Medicines optimisation - ensuring the right patients, get the right choice of medicine at the right time

NHS England and ABPI
PPRS/Medicines Optimisation Roadshow with West Midlands AHSN

28 May 2015
Welcome by the Chair
Dr Christopher Parker, Managing Director,
West Midlands Academic Health Sciences Network

• Housekeeping
• Write-up and photography
• How the day will run
• Desired outcomes

• Tweet using the hashtags #medsop #roadshow
PROFESSOR SIR BRUCE KEOGH

National Medical Director, NHS England
HIGH QUALITY
CARE FOR ALL,
NOW AND FOR
FUTURE
GENERATIONS
Chief Pharmaceutical Officer, NHS England

DR KEITH RIDGE
Medicines have a vital role to play

Medicines:

• Prevent life-threatening diseases
• Help to change previously life-threatening illnesses to long-term conditions eg HIV
• Improve the quality of life for people with long-term conditions
• Reduce mortality across a wide range of diseases and thereby help increase life expectancy

They are the most common therapeutic intervention - NHS spends £14.4 billion each year on them – 15% of its annual budget.
But there are issues that prevent their effectiveness...

- Patients report having insufficient supporting information
- Poor adherence: 30 - 50% of medicines not taken as intended
- Medicines wastage in primary care: £300M pa with £150M pa avoidable
- UK literature suggests 5% - 8% of hospital admissions due to *preventable* adverse effects of medicines
In addition...

- Inadequate review and monitoring of medicines outcomes
- Polypharmacy
- Uptake of newer medicines can be patchy
- Unwarranted variation in use of medicines across England
- Real threat of antimicrobial resistance
- Unacceptable level of medication error
Current challenges facing the NHS

Given the growing demand for medicines that comes with an ageing population and budget constraints, it is more important than ever that the NHS and patients get the best value, in terms of money and outcomes, from our substantial investment in medicines.
Tackling these challenges

We need to help improve patient outcomes, quality and value from all medicines use by:

• Finding new and innovative ways to deliver services to patients.
• Extracting more value from the money spent in the NHS, including from medicines
• Tackling variation eg Innovation Scorecard
What does PPRS/MO facilitate?

- Identifying the role MO has to play in local system redesign and integrated care
- A move from the ‘cost’ to the ‘value’ discussion
- Identification of the role MO has to play in defining what the next 5 years looks like
- A new approach of value in system redesign rather than doing things as we have done for the past 20 years
- Commissioning of innovative medicines where they show overall value
- Identifying the role of MO in delivering £22bn system efficiencies over the 5 year Forward View
NHSE and ABPI
PPRS/Medicines Optimisation
Programme

NHS England and ABPI are developing a joint programme of work, guided by the Principles of Medicines Optimisation that were published by the Royal Pharmaceutical Society in May 2013.
“Medicines optimisation is about ensuring the right patients, get the right choice of medicine at the right time”

RPS, Medicines Optimisation: Helping patients to make the most of medicines, May 2013
The goal of medicines optimisation

Medicines optimisation looks beyond the cost of medicines to the value they deliver and recognises medicines as an investment in patient outcomes.

The goal is to help patients to:

• Improve their outcomes, including better monitoring and metrics
• Have access to an evidence-based choice of medicine
• Improve adherence and take medicines correctly
• Avoid taking unnecessary medicines
• Reduce wastage of medicines
• And improve medicines safety

“Where a medicine or technology is clinically sound and cost effective for the NHS, patients should have access to it – no question, no qualification.”

Baroness Barbara Young, Chair, Diabetes UK
NICE guideline (4th March 2015) – Medicines optimisation

• Medicines optimisation pathway incorporates medicines adherence guideline

• Definition used in the guideline: ‘a process that aims to ensure a person-centred approach to safe and effective medicines use, enabling people to obtain the best possible outcomes from their medicines’
NICE guideline (4th March 2015) – Medicines optimisation

• Topic areas covered:
  o Systems for identifying, reporting and learning from medicines-related patient safety incidents
  o Medicines-related communication systems when patients move from one care setting to another
  o Medicines reconciliation / review
  o Self-management plans / use of patient decision aids
  o Clinical decision support
  o Medicines-related models of organisational and cross-sector working
Key principles

• Aligns with the Royal Pharmaceutical Society principles of medicines optimisation

• NICE guideline sets out what needs to be done by all health and social care practitioners and organisations to put in place the person-centred systems and processes required for the optimal use of medicines, including:
  – involving people in decisions about their medicines
  – discussing options with the patient (and/or family member or carer)
  – understanding people’s knowledge, beliefs and concerns about medicines
  – reviewing people’s medicines when they may be at more risk of medicines-related patient safety incidents, for example, those taking multiple medicines.
The role of industry and opportunity of PPRS

• To address persistent low levels of patient access to modern medicines, industry has agreed to keep growth in the branded medicines bill flat for 2 years and below 2% for a further 3 years

• This presents the NHS with a unique opportunity to ensure patients are getting the right medicines at the right time, less constrained by cost

• It gives the NHS the flexibility to act based on the full long-term value of medicines rather than using short-term cost containment measures
PPRS and NHS funding

• PPRS payments are centrally factored into NHS England’s overall Mandate budget from the DH, and are part of the funding growth provided.
• The additional £2bn funding recently announced for 2015/16 thus takes account of revised PPRS forecasts, as well as additional funding from HMT and reprioritisation by DH and NHS England.
• This is a simple and effective approach which enables additional funds to be factored into allocations up front, and used to benefit the whole of the NHS.
• A significant element of the additional 2015/16 funding has been allocated to CCGs, with those below target benefiting the most.
• A central mechanism to directly link payments from industry directly to individual CCGs would be very complex and bureaucratic to operate. It would also reduce the scope for this strategic approach to allocation decisions.
Director Pricing and Reimbursement, ABPI

DAVID WATSON
Pharmaceutical Price Regulation Scheme

Unique deal underwrites branded medicines growth, through direct industry payments to DH

Agreed growth rates

£800m

Estimated that industry will pay into the NHS budget in 15/16
Understanding the PPRS for the NHS, taxpayers and patients

- Previous PPRS have featured price cuts
- The 2014 scheme underwrites the overall growth in spend by the NHS on branded medicines within the scheme

- Industry is a committed partner with NHS England
- Supports patients and clinicians access to newer medicines
- Five-year agreement covering 2014-2018
- Commitments to dialogue on NICE and uptake
- Vast majority (93%) of branded medicines included in the scheme
PPRS provides a one-off opportunity

- **For patients and clinicians**, PPRS provides an opportunity to find the right level of usage of branded medicines, based on clinical factors rather than cost.

- **For the NHS**, medicines bill growth has been underwritten, so commissioners can remove barriers to clinicians choosing which medicines to use.

- **For industry**, PPRS gives stability and supports innovative companies, but there is a level of risk driven by austerity issues.

- **For Government and the taxpayer**, PPRS achieves predictability on the branded medicines bill through this period.
Harnessing this opportunity

The Rt Hon Jeremy Hunt MP, the Secretary of State for Health wrote to ABPI & NHS England in April and asked that they work together....

“to agree and carry through a solution for accelerating uptake of clinically and cost effective medicines which maximises the benefits of the PPRS within the current financial situation. This means an end to cost containment measures on branded medicines which will not in the long run save the NHS any money. It also means creating a real clinical pull for innovative and cost effective medicines, replacing costly non drug treatments by a programme of cultural change led jointly by NHS England and the industry using all the management levers available”.
Aims of the PPRS / Medicines Optimisation programme

Working in partnership with a range of national and local stakeholders, NHSE and ABPI are developing a programme of activities that will:

• Explain and highlight the importance of medicines optimisation to healthcare professionals
• Share best practice examples
• Understand current barriers that exist to making this a reality
• Work together to overcome these barriers
Outline work programme

• Establishing a patient panel on medicines optimisation
• Further developing the medicines optimisation dashboard
• Specialised commissioning: utilisation of “commissioning through evaluation”
• NICE Clinical Guideline on medicines optimisation (March 2015) and implementation support workshops
• Developing medicines optimisation strategy and best practice resource
• Winning hearts and minds:
  – Joint NHS England/ABPI roadshows with AHSNs
  – Working with senior clinical leaders
  – Engaging NHS finance professionals
  – Strategic communications plan
Project steering group

• Jointly chaired by NHS England and ABPI (Keith Ridge and Stephen Whitehead)
• Membership: National Voices, CCGs, Royal Pharmaceutical Society, Royal College of Nursing, Academy of Medical Royal Colleges, AHSNs, NHS England, ABPI, British Generic Manufacturers Association, DH
PPRS / Medicines Optimisation
Roadshows

A series of 14 events from March - May across England, delivered as a joint programme of action by NHS England, AHSNs, and the ABPI
Aim of the roadshows

• Communicate the focus on helping patients across England to make the most of their medicines to help improve health outcomes
• Introduce the national medicines optimisation programme and communicate and explain priority attached to implementation of PPRS
• Give stakeholders the opportunity to feed into development of this work
• Hear and share local perspectives and also best practice initiatives already taking place
• Support AHSNs to work with all local stakeholders to develop a local medicines optimisation strategy
Outputs of the roadshows

• A local medicines optimisation action plan for each region
• A summary of each event
• A publication that collates and consolidates recommendations from the series of events into a set of national and local recommendations
Q & A panel

Dr Keith Ridge, Chief Pharmaceutical Officer, NHS England
David Watson, Director Pricing and Reimbursement, ABPI
Andy Cooke, Bedfordshire CCG

Chaired by: Dr Christopher Parker, Managing Director, West Midlands Academic Health Sciences Network
Rachel Hornabrook, Clinical Operations Manager

GENOMICS MEDICINE CENTRE
WEST MIDLANDS
WM GMC
Vision Statement

In the next 3 years:
We will implement a genomics programme,
- investigating about 7,500 patients,
- treated at 18 hospitals across the region.

