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Medicines Optimisation Guidance for Adults with a Limited Prognosis:

Optimising medicines to improve symptom relief and comfort, aligned with each person's goals and priorities, while reducing treatment burden.

Developed by:
Leeds Oncology Frailty Initiative (LOFrI) and the LTHT Specialist Palliative Care Team (Adult)

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Palliative Care Team

Leeds Oncology Frailty Initiative

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Contents Page:

Section	Title	Page
1	**Introduction**	3
2	**Aims of Medicines Optimisation**	4
3	**Medicines Optimisation Principles – A Structured Review Approach**	5-6
4	**Medicines Optimisation Tool:**	7
4.1	*How to Find a Drug Class or Specific Drug*	7
4.2	*Overview of Colour-Coding (Red/Yellow/Green)*	7-8
4.3	*Medicines Optimisation Tool (table) By Drug Class:*	8
	Gastrointestinal	9
	Endocrine	9-12
	Cardiovascular	12-20
	Respiratory	20-21
	Central Nervous System	22-25
	Genitourinary	25-26
	Musculoskeletal	26-27
	Nutrition and supplements	27-28
	Other (e.g., topical treatments, antibiotics, antifungals, ophthalmology)	29
5	**Documenting Medicines Optimisation Outcomes**	30
6	**Sources of Help and Advice**	31
7	**Provenance and Acknowledgements**	21-32
8	**References**	33-34
Appendix 1	**Structured Medication Review Checklist**	35

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Section 1: Introduction

This guidance is designed to support healthcare professionals across all care settings to undertake structured medication reviews for adults with a limited prognosis, ranging from days to short years, due to living with frailty, multi-morbidities and/or progressive illness. Frailty, often assessed using the Clinical Frailty Scale (CFS), is a well-recognised marker of reduced physiological reserve and increased vulnerability to medicine-related harm[4]. People with a CFS score of 6–7 living in the community, on average have a life expectancy of 3–4 years, while inpatients with a CFS score of 7 have an average life expectancy of around 1 year. These associations highlight the need for timely and individualised decisions about medicine use and provide a valuable framework for aligning treatment with prognosis.

In this context, the goals of medicines optimisation move from disease modification and life prolongation, towards supporting symptom management, comfort, quality of life and sustainability. Prescribing should be guided by the person's prognosis, values and 'what matters most' to them, using the pragmatic Scottish Polypharmacy 7-Step Approach to Appropriate Prescribing to ensure that reviews are structured, person centred and sustainable[1].

The guidance has been developed using evidence-based tools, supported by clinical consensus across care settings:

- **STOPPFrail (v2)**: Designed for people living with frailty and a prognosis typically of less than a year, to guide deprescribing decisions in the context of advanced decline[2].
- **STOPP/START (v3):** A validated, system–based tool for identifying potentially inappropriate medicines and prescribing omissions in older adults. Although not prognosis-specific, its focus on reducing harm and maximising benefit in people with multi-morbidity and polypharmacy makes it highly relevant for patients with a limited life expectancy of short years. Here, it has been adapted to guide decisions where longer-term preventative medicines may no longer align with individual goals[3].
- **Expert consensus:** Incorporating the clinical insight of local specialist teams and the national Scottish Polypharmacy Guidance (2025 to 2028)[1], ensuring recommendations are evidence-informed and applicable across a range of care contexts.

This guideline outlines:

- The aims and principles of medicines optimisation for people with a limited prognosis (Section 2).
- A structured process for review (Section 3).
- A prognosis-based medicines optimisation tool (Section 4) to support safe continuation, simplification or deprescribing in line with prognosis, goals of care and symptom burden.

Advisory Positioning and Clinical Governance
This guidance is intended as advisory support to promote consistency and shared clinical understanding across West Yorkshire. It should be applied using professional judgement within usual clinical governance arrangements and, where appropriate, within a specialist or multidisciplinary team (MDT) framework.

It does not mandate specific actions nor transfer sole responsibility for complex or high-risk deprescribing decisions to any single clinician or care setting. Where uncertainty exists, or where decisions carry significant clinical risk, escalation to or co-working with relevant specialist teams is recommended in line with established governance pathways.

Section 2: Aims

The main aims of a structured medication review and medicines optimisation for adults with a limited prognosis are to:

- **Deprescribe safely**. Stop medicines that are unnecessary, inappropriate, or potentially harmful through a planned, monitored and person-centred process.
- **Review ongoing treatments**. Assess long-term medicines for side effects, interactions, anticholinergic burden and whether they continue to offer meaningful benefit in the context of prognosis and individual goals.
- **Prioritise symptom relief and quality of life**. Start or continue medicines that contribute to comfort, function, or what matters most to the person.
- **Reduce treatment burden**. Simplify regimens, minimise monitoring and avoid interventions that add workload or distress without clear benefit.
- **Apply the '7-Step Approach' systematically**. Ensure prescribing decisions are safe, effective, proportionate and aligned with prognosis and patient priorities (see Section 3).

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Section 3: Medicines Optimisation Principles – A Structured Review Approach

Medicines optimisation is a structured, person-centred process that focuses on what matters most to the individual. Prescribing decisions should align with the person's goals, prognosis and ability to tolerate treatment burden.

The Scottish Polypharmacy Guidance sets out a **7-Step Approach to Appropriate Prescribing**, which provides a clear framework for review[1]. This approach should be applied when prompts or triggers arise, for example:

- Clinical Frailty Scale (CFS) score ≥5[4]; recent decline in function; new or recurrent falls.
- Completion or update of a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form.
- Referral to palliative care or frailty services.
- Concerns from any member of the multidisciplinary team regarding polypharmacy, treatment burden, adverse effects, or the appropriateness of current medicines.

The 7-Step Approach to Appropriate Prescribing

Step 1: What matters most?
Agree and document the person's goals, values, beliefs and preferences (e.g., comfort, independence, symptom relief, reducing medicines, ability to self-administer). Document clearly in the patient's medical record.

Step 2: Identify essential medicines

- Take a complete medication history: prescribed, over the counter, and complementary medicines (e.g., herbal remedies, homeopathic products, vitamins, minerals and nutritional supplements).
- Document **indication**, dose, route, formulation, frequency, duration and monitoring requirements.
- Identify medicines essential for symptom control or prevention of immediate harm.
- Check adherence and administration issues (e.g., remembering, swallowing difficulties, side effects, crushing tablets for enteral feeding, device use).

Step 3. Stop unnecessary medicines

- **In discussion with the person** (and/or carer), deprescribe medicines with no known indication, duplication or misaligned with goals of care.
- Consider stopping long-term preventative medicines where time-to-benefit is unlikely to be realised.

- Prioritise high-risk or burdensome medicines first, usually one at a time.
- Decide whether stopping requires tapering or can be done abruptly; agree a monitoring plan.
- Tools such as Medstopper[8] may support safe withdrawal planning.

Step 4: Assess risk of harm
Consider factors that increase vulnerability to medicine-related harm, including frailty, multi-morbidity, renal/hepatic impairment, drug–drug and drug–disease interactions, falls risk and anticholinergic burden. Supporting tools include:

- Rockwood Clinical Frailty Scale[4]. (CFS ≥5 should prompt review; CFS ≥6 indicates higher vulnerability).
- Anticholinergic burden (ACB) guidance – WY ICS[5]
- Medicines and Falls Risk Toolkit (RPS –endorsed)[6]
- Cumulative toxicity tool and adverse drug reactions (ADR)[25]

Step 5: Assess benefit vs. prognosis

- Weigh expected time-to-benefit against likely life expectancy.
- Continue medicines where there is short-term benefit or clear symptomatic value.

Step 6: Optimise medicines to be continued

- Confirm correct indication, dose, route and formulation.
- Simplify regimens where possible (e.g., once daily, combination products, alternative formulations such as patches).
- Put in place practical medicines support (e.g., reminder charts, compliance aids, tablet crushing guidance for enteral feeding administration, carer support) using WY HCP Managing Medication[7].

Step 7: Review and follow up

- Agree and document a monitoring and follow-up plan, including what to watch for and when to reassess.
- Monitor for withdrawal effects or symptom recurrence; reintroduce if clinically indicated.
- As prognosis shortens (final weeks/days), prioritise comfort and reduce treatment burden more actively.

This structured approach is summarised in **Appendix 1: Structured Medication Review Checklist**, with links to supporting tools.

Section 4: Medicines Optimisation Tool

4.1 How to Find a Drug Class or Specific Medicine

Medicines are grouped by therapeutic class with key example drugs provided. Use **Ctrl + F** to locate a specific medicine or class.
For each class, guidance is structured according to three broad prognostic stages:

- Long months to short years
- Weeks to months
- Hours to days

For some medicines, recommendations are combined across two prognostic stages where the clinical approach is broadly the same. This reflects where management does not meaningfully change until the final days of life and is intended to support practical, proportionate decision-making.

