NHS

Vale of York
Clinical Commissioning Group

Medicines Safety

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Medicines Safety

- Background
- Top 10 prescribing errors
- WHO Global Patient Safety Challenge
- National Meds Safety Programme
- Medication Safety Dashboard

Medicines Safety

- PINCER
- CAS alerts
- NRLS
- Role of the Meds Optimisation team
- MHRA Valproate

Background

- Medication is the most common intervention in medicine
- Over 1 billion prescription items dispensed in the community in 2016.
- Cost of medicine is the second largest outgoing in the NHS after staff costs
- The total net ingredient cost (NIC) is over £9 billion for prescription items dispensed in 2016 in primary care
- £16 billion for total annual drug expenditure.

Background

- Medication has a huge potential to do good, but errors can occur at many points in the medication cycle – prescribing, dispensing, administering, monitoring and use.

- Prescription drugs 'contributed to Theresa Feehan's death' - https://www.bbc.co.uk/news/uk-england-london-48770988

Top 10 Prescribing Errors and How to Minimise the Risk

- https://www.pharmaceutical-journal.com/learning/learning-article/the-top-ten-prescribing-errors-in-practice-and-how-to-avoid-them/20206123.article?firstPass=false

Top 10 Prescribing Errors

- **Prescriptions for medicines were omitted or delayed**
- **Anticoagulants**
- **Opioid analgesics**
- **Insulin**
- **Nonsteroidal anti-inflammatory drugs**

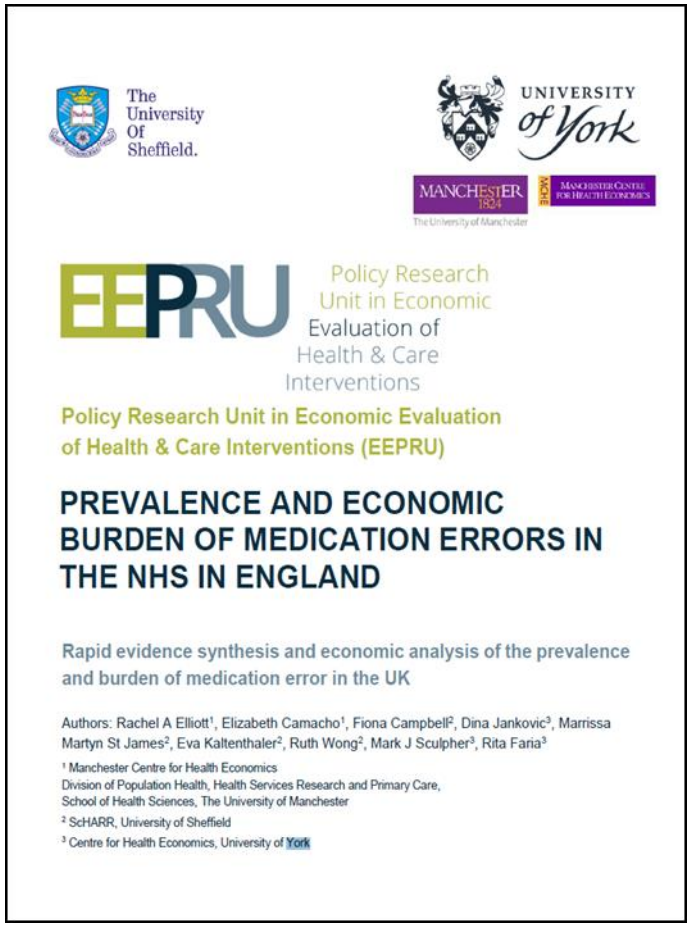
Top 10 Prescribing Errors

- **Drugs that require regular blood test monitoring**
- **Known allergy to medicine, including antibiotics**
- **Drug interactions**
- **Loading doses**
- **Oxygen**

WHO Global Patient Safety Challenge – Medication Without Harm

- In 2017, the World Health Organisation (WHO) launched its third Global Patient Safety Challenge ‘Medication Without Harm’, which aims to reduce the global burden of severe and avoidable medication-related harm by 50% over five years.