This will have a transformational effect on clinical services:
- embedding genomics medicine and stratified treatment in both cancers and rare diseases.
- creating a regional platform for world leading research.
WM GMC Consortium

- WM Consortium in collaboration with WM ASHN
- 14,000 samples for WGS (Cancer & Rare Diseases)

Three phase roll-out:
- Phase 1: UHB, BCH, SWBH, HEFT, BWNFT
- Phase 2: UHNW, WHT, UHCW, ROH
- Phase 3: RJAH, SaTH, WVT, SWT, GEH, BHFT, WAH, DGFT, and WHNT
High level impact

• World class network
  – Linking 18 hospitals
    • Sample collection (tissue/blood)
    • Data collection

• Attracting collaboration
  – Researchers
  – Companies

• Attracting grant funding
  – GeCIPs
  – MSc programme, IT infrastructure
Beyond the 100k Genomes Project

Health Education England in partnership with HEE & Genomics England (GEL), NHS England (NHSE) and Public Health England (PHE) are developing a Masters Programme in Genomic Medicine - first students in 2015. UoB has registered as a preferred provider.
Beyond the 100k Genome

**Wealth Creation / Sustainability**

**Initial discussions** have began with a large US corporate organisation on a potential of joint working and investment in the WMGMC, discussions are also ongoing with UK companies regarding potential provision of informatics support.

**Initial exploration** has engaged with the City/ City Region (GBSLEP) on the concept of a life science economic clustering approach to the creation of the WMGMC which could be a potential attraction to both the ITM and life science campus development.

**The WMAHSN and WMCLAHRC** are exploring the potential of commissioning of a study in to the potential impact of the GMC development on health and care services in the West Midlands.
What will a NHS WM GMC designation mean for us ....

- “Whole” region working
- **Access for our patients** to WGS
- **Strategic positioning for:**
  - Life Science growth in the region;
  - MRC Molecular Pathology Nodes call:
  - MSc in Translational Medicine tender:
  - NHSE Tender for genomic diagnostic services
  - IT infrastructure bid
What is involved in the project?
What is involved?

- Whole genome sequencing and other ‘omic’ analysis

Feedback of pertinent, clinically relevant findings:
  - Verified locally
    - Known pathogenic, causative results
    - Possible causative results (via GeCIPs)
  - Looked-for additional clinically important findings (opt-in)

- Linked access to participants health records
- Anonymised data and samples shared with approved partners
- Agreement to re-contact to invite to participate in further studies

Samples to be collected in clinic

<table>
<thead>
<tr>
<th></th>
<th>Solid cancer</th>
<th>Haematological cancer</th>
<th>Rare disease</th>
<th>Paediatric 3-14 years</th>
<th>Paediatric 0-3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EDTA BLOOD</strong></td>
<td>2 x 4.5ml</td>
<td>2 x 4.5ml</td>
<td>2 x 4.5ml</td>
<td>2 x 3ml</td>
<td>1 x 3ml</td>
</tr>
<tr>
<td><strong>HEPARIN BLOOD</strong></td>
<td>1 x 10ml</td>
<td>1 x 10ml</td>
<td>1 x 10ml</td>
<td>1 x 5ml</td>
<td>1 x 3ml</td>
</tr>
<tr>
<td><strong>PAXGENE FOR DNA</strong></td>
<td>1 x 5ml</td>
<td>1 x 5ml</td>
<td>1 x 5ml</td>
<td>1 x 2.5ml</td>
<td>1 x 1ml</td>
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<tr>
<td><strong>CLOTTED BLOOD</strong></td>
<td>1 x 10ml</td>
<td>1 x 10ml</td>
<td>1 x 10ml</td>
<td>1 x 8ml</td>
<td>1 x 1ml</td>
</tr>
<tr>
<td><strong>SALIVA</strong></td>
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<td>Not required</td>
<td>Not required</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>EDTA BLOOD</strong></td>
<td>1 x 10ml</td>
<td>Not required</td>
<td>Not required</td>
<td>Not required</td>
<td>Not required</td>
</tr>
</tbody>
</table>

Cancer
- Tumour DNA
- Germline DNA (blood)

Rare diseases
- Germline DNA Proband
- Parents (or 2 relatives)
Who can be recruited?: Rare Diseases

• A rare disease with residual unmet diagnostic need identified by a proband within the NHS in England
  – Clinical diagnosis or suspected rare genetic condition
  – Routine genetic tests normal
  – No molecular diagnosis
  – Trio available where possible

• About 4000 patients over 3 years
  – Cardiovascular disorders
  – Dermatological disorders
  – Dysmorphic /Congenital abnormalities
  – Endocrine disorders
  – Growth disorders
  – Haematological disorders
  – Hearing/ear disorders
  – Metabolic disorders
  – Neurology/neurodevelopmental disorders
  – Opthalmological disorders
  – Renal and urinary tract disorders
  – Skeletal /rheumatological /connective tissue disorders
  – Cancer predisposition syndromes
Who Can be Recruited

- Not appropriate for Sanger sequencing – not just 1 or 2 known genes
- Sanger sequencing / NGS panel testing negative.
- Very heterogeneous and difficult to discriminate clinically
- No known genetic cause but likely genetic
- Newly recognised genetic disorder
- If we “fill” with less good cases when we reach our cap we will not be able to include our “best cases” (approximately 2K p.a – or 40 per week)
Recruitment pathway: Rare Disease

**GMC Patient Identification & Consent Process Map for Rare Disease Patients**

- **Identification**
  - Patient identified as eligible (via clinic list/disease register)
  - CNS or Cons sends PIS & cover letter with appointment letter

- **Face 2 Face recruitment**
  - Usually at routine OPD visit, could be separate apt at patient request.
  - Discuss REC approved patient information sheet (1 of 6 variants)
  - Take relevant REC approved consent
  - Register on GENIE
  - Take blood sample
  - Family member consent samples at same time or in separate apt

- **Withdrawal**
  - Patient can withdraw at any stage from any further inclusion in the study
  - +/- destruction of existing samples/data

- **Phenotype data**
  - Entered up to 12 weeks later
  - Data set to be confirmed
WMRGL & MPDS (& LDPs)
NHS laboratory with retained DNA receives results via HBRC.
NHS laboratory with retained DNA is responsible for validation, via:
- Own existing tests
- Existing tests elsewhere in Bham GMC
- Existing tests elsewhere in GMC network, UKGTN network, or elsewhere.
- Bespoke assays.

HBRC
Single report receipt point within GMC
Distributes results to NHS laboratories
Links results to patient records.
Genomics Education Programme

100k Genomes: workshops/seminars
- Overview Recruitment Education/Training
- All staff groups
- December 2014 - April 2015

GeL/HEE E-modules
- Genomics, Bioinformatics, Consent and Ethics
- All staff groups (clinical staff)
- Open access

100k Genomes recruitment course
- Genomics, Recruitment and consent, Communicating results and counselling issues
- All staff groups (Clinical nurse specialists, genomics nurses, Genomic ambassadors)
- 2 day programme: 4th/5th March, 6th/7th May, 18th/19th June, 2nd/3rd September, 11th/12th November.