In addition to prognosis, medicines should be reviewed in the context of changing physiology and practical use. This includes reviewing dose appropriateness, body weight, oral intake, renal and hepatic function, swallowing ability, adherence, and whether the person can still safely and reliably use or administer the treatment. These factors may alter the balance of benefit and harm even where the original indication remains valid.

The tool should be applied within the structured **7-Step Approach** outlined in **Section 3.**

4.2. Overview of Colour-Coding (Red/Yellow/Green)

The colour-coding framework provides a visual guide to support structured clinical decision-making. It does not replace professional judgement or shared decision-making. Where decisions are complex, high risk or uncertain, escalation to or co-working with relevant specialist teams is recommended.

Green = Appropriate to continue

- Start or continue where there is clear symptom relief, short-term benefit, or essential disease control (e.g., insulin to prevent symptomatic hyperglycaemia).
- Consider simplification to reduce treatment burden.

Yellow = Review and optimise

- Requires regular review of dose, side effects, interactions and ongoing benefit.
- Continue if aligned with prognosis and patient goals; consider dose reduction, simplification or deprescribing where appropriate

Red = Usually stop or taper

- In most cases, these medicines are unlikely to provide meaningful benefit in the context of limited prognosis, or potential harms may outweigh benefits.
- If continued, there should be a clear, documented rationale aligned with the person's goals of care.

Note:
The colour coding reflects typical patterns of benefit versus burden at different stages of prognosis. Individual circumstances may justify deviation from the suggested approach.

4.3. Medicines Optimisation Tool

The following tables provide guidance by drug class across broad prognostic stages. They are intended to support structured review and shared decision-making.

This tool is intended to support, not replace, existing disease-specific or specialist guidance where relevant.

Where medicines are used for complex indications, or where significant clinical risk exists, discussion with or input from relevant specialist teams should be considered in line with usual governance arrangements.

Where prognosis-based or high-risk medicines changes are identified in secondary or specialist care, these should ideally be initiated or clearly actioned within that setting, rather than transferred as unfinished work across care interfaces.

Patients may wish to continue some medicines. Decisions should be individualised and aligned with the person's goals of care.

Drug or Drug Class	Prognosis Long Months to Short Years	Prognosis Weeks to Months	Prognosis Hours to Days
Gastrointestinal			
PPIs / H_2 - receptor antagonists *(e.g., lansoprazole, omeprazole, famotidine)*	• **Continue** where there is clear symptom benefit or a current indication (e.g., history of GI bleed, peptic ulcer disease, severe GORD, or gastroprotection with NSAIDs, steroids, antiplatelets or anticoagulants). • Use the lowest effective dose; consider step-down or PRN use where appropriate. • Deprescribe if no ongoing indication.	• **Review ongoing need regularly**. • **Continue** if required for symptom relief or active gastroprotection. • Consider discontinuation where indication no longer applies, or treatment burden outweighs likely short-term benefit.	• **Review necessity and stop** if no clear short-term symptomatic benefit. • Continue only if clearly relieving distressing upper GI symptoms or preventing significant discomfort (e.g., active ulceration, ongoing dyspepsia, bleeding).
Endocrine			
Oral hypoglycaemic agents *(e.g., metformin, sulfonylureas, pioglitazone, DPP-4 inhibitors, GLP-1 analogues, acarbose, SGLT2 inhibitors)*	• **Continue if well tolerated and contributing to symptom-free glucose control.** • Aim for **Capillary Blood Glucose (CBG) 6–15 mmol/L (**individualise; agree with person). • HbA1c target needs to be individualised, up to 75 mmol/mol. • **Reduce or stop agents** stepwise if: eating less; losing weight; at risk of hypoglycaemia; or no longer contributing to symptom control. • **SGLT2 inhibitors:** apply sick-day rules; stop if hypotensive or volume-depleted. May continue for HF symptom benefit if well tolerated. • Involve Diabetes Specialist Nurses (DSNs) if control is unstable or complex. • To support decisions use NICE, Glycaemic Control for Older People with Type 2	• **Review regularly.** • Aim for **CBG 6–15 mmol/L** to avoid symptoms (individualise; agree with person). • HbA1c target needs to be individualised, up to 75 mmol/mol, although not helpful with short prognosis. • Minimise testing. • **Reduce or stop agents stepwise** if: eating less; losing weight; at risk of hypoglycaemia or no longer contributing to comfort. • Involve DSNs if control is unstable or complex. • To support decisions use Diabetes UK Guidance towards EOL[10]	• **Stop oral agents**. No benefit at this stage, risk of harm. • Check CBG only if symptomatic hypo- or hyperglycaemia is suspected. • For organisation-specific guidance (e.g., LTHT: Palliative Care Intranet – Managing diabetes at the end of life[11]), clinicians should refer to their local diabetes or palliative care protocols.

	Diabetes and Frailty and or Multi-morbidity[9] and Diabetes UK Guidance towards EOL[10]		

Insulin ***(e.g., long acting, short acting, mixed preparations)***	• **Continue if needed for symptom free control.**
	• **Aim for CBG target range 6-15mmol/L (individualise; agree with the person).**
	• HbA1c target needs to be individualised (up to 75mmol/mol depending on context).
	• Prefer simple regimens (e.g., once-daily long-acting insulin where appropriate).
	• Anticipate dose reduction with reduced oral intake or weight loss.
	• Involve DSNs if control is unstable or complex.
	• To support decisions use:
	  ○ Glycaemic Control for Older People with Type 2 Diabetes and Frailty and or Multi-morbidity[9] and
	  ○ Diabetes UK Guidance towards EOL[10]
		Type 1 diabetes (including pancreatitis or cystic fibrosis-related diabetes)
		• Insulin must be continued to prevent ketoacidosis.
		• Simplify regimen where possible but do not discontinue.
		• Seek DSN input if regimen complexity or instability arises.
		
		Type 2 diabetes
		• **Review regularly.**
		• **Continue only** if preventing symptomatic hyperglycaemia.
		• Simplify insulin regimen where possible.
		• Reduce dose in line with reduced oral intake or weight loss.
		• Monitor CBG daily or sooner if symptoms of hypo/hyperglycaemia arise.
		• Involve DSNs if control is unstable or complex.
		
		• To support decisions use Diabetes UK Guidance towards EOL[10]
			Type 1 diabetes, pancreatitis or CF related diabetes:
			• Continue insulin at a reduced dose to avoid ketoacidosis.
			• Simplify to once-daily long-acting insulin where appropriate.
			• Minimise monitoring but check CBG if symptomatic.
			• For organisation-specific guidance (e.g., LTHT: Palliative Care Intranet – Managing diabetes at the end of life[11]), clinicians should refer to their local diabetes or palliative care protocols.
			
			Type 2 diabetes:
			• Review need for insulin.
			• Consider stopping if on very low dose (≤6 units daily) and CBG <10 mmol/L.
			• Otherwise continue a reduced once-daily long-acting preparation (e.g., 25% reduction of previous total daily dose) if required for comfort.
			• Avoid burdensome monitoring; check CBG only if clinically indicated.
			• For organisation-specific guidance (e.g., LTHT: Palliative Care Intranet – Managing diabetes at the end of life[11]), clinicians should refer to their

			local diabetes or palliative care protocols.
Thyroid hormones ***(e.g., levothyroxine)***	• **Continue** to prevent symptomatic hypothyroidism. • Check thyroid function if clinically indicated.	• **Continue** where oral route is tolerated and treatment burden is minimal. • Review if clinical status changes significantly.	• Consider **stopping i**f oral route is lost or treatment burden outweighs likely short-term benefit. • **Stopping** in the final days of life is unlikely to cause immediate harm.
Osteoporosis medicines ***(e.g., bisphosphonates, denosumab)***	• **Review regularly**; fracture prevention benefits accrue over years and may have limited short-term impact. • Consider stopping if no fracture within the last 12–24 months and fracture risk has reduced (e.g., long-term steroids discontinued). • Continue where fracture risk remains high or long-term steroids continue. **Denosumab:** • Avoid abrupt discontinuation due to risk of rebound vertebral fractures. If stopping is being considered, assess fracture risk and discuss with relevant specialist services where appropriate. **Bisphosphonates:** • Long residual skeletal effect: discontinuation is usually safe. • May remain appropriate if used for hypercalcaemia or metastatic bone pain.	• Fracture prevention benefits unlikely to be realised within limited prognosis. • **Stop** fracture-prevention therapy. • Continue only if used for symptom control (e.g., hypercalcaemia, metastatic bone pain). **Denosumab:** • Avoid abrupt cessation where possible; balance rebound fracture risk against treatment burden. Consider specialist advice if uncertainty exists.	• **Stop** fracture prevention therapy. • Focus on comfort. • Continue only if clearly used for symptom relief (e.g., hypercalcaemia, metastatic bone pain).

