Consultation Response

National Medicines Safety Programme Priority Setting
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For enquiries regarding this response, please contact:

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About Community Pharmacy Surrey & Sussex

Community Pharmacy Surrey & Sussex is the local voice for all community pharmacies on behalf of East Sussex, West Sussex and Surrey Local Pharmaceutical Committees (LPCs).

We represent over 560 pharmacies, on all matters relating to the NHS and public health work undertaken by community pharmacy. This includes single handed independent pharmacies through to medium and large pharmacy businesses. Pharmacies in our area, between them, employ thousands of local people and are at the heart of communities.

Community Pharmacy Surrey and Sussex negotiates and discusses local pharmacy services with commissioners and is available to give advice to community pharmacy contractors and others wanting to know more about local pharmacy. We are committed to helping to develop and support community pharmacy teams, to deliver high quality health services.

Working closely with the local NHS, including NHS England Area Teams, CCGs and local government, we are responsible for advancing the enhanced role of community pharmacy to ensure it plays an active part in promoting health and wellbeing across Surrey and Sussex.

Further information is available on our website at http://communitypharmacyss.co.uk/
Consultation Response

We welcome the opportunity to be able to provide our response to the consultation of priory setting for the National Medicines Safety Programme, on behalf of Community Pharmacies in Surrey & Sussex. Together they dispense millions of items each year and deliver over a hundred thousand Medicines Use Reviews.

Headline Response

Ranking priorities 5 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).

Headline issue ranking - Anticoagulants: 2 Headline issue ranking - Care Homes: 4 Headline issue ranking - Drug Administration: 5 Headline issue ranking - Frail Elderly People: 3 Headline issue ranking - Shared Decision Making: 6 Headline issue ranking - Transitions of Care: 1 6

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

Other headline issue(s):

Branded Generic Prescribing Policies

We remain deeply concerned about the practice of some CCGs locally seeking to increase the prescribing of ‘branded generics’. For clarity, a ‘branded generic’ (BG) is a drug which is available as a generic but that a manufacturer has marketed so that prescribers associate it with a particular brand name.

Potential patient safety issues

- Patients (and some prescribers) do not always associate the brand name with the actual molecule involved.
- Constant changing of patients’ medicines can have a negative impact on patient understanding and compliance.
- Many branded generic medicines are not listed by brand name in key resources e.g. BNF, which could potentially lead to confusion on admission to hospital.
- Branded generics add to the plethora of drug names that can look and/or sound alike. Some are dangerously close and many have similar packaging, which given the choice, community pharmacies may choose not to stock. An example is available below:
Delays in receiving medicines

- Where branded generics have been prescribed, patients must receive that specific product.
- Some branded generic products may not be available from all mainline wholesalers so have to be sourced from an alternative supplier, which can lead to delays.
- Patients may also face problems if they go to a pharmacy outside of the local area where pharmacies are unlikely to stock the product as standard.
- If the particular branded product listed on a prescription is unavailable, the prescriber will need to issue a new prescription as the pharmacist cannot dispense an alternative, delaying access to medicines.

Anticoagulants

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.

Anticoagulant ranking

- Enable and equip patients to be their own safety advocate in their care: 3
- Ensure patients are counselled appropriately to provide an understanding of the risks and benefits: 2
- Anticoagulant ranking - Better processes in the patient pathway to ensure that patients taking anticoagulants are always identified: 1

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. Maximum 100 words:

Community Pharmacy Access to a local Electronic Health Care Record providing access to:

- Diagnoses
- Medical history
- Allergies & adverse drug reactions (ADR)
- Routine monitoring
- Results of pathology and other tests
- Prescribing history

would allow more comprehensive monitoring as part of the dispensing process of anticoagulants. We call upon NHSE/NHSI to facilitate this to improve the safety of the pathway by facilitating local access and have clear requirements for commissioners and health economies to integrate community pharmacies locally.
Care Homes

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.

