the national agenda.
- **Continued access to resources**. For the programme's legacy to continue, the materials developed must remain accessible. There is a plan to host all resources on the Health Innovation Network (HIN) website, but there remains a risk this won't be used without active promotion. Ideally, materials would be embedded directly into clinical IT systems for automated inclusion into relevant workflows.
- **Ongoing education**. The educational component, specifically the Polypharmacy Action Learning Sets (ALS), was described as the "glue" of the programme. Without continued funding for this training, it was felt the reach and impact of the other programme elements would be significantly diminished as there would be no one "physically doing the teaching anymore".

However, they also expressed concern due to a lack of secure, long-term funding. The need to constantly seek funding was described as a major issue that prevented the team from focusing fully on delivery and embedding the programme sustainably.

9. Conclusions and recommendations

The following section presents set of conclusions based on review analysis, and recommendations shared by local HIN programme teams and the National Polypharmacy Programme team. Pillar-specific learning identified by local stakeholders is presented within relevant sections of the report and helps to provide further tangible ways in which programme pillars might be developed for future programmes.

9.2. Pillar 1: Population Health Management

Conclusion

Pillar 1 successfully raised awareness and knowledge of the NHSBSA Polypharmacy Prescribing Comparators, which saw a 90% increase in weekly unique users of the dashboard from 2021 to 2025. The data proved to be a useful "hook" for engaging system leaders when used to create more compelling "Case for change" packs. However, a significant gap remained between awareness and practical application, as evidenced by low numbers of direct patient NHS number requests from the dashboard. Overall, clinicians reported finding the dashboard "cumbersome" and "overwhelming," suggesting that its complexity and the expertise required to use it effectively were key barriers to wider adoption in day-to-day practice.

Recommendations

- **Provide targeted data support.** To bridge the gap between awareness and application, future programming should provide targeted, practical support to primary care staff on how to interpret the comparator data and integrate it into their patient prioritisation workflows.
- **Support development of accessible data tools.** To overcome the complexity of the national dashboard and encourage broader use, support the development and use of more accessible local tools, such as the bespoke Power BI dashboards created by some HINs, which provide a more familiar interface for local system stakeholders.
- **Leverage data for strategic engagement.** Continue to use localised data to create tailored "case for change" packs for ICB and system leaders, as this was deemed a highly effective strategy for securing strategic buy-in and demonstrating the value of the work.

9.3. Pillar 2: Education and Training – Polypharmacy ALSs and Polypharmacy Masterclasses

Conclusion

The learning from this programme highlighted the significant, unmet need for education for clinicians and practitioners around tackling polypharmacy. Pillar 2 was a highly rated component of the programme by participants. Both the Polypharmacy Action Learning Sets (ALS) and the Polypharmacy Masterclass series received consistently positive feedback, reached thousands of clinicians, and led to self-reported changes in practice. A large majority of Polypharmacy ALS attendees (83%) reported making positive changes in their practice, including increased shared decision-making and greater confidence in deprescribing.

The national Polypharmacy ALS model faced challenges regarding perceived restrictive eligibility criteria and time commitment required, which led some HINs to develop their own bespoke local educational and learning offers. Local offers typically took a systems-based approach, encouraging participation from more junior prescribers, non-prescribers and pharmacy technicians who support broader prescribing processes within primary care.

Recommendations

- **Continue Polypharmacy ALS and Polypharmacy Masterclass series as core components of future programming.** Future programmes should continue to offer evidence-based educational models like the Polypharmacy ALS and polypharmacy Masterclasses, retaining the key success factors of specialist input (particularly from geriatricians), peer-to-peer discussion, and a focus on practical tools.
- **Expand the national training offer to provide formalised training for junior staff.** Given local HIN calls for more inclusive training to incorporate junior staff, the National Polypharmacy Programme training offer could consider formally integrating the established Polypharmacy ALS Foundation Course into future national programming. This could help address the call for training for junior staff, whilst retaining the fidelity of existing National Polypharmacy ALS models catering for more experienced prescribers.

9.4. Pillar 3: Public Behaviour Change

Conclusion

Pillar 3 demonstrated that patient-facing materials can empower patients and improve shared decision-making in Structured Medication Reviews (SMRs). However, the adoption of these materials was inconsistent and highly dependent on two key factors: the availability of targeted, small-scale funding (such as the CORE20Plus5 initiative) to give practices the capacity to engage, and proactive, hands-on support from HINs to help embed the materials into clinical workflows. Simply making resources available was not enough to ensure uptake, and the lack of a systematic monitoring mechanism made it difficult to track true outcomes and impact.

