

Deprescribing, waste and safety: where environmental sustainability meets hospice quality

Hospice UK Big Conversation webinar
13 October 2026

Housekeeping



Please keep your mic muted unless you are asking a question



Please note that the presentation (excluding the Q&A) is being recorded



The recording and slides will be on the Hospice UK website after the event



Please use the Chat function to ask any questions as we go along



AI bots are not permitted in these meetings and will be removed

Agenda

11:00	Welcome & Introductions	Paul Fraser , Deputy Director of Programmes, Hospice UK
11:10	Deprescribing in practice – tools and pharmacist perspective	Melinda Presland , Consultant Pharmacist in Palliative Care, Oxford University Hospitals
11:25	QI/audit case study	Dr Louise Hills , Specialty Dr, Myton Hospice
11:40	Facilitated panel conversation/ Q + A	All
11:55 – 12:00	Hospice UK updates and Close	Julia Russell , Clinical Quality Advisor, Hospice UK



Oxford University Hospitals
NHS Foundation Trust

Deprescribing

Melinda Presland

**Consultant Pharmacist, Palliative and End
of Life Care**



Deprescribing

- It is the process of tapering, withdrawing, discontinuing or stopping medicines to reduce potentially problematic polypharmacy, adverse drug effects and inappropriate or ineffective medicine use
- It should be undertaken in the context of reviews for appropriate polypharmacy in partnership with the patient (and sometimes their carer) and supervised by a healthcare professional



Polypharmacy



Deprescribing

- Stopping a medication may be just as challenging in terms of weighing the benefits or providing support as starting it.
- Deprescribing seeks to apply best practice in prescribing to the process of stopping a medicine. It needs the same skill and experience from prescribers, and the same level of support from pharmacists, and from guidance, data and insight, even from the pharmaceutical manufacturers, to get the best results.
- Deprescribing - just as with prescribing, should place patients at the centre of the process, to ensure medicines optimisation.

Approaching Deprescribing

- Done with the patient, not to the patient
- Requires a thorough drug history
- Part of shared-decision making
- Prescribers have to embrace uncertainty
- Where appropriate, not prescribing should be offered as an option
- Difficult discussions now can simplify discussions in the future
- Deprescribing is part of prescribing
- Clearly document & share conversations and decisions

Different approaches to stopping medicines

Stepwise approach

- Useful if the patient is well and clinically stable but there is a risk that multiple changes in drugs will destabilise their situation
- Tapering the dose helps reduce the likelihood of an adverse withdrawal event for some medicines.

All at once

- Useful if the patient is unwell as a result of likely drug side effects or in a safe monitored environment (e.g. admission to hospital)

Mixed approach

- In practice, often several drugs can be stopped or reduced at once with little chance of harm
- However, certain drugs (e.g. antidepressant and antipsychotic drugs) will need to be withdrawn more cautiously
- In these situations it should be documented clearly which drugs can be stopped immediately and which drugs are to be withdrawn more cautiously



What to stop?

Deprescribing tools & resources - STOPPFrail

STOPPFrail is a list of potentially inappropriate prescribing indicators designed to assist physicians with stopping such medications in older patients (≥65 years) who meet ALL of the criteria listed below:

1. End-stage irreversible pathology
2. Poor one year survival prognosis
3. Severe functional impairment or severe cognitive impairment or both
4. Symptom control is the priority rather than prevention of disease progression

The decision to prescribe/not prescribe medications to the patient, should also be influenced by the following issues:

1. Risk of the medication outweighing the benefit
2. Administration of the medication is challenging
3. Monitoring of the medication effect is challenging
4. Drug adherence/compliance is difficult

General

- Any drug that the patient persistently fails to take or tolerate despite adequate education and consideration of all appropriate formulations.
- Any drug without clear clinical indication.