Oestrogen hormones ***(e.g., systemic HRT, vaginal oestrogen)***	• **Review** ongoing indication and symptom burden. • Consider discontinuing systemic HRT where risks outweigh benefit (e.g., previous VTE or breast cancer) or where long-term preventive benefit is no longer relevant. • Continue systemic HRT only where clear symptomatic benefit persists. • Continue vaginal oestrogen where effective for recurrent UTIs or urogenital symptoms and treatment burden is minimal.		• **Stop** systemic HRT. • Continue vaginal oestrogen only if clearly relieving distressing local symptoms and not burdensome.
Hormone therapy for breast cancer: tamoxifen; aromatase inhibitors ***(e.g., anastrozole, letrozole)***	*These agents may be used either as adjuvant therapy (long-term recurrence prevention) or for metastatic disease control. Time-to-benefit in the adjuvant setting is measured in years.* • **Review** treatment intent (adjuvant vs metastatic disease control). • Discontinue where being used for long-term recurrence prevention and prognosis is limited. • Continue where providing ongoing disease control or palliative benefit. • Consider oncology input if uncertainty exists regarding current intent of therapy.		• **Stop** to focus on comfort; symptom control and reduce treatment burden.
Hormone therapy for prostate cancer: ***LHRH analogues (e.g., goserelin, leuprorelin, triptorelin); anti-androgens (e.g., bicalutamide)***	• *These agents are used for long-term disease suppression. Benefit is generally realised over months to years. Treatment burden is usually low.* • **Continue** where providing disease control. Review treatment intent periodically in line with prognosis and goals of care.	• Disease-modifying benefit is unlikely to meaningfully influence long-term outcomes within limited prognosis. • Review indication and disease trajectory. • Continue where ongoing tumour control is likely to contribute to stability or symptom prevention. • Consider oncology input before discontinuation, particularly in metastatic disease or if uncertainty exists, and discuss with the patient where appropriate**.**	• Stop, no meaningful benefit to comfort is likely at this stage. • Focus on comfort and symptom control

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Cardiovascular			
Antihypertensives ***(e.g., ACE inhibitors, ARBs, beta blockers, calcium channel blockers, thiazides, diuretics)*** **Important:** Clarify primary indication (hypertension vs heart failure, AF rate control, angina, albuminuric CKD). Management depends on indication	**Hypertension** • **Continue**; individualise BP targets based on frailty, cardiovascular risk, prognosis and patient preference. • **Aim**: <140/80 mmHg; in ≥80 years/frail, <150/80 mmHg if tolerated (use standing BP if lower). • **Consider de-intensifying** if SBP <130 mmHg with symptoms (e.g., postural hypotension, fatigue, AKI). • Antihypertensive benefits accrue over years, while risks (falls, AKI, dizziness) may occur sooner. Balance time-to-benefit against prognosis. • **Risks** increase with confusion, infection, dehydration, vomiting or concurrent diuretic use. • **Continue** if also indicated for: angina; AF rate control; HFrEF; albuminuric CKD • **Withdraw sequentially** if on multiple agents, guided by BP targets and co-morbidities. • **Avoid** centrally acting agents and high-risk combinations (e.g., beta-blocker + verapamil). **To support decisions use:** • Hypertension Treatment Guidance - WY ICS Healthy Hearts CVD Hypertension Guidelines[12]	**Hypertension** • **Review regularly** with focus on comfort and harm minimisation. • Time-to-benefit for BP prevention is long (months–years); in limited prognosis, near-term risks and treatment burden often outweigh benefit. • Stop if used solely for BP control or causing harm (e.g., postural hypotension, fatigue, AKI). • Continue only if providing symptom benefit (e.g., angina, fluid overload in heart failure, AF rate control). • Use standing BP to guide decisions where lower. • Risks increase with infection, confusion, dehydration, vomiting or diuretic use. • Withdraw sequentially if on multiple agents, guided by co-morbidities and overall goals. • Avoid centrally acting agents and high-risk combinations (e.g., beta-blocker + verapamil). **To support decisions use:**	**Hypertension** • **Stop** antihypertensives used solely for BP control. • Discontinue to reduce treatment burden and avoid hypotension and dizziness. • Continue only if required for symptom relief (e.g., distressing tachycardia, pulmonary congestion).

	• Right decisions: Hypertension[27] • Medicines and Falls Risk[6]	• Hypertension Treatment Guidance - WY ICS Healthy Hearts CVD Hypertension Guidelines[12] • Right decisions: Hypertension[26] • Medicines and Falls Risk[6]	
	Congestive Cardiac Failure (HFrEF) • **Continue** where improving symptoms (e.g., breathlessness, oedema) and quality of life. • Reduce or stop if causing harm (e.g., symptomatic hypotension, hyperkalaemia, renal impairment, contributing to dizziness, fatigue, or falls). • Benefits such as reduced HF admissions may occur within months; weigh this against prognosis. • As prognosis shortens, shift focus from prevention of admissions to relief of breathlessness and congestion (see diuretics). • Prioritise comfort, symptom control and quality of life. • To support decisions use: Medicines and Falls Risk[6]		**Congestive Cardiac Failure (HFrEF)** • **Stop** disease-modifying heart failure therapies used solely for long-term prognostic benefit. • Continue medicines providing clear symptom relief (e.g., loop diuretics for pulmonary congestion). • Discontinue agents causing hypotension, dizziness or distress. • Focus on comfort and relief of breathlessness.
Diuretics ***(e.g., bendroflumethiazide, furosemide, bumetanide, spironolactone)***	**Congestive Cardiac Failure (HFrEF)** • **Review regularly.** • **Continue** loop diuretics (e.g., furosemide) where managing symptomatic fluid overload (e.g., heart failure, liver disease). • Use the lowest effective dose. • Avoid loop diuretics for isolated ankle oedema unless due to heart failure, liver disease or nephrotic syndrome, as risks may outweigh benefit. • Stop thiazides if used solely for hypertension or if causing harm (e.g., hypokalaemia, hyponatraemia, hypercalcaemia, gout). • Monitor for dehydration, postural hypotension, renal impairment and electrolyte imbalance. • Adjust dose if oral intake or fluid intake is significantly reduced. • Deprescribe gradually if fluid overload resolves or harms outweigh benefits. • To support decisions use: Medicines and Falls Risk[6]		**Congestive Cardiac Failure (HFrEF)** • **Review regularly.** • **Continue** only if clearly relieving breathlessness or distress from fluid overload. • **Stop** if no clear comfort benefit or fluid overload has resolved. • If oral route lost, consider subcutaneous furosemide only if appropriate. • Focus on comfort and minimise burdensome monitoring.

Beta blockers for rate control *(e.g., bisoprolol, atenolol)*	• **Continue** where providing **symptomatic or clinical benefit** (e.g., atrial fibrillation rate control, angina, heart failure symptom management). • Review regularly for bradycardia, hypotension, fatigue, dizziness and falls risk. • Stop or reduce if causing harm (e.g. HR < 50 bpm; heart block without a pacemaker; symptomatic hypotension; bronchospasm /asthma; or poor tolerance. • Avoid co-prescribing with verapamil or diltiazem due to risk of heart block. • Consider digoxin if beta-blockers are not tolerated or contraindicated, particularly where rate control remains important. • Consider gradual dose reduction if deprescribing, to reduce risk of rebound tachyarrhythmia or angina. • To support decisions use: Medicines and Falls Risk[6]	• **Continue only if providing clear symptomatic benefit,** such as rate control in symptomatic atrial fibrillation or relief of angina/heart failure symptoms. • Review regularly and stop if causing bradycardia, fatigue, dizziness, hypotension or falls, or if treatment burden outweighs benefit. • Avoid co-prescribing with verapamil or diltiazem due to risk of heart block. • Consider digoxin if beta-blockers are not tolerated or contraindicated and symptom control remains important. • If stopping, gradual dose reduction where clinically appropriate to reduce risk of rebound tachyarrhythmia or angina. • To support decisions use: Medicines and Falls Risk[6]	• **Stop** unless clearly needed for comfort, for example distressing tachycardia or symptomatic angina**.** • Stop if not tolerated or if oral route is lost. • If discontinuing, consider whether gradual reduction is appropriate depending on clinical context and likely benefit. • Do not replace unless essential for symptom relief.