England – Response to WHO challenge National Medicines Safety Programme



The University Of Sheffield.

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MANCHESTER 1824 The University of Manchester

Manchester Centre for Health Economics

EEPRU Policy Research Unit in Economic Evaluation of Health & Care Interventions

Policy Research Unit in Economic Evaluation of Health & Care Interventions (EEPRU)

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[1], Elizabeth Camacho[1], Fiona Campbell[2], Dina Jankovic[3], Marrissa Martyn St James[2], Eva Kaltenthaler[2], Ruth Wong[2], Mark J Sculpher[3], Rita Faria[3]

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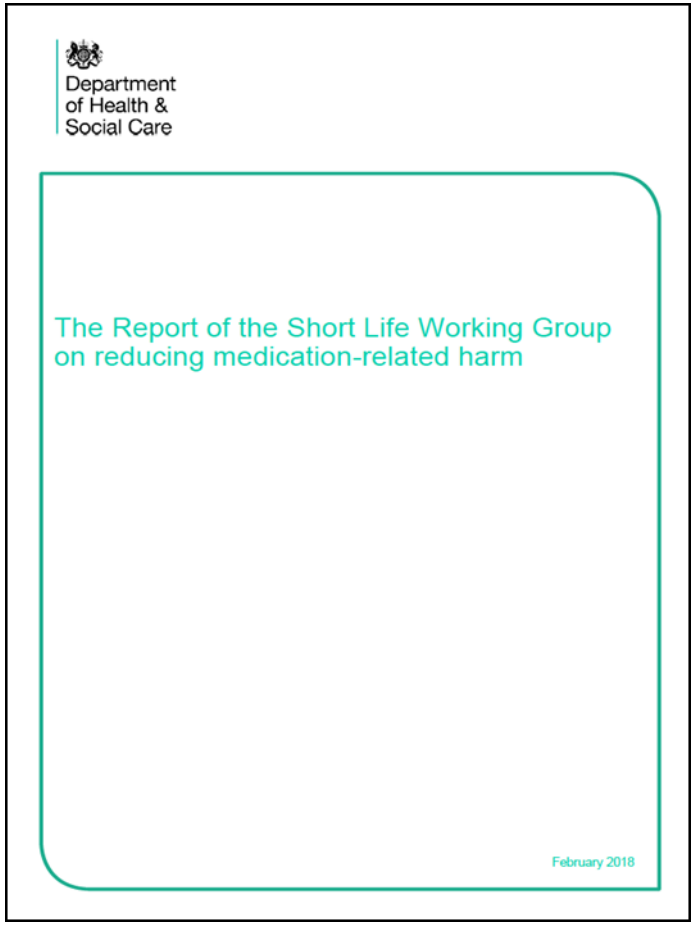


Department of Health & Social Care

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

February 2018

National medicines safety programme

- There are an estimated 237 million ‘medication errors’ per year in the NHS in England, with 66 million of these potentially clinically significant
- ‘Definitely avoidable’ adverse drug reactions collectively cost £98.5 million annually, contribute to 1700, and are directly responsible for, approximately 700 deaths per year

National medicines safety programme

- The national medicines safety programme has 4 domains:
- Patients and public
- Medicines
- Healthcare professionals
- Systems and practices

Patients and the Public

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

Patients and Public

Medicines

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

Healthcare Professionals

- Improved shared care between health and care professionals
- Training in safe and effective medicines use is embedded in undergraduate training
- Reporting and learning from medication errors
- Repository of good practice to share learning