Genomics access course
- Introduction to concepts required for MSc Genomic Medicine
- Nurses & AHPs considering MSc who need to refresh knowledge
- 1 week programme: coming soon

MSc Genomic Medicine
- Comprehensive range of core and optional modules
- All staff groups
- Plan to begin September 2015
Membership consists of:
- Pathologist
- Consultant from The Expert Advisory Group
- Clinical Geneticist

Feedback and Validation Pathways for Results

- **Relatives of the Proband**
- **Patient Clinics**
- **Report/Liaison**
- **Site Specific MDT/Cons**
- **Clinician/Notes**
- **Normal Results**
- **Results**
- **Incidental Findings**
- **Significance**
- **Results of Undetermined Disease Specific**
- **Sample Hub**
- **GEL Results Validation**
- **WMRGL**
- **MPDS**
Possible findings

• Results likely to be AT LEAST 6 months initially (later 2 weeks)

• Related to Clinical Diagnosis (validated in NHS lab)
  – Cancer:
    • Molecular changes in tumour (not present in blood) (somatic changes)
    • *Could be useful for treatment planning*
    • Unlikely to be in time for treatment
  – Rare diseases:
    • Normal
    • Known pathogenic
    • Variant of uncertain significance (VUS) but expected pathogenic will be reviewed first by GeCIPs

• Unrelated to clinical diagnosis
  – Additional ‘looked for’ findings
    • Affecting individual (cancer predispositions and Familial hypercholesterolemia)
    • Carrier status (Recessive and X-linked conditions)
  – Opt in
  – Developing list- may include further clinically useful findings as evidence develops
  – Incidental findings
    • Not usually fed back but occasionally advice may be sought from GeCIP
Additional looked-for findings

- Additional looked for findings
  - Adult Onset
    - BRCA1, BRCA2,
    - MLH1, MSH2, MSH6, PMS2,
    - MYH, APC,
    - Familial Hypercholesterolaemia
  
  - Childhood Onset
    - MEN1, MEN2, RB, VHL, FMTC
  
  - Carrier Testing
    - Sickle Cell Anaemia, Alpha Thalassemia, Beta Thalassemia
    - CF, CAH, SMA
    - DMD, Adrenoleukodystrophy, Haemophilia A
The 100k Genome project

- Health professionals:
  - Identify eligible patients (prospective)
  - Approach potential participants
  - Formal consent
  - Register for tracking
  - Sample collection
  - Phenotype information
  - Feedback results (6 months +)
Challenges

• Hybrid between clinical service and research project
  – Ethical challenges
  – Uncertainty of findings
• Time and Resources
• Lessons from other studies
  – Cancer
    • Timing
    • Sample quality
  – Rare Diseases
    • Motivated group- managing expectations
    • Equality for hard to reach groups
  – Prompt processing and receipt of samples/ data
• Training workforce in genomics
How can we (the Genomics team) help you

• Set up individual meetings with clinicians to start collating the information they hold on various forms onto one spreadsheet within the Neuro common folder with permission rights set.
• Establish how you all wish the data to be collected. – will be linked to the centre for rare disease
• Establish which clinics will be the recruiting clinics
• Establish if those clinics have nurse support.
• Establish the patient pathway to identify the best time to approach pts
Questions and discussion

WMGMC@UHB.nhs.uk
GMC Programme Manager – Debbie.Porter@uhb.nhs.uk
Clinical Operations Manager – rachel.hornabrook@uhb.nhs.uk
COFFEE BREAK
11.00 – 11.15
Andy Cooke, Assistant Director and Head of Continuing Healthcare (CHC) and Medicines Management, Bedfordshire CCG

IMPLEMENTATION
SERVICES TO SUPPORT MEDICINES OPTIMISATION: INNOVATION AND IMPLEMENTATION

Professor Stephen Chapman - Head of Medicines Optimisation & Enterprise / Deputy Head of School, Keele University
CASE STUDY: AWARD WINNING HARMS MEDICINES OPTIMISATION PROJECT

Rita Sanghera, Medicines Optimisation Pharmacist, NHS Arden & Greater East Midlands CSU
Reducing Hospital Admissions Related to Medicines (HARMs)

28 May 2015

Rita Sanghera
Medicines Optimisation Pharmacist
Introduction

- Adverse Drug Events responsible for a significant number of hospital admissions – a proportion of these are potentially preventable.
- 4-5% of admissions to secondary care are the result of Adverse Drug Reaction
- Burden to NHS is high
- Four out of five people aged over 75 years take a prescription medicine and 36% are taking four or more medications.
- Large elderly population in South Warwickshire
Polypharmacy in the elderly - complications

Physiologic changes associated with ageing:
- Decreases renal elimination
- Decreases hepatic function
- Decreases total body water and lean body mass
- Age related declines in vision and hearing

Multiple co-morbidity
Prescribing Incentive Scheme 2013/14

Reducing HARMs is a priority of South Warwickshire CCG.

- In order to support this priority, the 2013/14 Incentive Scheme contained an element looking at this area.
- Primary care clinicians in South Warwickshire were asked to conduct a medication review of patients ≥65 years, and identified as taking high risk medicines, with the aim of reducing Hospital Admissions Related to Medicines (HARMs)
HARMs workshop

➢ To understand the importance of reducing HARMs
➢ To explore the role of GPs in reducing polypharmacy in the elderly
➢ To explain the HARMs part of the Incentive Scheme 2013/14
➢ To share best practice related to HARMs
➢ To plan how to take HARMs forward at your practice
Design

1. Run a search on practice systems for patients ≥65 years & taking five or more medications (only include medicines, not wound management or stoma etc.)

2. Randomly selected a number of the identified patients - equivalent to 1% of practice population
   E.g. for a practice population of 4,000 patients, randomly select 40 patients who have been identified from above.

3. The NHS West Midlands SHA “Risk Indicator Tool” for medicines related problems was then run on these patients.

4. 25% of the highest risk patients were then selected and reviewed using the “Optimising Safe and Appropriate Medicines Use Tool”

5. Use the reporting sheet provided to fill in details/summary of detailed reviews.
Risk Indicator tool for medicines related problems

- Developed by Midlands and East Strategic Health Authority - a tool to identify patients who are at increased risk of medicines related problems
- Rates level of risk
- Can be used in a range of different health care settings
## Risk Indicator tool for medicines related problems

<table>
<thead>
<tr>
<th>Patient Identifier :</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Care home resident (Yes/No):</td>
<td></td>
</tr>
<tr>
<td>Assessed by:</td>
<td></td>
</tr>
<tr>
<td>Risk Factors (score 1 for each risk factor present)</td>
<td>Score</td>
</tr>
<tr>
<td><strong>Aged over 65 years</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Taking more than five medicines each day</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Recent change in medicines, Medicine added, Medicine stopped, Dose changed</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Higher risk medicines (score 1 for each)</strong></td>
<td></td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory drugs1 (see list below)</td>
<td></td>
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<tr>
<td>Aspirin</td>
<td></td>
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<tr>
<td>Diuretic (see list below)</td>
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<tr>
<td>ACE Inhibitor or Angiotensin II receptor antagonists (see list below)</td>
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<tr>
<td>Digoxin</td>
<td></td>
</tr>
<tr>
<td>Warfarin</td>
<td></td>
</tr>
<tr>
<td>Drugs for diabetes including insulin</td>
<td></td>
</tr>
<tr>
<td>Lithium</td>
<td></td>
</tr>
<tr>
<td>Methotrexate</td>
<td></td>
</tr>
<tr>
<td>Difficulty in taking medicines as prescribed eg. swallowing problems, forgetfulness, unable to open medicines containers etc.</td>
<td></td>
</tr>
<tr>
<td>Kidney or liver problems</td>
<td></td>
</tr>
<tr>
<td>Dependant on support to take medicines (eg. care home resident, pill dispenser aid, carer)</td>
<td></td>
</tr>
<tr>
<td>Has had medicines-related problems in the past eg. drug allergy, fall, hospital admission related to medicines</td>
<td></td>
</tr>
</tbody>
</table>

Total score (max 16) NB lower Score = lower Risk

<table>
<thead>
<tr>
<th>Lower risk</th>
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<tbody>
<tr>
<td>0 to 5</td>
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</table>

<table>
<thead>
<tr>
<th>Moderate risk</th>
<th></th>
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<tbody>
<tr>
<td>6 to 11</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Higher risk</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12 to 16</td>
<td></td>
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</tbody>
</table>
Optimising Safe and Appropriate Medicines Use tool

Risk drugs – PPI’s, laxatives, antiarrhythmics, antihypertensives, aspirin and other antiplatelets, anticoagulants, digoxin, oral corticosteroids, hypnotics, antipsychotics, opioid analgesics, NSAIDs and hypoglycaemics

Associated risk

Considerations to optimise medicines use
Optimising Safe and Appropriate Medicines Use tool - PrescQIPP