Lipid- lowering *drugs (e.g., statins, fibrates, ezetimibe, PCSK9 inhibitors)*	• **Review indication, treatment intent and likely time to benefit with the person.**
	• **Statins:**
	  • **Primary prevention**: usually stop as time to benefit is unlikely to align with limited prognosis.
	  • **Secondary prevention** (e.g., post-MI): consider stopping if prognosis is likely < 2 years and there has been no recent cardiovascular event (e.g., ACS or PCI, in the last 6 to 12 months).
		• **Usually stop lipid-lowering therapies** in most cases, as there is no meaningful short-term benefit in this timeframe for primary or secondary prevention.
		• **Discontinue** to reduce treatment burden and avoid adverse effects (e.g., muscle pain, fatigue, and liver dysfunction)
			• **Stop all lipid-lowering therapies.**
			• These medicines do not provide comfort of short-term symptomatic benefit and add unnecessary treatment burden.

	• Secondary prevention benefit is greatest within 1–5 years post-event but becomes less relevant when survival is limited. • If uncertain, consider a trial of cessation or dose reduction to reduce adverse effects and treatment burden. • **Ezetimibe, fibrates, and PCSK9 inhibitors** - usually stop, unless: • **fibrates** are being used to reduce pancreatitis risk in severe hypertriglyceridemia, or • lipid lowering treatment is being continued following a recent major cardiovascular event and expected survival > 2 years. • **Avoid PCSK9 inhibitors** in people living with frailty where treatment burden outweighs likely near-term benefit. • To support decisions use: A guide to deprescribing statins[13]	• Continue only in exceptional circumstances, for example when a fibrate is being used to reduce pancreatitis in severe hypertriglyceridemia.	
Antianginals ***(e.g., beta blockers, nitrates, nicorandil, ranolazine)***	• **Review regularly and continue only if providing symptomatic benefit.** • Consider whether **angina symptoms have occurred within the past 12 months.** • These medicines may no longer be needed if mobility is limited and exertional chest pain is no longer reported. • Antianginals may relieve angina symptoms, but they do not reduce mortality, prevent myocardial infarction, or modify long term disease progression. • If stopping, **taper gradually** where appropriate to reduce rebound angina. • Ensure GTN spray remains available for breakthrough chest pain if still relevant.		• **Stop** if no longer providing symptom relief. • Focus on comfort and adequate pain relief. • Continue or replace only if clearly needed to relieve distressing chest pain.
Digoxin ***(e.g., for atrial fibrillation or heart failure symptoms)***	• **Continue if used for atrial fibrillation rate control or symptom relief in heart failure.**	• **Review regularly and continue only if providing clear symptomatic**	• **Stop** if no longer providing symptom relief.

	• Review regularly and consider stopping if there is no clear ongoing benefit, if the person is in sinus rhythm, or treatment no longer aligns with goals of care. • Use with caution in renal impairment, low body weight or in people living with frailty due to increased risk of toxicity. • Consider as an alternative where beta-blockers are not tolerated or contraindicated, particularly if symptom control remains important.	**benefit,** such as relief of distressing tachycardia or heart failure symptoms. • Stop if no longer helpful, not tolerated, or if renal impairment / reduced clearance increases toxicity risk. • Avoid routine continuation in people living with frailty unless there is a strong ongoing indication. • Consider whether ongoing monitoring or dose adjustment remains proportionate to likely benefit.	• Discontinue if oral route is lost or if ongoing use adds treatment burden without comfort benefit. • Risk of toxicity may increase with renal impairment, dehydration and reduced clearance. • Prioritise comfort and symptom control.
Peripheral Vasodilators used for non-hypertensive indications *(e.g., nifedipine for Raynaud's phenomenon or smooth muscle spasm)*	• **Review regularly and continue only if providing meaningful symptom relief (**e.g., smooth muscle spasm, vasospastic angina, Raynaud's phenomenon). • Stop if used for prevention alone (e.g. intermittent claudication or vascular prevention) or if no longer providing benefit.	• **Review regularly and continue only if relieving distressing symptoms (e.g., Raynaud's phenomenon, smooth muscle spasm, angina).** • Stop if used for prevention alone (e.g., intermittent claudication) or if no current symptom benefit.	• **Review and stop** unless clearly providing symptom relief and oral route is tolerated**.** • Prioritise comfort. • Discontinue if used for prevention or if no immediate benefit.
Antiarrhythmics *(e.g., Amiodarone)*	• **Review regularly and continue** only if treating symptomatic arrhythmia or where rhythm control remains clinically important and alternatives are not suitable. • **Stop** if there have been no recent symptoms, if treatment no longer aligns with goals of care, or if adverse effects emerge (e.g., bradycardia, thyroid, liver or lung toxicity). • Avoid routine long-term continuation in people living with frailty where toxicity risk and treatment burden may outweigh likely benefit.	• **Review regularly and continue** only if controlling symptomatic arrhythmia and still contributing to comfort or stability. • **Stop** if there has been no recent arrhythmia, if treatment burden outweighs benefit, or if adverse effects / toxicity is a concern. • Avoid continuation if being used for **prevention alone** in the context of frailty or declining function.	• **Stop,** unless clearly providing symptom relief or control of distressing arrhythmia**.** • Focus on comfort and minimise treatment burden. • Discontinue if no immediate benefit or if oral route is lost.

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Antiplatelet and anticoagulants			
Antiplatelets ***(e.g., aspirin, clopidogrel, dipyridamole)***	• Review regularly and clarify whether treatment is being used for **primary or secondary prevention**. **Primary prevention:** • **Stop,** as bleeding risk likely to outweigh benefit. **Secondary prevention** • **Review indication, particularly if history of acute coronary syndrome (ACS), PCI/stent, stroke/TIA, myocardial infarction (MI); seek cardiology/stroke/vascular advice as needed.** • Treatment regimens are not absolute and can be shortened or extended based on bleeding risk; thromboembolic risk; overall cardiovascular risk; time since vascular event or intervention; prognosis and goals of care. • If on **dual antiplatelet therapy**, consider de-escalation if beyond the usual treatment window (e.g., > 12 months post-ACS or stent) or if bleeding outweighs benefit. • Time to benefit is often **months to years**, so in limited prognosis the balance may shift towards bleeding risk and treatment burden. • **Do not use aspirin alone** for stroke/TIA prevention in **atrial fibrillation** where anticoagulation would otherwise be indicated	**Primary prevention:** • **Stop**, no meaningful benefit in this timeframe; discontinue to reduce treatment burden and bleeding risk. **Secondary prevention** • **Review ongoing indication and stop where** bleeding risk or treatment burden outweighs likely short-term benefit. • If there has been a recent vascular event or intervention, **seek cardiology /stroke/vascular advice as needed.** • If on **dual antiplatelet therapy,** consider de-escalation unless within short-term indication window.	• **Stop**, no meaningful prevention benefit remains. • Risk of bleeding usually outweighs benefit. • Focus on comfort and reduce treatment burden.

Anticoagulants oral (*e.g., warfarin, rivaroxaban, apixaban, dabigatran, edoxaban)*	• **Continue if benefit is likely and bleeding risk is acceptable.**
	• Use shared decision-making with GARFIELD -AF score/ CHA_2DS_2-VASc (stroke risk) and ORBIT (bleeding risk) alongside clinical judgement.
	• Avoid rigid survival cut-offs.
	
	Atrial fibrillation or VTE <6 months ago:
	• Continue if there has been recent VTE; recent stroke or systemic embolism in last 6 months; CHA_2DS_2-VASc score indicates high stroke risk; bleeding risk acceptable; prognosis.
	• Considering stopping if CHA_2DS_2-VASc < 2, and bleeding risk is high.
	• Consider switching **warfarin to a DOAC** if suitable to reduce monitoring burden (not for complex indications).
	
	VTE >6 months ago:
	• Consider reducing to a **prevention dose** (apixaban/rivaroxaban) or stopping if treatment burdensome.
	
	Complex indications:
	• **Mechanical valve and antiphospholipid syndrome (APS) -**
	  ○ **Warfarin remains preferred**
	  ○ Consider **LMWH** if warfarin is high-risk or poorly tolerated.
		• **Review regularly - prioritise comfort and minimise burden.**
		• Continue only where **short-term benefit clearly outweighs bleeding risk or treatment burden**.
		• Use shared decision-making to **balance prognosis, bleeding risk, and patient priorities.**
		• Risk scoring systems (e.g., CHA_2DS_2-VASc, HAS-BLED, ORBIT) are less useful in this context, as older people and those living with frailty will score highly for both stroke and bleeding risk; decisions should therefore be guided by clinical context and individual goals.
		• In **atrial fibrillation**, consider stopping anticoagulation in the presence of active bleeding, recurrent bleeding, or very high bleeding risk (e.g. GI malignancy, advanced frailty, or falls), where treatment no longer aligns with goals of care.
		• New initiation of anticoagulant in this context is **rarely appropriate**.
		