Recommendations

- **Provide dedicated funding and support for adoption.** To ensure patient-facing materials are used more consistently, initiatives must provide dedicated funding and practical, hands-on support to help busy primary care teams integrate them into their existing workflows.
- **Build and publicise the evidence base early.** Develop and share testimonials and evidence of the materials' effectiveness early in a programme's lifecycle to help secure buy-in from clinicians, practice managers, and patients. Leverage programme champions at a system level to generate and promote evidence.
- **Develop mechanisms for monitoring uptake.** Future programmes should establish simple mechanisms from the outset to monitor the uptake and use of patient materials, which would allow for a better understanding of their impact and help target support more effectively.

9.5. Polypharmacy Communities of Practice (CoPs)

Conclusion

The Polypharmacy CoPs were successful in creating a space for networking and enhancing collaboration, particularly in bringing together primary and secondary care colleagues who would not normally interact. However, the intended "hands-off" theoretical model proved difficult to implement, as busy clinicians indicated preference for a more structured, educational format. Most HINs adapted CoPs to represent an educational, masterclass-style session, which improved engagement. The long-term sustainability of the CoPs is the most significant challenge, as it is almost entirely dependent on securing ownership from a local system partner and is threatened by a lack of ongoing funding and coordination.

Recommendations

- **Review the acceptability and feasibility of Polypharmacy CoPs.** Prior to future programming, assess the appropriateness of CoPs given programme objectives, local contextual factors, and type of commitment required for successful delivery.
- **Prioritise local ownership from the outset.** To ensure sustainability, CoPs should be co-designed with local systems. This might include establishing core planning groups with diverse local stakeholders and encouraging system leads to chair and facilitate sessions to foster a true sense of community ownership.

9.6. Programme recommendations

The following recommendations are proposed to inform the design and delivery of future national health transformation programmes.

- **Secure long-term, funding from the outset.** The "start-stop" nature of short-term, uncertain funding created instability and diverted leadership time away from delivery towards fundraising. To enable effective strategic planning and maintain confidence among delivery partners, future programmes should have stable, multi-year funding secured for their full intended programme duration.
- **Adopt a phased programme structure with a dedicated implementation stage.** Future national programmes should be designed with distinct, funded phases for setup, delivery, and a dedicated final stage focused on embedding and sustainable handover. A dedicated pre-implementation phase of at least six months is critical to allow for essential planning, relationship-building, and the co-design of delivery models before any performance metrics are expected.
- **Design for flexibility and local adaptation.** A rigid, "one-size-fits-all" approach can be ineffective across the varied landscape of local health systems. National programmes should provide a core evidence-based offer while enabling flexibility and autonomy for local teams to adapt delivery to their local capacity, priorities, and stakeholder needs. This approach is likely to foster greater ownership and engagement.
- **Develop a measurement framework that incentivises and supports achieving intended outcomes and impact.** A focus on quantitative process metrics can drive unintended behaviours, therefore a holistic, co-developed MEAL (monitoring, evaluation, accountability and learning) framework should be embedded into national programmes from the outset. Measurement and evaluation approaches should be mixed methods, formative, and underpinned by established implementation frameworks (e.g., RE-AIM). A clearly articulated theory of change with clearly defined outcomes should be developed, and a plan for how outcomes will be objectively and robustly measured to determine impact (including Value for Money) should be established.
- **Adopt a whole-systems and patient-centric approach.** To address complex challenges like polypharmacy, programmes might benefit from engaging the entire health system. Eligibility for participation should include junior staff, non-prescribers, and secondary care. Critically, the patient voice must be consistently and meaningfully integrated throughout all stages of programme design and delivery, not just at the start.
- **Plan for sustainability from the outset.** Future programmes should have a clear strategy from the outset for how their impact will be sustained. This involves not only embedding activities into local system structures and incentive schemes but also establishing a clear national framework—such as a national network—to host resources, continue promotion, and ensure the long-term value of the investment is realised after the programme formally concludes.

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- Health Innovation East Midlands
- Health Innovation Manchester
- Health Innovation Network South London
- Imperial College Health Partners
- Health Innovation Kent Surrey Sussex
- Health Innovation North East and North Cumbria
- Health Innovation North West Coast
- Health Innovation Oxford & Thames Valley
- Health Innovation Wessex
- Health Innovation West Midlands
- Health Innovation West of England
- Health Innovation Yorkshire & Humber

The clinicians who have helped to test these materials in structured medication reviews (SMRs) and those who have fed back how they found using the materials. The patients involved in the pilot testing and those that used the materials in their structured medication reviews and fed back on how these worked.