<table>
<thead>
<tr>
<th>BNF Chapter 1 - Gastrointestinal System</th>
<th>Considerations to optimise medicines use</th>
<th>Clinical Risk</th>
<th>Cost Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimicrobials</td>
<td>How long have they been prescribed? Avoid long term use, highly antibiotic preparations, uncertain effectiveness.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Check if there is a valid indication for prescribing (e.g. is an NSAID still being taken?)</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antacids</td>
<td>There has been no proven peptic ulcer. GI bleeding or dyspepsia for &gt;1 year. Can contribute to C difficile infection.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antacids</td>
<td>Previous use of opioid analgesics has reduced or stopped.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antacids</td>
<td>If antacids are used, reduce and stop one at a time.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antacids</td>
<td>Reduce stimulant laxatives if necessary.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BNF Chapter 2 - Cardiovascular System</th>
<th>Considerations to optimise medicines use</th>
<th>Clinical Risk</th>
<th>Cost Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Rate control has better balance of benefits and harms than rhythm control for most older adults.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Check if there is a valid indication for prescribing, is the BP at a normal level or too low?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Do the known possible adverse drug reactions outweigh the possible benefits (e.g. orthostatic hypotension)?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Are there any other side effects e.g. CNS effects, risk of falls, etc?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Is the patient on an optimal dose?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Check if there is a valid indication for prescribing.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Do the known possible adverse drug reactions outweigh the possible benefits?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Is the patient on an optimal dose?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Check if there is a valid indication for prescribing.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Are there any other side effects e.g. CNS effects, risk of falls, etc?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BNF Chapter 3 - Respiratory System</th>
<th>Considerations to optimise medicines use</th>
<th>Clinical Risk</th>
<th>Cost Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>When is the patient on an optimal dose?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Check if there is a valid indication for prescribing.</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
<tr>
<td>Antihypertensives - ACE inhibitors</td>
<td>Are there any other side effects e.g. CNS effects, risk of falls, etc?</td>
<td>Amber</td>
<td>Grey, Red</td>
</tr>
</tbody>
</table>

This information should be used as a pragmatic decision aid, in conjunction with other relevant, patient specific data. If therapy is considered appropriate, it should be continued. The clinical risk classifies the risk of continuing therapy based on maintenance doses. The cost risk identifies areas where total spend in primary care is high (high volume of low cost medicines or low volume of high cost medicines). The clinical and cost-risk highlighted areas which may be considered as a priority to focus on.
## Optimising Safe and Appropriate Medicines Use tool

<table>
<thead>
<tr>
<th>Risk Drug</th>
<th>Risk</th>
<th>Considerations to optimise medicines use*</th>
<th>Further information/evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPIs</td>
<td>C.Diff,</td>
<td>Check there is still a valid indication for prescribing (e.g. still on NSAID) Check there has been no proven peptic ulcer, GI bleeding or dyspepsia for 1 year. Continued use may contribute to C difficile infection. Check patient fracture risk/history. Consider long term PPI use as cause of hypomagnesaemia.</td>
<td>Public health england</td>
</tr>
<tr>
<td></td>
<td>Bone Fracture,</td>
<td>Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated to minimise the risk of C.diff [FDA].</td>
<td>MHRA</td>
</tr>
<tr>
<td></td>
<td>Hypomagnesaemia</td>
<td>Measurement of magnesium levels before starting PPI treatment and periodically during prolonged treatment, especially in those who will take a PPI concomitantly with digoxin or drugs that may cause hypomagnesaemia (e.g. diuretics). Take into account any use of PPIs obtained over-the-counter.</td>
<td>MHRA/SPC</td>
</tr>
<tr>
<td>Interaction with clopidogrel</td>
<td></td>
<td><strong>Advice for healthcare professionals re. bone fracture risk:</strong> Treat patients at risk of osteoporosis according to current clinical guidelines and ensure they have an adequate intake of vitamin D and calcium. Take into account any use of PPIs obtained over-the-counter.</td>
<td>MHRA</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Advice for healthcare professionals re. clopidogrel interaction:</strong> Concomitant use of clopidogrel and omeprazole or esomeprazole is to be discouraged unless considered essential. Doctors should check whether patients who are taking clopidogrel are also buying over-the-counter omeprazole and consider whether other gastrointestinal therapies would be more suitable. Pharmacists should check whether patients buying omeprazole are also taking clopidogrel. Consider PPIs other than omeprazole or esomeprazole in patients who are taking clopidogrel. Other gastrointestinal therapy such as H2 blockers (except cimetidine) or antacids may be more suitable in some patients. Discourage concomitant use of other known CYP2C19-inhibiting medicines with clopidogrel because these are expected to have a similar effect to omeprazole and</td>
<td></td>
</tr>
</tbody>
</table>
### Reporting sheet

#### DATA COLLECTION FORM - HARMs work for South Warwickshire

**CCG Incentive Scheme**

<table>
<thead>
<tr>
<th>Practice name</th>
<th>Practice code</th>
<th>Practice list size</th>
<th>Total number of patients reviewed:</th>
<th>Arden Commissioning Support</th>
<th>Patient number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Hospital Admissions in the last year</th>
<th>Number of Hospital Admissions in the last year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Drug 1</th>
<th>Risk Drug 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did you do?</td>
<td>What did you do?</td>
</tr>
<tr>
<td>Did you record this review and outcome in the medical notes</td>
<td>Did you record this review and outcome in the medical notes</td>
</tr>
<tr>
<td>Did you record this review and outcome in the medical notes</td>
<td>Did you record this review and outcome in the medical notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Drug 2</th>
<th>Risk Drug 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did you do?</td>
<td>What did you do?</td>
</tr>
<tr>
<td>Did you record this review and outcome in the medical notes</td>
<td>Did you record this review and outcome in the medical notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Drug 3</th>
<th>Risk Drug 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did you do?</td>
<td>What did you do?</td>
</tr>
<tr>
<td>Did you record this review and outcome in the medical notes</td>
<td>Did you record this review and outcome in the medical notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Drug 4</th>
<th>Risk Drug 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did you do?</td>
<td>What did you do?</td>
</tr>
<tr>
<td>Did you record this review and outcome in the medical notes</td>
<td>Did you record this review and outcome in the medical notes</td>
</tr>
</tbody>
</table>

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**NHS**

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**ARDEN&GEM**

**abpi**
Results

- 33/36 practices reviewed a total of 670 patients
- 2498 high risk medications reviewed
- 256 high risk drugs reviewed resulted in an intervention (stopped drug/dose changed/drug changed)
- 11.4% of high risk drugs reviewed resulted in an intervention
- 304 hospital admissions in 12 month period, ranging from 1-6 admissions per patient
Results continued

Breakdown of interventions

- 2242 Continued
- 256 Interventions
- 109 Stopped
- 117 Changed Dose
- 30 Changed Drug
## Results continued

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Number reviewed</th>
<th>Stopped</th>
<th>Changed Dose</th>
<th>Changed drug</th>
<th>Interventions %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral corticosteroids</td>
<td>41</td>
<td>4</td>
<td>9</td>
<td>0</td>
<td>31.7</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>67</td>
<td>15</td>
<td>4</td>
<td>2</td>
<td>31.3</td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>111</td>
<td>12</td>
<td>12</td>
<td>2</td>
<td>23.4</td>
</tr>
<tr>
<td>Laxatives</td>
<td>86</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>20.9</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>44</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>20.4</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>25</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Proton Pump Inhibitors</td>
<td>209</td>
<td>11</td>
<td>16</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>Antihyertensives</td>
<td>994</td>
<td>29</td>
<td>40</td>
<td>15</td>
<td>8.4</td>
</tr>
<tr>
<td>Hypoglycaemics</td>
<td>237</td>
<td>7</td>
<td>11</td>
<td>2</td>
<td>8.4</td>
</tr>
<tr>
<td>Aspirin and other antiplatelets</td>
<td>339</td>
<td>18</td>
<td>0</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Antiarrrhythmics</td>
<td>89</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4.4</td>
</tr>
<tr>
<td>Digoxin</td>
<td>75</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>181</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>2.2</td>
</tr>
</tbody>
</table>
Results continued

Polypharmacy and Risk of Hospital Admission (no. of admissions/no. of patients)

Number of Patients Reviewed

Number of Hospital Admissions

Ratio Risk of Hospital Admission
Examples of interventions

- 73 year old patient
- 5 high risk medications (3 x antihypertensives, NSAID & hypnotic)
- The review prompted the NSAID being changed from diclofenac to ibuprofen. This change is in line with Coventry and Warwickshire Area Prescribing Committee formulary choice - ibuprofen and naproxen being first line choice for oral NSAIDs.
- Risks associated with NSAID use include gastric ulcer, kidney damage and cardiovascular risk with diclofenac use.
Examples of interventions

- 77 year old patient
- 3 high risk medications (antihypertensive, opioid analgesic, & antiplatelet)
- Review prompted Oromorph® being stopped. Patient had been given Oromorph® when he/she underwent elective orthopaedic surgery in hospital; not been taken for four months but still being prescribed, highlighting a number of safety concerns due to the nature of the drug.
Examples of interventions

- 75 year old patient
- 2 high risk medications (PPI & antihypertensive)
- Review prompted PPI being stopped. PPI was initiated when patient was prescribed NSAID for flare up of gout in 2010, NSAID was prescribed acutely but PPI continued to be prescribed.
- Risks associated with PPI include hypomagnesaemia, bone fracture risk, and clostridium difficile. This intervention has eliminated risk associated with PPI use and reduced waste and cost.
Conclusion

11.4% of high risk medications resulted in an intervention

No follow up to measure impact on hospital admissions

Review prompted further appointments – not captured in this review

Review highlighted patients taking multiple high risk medications associated with greater risk of hospital admissions and raised the awareness of HARMs
Benefits of targeted medication reviews:

- Reduced HARMs
- Improved formulary adherence
- Improved concordance and compliance issues
- Treatments stopped that are no longer needed
- Improved harm: benefit ratio of prescribed drugs
- Dose optimisation
- Reduced waste  ➔ Cost savings
- Improved clinical outcomes
Limitations

- Retrospective data used for hospital admissions
- The review may have prompted a further appointment or a full clinical review – interventions not captured in the review
- Level of medication review conducted varied
- Data collection from the reporting sheet
Scope for future work....... 