		AF / VTE:
		• Consider switching **warfarin to a DOAC** if short-term benefit expected and INR monitoring is burdensome.
		• For **VTE >6 months ago**, consider reducing apixaban or rivaroxaban to a
			• **Stop,** unless clear immediate comfort-based indication.
			• No meaningful prevention benefit remains.
			• Risk of bleeding outweighs benefit.
			• Focus on comfort and reduce treatment burden.

	○ **DOACs are not recommended** for mechanical valves or **high-risk APS.** ○ In selected **lower risk APS (VTE-only APS**), a DOAC may be considered following specialist advice. • **Unusual site venous thrombosis** (e.g., portal, mesenteric, cerebral veins): ○ Consider switching to **DOAC** (possible unlicensed use, discuss with anticoagulation or thrombosis team) or LMWH. • **Arterial thrombosis and peripheral vascular disease (PVD):** weigh bleeding risk and consult local vascular advice /guidance if needed. **Check renal function and dosing**: • Stop **dabigatran** if CrCl <30 mL/min. • Stop **apixaban, edoxaban, rivaroxaban** if CrCl <15 mL/min. • Review DOAC dosing based on age, renal function, and actual body weight. • Adjust LMWH dose if CrCl <30 mL/min and dose according to actual body weight. • If unsure seek specialist advice.	prevention dose or stopping if treatment burden is high. **Complex indications:** • **Mechanical valve / APS / unusual thrombosis -** seek specialist advice before stopping or switching if possible. **Check renal function and dosing:** • Review renal function, dose appropriateness and bleeding risk. • If unsure seek specialist advice.	
Injectable anticoagulants *(e.g., LMWH, fondaparinux)*	• **Continue if benefit is likely and the treatment is tolerated.** • **Prophylactic use:**	• **Review regularly - prioritise comfort and minimise burden.** • **Prophylactic use:**	• **Stop,** no meaningful prevention or treatment benefit usually remains. • Increases risk of **bleeding, bruising**, and injection-related discomfort.

	○ Continue only if there is **increased VTE risk** (e.g., immobility, active cancer). ○ Reassess regularly as prognosis evolves. ○ Consider DOAC if oral route preferred, recognising this may be unlicensed in some settings. • **Therapeutic use:** ○ Continue if recent or symptomatic VTE. ○ Consider **once-daily** LMWH if on twice-daily dosing, where appropriate to reduce burden. ○ If **warfarin is** unsuitable, consider switch to LMWH. • **Dose adjustments**: Adjust LMWH dose if CrCl <30 mL/min and dose according to actual body weight. • If unsure seek specialist advice.	○ Stop unless **VTE risk remains high** (e.g., cancer-related or recent immobility or other ongoing risk factors). • **Therapeutic use:** ○ Continue only if treating symptomatic VTE with expected short-term benefit. ○ Avoid initiating new injectable anticoagulants unless clear short-term benefit. ○ Review renal function, bleeding risk and injection burden regularly. ○ Reassess whether treatment remains aligned with patient goals and comfort. • If unsure seek specialist advice.	• Focus on comfort and reduce treatment burden.
Respiratory System			
Inhalers: **Anti-muscarinic bronchodilators** ***(e.g., ipratropium, tiotropium)*** ***Beta-2-agonists (e.g., salbutamol)*** ***Steroid inhalers (e.g., beclomethasone)***	• **Review, continue only if there is a clinical indication for each drug class.** • Check **inhaler technique** and ability to use the device reliably; simplify regimens. • Sustainability: choose the **lower-carbon option** if clinically appropriate; avoid blanket switch. • Focus on **prevention of exacerbations** and relief of distressing breathlessness with the simplest effective regimen according to West Yorkshire Asthma and COPD guidelines. • **SABA overuse flag**: >3 canisters/year (or >1 per month) suggests poor control thus review preventer use, technique and adherence. • Consider switching to MART or AIR therapy, if appropriate, in line with West Yorkshire asthma guidance. • Inhaler devices are preferred over nebulised therapy where patients can use inhaler devices effectively.		• **Stop** regular inhalers and nebulisers unless they are clearly providing symptom relief and the person can still use them. • Consider **salbutamol (inhaler or nebuliser)** only if providing clear, short-term relief from breathlessness. • Stop if not effective or causing distress, fatigue, or treatment burden. • Focus on comfort and minimise burdensome interventions.

	• **Asthma:**
	  ○ Do **not stop inhaled corticosteroids**, due to risk of deterioration of asthma control and asthma exacerbations.
	
	• **Consider changing inhaled therapy:**
	  ○ Where inhaler technique is poor, switch to a device the person can use.
	  ○ In patients with good disease control, consider **simplifying regimen** according to West Yorkshire Asthma or COPD guidelines, (e.g., use of combination inhalers, step-down treatment).
	• **To support decisions use:**
	  ○ West Yorkshire COPD Prescribing Guidance [14]
	  ○ West Yorkshire Adult Asthma Management and Prescribing Guideline [15]	

Theophylline	• **Review,** continue only if **clearly relieving symptoms, blood levels are in the therapeutic range, and no safer alternative is effective**. • Stop if inhalers provide adequate symptom relief, toxicity risk is increased (e.g., weight loss, drug interactions, declining physiological reserve); or monitoring is burdensome. • Theophylline offers limited benefit, has many interactions, and a narrow therapeutic window. • Avoid use in people living with advanced frailty or where safe monitoring is not possible.	• **Usually stop, limited** role in symptom relief or disease control at this stage. • High risk of toxicity due to narrow therapeutic index, drug interactions, reduced physiological reserve and weight loss. • Prioritise comfort, reduce monitoring and minimise burden. • Continue only if there is clear ongoing symptom benefit and stopping is likely to worsen comfort.
Leukotriene receptor antagonists ***(e.g., montelukast)***	• **Review and stop unless clearly contributing to asthma control.** • No role in COPD or where asthma is well controlled with inhalers alone. • Stop if no current asthma diagnosis, or ongoing benefit. • Prioritise simplifying regimen and reducing treatment burden.	• **Stop,** no meaningful role in symptom control at this stage. • Does not provide immediate relief of breathlessness, cough, or distress. • Discontinue to reduce treatment burden and prioritise comfort.

NHS West Yorkshire Integrated Care Board

Central Nervous System			
Cholinesterase inhibitors for dementia *(e.g., donepezil, rivastigmine, galantamine)*	• **Review – consider stopping in advanced or end-stage dementia.** • **Stop** if: no clear benefit (e.g., no slowing of cognitive or functional decline); significant side effects (e.g., bradycardia, falls, and anorexia); high treatment burden. ○ To support decisions use: Medicines and Falls Risk[6] • Deprescribing can be trialled and reversed if symptoms deteriorate. Refer to dementia deprescribing guidance [16] • Involve patient/family/ carers in decision making where appropriate.		• **Usually stop,** as limited benefit is expected in cognition, function or symptom control at this stage. • May contribute to bradycardia, falls, nausea, and unnecessary treatment burden. • Focus on comfort, dignity, and minimising interventions.
Memantine for dementia	• **Continue if tolerated.** • May provide **behavioural benefit**, especially in those with **BPSD**. • There is **no MMSE** cut-off for discontinuation. • If stopped, benefit may not return on rechallenge. • Review regularly and consider ongoing benefit, tolerability, treatment burden, and goals of care. • To support decisions, consider referring to **Maudsley Prescribing Guidelines (14th ed.) pg. 640[24]**		• **Stop,** if no longer tolerated or oral route is lost. • Otherwise, may continue**,** if providing clear behavioural benefit.
Parkinson's disease medicines (*e.g., levodopa/benserazide [Madopar®], rotigotine*)	• **Continue**. Symptom benefit. • Consider rotigotine TD patch if unable to swallow. Contact local Parkinson's Disease Team /Specialist team.		• **Continue**. • Consider rotigotine TD patch if unable to swallow. Contact local Parkinson's Disease Team /Specialist team.
Antiepileptics for seizures or neuropathic pain *(e.g., levetiracetam, phenytoin, sodium valproate, carbamazepine)*	**Seizures** • **Continue if treating epilepsy or preventing seizures.** • **Review** gabapentinoids: monitor renal function, sedation, and falls risk. • If stopping, taper slowly to minimise withdrawal. • To support decisions use: Medicines and Falls Risk[6]		**Seizures** • Continue for seizure control. • Consider switching to SC (e.g., midazolam or levetiracetam). • Seek advice from Palliative Care, if unsure.
	Neuropathic pain		**Neuropathic pain**

