1. Please rank these 6 headline issues according to your view of the urgency and importance with which they should be tackled, in relation to medicines safety (1 being the highest priority and 6 being the lowest priority).

- **Anticoagulants - 6**
- **Care Homes - 4**
- **Drug Administration - 5**
- **Frail Elderly People - 3**
- **Shared Decision Making - 1**
- **Transitions of Care – 2**

Reasons:

SDM and personalised care are a key priority in the NHS and this is the basis for delivering good medicines optimisation including reducing over prescribing and improving medicines safety. This will underpin all of the other priorities and as such should perhaps not be an issue in itself.

Transitions of care is a significant problem in terms of medicines. Studies have shown that medicines are unintentionally altered when people move between care settings. Information about medicines and changes to medicines need to be communicated.

Frail, elderly people are often the ones with multiple LTCs and are being prescribed a number of medicines. They need to be reviewed and assessed in terms of the appropriateness of their medicines. In a way this covers care homes as most of the residents in care homes are frail elderly people.

Care Homes. Much of the involvement of pharmacists in care homes is work that has been started and will be ongoing in terms of pharmacist led medication reviews.

Drug administration: this is quite often an area of risk and a number of the patient safety alerts are around this. This is a significant pharmacy issue in secondary care where pharmacists lead on drug administration advice, particularly IV drugs, at both individual patient level and they are often responsible for development of trust protocols, guidelines and policy on administration of medicines.

Anticoagulants: Pharmacists are already involved in the use of anticoagulants, including early detection of AF, so there is a need to continue to build and spread this work. This is a definite group to consider under transitions of care as anticoagulation is a high risk when patients move between care settings. This is an area where better integration of pharmacists and improved two way communication systems across sectors will have an impact on medicines safety.

Obviously all of these priority areas and the actions underneath them are important and would eventually need to be actioned to ensure a safe environment for all patients. Pharmacists, as experts in medicines and their use, need to be included, and indeed lead, many of these initiatives.

2. If you have any other headline issues, which have not been identified above, please provide details

In terms of clinical areas other priorities could include Palliative care, CNS medicines, the prevention, detection and management of diabetes, systemic corticosteroids, opiods (pain highlighted as a specific issue in the NHS Long Term Plan), antibiotics in relation to AMS (highlighted on the national

risk register), learning disabilities and insulin (particularly in secondary care settings where type 1 diabetics have a 50% chance of a medication error).

In terms of process areas other priorities could include polypharmacy (overprescribing), high risk medicines, dispensing, general monitoring of medicines, repeat prescribing process.

3. The previous workshop came up with the following suggestions relating to anticoagulants. Please prioritise the top 3 suggestions that you would like to see taken forward for more consideration by the programme.

- Enable and equip patients to be their own safety advocate in their care
- Better processes in the patient pathway to ensure that patients taking anticoagulants are always identified
- Have a unified approach to the safe monitoring of anticoagulants across all health settings and in patient's homes
- Ensure patients are counselled appropriately to provide an understanding of the risks and benefits
- Upskill all staff with a role in caring for patients on anticoagulants

For each of the top 3 suggestions you have chosen, please briefly describe the key problem, and/or any other suggestions which have not been identified above.

Empowering and 'activating' patients to better self-care will support all of the other suggestions. This could be undertaken using the Patient Activation Measure (PAM). The conversations with patients need to be carried out in a way where shared decision making really happens and with an understanding of health literacy.

4. The previous workshop came up with the following suggestions relating to medicines safety in care homes. Please prioritise the top 3 suggestions that you would like to see taken forward for more consideration by the programme.

- Undertake regular medicine reviews to address problematic polypharmacy and optimise medicines use
- Encourage better use of technology in care homes
- Better emphasis on end of life pathways to improve safety of palliative medication
- Upskill care home staff in medicines safety
- Designate qualified nurse(s) whose only role is drug administration
- Better involvement of patients/ family member(s)/ carers in decision making
- Align policy drivers with those of the NHS (e.g. integrate workforce across sectors)
- Improve relationships between care homes, GP's and the whole health economy

For each of the top 3 suggestions you have chosen, please briefly describe the key problem, and/or any other suggestions which have not been identified above.

Regular medicines reviews will support the optimal use of medicines and reduce overprescribing for patients in care homes. However, for this to be successful it has to be undertaken with the patient / family member / carer fully involved in the decisions that are made.

If care home staff are more aware of the medicines and their use they will be better able to carry out their role. For example, not waking a patient up to give them their sleeping tablet.

The last two bullet points are already happening and embedded in NHS policy but we understand that getting engagement is absolutely key as otherwise nothing will happen or change with residents or carers. There needs to be a continued awareness that care homes are actually "people's homes" and not the NHS.