Systems and Practices

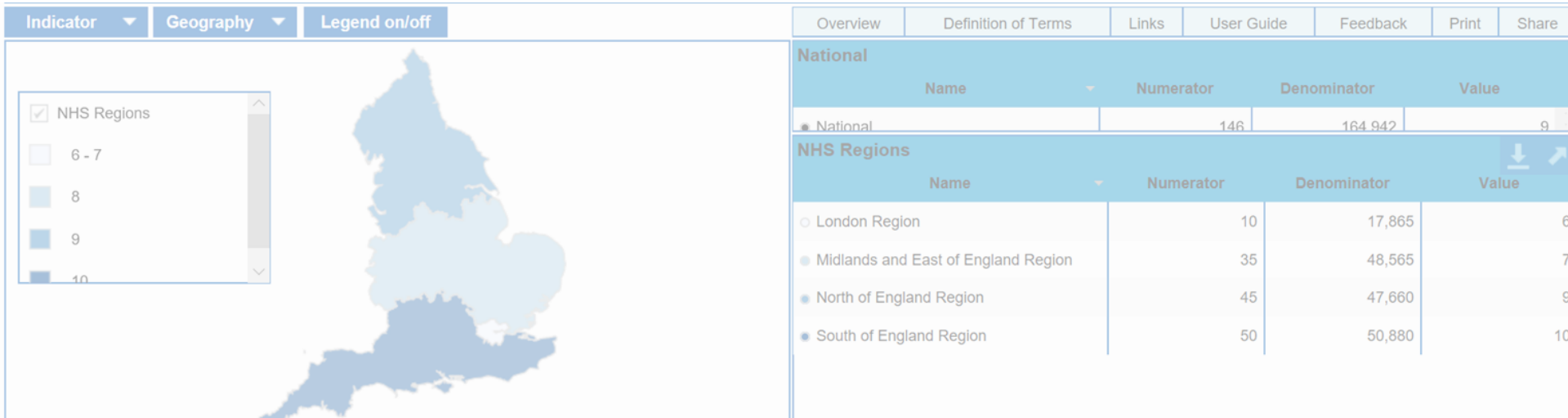
- The accelerated roll-out of hospital e-prescribing and medicines administration systems
- The roll-out of proven interventions in primary care such as PINCER
- The development of a prioritised and comprehensive suite of metrics
- New systems linking prescribing data in primary care to hospital admissions
- New research on medication error to be encouraged.

Medication Safety Dashboard

- https://apps.nhsbsa.nhs.uk/MOD/MedicationSafety/atlas.html

Or

- Via ePACT2 - https://www.nhsbsa.nhs.uk/epact2



Medication Safety Dashboard

- Indicator 1 – GIB01 Patients 65 years old or over admitted to hospital with a gastrointestinal bleed prescribed a non-steroidal anti-inflammatory drug (NSAID) and NOT concurrently prescribed a gastroprotective medicine
- Indicator 2 – GIB02 Patients 18 years old or over admitted to hospital with a gastrointestinal bleed prescribed a non-steroidal anti-inflammatory drug (NSAID) and concurrently prescribed an oral anticoagulant (warfarin or a direct oral anticoagulant (DOAC))
- Indicator 3 – GIB03 Patients 18 years old or over admitted to hospital with a gastrointestinal bleed prescribed an oral anticoagulant (warfarin or a direct oral anticoagulant (DOAC)) with an anti-platelet and NOT concurrently prescribed a gastro-protective medicine
- Indicator 4 – GIB04 Patients 18 years old or over admitted to hospital with a gastrointestinal bleed prescribed aspirin and another anti-platelet and NOT concurrently prescribed a gastro-protective medicine.
- Indicator 5 – AKI01 Patients 18 years old or over admitted to hospital with acute kidney injury concurrently prescribed a non-steroidal anti-inflammatory drug (NSAID), a renin-angiotensin system (RAS) drug, and a diuretic
- Indicator 6 – GIBCI Composite Gastro Intestinal Bleeds comprising of unique patients from indicators 1 to 4
- Indicator 7 – PAIN01 Patients 18 years old or over admitted to hospital with respiratory depression, overdose or confusion concurrently prescribed an oral or transdermal opioid and a benzodiazepine, Z-drug, pregabalin or gabapentin