10. Appendices

10.1. NHSBSA Polypharmacy Comparator data usage

Table 4 shows the requests for NHS Patient numbers by Health Innovation Network region within the pre-programme baseline period, and in each of the subsequent programme delivery years. There are no clear trends across the local HIN group in terms of number of requests over the course of the programme compared to baseline.

Overall, the highest number of requests within a single year came within the pre-programme baseline, but this is skewed by the significant number of requests originating from HIN Wessex (accounting for 75% of overall baseline requests).

Some local HINs, such as UCL Partners and Health Innovation East and Imperial College Health Partners, requested fewer NHS patient numbers within each year of programme delivery compared to respective baseline numbers.

Health Innovation East Midlands and Health Innovation North East North Cumbria requested higher than baseline NHS numbers for each year of the programme, whereas others such as Health Innovation Kent Surrey Sussex presented a mixed picture with some years above baseline, and some below.

Table 4 *Number of requests for NHS Patient numbers by Health Innovation Network region*

Health Innovation Network	2021 (pre-programme baseline)	2022	2023	2024	2025	Total
Health Innovation East	4	0	0	0	0	4
Health Innovation East Midlands	2	11	8	3	3	27
Health Innovation Kent Surrey Sussex	0	6	3	1	0	10
Health Innovation Manchester	4	6	15	10	1	36
Health Innovation Network South London	0	0	1	4	1	6
Health Innovation North East and North Cumbria	0	2	1	29	11	43
Health Innovation North West Coast	0	0	2	17	6	25
Health Innovation Oxford & Thames Valley	0	2	0	1	0	3
Health Innovation South West	2	1	5	4	0	12
Health Innovation Wessex	154	90	14	10	6	274
Health Innovation West Midlands	8	0	3	13	1	25
Health Innovation West of England	0	0	4	3	0	7
Health Innovation Yorkshire & Humber	2	0	5	7	0	14
Imperial College Health Partners	5	1	0	1	1	8
UCL Partners	23	0	15	0	0	38
Total	**204**	**119**	**76**	**103**	**30**	**532**

Figure 12 indicates the number of unique users of the NHSBSA Polypharmacy Prescribing Comparators

dashboard by week and year, with square graph markers on the weeks where a webinar was run.

Figure 12 *Number of unique users of the NHSBSA Polypharmacy Prescribing Comparators dashboard by week and year. Webinar dates are marked with square markers*