	• **Review - continue,** only if providing clear relief from neuropathic pain and is well tolerated. • For gabapentinoids: monitor renal function, sedation and falls risk. • **Stop** if no neuropathic pain symptoms or side effects outweigh benefit (e.g., sedation, dizziness, confusion). • Consider switching to safer or simpler agents (e.g., gabapentin or duloxetine). Taper slowly. • To support decisions use: Medicines and Falls Risk[6]	• **Stop** if no clear benefit or unable to take orally. • Prioritise comfort and simplify regimen.
Antipsychotics for psychiatric disorder *(e.g., olanzapine, risperidone, quetiapine)*	• **Continue if treating schizophrenia, bipolar disorder, or persistent psychotic symptoms with clear benefit.** • **Review** regularly, if used long term for BPSD. • Consider cautious reduction if: stable; causing sedation; falls; confusion. To support decisions use: Medicines and Falls Risk[6] • **Avoid abrupt stopping** if previous attempts led to relapse. • Seek psychiatry advice if unsure.	• **Stop,** unless clearly relieving distress (e.g., psychosis, terminal agitation). • Continue only if symptom benefit. • Consider SC alternatives (e.g., haloperidol, levomepromazine). • Taper if long-term use; avoid abrupt withdrawal. • Seek specialist advice if unsure.
Lithium (mood stabiliser)	• **Continue only with clear benefit and close monitoring.** • **Review** if oral route or monitoring is difficult. • Stop if risk of toxicity (e.g., renal impairment, dehydration). • Seek psychiatry advice if unsure.	• **Stop,** no benefit at this stage and high risk of toxicity. • Seek psychiatry advice if unsure.
Antipsychotics for nausea, vomiting or agitation. *(e.g., haloperidol, levomepromazine)*	• **Continue if providing symptom relief.** • Use the lowest effective dose and review regularly. • Stop if causing excessive sedation; extrapyramidal symptoms; no clear benefit. • Use with caution in dementia and people living with frailty due to increased risk of stroke, falls, and sedation. • To support decisions use: Medicines and Falls Risk[6]	• **Continue.** Symptom benefit. • Consider alternative route when oral route is lost.
Antidepressants for depression or anxiety disorder *(for neuropathic pain, see below)*	• **Review for tolerability, side effects, and ongoing need.** • To support decisions use: Medicines and Falls Risk[6] • **Continue** if stable and beneficial, especially for recurrent depression. • Avoid stopping prematurely**.** • **Mirtazapine**: may support sleep/appetite. Monitor for hyponatraemia.	• **Stop i**f not contributing to comfort. • Tapering often unnecessary. • Prioritise symptom control and reduce treatment burden.

(*e.g., tricyclic antidepressants such as amitriptyline; SSRIs such as citalopram or sertraline]; SNRIs such as duloxetine and venlafaxine; mirtazapine)*	• **SSRIs**: monitor for hyponatraemia; GI bleed (consider PPI); falls risk; QT prolongation (especially citalopram, consider ECG if history of syncope). • **Tricyclics**: avoid in people living with frailty; dementia; delirium; cardiac disease; constipation; falls risk (high Anticholinergic burden (ACB) guidance – WY ICS[5] **).** • **Sertraline** is preferred if postural hypotension or falls are a concern. • **Stop** if no benefit, especially in advanced frailty or intolerable side effects or oral route is lost. • For reducing and stopping guidance: SPS[17] or Right Decisions: Antidepressants[18] • Seek psychiatry advice if uncertain.		
Antidepressants for <u>neuropathic pain</u> ***e.g., tricyclic antidepressants such as amitriptyline; SNRI such as duloxetine)***	• **Review for effectiveness, tolerability and side effects.** ○ To support decisions use: Anticholinergic burden (ACB) guidance – WY ICS[5] and Medicines and Falls Risk[6] • **Continue** if clear symptom control and safer alternatives are unsuitable. • Stop if no neuropathic pain symptoms or if side effects outweigh the benefit (e.g., sedation, dizziness, confusion). • **Amitriptyline** (ACB 3): avoid in frailty; dementia; delirium; falls; constipation; urinary retention; cardiac disease. • Consider switching to **nortriptyline**, **duloxetine**, or gabapentinoid. • For reducing and stopping guidance: SPS[18] or Right Decisions: Antidepressants[18]		• **Continue** until oral route is lost (if symptom benefit).

Benzodiazepines and Z-drugs for anxiety and insomnia disorders ***(e.g., lorazepam, diazepam, zopiclone)***	• **Review** and **consider stopping if no clear symptom benefit.**
	• **Risks** in people living with frailty**:** falls; confusion; dependence; sedation.
	  ○ To support decisions use: Medicines and Falls Risk[6]
	• If used long term, taper gradually (consider diazepam for slow wean).
	  ○ For guidance consider: Right Decisions: Benzodiazepines and z-drugs[19] OR Ashton Manual – Benzodiazepine Withdrawal Guide[20]
		• **Review** and **continue only if clearly providing symptom relief.**
		• **Risks** in people living with frailty**:** falls, confusion, dependence, sedation.
		  ○ To support decisions use: Medicines and Falls Risk[6]
		• Avoid long-term use for insomnia; consider alternatives (e.g., mirtazapine, CBTi, sleep hygiene).
		• If deteriorating or losing oral route, consider switching or stopping.
			• **Continue** if providing comfort or symptom relief.
			• Use SC or buccal route.
			• Indications: agitation, anxiety, breathlessness, seizures, insomnia.
			• If already on long term BNZ, avoid abrupt withdrawal.
			• Seek palliative care advice if needed.

	• Avoid long-term use for insomnia; consider alternatives (e.g., mirtazapine, CBTi, sleep hygiene). • Note: BNZs may be appropriate short-term or intermittently in palliative care. Use clinical judgement and seek palliative care advice if needed.	• Taper gradually if used long term (consider diazepam for slow wean). ○ For guidance consider: Right Decisions: Benzodiazepines and z-drugs[19] OR Ashton Manual – Benzodiazepine Withdrawal Guide[20] • BNZs may still be appropriate in palliative care (e.g., anxiety, breathlessness, agitation, seizures. Use clinical judgement and seek palliative care advice if needed.	
Antihistamines ***(e.g., cetirizine, chlorphenamine)***	• **Review and continue only if symptoms of troublesome itch, allergy, or hay fever are relieved.** • **Chlorpheniramine** and other sedating antihistamines have a **high** anticholinergic burden[5] – avoid in frailty, delirium, dementia, cardiac disease, constipation, or falls risk. • Prefer **non-sedating agents** (e.g., cetirizine, loratadine) if antihistamine still needed. • To support decisions use**:** Medicines and Falls Risk[6] for drug classes linked to postural hypotension, sedation, and increased fall risk.		• **Stop.** unless providing specific symptom relief and the oral route is tolerated.
Anticholinergics in general	• **Review regularly and deprescribe where possible.** • Anticholinergic medicines are associated with significant risks in people living with frailty: cognitive decline; delirium; falls, sedation; constipation; urinary retention. • **For all patients**, calculate their total Anticholinergic Cognitive Burden (ACB) score using West Yorkshire ACB guidance[5] – a cumulative score of 3 or more is associated with a higher risk of cognitive impairment, falls, and hospital admissions. • To support decisions use: Medicines and Falls Risk[6] for drug classes linked to postural hypotension, sedation, and increased fall risk.		• **Stop**, if no symptom benefit.
Opioids e.g. ***morphine, oxycodone***	• **Review indication, risk/benefits**. • **Continue** at lowest dose to control symptoms and consider regular laxatives. • To support decisions use: opioid guidance.[21]		• **Continue.** Symptom benefit. • Consider alternative route.

