

Medicines Safety Improvement Programme (MedSIP)

Reduce severe avoidable medication related harm by 50% by 2024

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Delivered by:

*The***AHSN***Network*

**North East and North
Cumbria Patient Safety
Collaborative**

Led by:

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Medicines Safety Improvement Programme (MedSIP)

**Aim: Reduce severe avoidable medication related harm
by 50% by 2024**

This Safety Improvement Programme (SIP) has two main drivers:

- **Opioid Primary Driver** – Reduce inappropriate high dose opioid prescriptions for non-cancer pain
 - Opioids are very good analgesics for acute pain and pain at the end of life. There is no evidence that high dose opioids (>120mg/day morphine equivalent) are effective in long term pain. Increasing opioid dose above this is unlikely to improve pain control and exposes patients to increased harm.

- **Care Home Primary Driver** – Safer administration of medicines in care homes
 - Safety Huddles
 - Learning from errors
 - 3-way communication
 - Managing interruptions

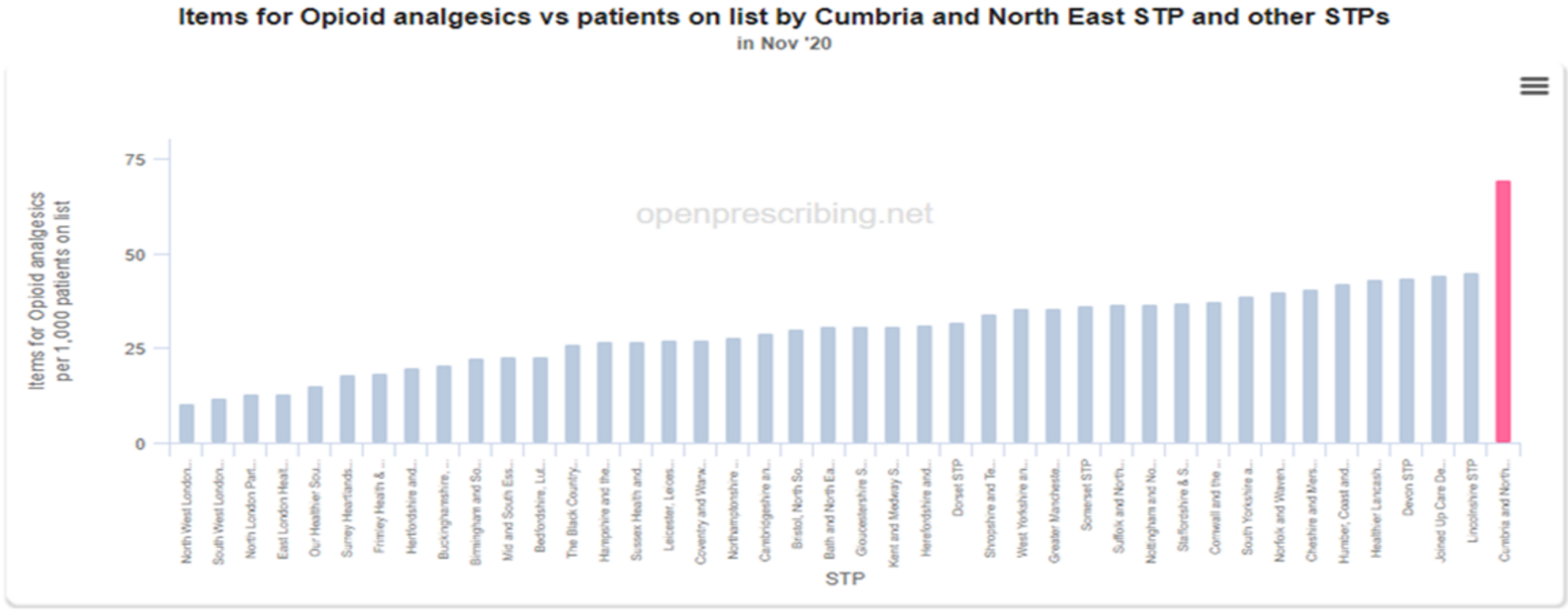
The concept of Safety Champions in care homes is also being explored and will be tested in partnership with these four interventions.

What are opioids and why are we trying to reduce prescribing?

- Opioids are very good analgesics for acute pain and pain at the end of life. There is no evidence that high dose opioids (>120mg/day morphine equivalent) are effective in long term pain. Increasing opioid dose above this is unlikely to improve pain control and exposes patients to increased harm.
- While the Commission on Human Medicines (CHM) continues to consider opioids as important and effective medicines in the treatment of short-term pain relief, they have advised against their long-term use in the treatment of non-cancer pain, due to the risk of dependence and addiction.
- Despite this, Public Health England's review (2019) shows that from 2017 to 2018, 5.6 million adults in England received opioid pain medicines (13% of the adult population).

Opioids

Items for opioid analgesics per 1,000 patients on list



Harm from drug misuse

Age-standardised mortality rate for deaths related to drug misuse, by sex, for countries and regions of England and Wales, registered between 1993 and 2019



Source: Office for National Statistics - Deaths related to drug poisoning in England and Wales

NHS actions taken so far:

- Communications campaigns, including www.painkillersdontexist.com, www.livewellwithpain.co.uk and www.flippinpain.co.uk
- Provision of prescribing data to prescribers in multiple formats including <https://www.westyorksrd.nhs.uk/crop>
- Incentive schemes for general practice to reduce opioid prescribing rates
- Collaborative work across different healthcare organisations
- Pain clinic service reviews and transformation
- Increased access to non-pharmacological interventions including:
 - Helplines and telephone support
 - Counselling and support groups

What AHSN has done so far on the MedSIP project

The AHSN have undertaken 9 structured interviews with colleagues in North East and North Cumbria to scope opioid reduction pathways currently being undertaken in our area. This information has been fed back to the national NHS team who will collate information from our AHSN along with the other 14 AHSNs in the country to develop strategies to be tried in localities.

- A report¹ in 2018 showed that of the estimated **237 million** medication errors per year in England, **92 million** occurred in care homes.
- Residents of care homes often have complex needs, which in turn means many residents are prescribed multiple medications and rely heavily on their carers to access the medicines they need.
- While no single intervention has been identified as having a direct impact on the safer administration of medicines in care homes, one of the outputs of a diagnostic phase of work² suggested **four** interventions that require further testing to establish if they can make a difference

Interventions to test:

- Safety Huddles – regular safety meetings
- Learning from errors – reporting, review and learning from errors
- 3-way communication – between prescriber, dispensing pharmacy and care home
- Managing interruptions – during medication administration rounds in care homes

In addition:

- Safety Champions

In Care Homes, Patient Safety Collaboratives (PSCs) are asked to work collectively to ensure sufficient learning is generated to test enough interventions across the four themes, and the concept of safety champions, to identify interventions that can be considered for roll out.

- 1 (by Elliot RAA, Camacho E, Campbell F et al.)
- 2 (by Patient Safety Collaboratives (PSCs)- 11/2019-01/2020),

Actions taken so far:

- Engagement meeting held on 22nd March 2021 with care home managers and regional stakeholders.
- Six care homes onboard in cohort one to test a chosen intervention.
- Focus groups planned to continually improve interventions, share learning and improve practice.
- Safety Attitude Questionnaires (SAQs) distributed to the first phase of care homes to determine the working culture.

Please share your experiences and thoughts

Opioids

Care Homes

- How do you feel we can engage the wider public in our work?
- Do you have any experience that you'd like to share where you would have liked some further support?
- In future would you be interested in joining focus groups to help to shape interventions?
- How can we involve the patient/resident better in our work as part of our projects?