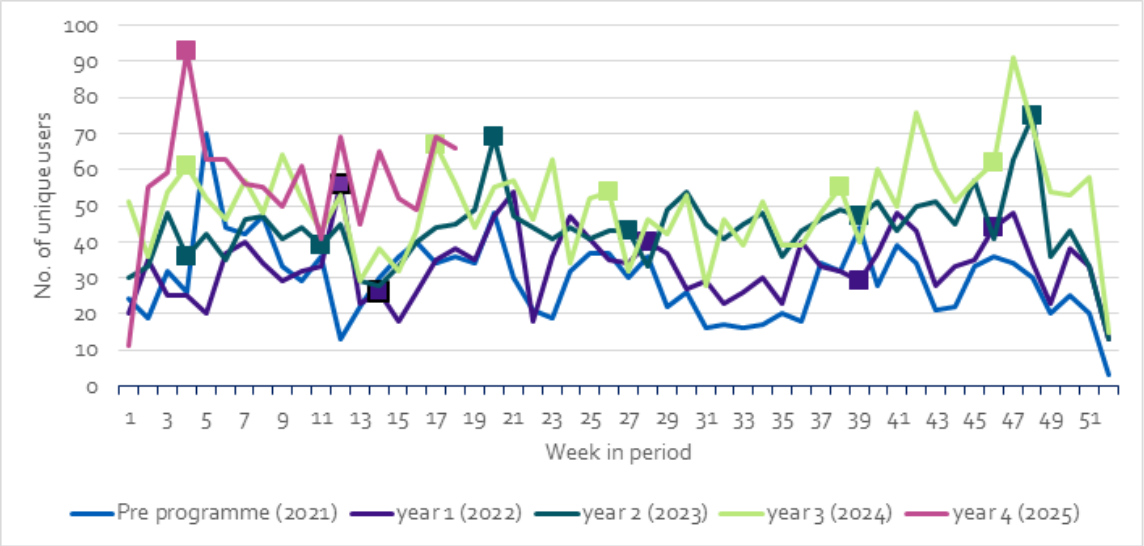
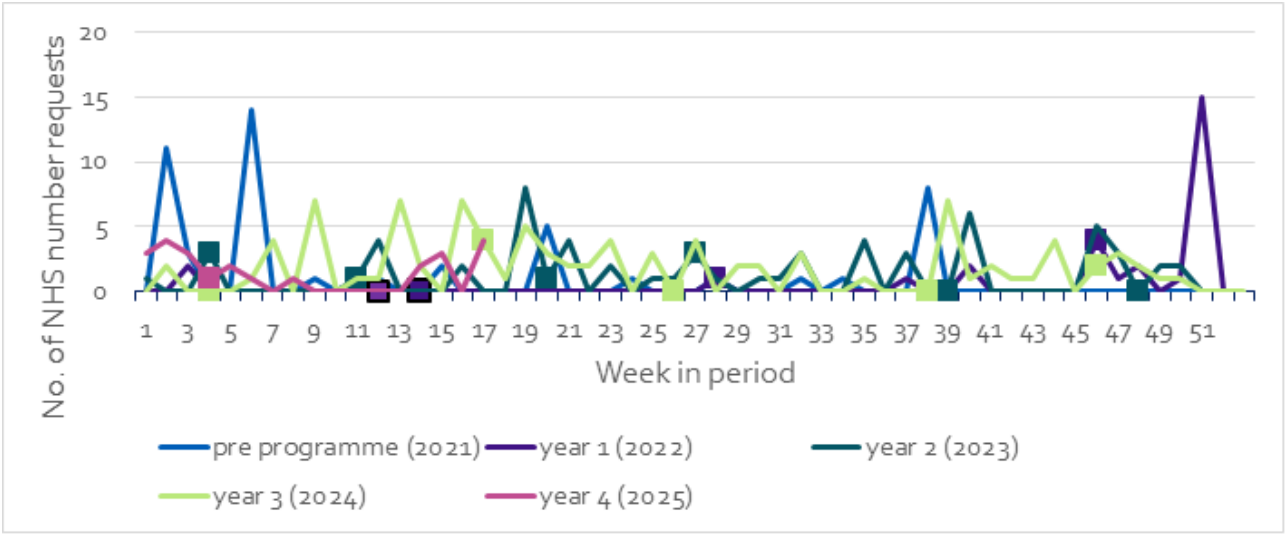


Figure 13 indicates the number of requests for NHS numbers by week and year, with square graph markers on the weeks where a webinar was run.

Figure 13 *Number of requests for NHS numbers by week and year. Square markers indicate webinar dates.*