Medication Safety Dashboard

- Indicator 8 – PAIN02 Patients 18 years old or over admitted to hospital with constipation prescribed an oral or transdermal opioid and NOT prescribed a laxative
- Indicator 9 – PAIN03 Patients 18 years old or over admitted to hospital with respiratory depression, overdose (accidental poisoning) or confusion currently prescribed an oral or transdermal opioid for more than 3 months
- Indicator 10 – FRAC01a Patients 65 years old or over admitted to hospital as a result of a fall prescribed a Z-drug for more than one month
- Indicator 11 – FRAC01b Patients 65 years old or over admitted to hospital with a fracture (hip, colles or humerus) as a result of a fall prescribed a Z-drug for more than one month
- Indicator 12 – FRAC02a Patients 65 years old or over admitted to hospital as a result of a fall prescribed a benzodiazepine for more than one month
- Indicator 13 – FRAC02b Patients 65 years old or over admitted to hospital with a fracture (hip, colles or humerus) as a result of a fall prescribed a benzodiazepine for more than one month
- Indicator 14 – FRAC03a Patients 65 years old or over admitted to hospital as a result of a fall prescribed a benzodiazepine and a Z-drug (not concurrently) for more than one month
- Indicator 15 – FRAC03b Patients 65 years old or over admitted to hospital with a fracture (hip, colles or humerus) as a result of a fall prescribed a benzodiazepine or a Z-drug (not concurrently) for more than one month
- Indicator 16 – RESP01 Patients admitted to hospital as an emergency for an exacerbation of asthma prescribed an inhaled Long Acting Beta-agonist (LABA) without an inhaled corticosteroid (ICS)

PINCER

- The Pharmacist-led information technology intervention for reducing clinically important errors
- A robust, evidence-based National Institute of Clinical Excellence (NICE) approved intervention proven to have clinical impact
- Pharmacist-led review of prescribing and system issues, to significantly reduce rates of clinically important and commonly made prescribing errors in primary care
- Comparative data on numbers of at risk patients at a practice, CCG population and national level

PINCER

- Using software to search clinical systems to identify patients at risk of hazardous prescribing
- Conducting clinical reviews of patient notes and medication
- Carrying out root cause analysis and providing feedback to the GP practice
- Establishing action planning to improve systems and reduce risk

PINCER datasets

GI BLEED PRESCRIBING INDICATORS

- A2 Prescription of an oral NSAID, without co-prescription of an ulcer healing drug, to a patient aged ≥65 years
- B2 Prescription of an oral NSAID, without co-prescription of an ulcer healing drug, to a patient with a history of peptic ulceration
- B3 Prescription of an antiplatelet drug without co-prescription of an ulcer healing drug, to a patient with a history of peptic ulceration
- C2 Prescription of warfarin or DOAC in combination with an oral NSAID
- D2 Prescription of warfarin or DOAC and an antiplatelet drug in combination without co-prescription of an ulcer-healing drug
- E2 Prescription of aspirin in combination with another antiplatelet drug without co-prescription of an ulcer-healing drug