- Actually assess impact on HARMS by looking at prospective data
- Work in care homes / residential homes using a similar model
- Prompted potential collaborative work with local provider
- Developing local STOPP START Toolkit
Thanks for listening

Any questions?

medicines@ardengemcsu.nhs.uk
rita.sanghera@ardengemcsu.nhs.uk
PATIENT VIDEOS AND DISCUSSION

Lucy Chatwin, WMAHSN
This video has been reproduced from the Pharmacy Management National Forum entitled “Medicines Management to Medicines Optimisation: Are We There Yet?” held in November 2014 in Central London.

Pharmacy Management has over 25 years’ experience of supporting the NHS and the pharmaceutical industry to work together for mutual benefit and for the greater gain of ensuring that patients get the most from their medicines.

THE PATIENT’S VOICE: ANN YATES
“Words are the most powerful drug used by mankind.”

Rudyard Kipling

Remember Own methods Daunting
Worrying Tolerate Variable Too many
people involved Timing Symptoms
Battle Always on their terms When I was
able to think about things Communication Reliance
Everything these days seems to relate to money Nothing should be given that interacts and causes damage
Pause for thought...

“What one does is what counts and not what one had the intentions of doing.”

Pablo Picasso

“Words are the most powerful drug used by mankind.”

Rudyard Kipling
How can we deliver on the patient centred element of medicines optimisation?

To understand the patients’ experience?

Make medicines optimisation part of routine practice?

What will you do?

Ensure medicines use is as safe as possible?

Use an evidence based choice of medicines?
How can medicines optimisation improve patient outcomes and support informal carers?

Jim Ellam

Staffordshire County Council
Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety. Ultimately medicines optimisation can help encourage patients to take ownership of their treatment.

Personalised Health and Care 2020

Using Data and Technology to Transform Outcomes for Patients and Citizens
A Framework for Action

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”
(National Voices 2013)
• Age of Austerity
• Better Care Fund
• Care Act
• Personalisation
• TECS
THE STAFFORDSHIRE STORY

By 2033, 28% of the Staffordshire population will be over 65.

That’s a population of over 242,300.

And by 2030, 50% of over 65s will have a limiting long-term illness that may require some sort of care.

But, in Staffordshire...

We’re leading a huge cultural and infrastructure change to tackle this.
Focus on Prevention & Early Intervention
Staffordshire Context

• More Commissioning
• Local partners delivering
• Communities increasingly important
• Public expectations
• Organisations working in a digital way
John’s Life prior to managing his medication

- Frequent severe seizures
- Paramedics called out to my house regularly
- Forgetting to take meds
- Fear of going out with friends
- Dependence on care staff to assist with meds
- Desire to do voluntary work
- Fear of having a seizure while @ work
- Social care visits twice daily
- Invasion of my privacy i.e carer visits
- Absent periods in the day
Outcomes for John

• Improved independence & gained control of his life.
• Significant reduction in episodes of seizures
• Improved lifestyle
  – Improved ability to manage day to day activities i.e. housework, tenancy issues, personal hygiene etc
  – Now able to go out with friends and undertake meaningful activities in the community
  – Improved communication
  – Improved confidence and self esteem
  – Undertakes voluntary work weekly
Outcomes for Social Care and Health

- Social care input no longer required
  - John self medicating
- Significant reduction in health input
  - no recent reports of paramedics called out
  - No attendance at A & E
  - Now just routine contact with community nurses.
- Improved life style for service user
- Long term savings from short term intervention
"Switched-on" generation switched off to life-changing care technology

Carers UK The report, *Potential for Change*, shows that while over 7 in 10 UK adults routinely turn to technology for banking, shopping and communications, only 3 in 10 are embracing health and care technology to help care for older or disabled relatives.
### A Strategy to support Technology Enabled Care Services in Staffordshire & Stoke-on-Trent

#### Summary Document

**Version 1.0**

**011014**

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<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Assistive Technology</th>
<th>Tele-care</th>
<th>Tele-health</th>
<th>Mobile apps &amp; Self Management</th>
<th>Video consultations &amp; Tele-diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>Promotes adoption, choice and control</td>
<td>Increased self-management, Increased self-management</td>
<td>Improved adherence</td>
<td>Education, support &amp; self-management</td>
<td>Reduced travel, improved access, improved adherence, Transferable skills for social interaction e.g. FaceTime to reduce loneliness</td>
</tr>
<tr>
<td>CCGs</td>
<td>Supports adoption and support for care</td>
<td>Increased self-management and thus reducing demand on services due to earlier intervention</td>
<td>Reduced utilisation costs in terms of GP visits and community care costs</td>
<td>Increased access, reduced demand across all sectors</td>
<td>Reduced costs across all sectors, reduced travel</td>
</tr>
<tr>
<td>Acute Trusts</td>
<td>Promotes adherence through AS&amp;I, falls, and other interventions</td>
<td>Reduced readmission and length of stay</td>
<td>Improved management of chronic conditions</td>
<td>Increased access to support and decision aids</td>
<td>Reduced admissions and length of stay, reduced travel</td>
</tr>
<tr>
<td>Mental Health Trusts</td>
<td>Range of practical, tailored to support self-care and management</td>
<td>Increased ability for patients to stay at home and maintain independence</td>
<td>Reduced admissions and length of stay</td>
<td>Can capture patient data and reduce costs</td>
<td>Reduced admissions and length of stay, reduced travel</td>
</tr>
<tr>
<td>Community Provider</td>
<td>Opportunity to support engagement and reduce on individual, and enables reducing isolation</td>
<td>Increased self-management and support of independence with minimal costs</td>
<td>Reduced costs in terms of home visits</td>
<td>Can support patient data and improved self-management</td>
<td>Can provide support for community team and support data sharing</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>Peer engagement and promotion of self-care and management, Offers support</td>
<td>Can provide a platform for volunteering and engage with voluntary sector</td>
<td>Can provide a platform for volunteering and engage with voluntary sector</td>
<td>Can provide support for patients to maintain independence</td>
<td>Reduced travel</td>
</tr>
<tr>
<td>Local Authority</td>
<td>Information, advice and guidance, promotion of self-care and volunteering</td>
<td>Can improve levels of self-care</td>
<td>Directly reduces need for home visits and can trigger earlier interventions</td>
<td>Can support navigation of services and improve quality of care</td>
<td>Reduced travel</td>
</tr>
<tr>
<td>GPs</td>
<td>Can help people reduce likelihood of falls, self-injury and maintain food and fluid intake</td>
<td>Reduced face-to-face interaction with GPs</td>
<td>Reduced costs and unnecessary GP visits</td>
<td>Can improve access to community services and support for patient data</td>
<td>Improved access Greater access to consultations Avoid lengthy appointments Reduced travel</td>
</tr>
</tbody>
</table>
• Training, cultural change and service transformation
• Embed TECS in Care Pathways
• Making best use of existing technologies
• Understanding potential and limitations of new and emerging technologies
• Adopting and implementing new technologies
15 WAYS YOUR SMARTPHONE CAN MAKE YOU HEALTHIER

Unique Attributes of Mobile

MOBILE IS

PERSONAL AND IMMEDIATE, always on and available at the decision point.

CONTEXT AWARE, capable of identifying the location, social context and activity of the user.

MOBILE CAN

ACT AS A SENSOR, collecting relevant data via accelerometers, cameras, microphones, etc. with minimal effort required by the user.

DISTRIBUTE INSTANT REWARDS, handing out rewards and discounts tied to specific behaviors and goals.

MOBILE DELIVERS

THE RIGHT MESSAGE, AT THE RIGHT TIME, IN THE RIGHT PLACE – key to successfully changing behavior.

WHO ELSE WILL BENEFIT?

- PHARMACEUTICALS
- HEALTH INSURERS
- WELLNESS PROVIDERS
- HOSPITALS

Cognitive Behavior Therapy

A psychosocial approach to help patients understand the thoughts and feelings that influence behaviors.

Monitoring

Ongoing, systematic measurement of behavior.

Self-Monitoring

Users collect, review and act on information on their own.

Reminders

Alerts or notifications.

Social Networks

Social sharing and feedback of progress, goals, achievements.

Journaling

Self-logging of activities.

Gamification

The use of competition or game mechanics.

Hypnosis

The use of verbal repetition and mental images when the user is in a trance-like state.

Behavioral Economics

Incentives and rewards based on cognitive psychology.

Behavioral Science

Through observing and facilitating human interactions.

Motivational / Inspirational Messages

Presenting content to elicit an emotional response.

