Medicines Safety Programme

Richard Cattell, Deputy Chief Pharmaceutical Officer, NHS Improvement
Medicines are an important part of NHS care and help many people to get well

However, quality, safety and increasing costs continue to be issues...

- Around 5-8% of hospital admissions are medicines related, many preventable
- Bacteria are becoming resistant to antibiotics through overuse which is a global issue
- Up to 50% of patients don’t take their medicines as intended, meaning their health is affected
- Use of multiple medicines is increasing – over 1 million people now take 8 or more medicines a day, many of whom are older people

We spend £17.4 billion a year on medicines (£1 in every £7 that the NHS spends) and they are a major part of the UK economy
The Medicines Value Programme has been set up to respond to these challenges

Following the Next Steps on the NHS Five Year Forward View and Carter Report

The NHS wants to help people to get the best results from their medicines – while achieving best value for the taxpayer

Savings will be reinvested in improving patient care and providing new treatments to grow the NHS for the future

The NHS policy framework that governs access to and pricing of medicines

The commercial arrangements that influence price

Optimising the use of medicines

Developing the infrastructure to support an efficient supply chain

A whole system approach....

• NHS England, NHS Improvement, NHS Digital, Health Education England
• Regional offices link with STPs, ICSs, CCGs, and providers
• Nationally coordinated with AHSNs, Getting It Right First Time, NHS Right Care and NHSCC

Following the Next Steps on the NHS Five Year Forward View and Carter Report
Supported by system-wide pharmacy leadership

Bill Rial (interim)  Richard Seal  Michele Cossey  Steve Brown

Gail Fleming  Ros Cheeseman  Chris Cutts  Trevor Beswick
3rd WHO Global Patient Safety Challenge

WHO Global Patient Safety Challenge –
Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally

3 early priority actions:
• Polypharmacy
• High risk situations
• Transfers of care
Medication without Harm

Actions

1. Take early action to protect patients from harm arising from: high-risk situations; polypharmacy; and transitions of care.

2. Convene national experts, health system leaders and practitioners to produce guidance and action plans for each of the targeted domains.

3. Put mechanisms in place, including the use of tools and technologies, to enhance patient awareness and knowledge about medicines and medication use process, and patients’ role in managing their own medicines safely.


5. Assess progress regularly.
England Response to WHO Challenge

PREVALENCE AND ECONOMIC BURDEN OF MEDICATION ERRORS IN THE NHS IN ENGLAND

Rapid evidence synthesis and economic analysis of the prevalence and burden of medication error in the UK

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The Report of the Short Life Working Group on reducing medication-related harm

February 2019
The burden of medication errors

Medication errors can include prescribing, dispensing, administration and monitoring errors. Medication error can result in adverse drug reactions, drug-drug interactions, lack of efficacy, suboptimal patient adherence and poor quality of life and patient experience.

An estimated 237 million medication errors occur in the NHS in England every year.

68.3 million errors (28% of total) cause moderate or serious harm.

The estimated NHS costs of definitely avoidable ADRs are £98.5 million per year, consuming 181,626 bed-days, causing 712 deaths, and contributing to 1,708 deaths.

EEPRU report - PREVALENCE AND ECONOMIC BURDEN OF MEDICATION ERRORS IN THE NHS IN ENGLAND November 2017*
# Medicines Safety Programme

Set up following the recommendations of the Short Life Working Group

## 1. Patients
- Improved shared decision making, including when to stop medication
- Improve information for patients and families, and access to inpatient medication information
- Encourage and support patients and families to raise any concerns about their medication

## 2. Medicines
- Increase awareness of ‘look alike sound alike’ drugs and develop solutions to prevent these being introduced
- Patient friendly packaging and labelling
- Ensure that labelling contributes to safer use of medicines

## 3. Healthcare professionals
- Improved shared care between health and care professionals
- Training in safe and effective medicines use is embedded in undergraduate training
- Reporting and learning from medication errors
- Repository of good practice to share learning
- New defences for pharmacists if they make accidental medication errors

## 4. Systems and practice
- The accelerated roll-out of hospital e-prescribing and medicines administration systems
- The roll-out of proven interventions in primary care such as PINCER
- The development of a prioritised and comprehensive suite of metrics
- New systems linking prescribing data in primary care to hospital admissions
- New research on medication error to be encouraged
Delivering the 4 Medicines Safety domains:

1. Patients

Medicines Safety Programme actions

- Improved shared decision making so that patients and carers are encouraged to ask questions about their medications and health and care professionals actively support patients and carers in making decisions jointly, including when to stop medication.

- Work closely with NHS Digital and others to improve information for patients and families, and improve access to inpatient medication information.

- Encourage and support patients and families to raise any concerns about their medication.
I would like to help you get the best from your medicines, and to achieve that we need to work together.

Though I am your doctor, you are the expert when it comes to things affecting you and your life.

Being honest about your understanding and feelings towards medicines helps me better appreciate your situation.