PINCER datasets

OTHER PRESCRIBING INDICATORS

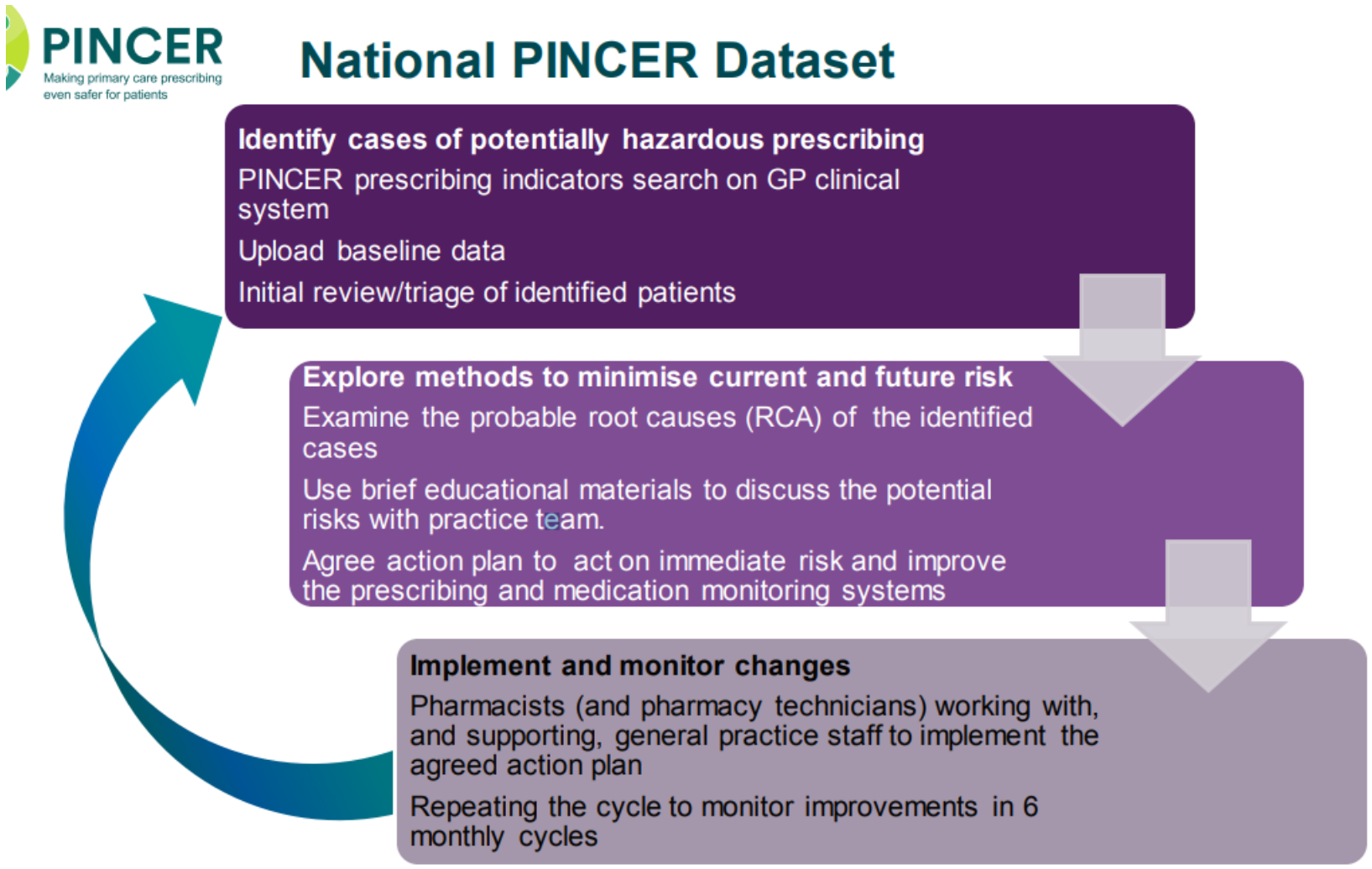
- F2 Prescription of an oral NSAID to a patient with heart failure
- G2 Prescription of an oral NSAID to a patient with eGFR

PINCER datasets

MONITORING INDICATORS

- I2 Patients aged 75 years and older who have been prescribed an angiotensin converting enzyme (ACE) inhibitor or a loop diuretic long term who have not had a computer-recorded check of their renal function and electrolytes in the previous 15 months
- J2 Patients receiving methotrexate for at least three months who have not had: a full blood count (FBC) in the previous three months J3 or liver function test (LFT) in the previous three months
- K2 Patients receiving lithium for at least three months who do not have a recorded check of their lithium concentrations in the previous three months
- L2 Patients receiving amiodarone for at least six months who have not had a thyroid function test (TFT) within the previous six months

PINCER Cycle



PINCER - the GP Contract

- https://www.england.nhs.uk/wp-content/uploads/2019/05/gms-contract-qof-guidance-april-2019.pdf

Prescribing safety

Indicator	Points	Achievement thresholds
QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.	27	NA
QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.	10	NA

PINCER - the GP Contract

- https://www.england.nhs.uk/publication/quality-improvement-reporting-template-safe-prescribing/

CAS alerts
Central Alerting System

- The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.
- Alerts available on the CAS website include NHS Improvement Patient Safety Alerts (PSA) and Estates Alerts, MHRA Dear Doctor letters, Medical Device Alerts (MDA) and Drug Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