Subliminal Messaging

The use of hidden words or images.

Feedback

Critique and/or recommendations on how to improve.

Biofeedback

Direct measurement of physiological or biological indicators.

Information / Dashboards

The visual presentation of data or progress.
https://vimeo.com/channels/simpletelehealthflo/94149163
Mobile apps & self care
Supporting .......

Informing .......

Acting!

http://www.memyselfandigame.co.uk/
http://www.staffordshirecares.info/Homepage.aspx
https://www.staffordshiremarketplace.co.uk
Equipment for easier living

Help at home

Domestic Services
AskSARA helps you find useful advice and products that make daily living easier

- **Your health**: Products and ideas on a range of physical and mental health topics
  - Medication management
  - Hearing
- **Your home**: Products and ideas which may help you complete tasks in a number of household locations
  - Bathroom
  - Toilet
- **Daily activities**: Products and ideas which may help with a range of daily activities
  - Preparing meals, eating and drinking
  - Shopping, driving and transport

http://asksara.dlf.org.uk/
Your health
Products and ideas on a range of physical and mental health topics

- Medication management
- Hearing
- Vision
- Smell
- Memory and mood
- Walking, falls and wheelchair accessories

Your home
Products and ideas which may help you complete tasks in a number of household locations

- Bathroom
- Toilet
- Bedroom
- Kitchen
- Stairs
- Living room

Daily activities
Products and ideas which may help with a range of daily activities

- Preparing meals, eating and drinking
- Shopping, driving and transport
- Clothes, shoes and dressing
- Communicating
- Gardening, hobbies and leisure
- Help in emergencies
Medication management

I take medication at different times during the day

- Agree
- Disagree
3. I find opening medication bottles or removing a pill from a blister pack difficult to manage

YOU ANSWERED: AGREE

**Pill removers**
This section includes foil cutting pens and plastic devices which aid the dispensing of pills and tablets from foil blister packs. Products which help open medication bottle lids are also included.

**Screw lid bottle openers**
Handheld devices which provide an additional, enlarged gripping surface for removing a screw lid bottle tops. Openers designed specifically for opening childproof safety caps are also included in this section. View references >
Pharmacy and medicines

What your pharmacist can help with

http://www.nhs.uk/Livewell/Pharmacy/Pages/Pharmacyhome.aspx
https://www.youtube.com/watch?v=mg_AKfjFkDo
It’s never too early to shop for Xmas!!!!
Welcome to FALLCHECK

FALLCHECK is an app to help prevent falls in the home. Based on information from occupational therapists and falls experts in the United Kingdom, the app gives a comprehensive guide to alert you to potential fall hazards that might be present in your own or a relative's home. Information on how to remove or reduce the risk to help prevent falls is provided by the app.

https://cele.coventry.ac.uk/fallcheck/
Jim Ellam

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07966857526
NICE guideline 5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes

March 2015
Key messages (1)

• NICE guideline on medicines optimisation covers 8 key areas where medicines use could be optimised
• Opportunity to reduce preventable medicines-related patient safety incidents – systems and processes can help to minimise harm
• Involving people in decisions about their medicines is crucial – there are many opportunities to do this e.g. using patient decision aids
• Aim to understand people’s knowledge, beliefs and concerns about medicines
• Ensure people have complete and accurate information about their medicines, in a format that they can understand
Key messages (2)

• Prioritise additional support for people who may need it most e.g. people with multimorbidities, polypharmacy and older people

• Target ‘risky times’ when medicines-related problems are most likely to occur e.g. hospital discharge
  – Medicines reconciliation
  – Medication review
  – Post-discharge support

• Effective 2-way, secure and timely communication between providers is needed

• Needs engagement from everyone across health and social care, not just pharmacy teams

• Review patients regularly
Contents

• Background
• Summary of key points – refer to guideline for full recommendations
• What are the possible medicines optimisation issues?
Contents

• Background

• Summary of key points – refer to guideline for full recommendations

• What are the possible medicines optimisation issues?
Related NICE guidance

Overarching NICE guidance

Patient experience in adult NHS services
CG138 2012

Medicines optimisation
NG5 2015

Medicines adherence
CG76 2009

Drug allergy
CG183 2014
The problem...

• Berwick report (2013)
  • patient safety problems exist throughout the NHS as with every other health system in the world

• Frontier report (2014)
  • putting in place systems and procedures to improve safety of care might reduce the financial cost of care, as well as improve the quality of life….
  • an increase in polypharmacy has the potential to increase errors and related harm
  • cost of preventable adverse events is likely to be more that £1 billion annually to the NHS
Why is medicines optimisation important?

• Ageing population
  – use more medicines

• More people diagnosed with long-term conditions
  – 15 million people in England
  – approx. 30-50% of medicines not taken as intended

• More people diagnosed with >3 long-term conditions
  – from 1.9 million (2008) to ~3 million (2018)

• More people taking multiple medicines (polypharmacy)
  – Risk of harm increases with polypharmacy
  – average number of prescription items per year for any one person in England increased from 13 (2003) to 19 (2013)

• 5-8% of hospital admissions due to preventable adverse effects
Definition of medicines optimisation

For the purpose of the NICE guideline:

‘a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines’
Areas covered in the guideline

• Systems for identifying, reporting and learning from medicines-related patient safety incidents (2 RCTs; 16 OS)
• Medicines related communication systems when patients move from one care setting to another (11 RCTs)
• Medicines reconciliation (4 RCTs)
• Medication review (28 RCTs)
• Self-management plans (14 RCTs)
• Patient decision aids used in consultations involving medicines (28 RCTs)
• Clinical decision support (20 RCTs)
• Medicines-related models of organisational and cross-sector working (18 RCTs)
‘Offer’ and ‘consider’

- For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences.

- NICE uses ‘offer’ (and similar words such as ‘refer’) when it is confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective.
  - It uses similar forms of words (for example, ‘Do not offer...’) when it is confident that an intervention will not be of benefit for most patients.

- NICE uses ‘consider’ when it is confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective.
  - The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient’s values and preferences than for a strong recommendation.
Contents

• Background

• Summary of key points – refer to guideline for full recommendations

• What are the possible medicines optimisation issues?
The patient journey...

Doris
The patient journey...

Systems for identifying, reporting and learning from medicines-related patient safety incidents
Systems for identifying, reporting and learning from medicines-related patient safety incidents (1)

- Identify
- Report
- Prioritise
- Take action
- Apply and share learning

Person-centred

‘Fair blame’ culture
Systems for identifying, reporting and learning from medicines-related patient safety incidents (2)

Key points:

• Consider using multiple methods to identify incidents
• Explore barriers that may reduce reporting
• Consider applying the principles of PINCER intervention
• Consider using screening tools (e.g. STOPP/START tool) in some people (e.g. older people, long term conditions, polypharmacy) to identify potential incidents
• Consider assessing training and education needs
The patient journey...

Systems for identifying reporting and learning from medicines-related patient safety incidents

Medicines-related communication systems when patients move from one care setting to another
Medicines-related communication systems when patients move from one care setting to another (1)

Key points:

• Complete and accurate information needs to be shared, received, documented and acted upon:
  – 2-way responsibility
  – ideally within 24 hours
  – most effective and secure way
  – specific information to be shared (see guideline)

• Person-centred:
  – Discuss medicines with the person at the time of transfer
  – Give them a complete and accurate list of their medicines in a suitable format
Medicines-related communication systems when patients move from one care setting to another (2)

Key points:

• Consider sending a person’s medicines discharge information to their nominated community pharmacy

• Consider additional support for some groups of people:
  – adults, children and young people taking multiple medicines (polypharmacy)
  – adults, children and young people with chronic or long-term conditions
  – older people
The patient journey...

- Systems for identifying reporting and learning from medicines-related patient safety incidents

- Medicines reconciliation

- Medicines-related communication systems when patients move from one care setting to another
Medicines reconciliation

**Key points:**

**When and where?**
- In an acute setting – within 24 hours
- In primary care – as soon as practically possible, and within 1 week of the GP practice receiving the information
- Process may need to be carried out more than once during a hospital stay

**Who to involve?**
- Patients and their family members or carers, where appropriate

**Who does it?**
- Trained and competent health professional
- Designated health professional to have overall organisational responsibility
The patient journey...

Systems for identifying reporting and learning from medicines-related patient safety incidents

Medicines reconciliation

Medication review

Medicines-related communication systems when patients move from one care setting to another
Medication review

Key points:

• Consider medication review for some groups of people where a clear purpose has been identified. For example:
  – adults, children and young people taking multiple medicines (polypharmacy)
  – adults, children and young people with chronic or long-term conditions
  – older people

• Determine locally who is the most appropriate health professional to carry it out – based on knowledge and skills

• See guideline for specific details on what needs to be taken into account when carrying out a medication review
The patient journey...