		• To support decisions use: opioid guidance[21].
Genitourinary		
Alpha receptor blockers (*e.g., doxazosin, prazosin, tamsulosin*)	• **Review and continue only if relieving urinary symptoms (e.g., painful bladder spasms).** • Stop if: catheter in situ; **orthostatic hypotension**; **falls**; **micturition syncope**. • Alpha-blockers may contribute to dizziness and falls in people living with frailty. • Regularly reassess in context of **continence status**, **blood pressure**, and **prognosis**. • To support decisions use**:** Medicines and Falls Risk[6] for drug classes linked to postural hypotension, sedation, and increased fall risk.	• **Stop, unless relieving painful bladder spasms.** • Discontinue if prescribed for prostatic symptoms alone (e.g., LUTS, BPH) — no meaningful benefit at this stage. • Stop if catheter is in situ. • Continue only if providing comfort and oral route is still available. • Alpha-blockers can contribute to hypotension, drowsiness, or falls, and offer no benefit at the end of life.
5-alpha reductase inhibitors *(e.g., finasteride, dutasteride)*	• **Review and continue only if still providing symptom benefit (e.g., bothersome LUTS/BPH).** • Stop if catheter in situ or if no longer indicated (e.g., symptoms resolved, prognosis limited). • Finasteride has a delayed onset of action (months) and limited value in short prognosis. • Consider switching to a short-acting agent (e.g., tamsulosin) if symptom relief is still needed. • If anticholinergic burden is a concern, consider mirabegron for persistent bladder symptoms.	• **Stop,** no role in symptom management at end of life. • Offers no short-term benefit. • Discontinue when: oral route is lost; to reduce treatment burden; catheter in place (prostate-specific treatment no longer necessary) • Focus on comfort.
Overactive bladder or incontinence (e.g., oxybutynin [very high ACB], **tolterodine**, **solifenacin, mirabegron, vibegron)**	• **Review and continue only if the patient reports a clear symptomatic benefit.** • Anticholinergics may reduce urinary urgency or wet episodes, but benefit is often modest; stop if benefit is unclear or no longer meaningful. • Avoid anticholinergics in people living with frailty, dementia, falls risk, cardiac disease, or constipation due to high anticholinergic burden[5] .	• **Stop,** no meaningful role in symptom management at this stage; onset of benefit is slow (days to weeks). • Anticholinergics provide no short-term benefit and may increase delirium, dry mouth, and constipation.

	• **Consider switching to beta-3 agonist** (e.g. mirabegron or vibegron) if clinically appropriate and better tolerated in some patients but still requires review of benefit, blood pressure, and overall treatment burden. • To support decisions use**:** Medicines and Falls Risk[6]	• If painful bladder spasms occur, consider PRN hyoscine butylbromide (SC), if appropriate. • Continence control is often no longer a goal; catheterisation may already be in place. • Focus on comfort.

Phosphodiesterase-5 inhibitors (e.g., sildenafil, tadalafil)	• **Review** and **consider stopping.**
	• Unlikely to offer meaningful benefit in limited prognosis.
	• Inappropriate with nitrates or in heart failure due to risk of hypotension.
	• May contribute to postural hypotension and falls. To support decisions use**:** Medicines and Falls Risk[6]
	• Discuss goals of care and individual priorities.
		• **Stop,** no benefit at the end of life.
		• Discontinue:
		  ○ To reduce treatment burden.
		  ○ Avoid risks.
		  ○ When oral route is lost.

Musculoskeletal		
NSAIDs (e.g., ibuprofen, naproxen, celecoxib, parecoxib)	• **Review and continue** only if providing clear symptom benefit (e.g., inflammatory or cancer pain), and no safer alternative exists. • Use the **lowest effective dose** and consider a **PPI** to reduce GI risk. • **Avoid** long term use (>2 months) in high-risk patients: age >65; history of GI bleed; AKI or CKD (eGFR <50); heart failure; uncontrolled hypertension; concurrent use of steroids, antiplatelets, anticoagulants, or SSRIs (↑ bleeding risk). • Avoid in NSAID- sensitive asthma. • Celecoxib preferred in people living with frailty due to lower GI/CVS risk and no effect on platelets. • Stop, if used for non-specific pain without clear ongoing benefit.	• **Stop** all regular NSAIDs. • No role in disease control or symptom prevention at this stage. • Consider SC parecoxib only if needed for short-term pain relief and oral route is lost. • Prioritise comfort, reduce treatment burden, and monitor for injection site reactions if used.
Paracetamol (e.g., oral, IV)	• **Continue, if clear symptom benefit.** • Caution in patients living with frailty (Paracetamol Guidance)[22] - risk of overdosing and treatment burden.	• **Stop** to reduce treatment burden or when PO route is lost.
Systemic corticosteroids	• **Review and continue only if there is clear ongoing benefit for symptom control or disease-specific indication: raised intracranial pressure (e.g., brain metastases); obstructive syndromes (e.g., SVC, bowel, ureter, and bronchus); spinal cord/nerve**	• **Review indication** and continue only if clearly needed for symptom control (e.g., cerebral oedema, spinal cord compression, SVC obstruction).

(e.g., dexamethasone, fludrocortisone, prednisolone)	**compression; persistent nausea, vomiting, or poor appetite; hormone-sensitive cancers or paraneoplastic syndromes.** • **Stop** or reduce if: no clear symptom benefit; no active inflammation; significant side effects (e.g., agitation, hyperglycaemia, infection). • If continuing monitor CBGs; consider PPI, bone protection, PCP prophylaxis; document (indication, review date, and stop date); taper if used >3 weeks; consider temporary dose increase if acutely unwell. • To support decisions use: steroids and hyperglycaemia guidance[23].		• **Stop** if no ongoing symptom benefit. • If risk of withdrawal symptoms (e.g., after >3 weeks' use), taper or continue at lowest effective dose. • Switch to SC dexamethasone if oral route is lost. • Seek palliative care advice if unsure.
Disease-modifying anti-rheumatic drugs *(e.g., methotrexate, sulfasalazine)*	• **Review indication.** • **Continue** if symptom benefit. • Discuss with specialist before stopping.		• **Stop.** No symptom benefit.
Colchicine	• **Review** and stop if eGFR <10		• **Stop.** No symptom benefit.
Quinine	• **Review** and stop if no benefit, known to prolong QTc		• **Stop**. No symptom benefit.
Nutrition and Supplements			
Parenteral Nutrition (Inpatient and home)	• **Continue.** • Review regularly in liaison with the Specialised Intestinal Failure (SIF) Team / Nutrition Support Team (NST) for patients known to them**.** • For additional medicines, check the home PN prescription (which may not appear on the GP system) and/or eMeds (for inpatients) and assess on an individual basis in discussion with the SIF/NST.	• **Review regularly** in liaison with Specialised Intestinal Failure (SIF) team/ Nutrition Support Team (NST) for patients known to them**.** • For additional medicines, check the home PN prescription (which may not appear on the GP system) and/or eMeds (for inpatients) and assess on an individual basis in discussion with the SIF/NST.	• **Review** and continue or stop and change to suitable intravenous fluid for symptom relief of dehydration if appropriate. • Liaise with Specialised Intestinal Failure (SIF) team/ Nutrition Support Team (NST) for patients known to them**.** • Nutritional content of parenteral nutrition unlikely to offer any benefit at this stage.
Intravenous Fluids (Inpatient and home)	• **Continue.** • Review regularly in liaison with Specialised Intestinal Failure (SIF) team / Nutritional	• **Review regularly** in liaison with Specialised Intestinal Failure (SIF) team/ Nutrition Support Team (NST) for patients known to them**.**	• **Review -** stop or continue (with suitable IV fluid) for symptom relief of dehydration, if appropriate.

	Support Team (NST) for patients known to them. • For additional medicines, check the home PN prescription (which may not appear on the GP system) and/or eMeds (for inpatients) and assess on an individual basis in discussion with the SIF/NST.	• For additional medicines, check the home PN prescription (which may not appear on the GP system) and/or eMeds (for inpatients) and assess on an individual basis in discussion with the SIF/NST.	• Liaise with Specialised Intestinal Failure (SIF) team/ Nutrition Support Team (NST) for patients known to them.
Nutritional supplements	• **Stop** when prescribed for prophylaxis rather than treatment of malnutrition.		
Calcium	• **Review – continue only if treating symptomatic hypocalcaemia, confirmed deficiency, or as part of ongoing osteoporosis therapy.** • Only continue with **denosumab** or another high-risk osteoporosis drug and there is a clear rationale to maintain treatment despite limited prognosis. • No evidence of benefit for fracture prevention in frailty or life expectancy <2 years. • Risks: constipation, kidney stones, and contribute to tablet burden. • Stop if no active deficiency or if osteoporosis treatment has been discontinued.		• **Stop.** No symptom benefit
Vitamin D ***(e.g., ergocalciferol and colecalciferol)***	• **Review – stop unless treating confirmed or symptomatic deficiency.** • Vitamin D does not reduce falls, fractures, cardiovascular events, or cancers in people living with frailty with limited prognosis. • Often continued preventively without benefit. • Stop unless deficiency is documented or clinically relevant.		• **Stop.** No symptom benefit
Folic acid	• **Review – continue only if used for a specific ongoing indication** (e.g., malabsorption, malnutrition, methotrexate therapy or megaloblastic anaemia). • Often continued long after a completed course (1–4 months) without benefit. • Stop if no active deficiency or ongoing clinical need.		• **Stop.** No symptom benefit
Multivitamins	• **Stop when prescribed for prophylaxis rather than treatment of hypovitaminosis.**		
Other			
Topical treatments (*e.g., moisturisers,*	• **Review indication and continue if benefit**	• **Review indication and continue if symptom benefit.**	• **Review.** Continue only if patient still able to use and benefit