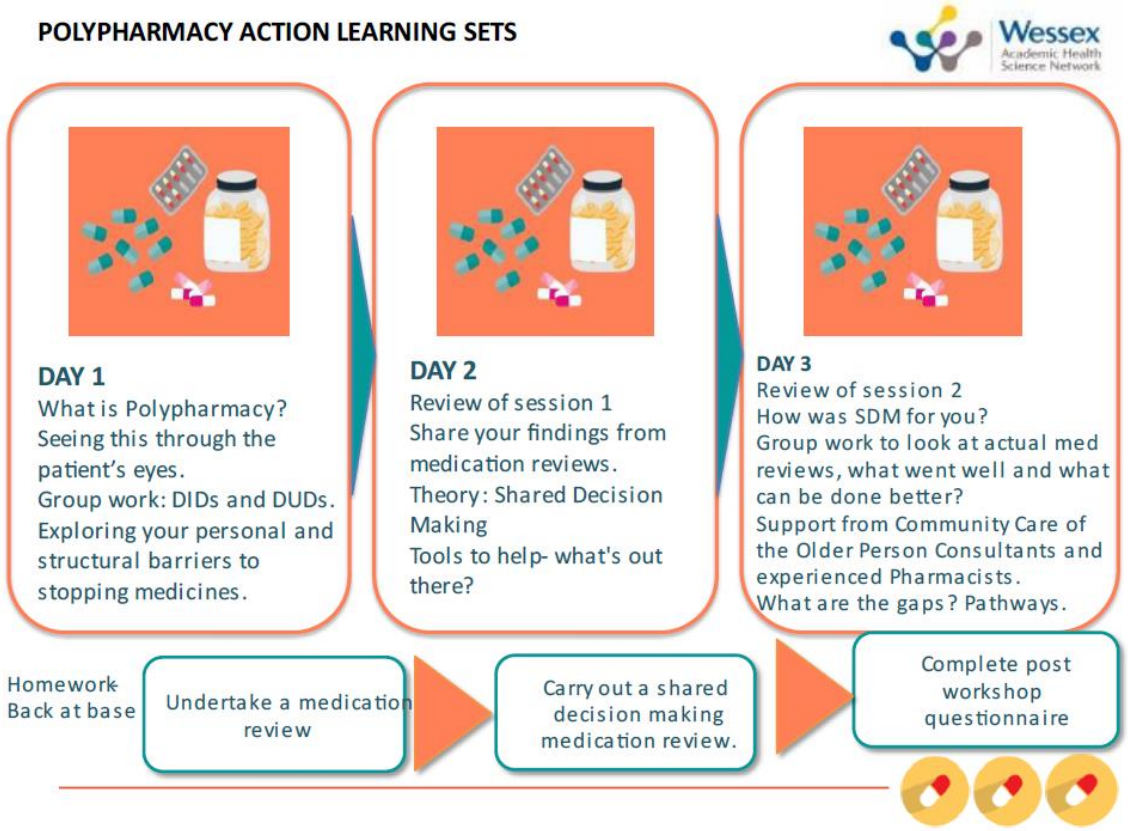


10.2. National Polypharmacy Action Learning Set: Content overview, aims, and most helpful aspects

Polypharmacy Action Learning Set aims

1. Understand from participants the **barriers (practical and cognitive) to systematically stopping medicines** that are no longer warranted in older patients.
2. Explore with participants **how barriers within General Practice can be addressed** and support better medication reviews.
3. Provide a **deeper understanding of shared decision making** and how to incorporate this into all medication reviews (especially for older people with multimorbidity).
4. Outline some of the many **tools available to help prescribers** to conduct successful medication reviews and test if the eLearning for high-risk medicines is useful.

Figure 14 *Polypharmacy Action Learning Set learning objectives and session structure*



Aspects of the Polypharmacy ALS participants (cohorts 5-23) ranked as most helpful.

1. Geriatricians involvement Day 3 = 504 selections (82% of respondents).
2. Breakout room discussions = 392 selections (64%).
3. Practical tools and resources Day 2 = 382 selections (62%).
4. Shared Decision Making Day 2 = 283 selections (56%).
5. Facilitators discussion and guidance = 298 selections (49%).
6. Polypharmacy pathways discussion Day 3 = 270 selections (44%).
7. Polypharmacy 'Setting the scene' Day 1 = 263 selections (43%).
8. Use of language in Shared Decision Making Day 3 = 214 selections (35%).
9. Homework = 106 selections (17%).
10. Other (Please specify) = 33 selections (5%).

10.3. Polypharmacy Masterclass session registration and attendee metrics

Table 5 presents data accurate as of July 2025.

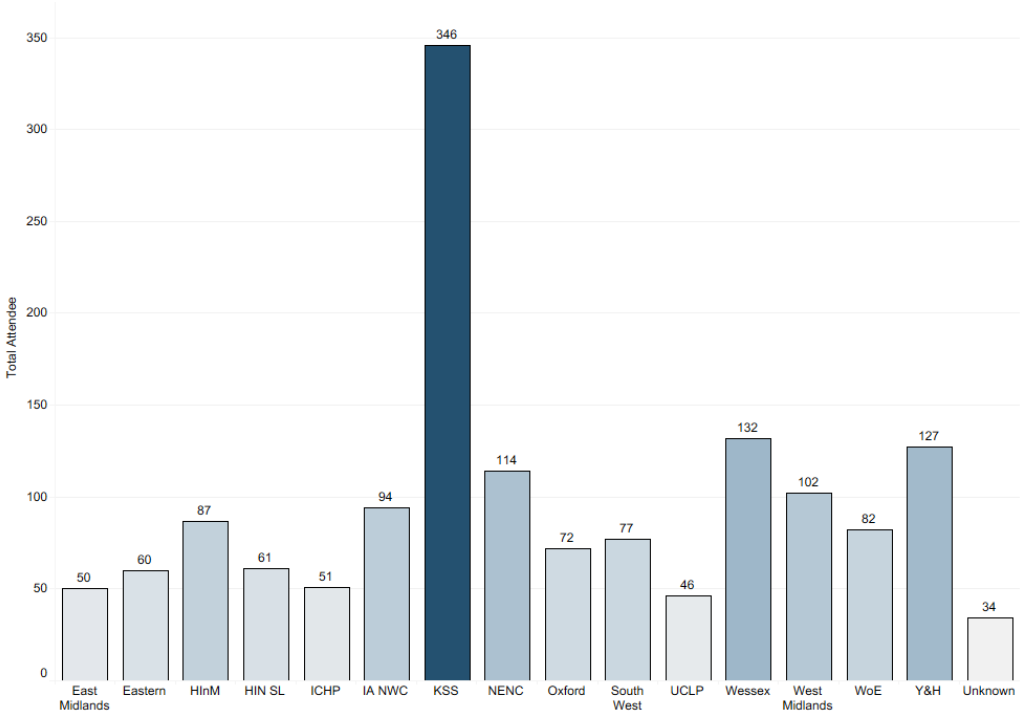
Table 5 *Masterclass session registration and attendee data*