I will listen to you and respect what you tell me, so we can share responsibilities.

We will share honest and clear advice and support decisions.

This will help us to have a more meaningful conversation and agree away from.

If you wish, I can write things down for you.
In October 2016 the Academy launched the UK version of Choosing Wisely, a campaign which began in the US, but has since spread throughout the world.
# 2. Medicines

Medicines Safety Programme actions

- Build on work to identify and increase awareness of ‘look alike sound alike’ drugs and develop solutions to prevent these being introduced.

- Work with industry and MHRA to produce more patient friendly packaging and labelling.

- Work with pharmacy dispensing computer system suppliers to ensure that labelling contributes to safer use of medicines and does not hinder, for example by labels being stuck over packaging or by using unfamiliar language.
### 3. Healthcare professionals

#### Medicines Safety Programme actions

- Improved shared care between health and care professionals; with increased knowledge and support.

- Professional regulators must ensure adequate training in safe and effective medicines use is embedded in undergraduate training, and professional leadership bodies.

- Professional regulators and professional leadership bodies should also encourage reporting and learning from medication errors.

- Development of a repository of good practice to share learning.

- New defences for pharmacists if they make accidental medication errors rather than being prosecuted for genuine mistakes as is the case currently. This will ensure the NHS learns from mistakes and builds a culture of openness and transparency.
4. Systems and practice

Medicines Safety Programme actions

- The accelerated roll-out and optimisation of hospital e-prescribing and medicines administration systems.

- The roll-out of proven interventions in primary care such as PINCER.

- The development of a prioritised and comprehensive suite of metrics on medication error aimed at improvement.

- New systems linking prescribing data in primary care to hospital admissions so the NHS can see if a prescription was the likely cause of a patient being admitted to hospital.

- New research on medication error should be encouraged and directed down the best avenue to facilitate positive change.
New medicines safety metrics

Transparency and measurement are key to learning and improvement

Prescribing indicators in a dashboard being developed by NHS Digital and NHS BSA

Indicators that quantify prescribing practice that has a high or higher risk of harm and that is associated with admission to hospital

Further development on a broader selection of indicators to develop a more comprehensive overview

Phase 1 - 5 indicators with a focus on gastrointestinal bleeds

Linkage of patient level and identifiable primary care prescribing data (NHSBSA) with Hospital Episode Statistics data (NHS Digital)
## Phase 1 metrics (published 10/05/18)

<table>
<thead>
<tr>
<th>Indicator 1</th>
<th>Patients 65yrs old or over taking a Non-Steroidal Anti-Inflammatory Drugs (NSAID) and NOT taking a gastro-protective medicine.</th>
<th>Hospital admissions for GI bleed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 2</td>
<td>Patients 18 years of age or over taking selected NSAID and taking either warfarin or a NOAC.</td>
<td>Hospital admissions for GI bleed</td>
</tr>
<tr>
<td>Indicator 3</td>
<td>Patients 18 years of age or over taking selected warfarin or NOAC with an anti-platelet medicine and NOT taking gastro protective medicine</td>
<td>Hospital admissions for GI bleed</td>
</tr>
<tr>
<td>Indicator 4</td>
<td>Patients 18 years of age or over taking aspirin and another anti-platelet medicine and NOT taking gastro protective medicine</td>
<td>Hospital admissions for GI bleed</td>
</tr>
<tr>
<td>Indicator 5</td>
<td>Patients 18 years of age or over taking a NSAID, an ACE inhibitor/ARB and a diuretic</td>
<td>Hospital admissions for Acute Kidney Injury</td>
</tr>
<tr>
<td>Composite indicator</td>
<td>Medicines with a risk of GI Bleed – composite of Indicators 1-4</td>
<td>Hospital admissions for GI Bleed</td>
</tr>
</tbody>
</table>
Potential phase 2 metrics

- Falls
- Electrolyte imbalance
- Anticholinergic burden
- Pain
- Respiratory
- Mental health
- Secondary care
Governance structure

- Medicines Safety Programme Board
- Medicines Safety Advisory Panel and Stakeholder Group
- Medicines Safety Programme Delivery Group
- Medicines Safety Programme Research, Evaluation and Measurement Group
- Patients
- Medicines
- Systems and processes
- Healthcare Professionals
- Medication Safety Metrics
Engagement plan

A whole system approach....

- Regional offices engagement with STPs/ICSs, CCGs, and providers
- Nationally coordinated with Royal Colleges, professional bodies, academia, AHSNs, regulators

Building a consensus and supporting change

Clinical and patient engagement:
Initial engagement meetings with stakeholders
Partnerships with key professional organisations
National patient engagement
Regional engagement by the RMOCs and AHSNs

Involves stakeholders:
Joint working groups across the domains of the programme
Patient and public involvement
Identifying and celebrating best practice
Engaging with clinical thought leaders

A clear voice and position:
Presentations at national conferences and events
Articles for stakeholder publications
Website and social media content
Thanks, any questions