- Identifying reporting and learning from medicines-related patient safety incidents
- Medicines reconciliation
- Medication review

Decision-making
- Self-management plans
- Patient decision aids (medicines)
- Clinical decision support

Medicines-related communication systems when patients move from one care setting to another
The patient journey...

- Identifying reporting and learning from medicines-related patient safety incidents
- Medicines reconciliation
- Medication review

Decision making
- Self-management plans
- Patient decision aids (medicines)
- Clinical decision support

Medicines-related communication systems when patients move from one care setting to another
Self-management plans

Key points:

• Consider using an individualised self-management plan:
  – people with chronic or long-term conditions
  – to support people who want to be involved in managing their medicines

• Details of what should be discussed and included in the individualised self-management plan is outlined in the guideline

• Review the self-management plan to ensure the person does not have problems using it
The patient journey...

- Identifying reporting and learning from medicines-related patient safety incidents
- Medicines reconciliation
- Medication review

Decision-making
- Self-management plans
- Patient decision aids (medicines)
- Clinical decision support

Medicines-related communication systems when patients move from one care setting to another
Patient decision aids used in consultations involving medicines (1)

Key points:

Shared decision-making

• Offer all people the opportunity to be involved in decisions about their medicines

• Find out about the person’s values and preferences – they may be different from the health professional
Patient decision aids used in consultations involving medicines (2)

Key points:

Patient decision aids

• In a consultation about medicines:
  – offer the person the opportunity to use a patient decision aid (when one is available), to help them make a preference-sensitive decision
  – do not use a patient decision aid to replace discussions with a person
  – may be appropriate to have more than 1 consultation to make an informed decision
  – robust development process, in line with the IPDAS criteria
Patient decision aids used in consultations involving medicines (3)

Key points:

Organisational responsibilities

- Consider training and education needs to support health professionals
- Consider identifying and prioritising which patient decision aids are needed for their patient population through, for example, a local medicines decision-making group
- Disseminate to all relevant health professionals and stakeholders
The patient journey...

- Identifying reporting and learning from medicines-related patient safety incidents
- Medicines reconciliation
- Medication review

Decision-making
- Self-management plans
- Patient decision aids (medicines)
- Clinical decision support

Medicines-related communication systems when patients move from one care setting to another
Clinical decision support

Key points:

• Consider computerised clinical decision support systems to support clinical decision-making and prescribing
• Should not replace clinical judgement
• Health professionals need to have the necessary knowledge and skills to use the system, including an understanding of its limitations
• Requirements of the system outlined in guideline
The patient journey...

- Identifying reporting and learning from medicines-related patient safety incidents
- Medicines reconciliation
- Medication review

Decision-making: Self-management plans, Patient decision aids (medicines), Clinical decision support

Models of care: Home, GP, Hospital, Community care

Medicines-related communication systems when patients move from one care setting to another
Medicines-related models of organisational and cross-sector working

Key points:

• Consider multidisciplinary team approach for people who have long-term conditions and take multiple medicines (polypharmacy)

• Involve a pharmacist with relevant clinical knowledge and skills when making strategic decisions about medicines use or when developing care pathways that involve medicines use
The patient journey...

- Identifying reporting and learning from medicines-related patient safety incidents
- Medicines reconciliation
- Medication review

Models of care:
- Home
- GP
- Hospital
- Community care

Decision-making:
- Self-management plans
- Patient decision aids (medicines)
- Clinical decision support

Medicines-related communication systems when patients move from one care setting to another
Contents

- Background
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- What are the possible medicines optimisation issues?
Evidence into practice

Maskrey N, 2014

Research → National guidance → Local implementation → Care of Individual people
Possible issues for individual patient decision-making (L → I) (1)

Questions for reflection:

Patient involvement

• Many patients do not receive an effective shared decision-making consultation
  – What are the barriers? How can these be addressed?
• What are the local strategies to promote shared decision-making and targeted use of patient decision aids?
• What are the training and education needs?
  – e.g. how to find out about values and preferences
• How can patient involvement in medication reviews be increased?
Questions for reflection:

Other issues

• How do you explain to people how to identify and report incidents? What happens currently?
• What additional support is offered locally for individual people at key times in the pathway?
• Do people get the required information about their medicines in a format that is suitable for them?
• How do you explain and involve patients (and their family members or carers) in medicines reconciliation?
• How do you support people to decide about self-management plans?
Questions for patients to ask

The safe and effective use of medicines
(medicines optimisation): Information for the public

• These questions may help you discuss your condition or the treatments you have been offered with your care team:
  – How often should my medicines be reviewed?
  – Who sees the information about what medicines I'm taking?
  – Will the information about my medicines be kept confidential?
  – What are the benefits of using a self-management plan?
  – Can you tell me more about using a patient decision aid?
  – How do I report a side effect or a bad reaction to a medicine?
  – What do I do if I think I no longer need a medicine?
  – What do I do if I think a medicine isn't working?
  – Who do I speak to if I want to stop taking a medicine?
  – What do I do if I think a mistake has been made with my medicines?
Tools and resources

- NICE guideline
- Full guideline
- Information for the public
- Baseline assessment tool
- Costing statement
- Implementation workshops:
  - London 9<sup>th</sup> July
  - Birmingham 14<sup>th</sup> July
  - Leeds 16<sup>th</sup> July
NICE Pathway – Medicines optimisation

incorporating NICE CG 76: Medicines adherence
Summary

• Person-centred: routinely involve people in decisions about their medicines
• Use medicines optimisation as an opportunity to prevent medicines-related problems
• Target ‘risky times’, such as when transferring to another care provider
• Communication, communication, communication!
Any questions?

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Urgent and Acute Workforce Transformation Programme

Pharmacy Projects

May 2015

Matt Aiello,
Special Projects Manager, Transformation
Health Education West Midlands
West Midlands Project Portfolio – 2014-15

January 2014 – November 2015:
A 12 month, Post-CCT (EM) Fellowship programme; aimed at providing urgent, emergency and acute care training for GPs.
Objective: To remove the "safety net" from the ED, back into the community.

May 2014 – May 2015:
Launch of a regionally standardised Advanced Practice training course pilot.
Objective: To inform regional planning.
15-strong cohort – 3 from each of 5 disciplines: nursing, pharmacy, podiatry, physiotherapy, paramedic.

From December 2014:
1) A bespoke 12 month portfolio of practical skills-based SAS EM Training.
2) An EM Fellowship pilot for SAS Doctors.

Ongoing:
1) Supporting the West Midlands re-launch of the Physician Associate role from January 2014.
2) Supporting the national plan for statutory registration.
3) Sharing learning across regional LETBs.

April 2014 – September 2015:
Launch of a bespoke Non-Medical Prescribing course – to up-skill Pharmacists to Independent Prescriber level, with additional skills training in clinical diagnosis / minor injuries & minor ailments.

West Mids: December 2013 – June 2014
National: March 2015 – April 2015
A UK-first pilot study, investigating the role of clinically-focussed Independent Prescriber Pharmacists in the ED, across three regional Trusts. Now scaled up to national project, with 53 trusts across 12 LTB areas nationally.

Taskforce Aims:
To develop innovative workforce solutions to:
1) Meet Emergency Medicine workforce demands within the Emergency Department.
2) Improve Admissions avoidance, through primary-care / community pathway strategies.
Pharmacy Projects… the “why” of it…

From April 2013, a series of questions were posed by Health Education West Midlands (HEWM) to investigate development potential of clinical Pharmacists in Urgent and Acute care pathways:

1) “To what extent can Pharmacists manage patients in the ED?”

2) “What extra training is needed to create an enhanced clinical Pharmacist, capable of confidently and competently treating patients, as part of a multi-skilled, multi-disciplinary, Urgent and Acute / Emergency Care workforce?”

3) “Is the existing non-medical prescribing module sufficient to adequately prepare pharmacists for a role in the future Urgent and Acute / Emergency care pathway?”

2013-14 West Midlands ED Pharmacy pilot demonstrated the potential for a “near patient” clinical pharmacy role on a regional scale.

Was considered appropriate to scale up the model to:

- Evaluate cross-region patient flow.
- Investigate potential for a clinical pharmacy role to affect national workforce change.