Body Systems

- Cardiovascular
- Coagulation
- CNS
- GI
- Respiratory
- Musculoskeletal
- Urogenital
- Endocrine
- Miscellaneous

Deprescribing tools & resources - OncPal

Table 1. The OncPal deprescribing guideline.

Class of medication	Medication	Situations of limited benefit
Aspirin	Aspirin	Primary prevention
Lipid lowering medications	Statins	All indications
	Fibrates	
	Ezetimibe	
Blood pressure lowering medications	ACE inhibitors	Mild to moderate hypertension
	Sartans	Secondary prevention of cardiovascular events
	Beta blockers	Management of stable coronary artery disease
	Calcium channel blockers	
	Thiazide	
	Diuretics	
Anti-ulcer medications	Proton pump inhibitors	All indications unless recent history of gastrointestinal bleeding, peptic ulcer, gastritis, GORD, or the concomitant use of NSAIDs and steroids
	H2 antagonists	
Oral hypoglycaemics	Metformin	Mild hyperglycaemia (prevention of diabetic complications)
	Sulfonylureas	
	Thiazolidinediones	
	DPP-4 inhibitors	
	GLP-1 analogues	
	Acarbose	
Osteoporosis medications	Bisphosphonates	All indications except hypercalcaemia
	Raloxifene	
	Strontium	
	Denosumab	
Vitamins	n/a	All except treatment of low serum concentrations
Minerals	n/a	All except treatment of low serum concentrations
Complementary therapies	n/a	All indications

Adapted with permission from Lindsay J, Dooley M, Martin J et al. The development and evaluation of an oncological palliative care deprescribing guideline: the 'OncPal deprescribing guideline'. *Support Care Cancer* 2015;23:71–8.

ACE = angiotensin-converting enzyme; DPP-4 = dipeptidyl peptidase-4; GLP-1 = glucagon-like peptide-1; GORD = gastro-oesophageal reflux disease; NSAIDs = nonsteroidal anti-inflammatory drugs; n/a = not applicable.

Other Deprescribing tools & resources



Understanding polypharmacy, overprescribing and
deprescribing

Barriers to Deprescribing

- Time
- Who should do it?
- Stopping medicines started by specialists
- ? Ongoing benefit
- Withdrawal or adverse effects of stopping
- Unclear goals of care & where deprescribing might fit
- Fear that patients will feel we're 'giving up'
- Reluctance from patients



Deprescribing is not a 'tick-box' exercise

References

- Todd A and Holmes HM. Recommendations to support deprescribing medications late in life. *Int J Clin Pharm*. 2015; **36** (3): 535-43.
- http://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/clinical_guidelines_front_page/Deprescribing.pdf
- STOPPFrail. <https://academic.oup.com/ageing/article/46/4/600/2948308>
- Reeve E, et al. Assessment of attitudes toward deprescribing in older medicare beneficiaries in the United States. *JAMA Intern Med*. 2018; **178** (12): 1673-1680
- Okeowo D, et al. Clinical practice guidelines for older people with multimorbidity and life-limiting illness: what are the implications for deprescribing? *Ther Adv Drug Saf*. 2018; **9**(11): 619-630.
- Rochon PA, Gurwitz JH. Optimising drug treatment for elderly people: the prescribing cascade. *BMJ*. 1997; **315**(7115): 1096-9.

References

- [Understanding polypharmacy, overprescribing and deprescribing – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#)
- <https://www.gov.uk/government/publications/national-overprescribing-review-report>
- [Deprescribing Guidelines and Algorithms - Deprescribing.org](#)
- [Anticholinergic Burden Calculator - ACB Calculator](#)
- Thompson, J. Deprescribing in palliative care. *Clinical Medicine*, 2019, **19** (4): 311-314

Deprescribing in the hospice inpatient setting

An audit and sustainability QIP



Dr Louise Hills, October 2026

*Specialty Doctor in Palliative Medicine,
The Myton Hospices*



www.mytonhospice.org

   @MytonHospices



Aims and objectives of audit & QIP

Baseline evaluation to assess:

- 1) Number and type of potentially inappropriate medications our patients are prescribed
- 2) Current deprescribing practice on our inpatient units



- Use a deprescribing tool to help objectively assess this
- **QIP** to promote deprescribing, to reduce cost, time, waste, complications and tablet burden for the patients

Methods

Methodology

- Researched deprescribing audits in other settings
- Validated tool from Australia for use in deprescribing in palliative care
- Evidence based for deprescribing in palliative oncology patients with prognosis ≤ 6 months
- Situation specific and exclusions apply

Table 1. The OncPal deprescribing guideline.

Class of medication	Medication	Situations of limited benefit
Aspirin	Aspirin	Primary prevention
Lipid lowering medications	Statins	All indications
	Fibrates	
	Ezetimibe	
Blood pressure lowering medications	ACE inhibitors	Mild to moderate hypertension
	Sartans	Secondary prevention of cardiovascular events
	Beta blockers	Management of stable coronary artery disease
	Calcium channel blockers	
	Thiazide	
	Diuretics	
Anti-ulcer medications	Proton pump inhibitors	All indications unless recent history of gastrointestinal bleeding, peptic ulcer, gastritis, GORD, or the concomitant use of NSAIDs and steroids
	H2 antagonists	
Oral hypoglycaemics	Metformin	Mild hyperglycaemia (prevention of diabetic complications)
	Sulfonylureas	
	Thiazolidinediones	
	DPP-4 inhibitors	
	GLP-1 analogues	
	Acarbose	
Osteoporosis medications	Bisphosphonates	All indications except hypercalcaemia
	Raloxifene	
	Strontium	
	Denosumab	
Vitamins	n/a	All except treatment of low serum concentrations
Minerals	n/a	All except treatment of low serum concentrations
Complementary therapies	n/a	All indications

Adapted with permission from Lindsay J, Dooley M, Martin J *et al.* The development and evaluation of an oncological palliative care deprescribing guideline: the 'OncPal deprescribing guideline'. *Support Care Cancer* 2015;23:71–8.

ACE = angiotensin-converting enzyme; DPP-4 = dipeptidyl peptidase-4; GLP-1 = glucagon-like peptide-1; GORD = gastro-oesophageal reflux disease; NSAIDs = nonsteroidal anti-inflammatory drugs; n/a = not applicable.

Methodology

- Sample = **all** admissions into Myton inpatient units during February 2026 (38 patients)
- 1 month period selected as manageable sample size. Retrospective
- All patients have a palliative diagnosis, most had oncological diagnosis
- Reviewed medical notes and drug charts covering the first **7 days** of each admission to collect data with reference to the OncPal deprescribing guideline to define 'medications of limited benefit'
- Looked at regular prescribed medications, **did not include PRN medications/anticipatories, non prescribed medications, did not look at how many medications we started..!**

Date



Patient ID					
Age					
Number of medications on admission					
Number of 'medications of limited benefit' as per OncPal deprescribing tool					
Other potentially inappropriate medications e.g. anticoagulants					
Total number of medications stopped within 7 days of admission (deprescribed)? Proactive vs reactive?					
...Number of 'medications of limited benefit' as per OncPal deprescribing tool stopped?					
Any record or discussion about deprescribing in medical notes (Y/N)					