Masterclass topic	# Registered	# Attended	# Views online *as at 18 June 25	Total views (live & recording)	# Survey
Prescribing safely in older people (May 2024)	1000	769	597	1366	81
Stopping antidepressants safely (June 2024)	1000	723	984	1707	63
Supporting patients to get the most out of their SMR (July 2024)	807	510	165	675	N/A
Meds and risk of falls (October 2024).	979	617	385	1002	39
Health inequalities (November 2024).	378	183	85	268	22
End of life (November 2024).	645	395	206	601	57
Polypharmacy and Parkinson's Disease (March 2025).	590	343	138	481	67
Polypharmacy and Learning Disabilities (March 2025)	647	390	186	576	19
Polypharmacy and Pharmcogenomics (June 2025)	313	128	97	225	21
Total	**6359**	**4058**	**2843**	**6901**	**369**

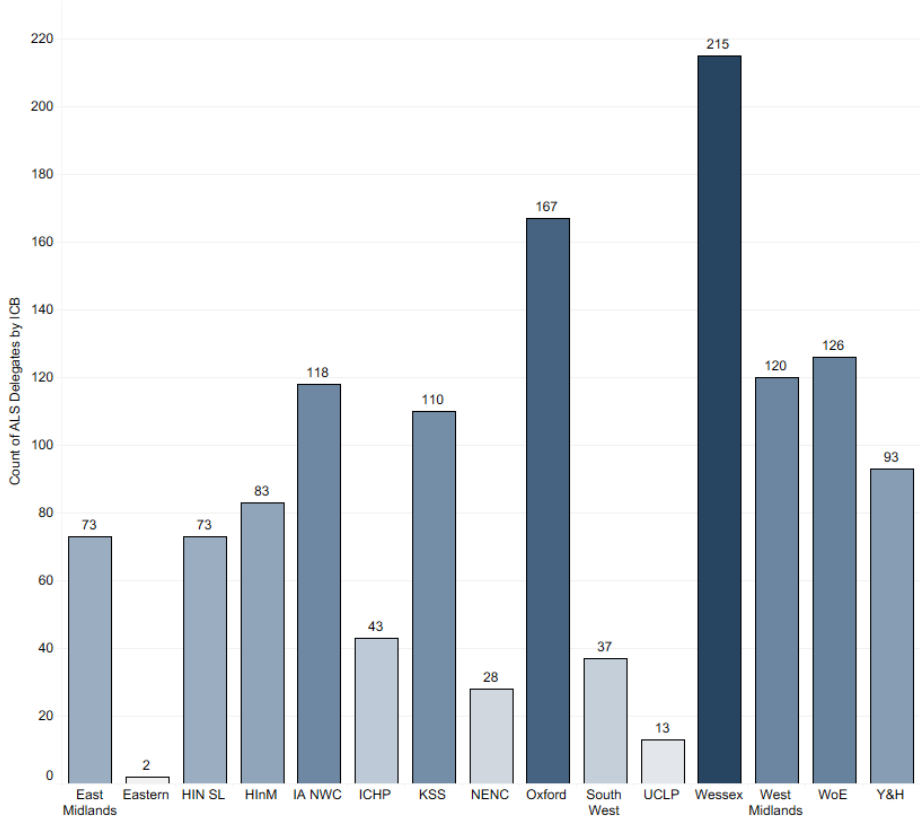
10.4. Local engagement with programme pillars

The following graphs have been provided by the National Programme Team based on their analysis of participation and engagement data.

