Medicines Safety Programme Overview

Dr Bruce Warner, Deputy Chief Pharmaceutical Officer

June 2018
Medicines are an important part of NHS care and help many people to get well

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 quality and safety of medicines use continues to be an issue:

- Use of multiple medicines is increasing – over 1 million people now take 8 or more medicines a day, many of whom are older people
- 30-50% medicines not taken as intended
- 5-8% of hospital admissions due to preventable adverse effects of medicines
- Medication error rates across all sectors are at unacceptable levels
- Wastage in primary care in the region of £300 million
- Prescribing variation is still significant across England
- Threat of antimicrobial resistance
- Patients report a lack of information relating to their medicines
- Variation in uptake of new medicines
- Relatively little effort towards understanding clinical effectiveness of medicines in real practice
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
3rd WHO Global Safety Challenge

Four Key Domains

1. Patients
2. Healthcare professionals
3. Medicines
4. Systems and practices
Medication without Harm
3rd WHO Global Safety Challenge

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 medications 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

Authors: Rachel A Elliott, Elizabeth Cosgrove, Fiona Campbell, Dina Jankovic, Marissa Mayes, St James, Eva Kaltenbrunner, Ruth Wong, Mark J Sculpher, Aki Fara

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

February 2015
Objectives of SLWG

- In the context of the WHO Global Patient Safety Challenge *Medication Without Harm*, advise on the overall strategy and programme required to drive improvement in medicines safety, drawing on work underway across NHS England, NHS Improvement, the Care Quality Commission (CQC), the Medicines and Healthcare products Regulatory Agency (MHRA) and in the NHS and academia.

- Identify those areas in which efforts need to be targeted in the short, medium and long-term.

- Provide clinical and academic expertise and advice on the current barriers and issues in medicines safety, and how these can be overcome.

- Advise on the best ways to measure medication errors and medication safety.
The burden of medication errors

Estimate of 237 million medication errors reported
1.2bn prescriptions provided per year in community pharmacy

68.3 million errors (28% of total) cause moderate or serious harm
7.6% of administration errors cause harm
68.7% of clinically significant errors occur in primary care

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*

www.england.nhs.uk
SLWG Key Recommendations

- Improved shared care between health and care professionals
- Training in safe and effective medicines to be embedded in undergraduate training, and CPD to adequately reflect safe and effective medicines use.
- Reporting and learning from medication errors to be encouraged
- A repository of good practice to share learning to be developed
- New defences for pharmacists against making accidental medication errors
- Increased awareness and solution development of ‘look alike sound alike’ drugs.
- Industry and MHRA to produce more patient friendly packaging and labelling.
- Dispensing computer system suppliers to ensure that labelling contributes to safer use of medicines
SLWG Key Recommendations

- Improved shared decision making, including when to stop medication.
- Improve information for patients and families
- Encourage patients and families to raise concerns about their medication.
- Accelerated roll-out and optimisation of hospital EPMA systems.
- The roll-out of proven interventions in primary care such as PINCER.
- The development of metrics on medication error aimed at improvement.
- New systems linking prescribing data in primary care to hospital admissions
- New research on medication error
Medicines Safety Programme

A whole system approach….

• NHS England, NHS Improvement, NHS Digital, Health Education England

• Regional offices engagement with STPs, CCGs, and providers

• Nationally coordinated with Royal Colleges, professional bodies, academia, AHSNs, regulators
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

Linkage of patient level and identifiable primary care prescribing data (NHSBSA) with Hospital Episode Statistics data (NHS Digital)

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

Phase 1 - 5 indicators with a focus on gastrointestinal bleeds
Draft governance structure

Medicines Safety Programme Board

Medicines Safety Advisory Panel and Stakeholder Group

Medicines Safety Programme Delivery Group

Helping patients with their medicines
Making medicines safer
Systems to improve the safe use of medicines
Supporting healthcare professionals
Developing metrics to measure medication safety

Medicines Safety Programme Research, Evaluation and Measurement Group

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Engagement plan

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

Involve 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
Delivering the 4 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.
**It’s OK to ask...**

**me + my medicines**

This was shared with:  

By: 

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 , 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 responsibility.

We will share honest and clear advice and support decisions.

This will help us to have a more meaningful conversation and agree a way forward.

If you wish, I can write things down for you.

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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

<table>
<thead>
<tr>
<th>Improved shared care between health and care professionals; with increased knowledge and support.</th>
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<tbody>
<tr>
<td>Professional regulators must ensure adequate training in safe and effective medicines use is embedded in undergraduate training, and professional leadership bodies.</td>
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<td>Professional regulators and professional leadership bodies should also encourage reporting and learning from medication errors.</td>
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<tr>
<td>Development of a repository of good practice to share learning.</td>
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<td>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.</td>
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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.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Indicator 1</td>
<td>Patients 65yrs old or over taking a Non-Steroidal Anti-Inflammatory Drugs (NSAID) and NOT taking a gastro-protective medicine.</td>
<td>Hospital admissions for GI bleed</td>
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<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>
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<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>
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<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>
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<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>
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<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>
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Potential Phase 2 Metrics

- Falls
- Electrolyte Imbalance
- Anticholinergic Burden
- Pain
- Respiratory
- Mental health
- Secondary Care