Results

Key Results

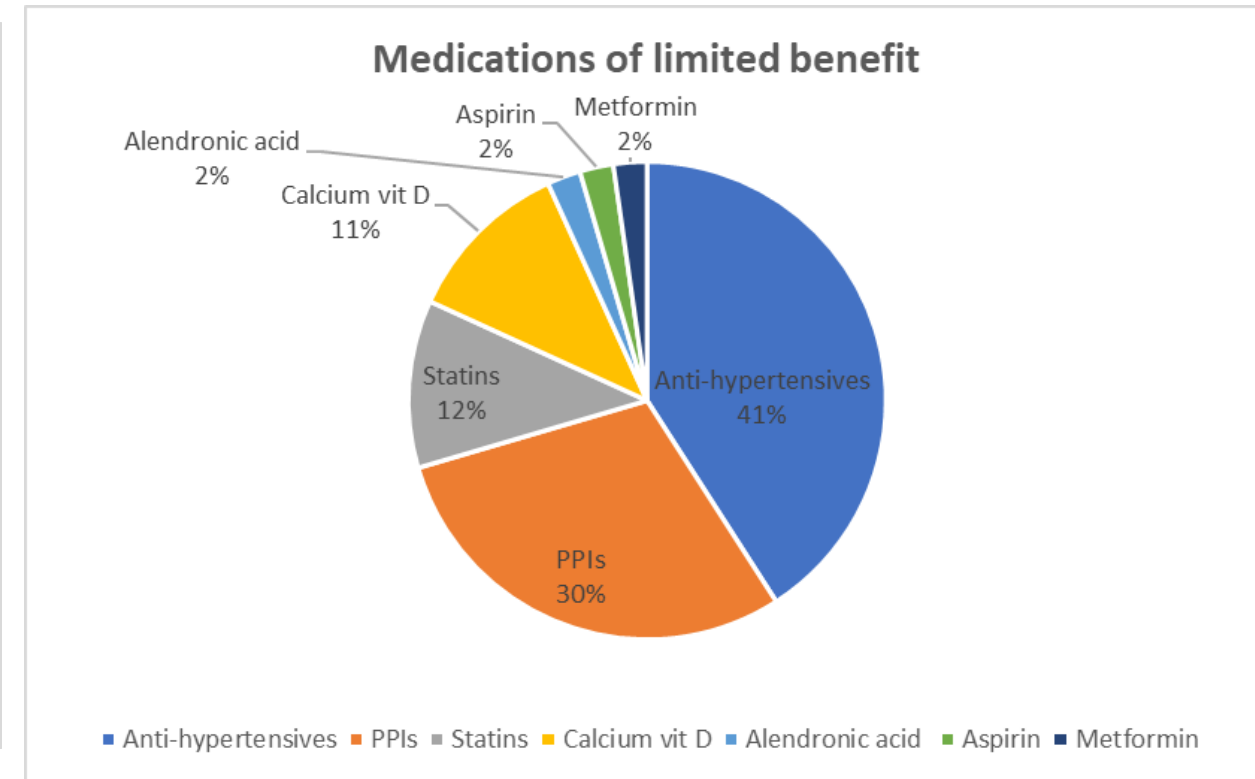
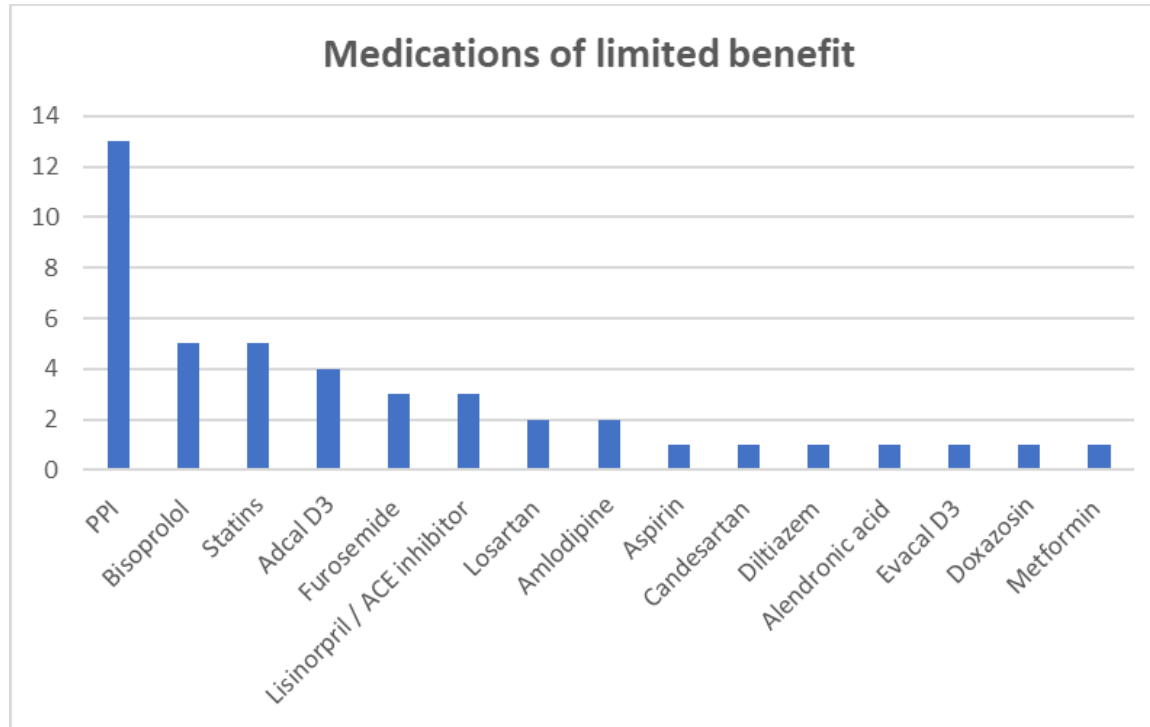
- 38 patients
- Mean age was **71.7 years**, range **42-100 years**
- Average number of prescribed regular medications on admission was **7**, with a range of **1- 15 regular medications**
- 21/38 patients were on at least 1 medication listed on OncPal tool