Pillar 1 NHSBSA Polypharmacy Prescribing Comparators Webinars attendance by Health Innovation region



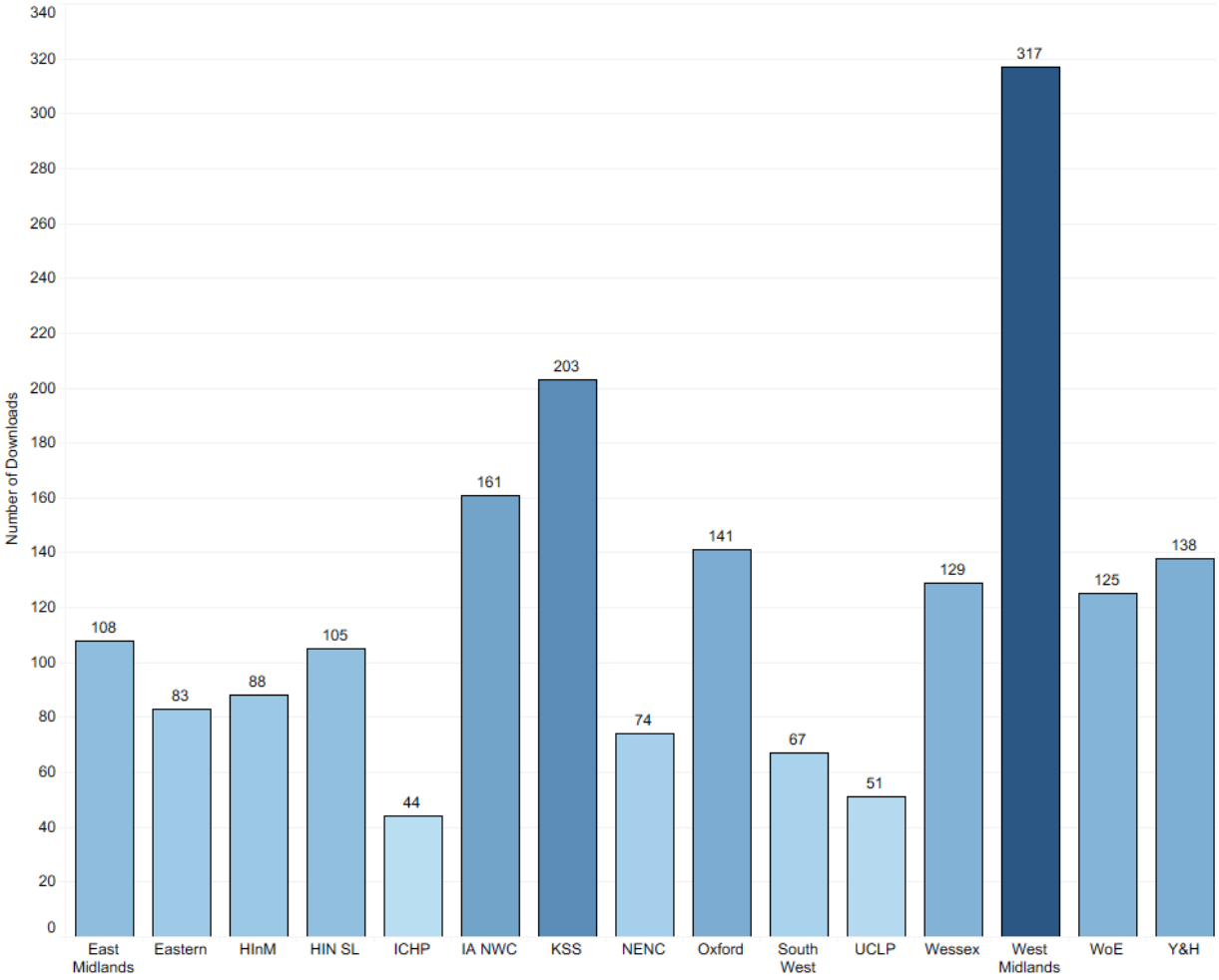
Pillar 2: Action Learning Set attendance by Health Innovation region