ointments, creams, drops, sprays)			
Antibacterials *(e.g., amoxicillin, piperacillin with tazobactam)*	• Review indication and continue if treating suspected or confirmed infection where there is potential for clinical benefit, including symptom improvement or recovery. • Ensure **indication, review date and stop date** are clearly documented. • Consider stopping **prophylactic antibiotics** unless there is a clear ongoing indication. • As prognosis shortens, review whether treatment remains aligned with goals of care, likely benefit, and treatment burden. • May still be appropriate where infection is contributing to distressing symptoms (e.g., pain, breathlessness, delirium) or where short-term improvement is expected.		• Review carefully, antibiotics are **often no longer appropriate** but may occasionally be used where infection is causing **distressing symptoms** and treatment is likely to provide meaningful short-term relief**.** • Avoid burdensome or invasive treatment where benefit is unlikely**.** • Stop if no clinical or symptomatic benefit**.** • Focus on comfort and minimise treatment burden.
Antifungals (e.g., fluconazole, nystatin)	• **Review indication & continue if symptom benefit. Ensure indication, review & stop date are specified.**		• **Review** - Oral thrush - considering continuation as may provide symptom benefit.
Topical non- selective beta-blockers (e.g., timolol, betaxolol, levobunolol)	• **Review and consider stopping if bradycardia, heart block, heart failure, asthma.**		• **Stop.** No symptom benefit.

Section 5: Documenting Medicines Optimisation Outcomes

For LTHT patients

- **In PPM+,** record**:**
  - The note type **"Medicines Optimisation Review"**, adding the tag **#MO** at the start of the entry to support audit and search functionality.
  - The person's priorities ("what matters most"), agreed goals of care and any limits on treatment or monitoring.
  - For each medicine, document the agreed action (continue / optimise / taper / stop), rationale, monitoring plan and date for re-review.
  - Shared decision-making conversations with the person and/or family, to evidence how decisions align with their goals of care.
- In **eMEDs:**
  - Use ***"medicines optimisation"*** as the reason for any medicine changes.
  - Ensure indications, review or stop dates and a clear rationale are documented where relevant.
- On the **eDAN (discharge summary) or clinic letter:**
  - Clearly document any medicine changes (e.g. "stopped as part of medicines optimisation review") and include the rationale for each decision.
  - Highlight where ongoing review or monitoring is required.
- **NHS Discharge Service (DMS):**
  - Where appropriate, the validating pharmacist at discharge should complete a DMS referral in PPM+ to notify the person's nominated community pharmacy.
  - Include key medicine changes and any monitoring or follow-up requirements to support safe transfer of care and continuity of medicines optimisation in the community.

For primary care patients

- Document medicines changes, discontinuations and the rationale in the GP record.
- Record shared decision-making conversations with the person and/or family.
- Communicate changes to the patient's nominated community pharmacy (good practice).

Shared Clinical Accountability and Escalation

Include:

- Decisions should be made within usual clinical governance structures.

Approved by WY ICS Area Prescribing Committee 21st May 2026

Review date: November 2029

- Where deprescribing follows specialist-led prognosis discussions (e.g. oncology, cardiology, palliative), initiation should occur at that point of care.

Where uncertainty exists, escalation to the relevant specialist team is recommended

Section 6: Sources of help and advice

If you are unsure, or additional advice is required, consider contacting:

- **The specialist or senior clinical team involved in the person's care**
- **The local Specialist Palliative Care Team**
- **Relevant specialty teams** where medicines are being used for complex or high-risk indications (e.g. cardiology, oncology, diabetes, Parkinson's disease, anticoagulation, respiratory, renal or neurology teams)
- **Local pharmacy / medicines information or advisory services**
- **Specialist Pharmacy Service (SPS)** where appropriate for medicines-related advice

Note:
Local contact details, referral pathways, and out-of-hours arrangements vary across West Yorkshire and should be accessed via **local trust, hospice, community, primary care, or ICB systems** as appropriate.

Section 7: Provenance and Acknowledgement

Originally adapted by:
This guidance was originally adapted from the LTHT Specialist Palliative Care Team (SPCT) 'Good Practice Guidance - Deprescribing for Palliative Care Patients 'by the Leeds Oncology Frailty Initiative (LOFrI) and LTHT SPCT and was led by:

- **Lisa Nicholson**, Advanced Clinical Pharmacist in Palliative Medicine, Leeds Teaching Hospitals NHS Trust
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Development and multidisciplinary input:
The development of this guidance was informed by the collective expertise of a multidisciplinary group of clinicians, pharmacists and healthcare professionals, including representatives from the following specialties and services:

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- Medicines Management and Pharmacy Services
- Cardiology
- Diabetes and Endocrinology
- Elderly Medicine
- Haematology
- Leeds Oncology Frailty Initiative Group
- Neurology
- Nutrition and Intestinal Failure
- Oncology
- Liaison psychiatry
- Palliative Care
- Respiratory Medicine
- Specialist Anticoagulation Services

In addition, specific contributions were provided by:

- Heather Smith, Consultant Pharmacist, NHS West Yorkshire ICB
- Gaye Sheerman-Chase, Principal Medical Advisor Medicines Optimisation, NHS West Yorkshire ICB.

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Appendix 1. Structured Medication Review Checklist. Developed by Leeds Teaching Hospitals NHS Trust. Included as part of: *Medicines Optimisation Guidance for Adult Patients with a Limited Prognosis* (September 2025).

Appendix 1: Structured Medication Review Checklist

NHS West Yorkshire Integrated Care Board

Step	Action	Tools & Resources
1. What matters most?	• Discuss and record the person's goals, values and priorities (comfort, symptom relief, independence, maintaining function, fewer medicines). • Document clearly in medical notes and care plan. • Use shared decision-making aids to support these conversations *(Appendix 2)*.	ReSPECT form Right decisions for health and care
2. Identify essential medicines?	• Compile a full medication history (prescribed, OTC, and complementary medicines (e.g., herbal, vitamins, supplements). • Document indications, dose, route, formulation, frequency, duration. • Check adherence, swallowing, administration issues, oral intake, device use, and whether the person can still safely and reliably take or use the medicine. • Identify medicines critical for symptom control or immediate harm prevention.	WY HCP Managing Medication
3. Stop unnecessary medicines	• In discussion with the person, identify medicines with no ongoing indication, duplication, or misaligned with goals. • Prioritise deprescribing long-term preventative drugs with no near-term benefit and those with high risk or treatment burden or unclear ongoing value. Decide whether to stop abruptly vs taper. • Communicate the rationale to person and/or carer, and document clearly in the medical notes / prescribing system.	Medstopper Medicines Optimisation Tool (Section 4)
4. Assess risk of harm	• Review frailty, multimorbidity, renal/liver function, drug-drug/drug-disease interactions. • Consider falls risk, anticholinergic burden, monitoring requirements, cumulative toxicity risk, body weight, reduced oral intake, and whether altered physiology may change the balance of benefit and harm. • Seek specialist input where the indication is complex, the medicine is high risk, or uncertainty remains.	Rockwood Clinical Frailty Scale. Anticholinergic burden (ACB) guidance – WY ICS Medicines and Falls Risk Cumulative toxicity tool
5. Assess benefit vs. prognosis	• Ask whether the indication is still relevant in the context of current prognosis, priorities and goals of care. • Balance expected time to benefit against likely prognosis and treatment burden. • Continue medicines with short-term or symptomatic benefit; consider deprescribing those used only for long-term prevention. • Use clinical judgment supported by shared decision-making.	Use clinical judgement supported by shared decision-making Medicines Optimisation Tool (Section 4)
6. Optimise necessary medicines	• Ensure the medicine remains appropriate for the indication, dose, route and formulation. • Simplify regimen where possible (e.g., once daily, combination products, patches, easier to use devices). • Consider whether a safer, lower burden, or more practical formulation is available. • Provide medicines support where needed (compliance aids, carer involvement, reminder charts).	WY HCP Managing Medication Medicines Optimisation Tool (Section 4)
7. Review and follow-up	• Agree and document a monitoring and review plan with the person and/ or carers and document. • Ensure clear communication and coordination across primary care, secondary care, community, and specialist teams where relevant. • Monitor for withdrawal effects, symptom recurrence, or new harms. • Re-introduce or adjust treatment if clinically appropriate. • In final weeks-days of life, review more actively, stopping non-beneficial medicines and focusing on comfort.	Local Palliative Care Symptom Management Guidance.

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