5. The previous workshop came up with the following suggestions relating to drug administration (all routes). Please prioritise the top 3 suggestions that you would like to see taken forward for more consideration by the programme.

- Empower patients to challenge during the drug administration process (e.g. "know, check, ask")
- Encourage better use of technology for safer drug administration
- Encourage ready to use injectables where appropriate
- Adopt recognised quality improvement approaches to improve the drug administration process
- Ensure better training and education for nurses in all aspects of the drug administration process
- Train non-nurse healthcare professionals to assist in the drug administration process (e.g. pharmacy technicians)
- Ensure adoption of national guidance relating to drug administration in all settings (e.g. workload and safe staffing)

For each of the top 3 suggestions you have chosen, please briefly describe the key problem, and/or any other suggestions which have not been identified above.

Technology is improving all the time and the better use of this could improve patient safety in terms of drug administration. Where there are approaches in place that improve quality then these should be spread and adopted.

An issue around drug administration is having the skills and knowledge to undertake it – having additional staff trained to an appropriate level will support this priority. Patients and their carers should also be taught how to administer their medicines.

6. The previous workshop came up with the following suggestions relating to frail older people. Please prioritise the top 3 suggestions that you would like to see taken forward for more consideration by the programme.

- Better involvement and empowerment of patients/ family member(s)/ carers in decision making
- More user-friendly products and processes (e.g. sensory, communication, technology) to reduce risk of error and increase patient knowledge
- Pro-active medicine reviews across all settings to optimise medicines use in this population (e.g. managing polypharmacy, promoting a culture of safe deprescribing)
- Upskill all staff/carers with a role in caring for frail older people, including in their own homes
- Tackle risk of falls relating to anticholinergic burden in frail older people
- Encourage personalised prescribing to prioritise quality of life

For each of the top 3 suggestions you have chosen, please briefly describe the key problem, and/or any other suggestions which have not been identified above.

Again, involvement of the patient / family member / carer in decision making around any treatments (medicines or other) is essential. Having a pro-active medicines review on a regular basis will ensure that these frail, elderly patient, whose conditions are of then changing, will have their medicines optimised for them. Where possible, prescribing should be personalised for the individual. So even if NICE guidance recommends a particular medicine for a particular condition, if that is not suitable for the patient then this needs to be taken into account.

7. The previous workshop came up with the following suggestions relating to improving shared decision making. Please prioritise the top 3 suggestions that you would like to see taken forward for more consideration by the programme.

- Empower patients/ family to lead in decision making relating to their medicines
- Better understanding of shared decision making amongst healthcare professionals/ patients/ family
- Better provision of patient information and training
- Develop measures to demonstrate whether shared decision making is in place
- Training and education in shared decision making for health care professionals

For each of the top 3 suggestions you have chosen, please briefly describe the key problem, and/or any other suggestions which have not been identified above.

Patients and their families need to be empowered and recognise that they can challenge what they are told by healthcare professionals, and also feel that they can ask questions about their treatments and conditions. Training and education for professionals is critical and this has to include health literacy. The information patient's receive needs to be in a format that they understand and this will be different for each patient. The system needs to e able to deal with this.

Bullet point 2 is covered by bullet point 1 and 5

8. The previous workshop came up with the following suggestions relating to transitions of care. Please prioritise the top 3 suggestions that you would like to see taken forward for more consideration by the programme.

- Enable patients to hold their own medication records
- Designate a nominated pharmacist to manage medicines during transitions between all settings
- Improve the safety of medicines management on admission to hospital
- Improve the safety of medicines management on discharge from hospital
- Improve the safety of medicines management during internal transitions (e.g. between and within hospital(s))
- Improve communication between health and care settings (e.g. quality of information, timely information)
- Improve the safety of medicines management during transitions between other settings (e.g. CAMHS, offenders, changes in intensity of packages of care)
- Create a single universal system of medication records which can be updated and read across all settings

For each of the top 3 suggestions you have chosen, please briefly describe the key problem, and/or any other suggestions which have not been identified above.

Improving the safety of medicines management during transitions must include bullet point 3 which is around improving the safety of medicines management on discharge from hospital. Only 1 in 10 older people discharged from hospital remain on the same medicines they were taking when admitted to hospital. One study estimated that risk of an adverse drug event post-discharge increased by 4.4% for every drug alteration or change. Therefore we need to improve medicines safety at discharge. However, this should be improved on discharge from all care settings, and not just hospitals.

The communication, particularly around changes to medicines, is critical to support ongoing care and this can be supported by clinical handover between hospital and community pharmacists, alongside the traditional handover between hospital and GP practice. If all healthcare professionals, and patients themselves, could have access to the same system of medication records, this would ensure that everyone knew the current state of play in terms of ongoing care and treatments – and also that they could add any relevant interventions that they make.