55% of patients were taking medication(s) listed on OncPal guideline

- Average of 1.18 potentially inappropriate medications per patient, range of 0-5 medications

All results are averages over both sites

Medications of (potentially) limited benefit



Results cont.

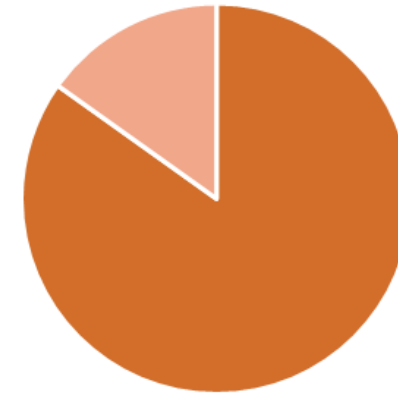
- Average of 3.68 medications per person were stopped within 7 days of admission, range 0-13 medications
- Total of 46 incidences of medications of limited benefit identified
- 32/46 of these medications were stopped within 7 days of admission

69.5% medications of limited benefit were stopped within 7 days

Results cont.

- In **84%** of cases there was documented discussion about deprescribing in the patient notes
- Mixture of proactive and reactive deprescribing

Any record or discussion about deprescribing in medical notes (Y/N)



■ yes ■ no

Discussion

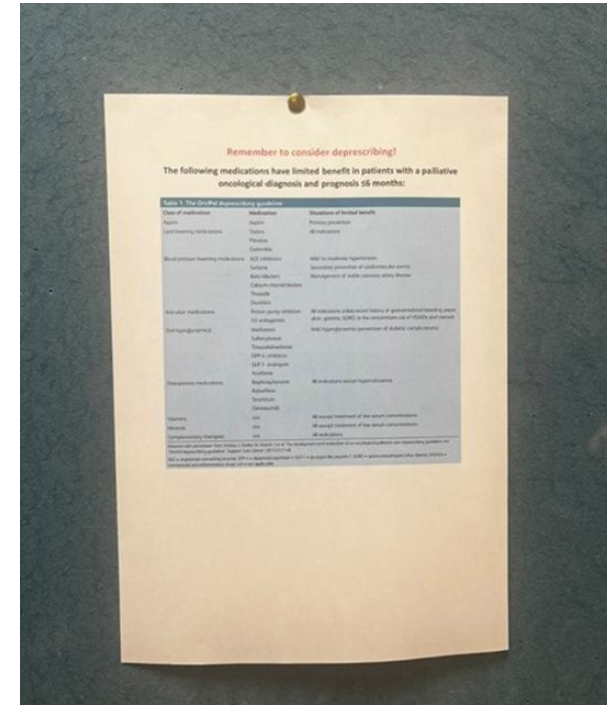
Discussion

- These are widely prescribed, common meds even at hospice stage
- Appropriate deprescribing occurred in the **majority** of our inpatients within 7 days of admission
- Hospice setting ideal for deprescribing
- Substantial amount of our deprescribing was reactive (e.g. unable to swallow) rather than proactive
- A deprescribing tool can help highlight these medications and improve confidence
- In most cases there was documented discussion with the patient/their family about deprescribing

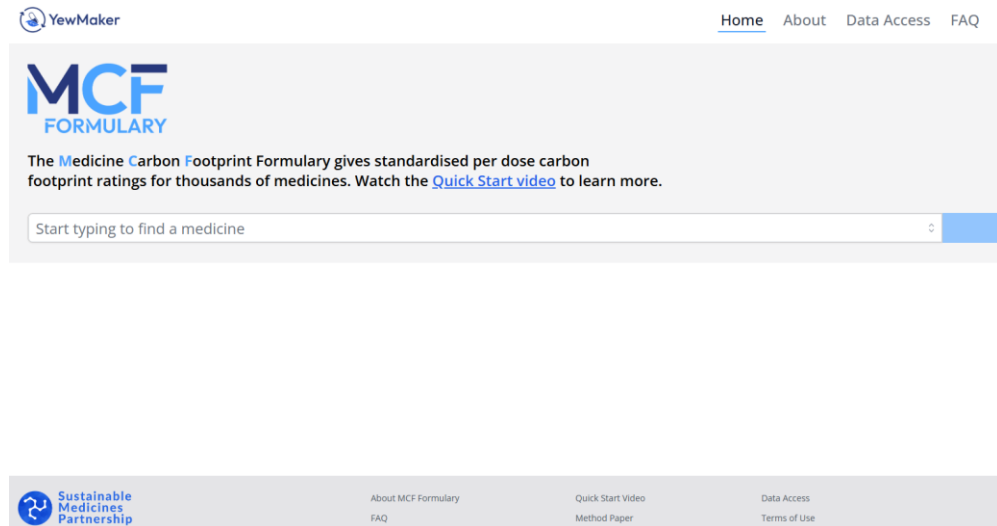
Recommendations/ QIP

Recommendations

- Re-audit later in 2026. Can be reproduced/upscaled in other settings
- Targets for deprescribing
- Presented audit to medical team (including rotating doctors), raised awareness of deprescribing and the environmental impact of medicines
- Cost implications – could this be measured?
- Carbon footprint – this can be looked at for specific meds MCF (4 ratings – low, medium, high, very high)



Carbon footprint calculator



The screenshot shows the MCF Formulary website. At the top left is the YewMaker logo. To its right are navigation links: Home, About, Data Access, and FAQ. Below the navigation is the MCF FORMULARY logo. Underneath the logo is a paragraph: "The Medicine Carbon Footprint Formulary gives standardised per dose carbon footprint ratings for thousands of medicines. Watch the [Quick Start video](#) to learn more." Below this is a search bar with the placeholder text "Start typing to find a medicine". At the bottom of the page is a footer with the Sustainable Medicines Partnership logo on the left and four links: About MCF Formulary, Quick Start Video, Data Access, and Terms of Use.