CAS alerts

- *NHS England & NHS Improvement Regional teams - please cascade this alert to all GP Practices.***
- All GP practices in England are required to register to receive CAS alerts directly by 01 October 2019.
- Practices are asked to use the link below to register by no later than 13 September 2019.
- GP Practices are responsible for ensuring they receive all and act on, as appropriate, CAS alerts

CAS alerts

- In support of improving patient safety alerting system resilience for general practice, there are new contractual requirements for practices to:
- register a practice email address with the CAS and monitor the email account to act on CAS alerts where appropriate;
- notify the MHRA if the email address changes to ensure MHRA distribution list is updated;
- register a mobile phone number (or several numbers) with the MHRA CAS which will only be used as an emergency back up to email for text alerts when e-mail systems are down.
- Until 1 October, NHS England and NHS Improvement regional teams will continue to issue CAS alerts to general practice.

CAS alerts

- Registration link:
- https://www.cas.mhra.gov.uk/Register.aspx

NRLS

- The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Since the NRLS was set up in 2003, the culture of reporting incidents to improve safety in healthcare has developed substantially.
- All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

Why Report?

- Every day over a million NHS patients are cared for by dedicated teams of general practitioners and practice staff. The majority of patients are treated safely and effectively, but unfortunately sometimes things can and do go wrong, no matter how caring and competent staff are.

- Practice staff should use the GP e-form to report all patient safety incidents and near misses whether they result in harm or not. These reports are used by to spot any emerging patterns of similar incidents or anything of particular concern. This will help protect patients by raising awareness of the risks through shared learning with general practices and other health providers across the country.