2015 ED Pharmacy National Project – Service Improvement audit
## Advanced Practice Model
(12 month, double module programme)

<table>
<thead>
<tr>
<th>Module 1: Clinical Examination Skills for Healthcare Professionals (40 CATS points at Masters level)</th>
<th>Module 2: Clinical Investigations &amp; Diagnostics for Healthcare Professionals (20 CATS points at Masters level)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim:</strong> To provide the theoretical underpinning and practice base to enable the health care professional to deliver safe and effective autonomous care. This will include patients presenting with undifferentiated and undiagnosed primary and secondary care conditions across the age and acuity spectrum.</td>
<td><strong>Aim:</strong> To complement the clinical examination module to provide the student with the theoretical underpinning for the acquisition of a range of skills and knowledge to support safe autonomous practice when requesting and interpreting clinical investigations for a wide clinical spectrum of conditions.</td>
</tr>
<tr>
<td><strong>Duration:</strong> 12 taught days delivered in 6 x 2 day blocks</td>
<td><strong>Duration:</strong> 5 taught days delivered via 2 and 3 day blocks</td>
</tr>
<tr>
<td><strong>Assessment:</strong></td>
<td><strong>Assessment:</strong></td>
</tr>
<tr>
<td>• Assessed Essay/course work 4000 words</td>
<td>• Assessed Essay/course work 2000 words</td>
</tr>
<tr>
<td>• Four observed structured clinical examinations (OSCE)</td>
<td>• Two observed structured clinical examinations (OSCE)</td>
</tr>
<tr>
<td>• Portfolio of evidence from own clinical practice</td>
<td>• Portfolio of evidence from own clinical practice</td>
</tr>
<tr>
<td><strong>Study Dates 2014:</strong></td>
<td><strong>Study Dates 2015:</strong></td>
</tr>
<tr>
<td>• 8th and 9th May; 29th and 30th May.</td>
<td>• Wednesday 11th and Thursday 12th February.</td>
</tr>
<tr>
<td>• 12th and 13th June; 26th and 27th June.</td>
<td>• Tuesday 3rd, Wednesday 4th and Thursday 5th March.</td>
</tr>
<tr>
<td>• 3rd 4th July; 30th and 31st July.</td>
<td><strong>OSCE Examination Day Friday 15th May.</strong></td>
</tr>
<tr>
<td>OSCE Examination Day Friday 5th September.</td>
<td><strong>Assessment:</strong></td>
</tr>
<tr>
<td></td>
<td>• Assessed Essay/course work 2000 words</td>
</tr>
<tr>
<td></td>
<td>• Two observed structured clinical examinations (OSCE)</td>
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<tr>
<td></td>
<td>• Portfolio of evidence from own clinical practice</td>
</tr>
</tbody>
</table>
HEE National ED Pharmacy Project

ED Pharmacy Project – West Midlands Pilot

Informed development of...

2015-16 HEWM Pharmacy Projects

Advanced Clinical Pharmacist (ACPh)

“Scale and Spread” Future commissioning potential of NMP

2014-15 Project Evaluations will inform...

2014-15 HEWM Pharmacy Projects

X 3 Pilot Pharmacists Joined Multi-Disciplinary Cohort

Following HEE EM Taskforce Mandate

“Fast Track” Clinically Enhanced Pharmacy Pilot

Informed development of...

Advanced Practice Pilot (12 month, 60 Credit)

Informed and Justified launch of...

HEWM Pharmacy Projects

Aligned to HEE multi-disciplinary, Advanced Practice planning

Development of a model competency and curriculum framework
Thank you for your time

Questions?
WHY BOTHER WITH A MEDICINES SAFETY OFFICER?
Patient Safety Alert

Stage Three: Directive
Improving medication error incident reporting and learning
20 March 2014


NHS England and MHRA are working together to simplify and increase reporting, improve data report quality, maximise learning and guide practice to minimise harm from medication errors by:

- sharing incident data between MHRA and NHS England reducing the need for duplicate data entry by frontline staff;
- providing new types of feedback from the National Reporting and Learning System (NRLS) and MHRA to improve learning at local level;
- clarifying medication safety roles and identifying key safety contacts to allow better communication between local and national levels; and,
- setting up a National Medication Safety Network as a new forum for discussing potential and recognised safety issues, identifying trends and actions to improve the safe use of medicines. The network will also work with new Patient Safety Improvement Collaboratives that will be set up during 2014.

The Yellow Card Scheme for reporting suspected adverse drug reactions to the MHRA will continue to operate as normal.

Actions (Target date for completion 19 September 2014)

All large* healthcare providers including NHS Trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:

1. Identify a board level director (medical or nursing supported by the chief pharmacist) or in community pharmacy and home health care, the equivalent pharmacist, to have the responsibility to oversee medication error incident reporting and learning;

2. Identify a Medication Safety Officer (MSO) and email their contact details to the Central Alerting System (CAS) team. This person will be a member of a new National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and MHRA; and,

3. Identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.

Small* healthcare providers including general practices, dental practices, community pharmacies and those in the independent sector should:

4. Continue to report medication error incidents to the NRLS using the e-form on the NRLS website, or other methods and take action to improve reporting and medication safety locally, supported by medication safety champions in local professional committees, networks, multi-professional groups and commissioners.

5. Identify a MSO and email their contact details to the CAS team. This person will be a member of the National Medication Safety Network, support reporting and learning and take local actions to improve medication safety.

Supporting information
*More detailed information to support the implementation of this guidance is available at: www.england.nhs.uk/patientsafety/PSA

Patient Safety | Domain 5
www.england.nhs.uk/patientsafety

Contact NHS England: patientsafety.enquiries@nhs.net
Contact MHRA: pharmacovigilance.service@mhra.gov.uk
Providers

‘identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.’

Commissioners

‘The MSO can also use learning to influence policy, planning and commissioning as part of clinical governance in the commissioning organisation’
What is the Role of an MSO?

• Ensure Delivery of Patient Safety Alerts
  – Warning
  – Resource
  – Directive

• Gather information about the types and numbers of errors

• Highlight and share learning

• Identify areas of risk and actions to reduce risk
So what information should MSOs be gathering?

- Numbers of incidents
- Type of incident
- Operational areas of risk
- Medicines or class of medicines associated with higher risks
Community Pharmacy dispensing errors – primary reason

- Picking/labelling error: 22
- SOP not followed: 12
- Prescription error: 6
- Communication: 4
- Other: 3

No of Incidents
Community Pharmacy dispensing incidents – secondary reason

- Staffing/workload: 20
- Too many distractions: 13
- Lack of training: 7
- Communication: 4
- Other: 1

No of incidents
What information should MSOs be sharing?

• Rates and trends
• Place of errors
• Training issues
• Documentation issues
• System issues
Who should MSOs be sending information to?

UP
• MSO network
• NRLS/STEIS
• Yellow card

IN
• Patient Safety Committees/Quality Committees
• Formulary Committees

OUT
• Commissioners
• Other stakeholders
Feedback and action to minimise risk

MHRA safety communications:
- Drug Safety Update (monthly)
- Safety Warnings (as required)
- Alerts (as required)
- Recalls (as required)

NHS England safety communications:
- Formally by three stage Alerts,
- Organisational Patient Safety Incident to NHS organisations by NRLS reports (6 monthly)
- Publication in professional journals

Healthcare Professionals Implementation

Local Medication Safety Committee Oversight and support

Medicines Safety Officer Ensures Implementation

MHRA Analysis

NHS England Analysis

NHS England

MHRA’s Yellow Card Scheme
www.mhra.gov.uk/yellow card

Analysis & regulatory action
Formulary Management

• Analysis of formulary documentation
• ALL require safety data for new drugs
• Safety data
  – New drugs – clinical data
  – Existing drugs – number of incidents, new data
  – Existing guidelines and documentation
SCRIPT Medicines Management

• Aim: Develop a suite of web-based eLearning modules to develop and maintain the professional knowledge and competence of qualified nursing staff relating to the safer use of medicines

• eLearning platform is available online at www.saferuseofmedicines.org

• Fifteen modules will eventually be available
Adverse Drug Reaction/Error Champions

Aim:
• To improve the reporting rate of suspected Adverse Drug Reactions (ADRs) across the region
• To adopt ADR ‘champions’ as advocates to disseminate information on the importance of reporting and to recruit a Lead ADR champion to coordinate and drive the project across the West Midlands

Outcomes:
• 17 acute trusts and 3 CCGs involved
• 18% increase in ADR reporting in WM
Transfer of medicines

Aim:
The transfer of medicines and medicine information programme has seen the review of all documents used to support the transfer of patient’s own drugs (PODS), including process to understand the current pathways for PODs on emergency admission. This work has led to improved usage of patients’ own medicines in hospital settings.

Outcome:
Documentation in place. WMAS using Green bag scheme at UHB. Plan is to roll out to other trusts.
Prescribers’ SPaCE (Sharing Practice and Continuing Education)

Aim:
To create a web-based engagement hub for non-medical prescribers (NMPs) that will provide an effective engagement channel, a workspace for collaborative working and a suite of tools for designing and sharing ideas, thoughts and concerns.

Outcome:
Platform being built. Content includes

• NMP good practice, for example protocols, implemented guidelines in NMP clinics,
• Business cases for new or extended NMP roles, useful resources and NMP success stories.
• NMP specific toolkits have been incorporated into the platform for hypertension, COPD, asthma, diabetes, antibiotic prescribing and secondary care inpatient non-medical prescribing.
Contacts

• SCRIPT Medicines Management – Sarah Thomas
• Adverse Drug Reaction/Error Champions – Karamjit Khangura
• Transfer of medicines – Gulnar Vasta
• Formulary Management Leadership – Alison Tennant
• Prescribers’ SPaCE (Sharing Practice and Continuing Education) – Bethan Knight