Pillar 2: Action Learning Set attendance by ICB

ICB	Total	Core20PCN
NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB	38	1
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES ICB	20	17
NHS BIRMINGHAM AND SOLIHULL ICB	26	6
NHS BLACK COUNTRY ICB	34	8
NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB	51	13
NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST ICB	119	2
NHS CAMBRIDGESHIRE AND PETERBOROUGH ICB	0	0
NHS CHESHIRE AND MERSEYSIDE ICB	92	15
NHS CORNWALL AND THE ISLES OF SCILLY ICB	1	0
NHS COVENTRY AND WARWICKSHIRE ICB	10	0
NHS DERBY AND DERBYSHIRE ICB	29	7
NHS DEVON ICB	35	4
NHS DORSET ICB	122	11
NHS FRIMLEY ICB	28	5
NHS GLOUCESTERSHIRE ICB	37	0
NHS GREATER MANCHESTER ICB	83	15
NHS HAMPSHIRE AND ISLE OF WIGHT ICB	93	13
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	15	0
NHS HERTFORDSHIRE AND WEST ESSEX ICB	0	0
NHS HUMBER AND NORTH YORKSHIRE ICB	18	0
NHS KENT AND MEDWAY ICB	54	12
NHS LANCASHIRE AND SOUTH CUMBRIA ICB	26	4
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	17	4
NHS LINCOLNSHIRE ICB	7	0
NHS MID AND SOUTH ESSEX ICB	1	0
NHS NORFOLK AND WAVENEY ICB	0	0
NHS NORTH CENTRAL LONDON ICB	14	1
NHS NORTH EAST AND NORTH CUMBRIA ICB	28	4
NHS NORTH EAST LONDON ICB	0	0
NHS NORTH WEST LONDON ICB	42	2
NHS NORTHAMPTONSHIRE ICB	9	0
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	11	3
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	9	0
NHS SOMERSET ICB	1	0
NHS SOUTH EAST LONDON ICB	55	8
NHS SOUTH WEST LONDON ICB	18	1
NHS SOUTH YORKSHIRE ICB	32	7
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	26	0
NHS SUFFOLK AND NORTH EAST ESSEX ICB	1	0
NHS SURREY HEARTLANDS ICB	26	0
NHS SUSSEX ICB	30	6
NHS WEST YORKSHIRE ICB	43	6

Pillar 3: Patient materials downloads by Health Innovation region (Sep 23 – June 25)



Pillar 3: Patient materials downloads by Integrated Care Board *ICB capture was optional so overall download total could be higher (Sept 23 – June 25)

NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB	57
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD	44
NHS BIRMINGHAM AND SOLIHULL INTEGRATED CARE BOARD	77
NHS BLACK COUNTRY INTEGRATED CARE BOARD	40
NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB	53
NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST INTEGRATED CARE BOARD	68
NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD	17
NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD	85
NHS CORNWALL AND THE ISLES OF SCILLY INTEGRATED CARE BOARD	12
NHS COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD	60
NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD	19
NHS DEVON INTEGRATED CARE BOARD	26
NHS DORSET INTEGRATED CARE BOARD	41
NHS FRIMLEY INTEGRATED CARE BOARD	29
NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD	15
NHS GREATER MANCHESTER INTEGRATED CARE BOARD	88
NHS HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE BOARD	88
NHS HEREFORDSHIRE AND WORCESTERSHIRE INTEGRATED CARE BOARD	38
NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	30
NHS HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD	30
NHS KENT AND MEDWAY INTEGRATED CARE BOARD	65
NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD	76
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD	46
NHS LINCOLNSHIRE INTEGRATED CARE BOARD	15
NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	18
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	18
NHS NORTH CENTRAL LONDON INTEGRATED CARE BOARD	13
NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD	74
NHS NORTH EAST LONDON INTEGRATED CARE BOARD	20
NHS NORTH WEST LONDON INTEGRATED CARE BOARD	44
NHS NORTHAMPTONSHIRE INTEGRATED CARE BOARD	8
NHS NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE BOARD	20
NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD	22
NHS SOMERSET INTEGRATED CARE BOARD	29
NHS SOUTH EAST LONDON INTEGRATED CARE BOARD	53
NHS SOUTH WEST LONDON INTEGRATED CARE BOARD	52
NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD	33
NHS STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD	80
NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	18
NHS SURREY HEARTLANDS INTEGRATED CARE BOARD	70
NHS SUSSEX INTEGRATED CARE BOARD	68
NHS WEST YORKSHIRE INTEGRATED CARE BOARD	75

'Communities of Practices' by Health Innovation region (April 22 – June 25)