3.2 Carbon footprint per MCF unit (gCO₂e)

This is the cradle-to-gate carbon footprint per MCF unit of the medicine product, expressed in grams of carbon dioxide equivalent.

3.3 MCF Rating

The MCF Rating gives a categorical band derived from the gCO₂e value:

- **LOW:** $0 \leq x < 10$ gCO₂e
- **MEDIUM:** $10 \leq x < 100$ gCO₂e
- **HIGH:** $100 \leq x < 1000$ gCO₂e
- **VERY HIGH:** $x \geq 1000$ gCO₂e

<https://formulary.yewmaker.com/>

Conclusions

- Appropriate deprescribing is a way to improve quality of life, outcomes, save time, reduce waste, cost and carbon
- Tools and resources are available to help prescribers
- Small but up-scalable project
- Deprescribing requires a collaborative, person centred approach

References

- [Prescribing in palliative care | Medicines guidance | BNF | NICE](#)
- [Prescribing and deprescribing in older people with life-limiting illnesses receiving hospice care at the end of life: A longitudinal, retrospective cohort study](#)
- [Deprescribing in palliative care](#)
- <https://www.palliativecarescotland.org.uk/content/publications/13.-De-Prescribing-in-Palliative-Care---A-Quality-Improvement-Approach-at-University->
- A BASELINE EVALUATION OF DEPRESCRIBING PRACTICE ON A HOSPICE INPATIENT UNIT Katy Hyams, Richella Ryan. Arthur Rank Hospice Charity 10.1136/spcare-2025-PCC.76
- [Polypharmacy and deprescribing](#)
- [RCGP Towards greener prescribing in general practice, March 2025](#)
- [MCF Formulary](#)
- [What is deprescribing? — Do I still need this medication? Is deprescribing for you?](#)

Deprescribing tools

- STOPPFrail criteria
- MedStopper
- PrescQIPP
- UpToDate
- OncPal deprescribing guideline
- RCGP 'Towards Greener prescribing in General Practice' 2025

Box 1. Steps to deprescribing

- > Take detailed medication history including indication for each drug.
- > Consider potential for drug induced harm ie age of patient, comorbidities, number of medications, types of medications.
- > Consider each individual medication and the potential to provide ongoing benefit.
- > Prioritise medications for deprescribing (usually one at a time), give explanations to patient. Agree follow-up arrangements.
- > Carry out follow-up assessment to assess effects of deprescribing. Consider further deprescribing.

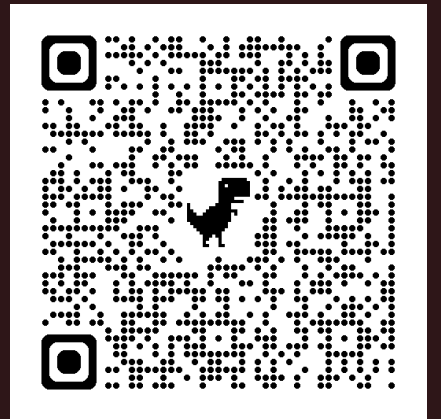
Patient Safety project

Over 100 hospice inpatient units currently submit patient safety data to us, but we would like to hear from even more of you!

As well as viewing your own data, in a time series chart, alongside the aggregated data for comparison each quarter, we also share the aggregated data at quarterly webinars for participating hospices.

Join our Patient Safety project to take part in the data collection. You can also connect with our online discussion group and take part in webinars and other engagement and learning opportunities.

