

## **Executive Summary**

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### **Key Recommendations**

- The NHS needs to develop a strategy specifically aimed at reducing levels of avoidable harm due to medicines
- The plan should involve significant service redesign and focus its efforts on:
  - Adherence
  - Health literacy
  - High risk settings
  - High risk medicines
  - Transfer between care settings
  - Collaboration and communication
- Patients need to be at the centre of any changes
- Pharmacists, are the experts in medicines and need to be:
  - An integral part of all medicines management in the future
  - The educator of other health professionals on the safe and effective use of medicines
  - Given sufficient time to spend with patients in order to help them understand their medicines
- All healthcare professionals should be better supported to deliver evidence based practice
- Patients in all settings should have access to the support and advice of a pharmacist

### **Background and Context**

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- Medicines are a crucial part of modern health care but they have great potential to cause harm.
- Each day around 2.5 million prescriptions are issued in the NHS and around 60,000 medication safety incidents are reported to the National Patient Safety Agency each year.
- There are three areas where harm can occur; non adherence by patients, molecular issues/drug issues, and human error.
- Errors are the result of the systems that produce them. The complexity and fragmentation of the medicines process across the NHS contributes to patient safety incidents and harm.
- Patient safety incidents can occur as a result of the information and work overload experienced by the health professionals involved in the medicines process.
- Many medication incidents are avoidable if better systems were in place across the NHS.
- It is estimated that around £750 million year could be saved in the NHS if better safeguards were put in place to reduce drug-related patient safety incidents.

### **Medicines Safety Symposium**

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- Set against this background a medicines safety symposium was organised by the Royal Pharmaceutical Society in association with 1000 Lives Plus and Public Health Wales.
- The event focused on the role pharmacists are able to play in improving patient safety, provided examples of innovative practice where pharmacists are positively influencing patient safety, and explored areas where improvements are needed and where barriers need to be overcome.

- Key speakers included Professor Sir Mansel Aylward (Chair, Public Health Wales), Dr Alan Willson, (Director, 1000 Lives Plus) Andrew Cottom (CEO Powys Health Board), Jonathan Simms (Clinical Director of Pharmacy, Aneurin Bevan Health Board) plus leading pharmacists with a specific interest in medicines safety.

### **Issues raised at the Symposium**

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- Change is urgently needed in NHS systems to reduce unacceptable levels of harm caused by medicines.
- There is too much congestion in the NHS causing significant risks for patients. Processes need to be improved to ensure we get more things right the first time around.
- Pharmacists have a key role to play in creating the right environment for safe practice, working closely with medical colleagues and others who can influence the patient safety agenda. Integration is the key.
- The skills of pharmacists should be harnessed across the NHS in professional decisions throughout the medicines process including prescribing, preparation, dispensing and administration.
- Patients need to be supported to understand more about their medicines and formal arrangements should be introduced to allow pharmacists to play an increasing role in this.
- Poor adherence is a key contributor to harm
- Pharmacists need protected learning time and access to the latest evidence based resources
- Sharing patient information effectively between health professionals, using new technologies, and ensuring pharmacists are more closely involved in prescribing processes and medicines management is needed to improve patient safety.
- There is a growing need in Wales to align the objectives of the different service frameworks, allowing for the integration of annual medicines reviews and MURs
- GPs and community pharmacists with a passion for working together should act as champions for collaborative arrangements to help improve medicines safety.
- E-Discharge arrangements are needed to help target high risk patients and provide information to primary care. A secure way of transmitting this information is essential.
- Mechanisms are needed to identify patients on high risk medications and to ensure MURs are undertaken by community pharmacists at an early stage.
- A focus on pharmaceutical care is critical when patients are transferred between care settings.
- Communication between health professionals is very important and needs improving and pharmacists need to be closely involved in these processes to help improve patient safety.

### **Conclusions**

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Patients are being harmed by medicines because systems within the NHS are fragmented and not designed to stop harm from happening. The patient is not at the centre of this process and isn't supported to understand their conditions and medicines. A fundamental look at medicines management is needed to address this.

Improving medicines safety should not solely focus on prescribing and dispensing errors, as it tends to now, but take a broader approach. Helping patients to understand more about their health and the medicines they have been prescribed should be a much more important part of the process than currently. Additionally, there should be a focus on reducing harm due to the use of high risk drugs, and care in high risk settings.

There needs to be improvement in communication between different care settings and better collaboration between healthcare professionals.

As the experts in medicines pharmacists should be a much more integral part of a clearly defined process of prescribing, dispensing and supporting medicines taking, to ensure that the risks of avoidable harm to patients from medicines are reduced.

## Next Steps

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The Royal Pharmaceutical society will address the key issues and challenges highlighted during the symposium and on behalf of the pharmacy profession will undertake to:

- Promote the recommendations of the medicines safety symposium to policy makers, NHS Boards and executive teams, politicians and other key stakeholders
- Work in partnership with the Welsh Assembly Government, 1000 Lives Plus, Health Boards and other appropriate bodies to advise on medicines safety and to push forward the recommendations made in this report
- Contribute to discussions and decisions made by the NHS Wales transformational programme on medicines management
- Facilitate arrangements to ensure the pharmacy profession is engaged in local and national work to develop models for improvement in medicines management across Wales
- Take this work forward on a GB basis.