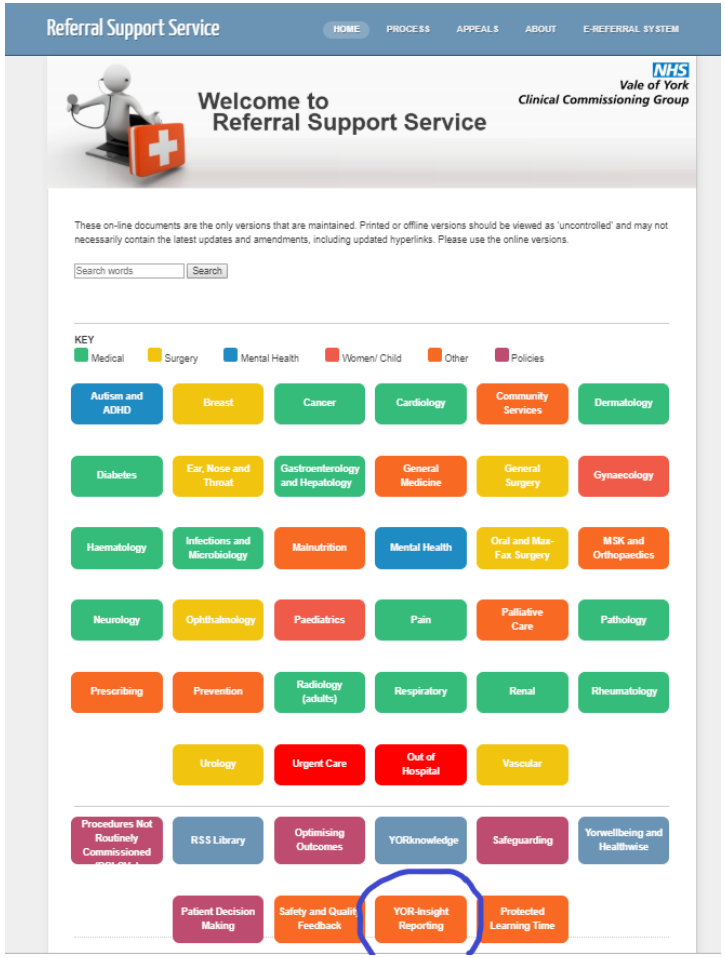
NRLS

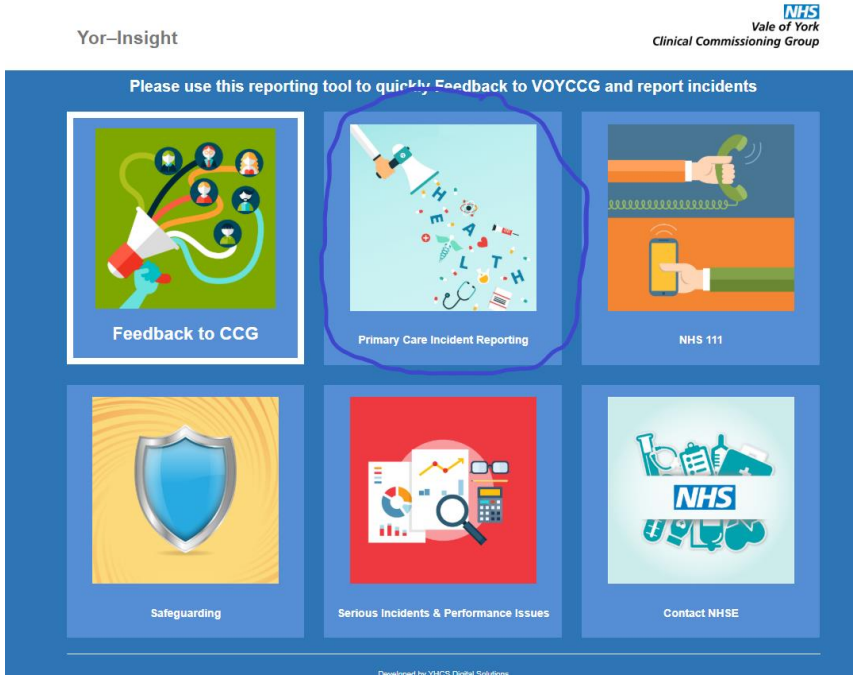
- Link on the NHS Vale of York CCG RSS
- https://www.valeofyorkccg.nhs.uk/rss/

Or

- https://yorinsight.valeofyorkccg.nhs.uk/

Where to find on RSS





Or direct link

- https://improvement.nhs.uk/resources/reporting-patient-safety-incidents-general-practice/

Serious Incidents

- Serious Incidents are where severe harm or death occurred (or could have), or there is severe interruption of service or breach of protocol. Where serious incidents meet the criteria defined within the Serious Incident Framework 2015 please inform the serious incident team by email on within 2 days of the incident being identified.
- Guidance is available - https://improvement.nhs.uk/resources/serious-incident-framework/
- Please use the form below (**F1**) to report Serious Incidents to nyyccgs.seriousincidents@nhs.net The form has some drop down boxes for ease of use.

When do the medicines optimisation team get involved?

- The CCG medicines optimisation team provide specialist advice and guidance, where appropriate, on individual patient safety incidents related to medication.
- The CCG medicines optimisation team seek to provide extra support and prompting to GP Practices regarding national patient safety alerts, as appropriate.

When do the medicines optimisation team get involved?

- The decision to provide extra support is considered by the York and Scarborough Medicines Commissioning Committee.
- An example would be MHRA Valproate Pregnancy Prevention Programme.
- GP Practices should still receive direct alerts from CAS and act of them but CCG Meds Opt team can provide further advice, as needed.

MHRA Valproate Pregnancy Prevention Programme

- Valproate medicines must not be used in women of childbearing potential unless the Pregnancy Prevention Programme is in place.

Actions for GPs

- identify and recall all women and girls on valproate who may be of childbearing potential
- provide the Patient Guide to the patient (or her parents or responsible person as necessary)
- check they have been reviewed by a specialist in the last year (i.e. they have an in-date Risk Acknowledgement Form) and are on highly effective contraception

MHRA Valproate Pregnancy Prevention Programme

- An updated Annual Risk Acknowledgement Form is available to support the Valproate Pregnancy Prevention Programme (version dated March 2019).
- Review needs to be completed annually.
- Some GP Practices started in July 2018 so will be due again soon.

Thank you