Care homes ranking

Care homes ranking - Upskill care home staff in medicines safety: 3

Improve relationships between care homes, GP’s and the whole health economy: 2

Undertake regular medicine reviews to address problematic polypharmacy and optimise medicines use: 1

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. Maximum 100 words:

We feel very strongly that relationships between care providers and care homes need to be strengthened, to ensure clarity of processes, communication and agree medicines optimisation pathways.

Due to the remote nature and lack of patient involvement, medicines in care homes are often dealt with silos. We have seen benefits to patient safety and better medicines use when a nominated GP/GP surgery is assigned to a home and works closely with the supplying community pharmacy, either F2F or digitally to optimise medicines use, ensure repeat prescription management is optimised and medicines reconciliation takes place.

The community pharmacy contractual framework should be developed to ensure care homes services are more in-scope or incentive local commissioners to formalise arrangements with community pharmacies

Drug Administration

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.

Drug Administration rankings

- Ensure better training and education for nurses in all aspects of the drug administration process: 3

- Drug Administration rankings - Encourage better use of technology for safer drug administration: 2

- Empower patients to challenge during the drug administration process (e.g. “know, check, ask”): 1
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. Maximum 100 words:

No further comments.

Frail Older People

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.

Key problems frail older people –

Pro-active medicine reviews across all settings to optimise medicines use in this population (e.g. managing polypharmacy, promoting a culture of safe deprescribing): 1

Upskill all staff/carers with a role in caring for frail older people, including in their own homes: 2

Key problems frail older people - Tackle risk of falls relating to anticholinergic burden in frail older people: 3

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. Maximum 100 words:

A limitation for community pharmacies to provide care in this area continues to be that Medicines Use Reviews, which have the real potential to deliver benefits for the frail elderly can rarely be delivered because there is no commissioning of the service for off-site, or via remote means such as telephone or using digital methods. We encourage NHS England to enable this provision.

More widely we encourage the programme to consider full implementation of the ‘Murray Review’ recommendations around Medicines Use Reviews, to improve patient safety, specifically redesigned to include on-going monitoring and regular follow-up with patients as an element of care pathways.

Shared Decision Making

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.

- Training and education in shared decision making for health care professionals: 3
- Better understanding of shared decision making amongst healthcare professionals/patients/family: 2
- Empower patients/family to lead in decision making relating to their medicines: 1

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. Maximum 100 words:

No further comments.
**Transitions of Care**

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.

**Transitions of care ranking**

- Create a single universal system of medication records which can be updated and read across all settings: 3
- Improve the safety of medicines management during internal transitions (e.g. between and within hospital(s)): 2
- Improve the safety of medicines management on discharge from hospital: 1

**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. Maximum 100 words:**

We strongly support much more robust arrangements around the transfer of care. Community pharmacies must be intimately involved in the process. Currently community pharmacies are not routinely informed that patients are admitted or discharged from hospital. Current sophisticated medicines optimisation processes taking place in secondary care could be taking place, but ultimately fail if the medicines waiting to be collected at the pharmacy are handed out or delivered, in good faith, without knowing there have been changes to medication.

We are working with the local AHSN and PharmOuctomes to roll out a pathway to improve the transfer of information on discharge -- this should be supported centrally by NHS England and reflected in the Community Pharmacy Contractual Framework, this work is well supporting be evidence driving the need for change:

- For every medicines reconciliation completed by a non-pharmacy member of staff, there are 1.3 unintended discrepancies 30-70 per cent of patients have either an error or unintentional change to their medicines when their care is transferred
- Up to 87 per cent of patients are affected by unintended discrepancies in their medicines after discharge from hospital
- Two-thirds of discharge summary letters are inaccurate or incomplete prior to pharmacy screening
- Around half of the £300m of medicines wasted each year is avoidable Every £1 spent on post-discharge MURs avoids £3 of NHS resources going on A&E attendances, hospital admissions and drug wastage

(All figures are from ‘Hospital referral to community pharmacy: an innovators’ toolkit to support the NHS in England’, published by the Royal Pharmaceutical Society)