Scan me



Hospice UK's Environmental Sustainability online discussion group

Online forum for hospice staff to connect and share challenges, solutions, ideas, knowledge and best practice related to environmental sustainability

Scan me





CSH network

Palliative Care Sustainability Network



230
members

24
events

64
topics

Joined ▾

[See network information](#)

Upcoming events

in the network



[Greener Palliative Care Award- sharing practice: life cycle analysis](#)
15 Dec 2025

[All Upcoming events](#)

- Revisions
- Revisions
- Stream
- About
- Events
- Topics
- Resources ▾



[Kate Crossland](#) created an event in [Palliative Care Sustainability Network](#)
2 weeks ago

EVENT



[Greener Palliative Care Award- sharing practice: life cycle analysis](#)

📅 15 Dec '25 08:00 - 09:00 (GMT)

Dear all, Our next sharing practice session is on Monday 15th December at 8am. We're making a small change by welcoming an external speaker, Dr Forbes McGain, to speak to us about life cycle...

🌐 Public ❤️ 1 🗨️ 0

[Read more](#)



[Cookie settings](#) created a topic in [Palliative Care Sustainability Network](#)

Greener Palliative Care Award

moving from awareness to action in environmental sustainability

Organisation and leadership

Get the right people involved in a Green Group and put support in place from senior leaders. Make sure all staff know how they can help.



Supply chains

Explore how what we buy and use affects the environment. Identify changes for the better. Work towards including the impact on the planet in all supply chain decisions.

Medicines and patient care

Understand how the right care at the right time in the right place can reduce waste and improve patient experiences. Work on projects to reduce environmental impacts from medicines. Offer the option of virtual clinics.



Travel and transport

Talk about the impact of emissions on health, and work to make walking, cycling and public transport easier to use. Prepare for electric vehicles across the whole organisation.

Facilities and estates

Measure energy, waste and water use and plan for how this can be reduced where possible. Think about how green spaces can improve the local and global environment.



Engagement

Listen to and include staff, volunteers and service users in green plans, and respond to their ideas for change. Celebrate and share successes!

Food

Consider the impact on the planet of food and drink across the organisation, and work on projects to reduce this.



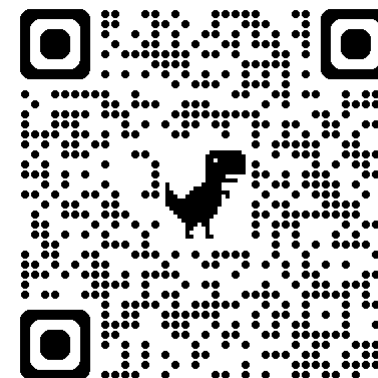
Greener Palliative Care
GOLD AWARD



Greener Palliative Care
SILVER AWARD



Greener Palliative Care
BRONZE AWARD



Hospice UK National Conference 2026

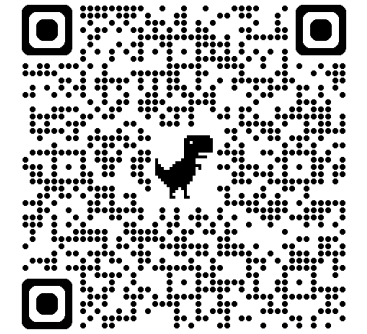
Scan here for
more details



Liverpool Experience Campus (formerly the ACC), 16 - 18 November 2026

Grants and bursaries for professional development

Scan here for
more details



Our professional development grants and bursaries help hospice staff attend courses, conferences and study days, to enhance their professional skills

Does your hospice have a garden?

Hospices with gardens in England, Wales and Northern Ireland can apply for a Community Garden Grant from The National Garden Scheme.

Grants from £1,500 - £5,000 can fund a range of garden improvements, including plants and containers, flower and vegetable beds, hard landscaping and more.

Applications are open 29 September to 30 October 2026 with early applications advised.



Scan here for
more details



Stay up to date



Scan me

Our [Member Update page](#) is updated regularly so you can keep up with our key work and priorities from week to week.

The page is hidden from the public and will not come up in web searches, so we'd recommend bookmarking it!

Feedback Survey

Please consider sparing a few minutes to answer this survey, so that we can continue to improve future Big Conversation events:

<https://www.surveymonkey.com/r/QWLGFIJN>



Thank you