SPSP Medicines Stakeholder Exchange Outcome Report

May 2018

Stakeholder Engagement Outcomes Report:

1. Purpose of this report:

This report describes the outcomes of the Scottish Patient Safety Programme (SPSP) Medicines Stakeholder Exchange held in February 2018 at COSLA Conference Centre, Edinburgh. This paper also describes the approaches taken to the interactive morning and afternoon sessions at the Exchange and methods used to analysis feedback received on the day.

The stakeholder exchange brought together approximately 80 delegates from NHS boards; Health and Social Care Partnerships; Digital Health in Scottish Government; Healthcare Improvement Scotland and patient representatives for the purpose of informing the future direction of the SPSP Medicines programme. The delegate agenda is provided as Appendix 1.

2. Aims of the Event:

The aims of the stakeholder exchange were to:

- share the achievements of the first 2 years of SPSP Medicines,
- discuss national and international strategies for achieving medicines safety, and
- inform future priorities.

3. Methods:

Morning Session – Medicines Safety: What matters to us?

Seating at tables of 8, delegates were asked a series of questions to facilitate the exploration of what matters in the context of medicines safety, starting from a personal perspective and then a professional perspective.

Question:

What factors supported you or your family members to use medicines both confidently and safely?

Question:

In your day to day professional role how do you contribute to others being able to use medicines both confidently and safely?

Using a semi-structured approach, delegates were then asked to consider what changes they would see at work if there was a dramatic improvement in medicines safety.

Question:

If things improved dramatically in the context of medicines safety, what are the biggest differences you would see at your workplace?

Delegates firstly considered the above question as a silent, self-reflective activity and were also asked write down what needed to be done and who needed to act to make these change possible. Delegates were given the opportunity to identify two differences through the self-reflection exercise.

Working in pairs, delegates then shared their responses and considered the feasibility and impact of the ideas generated, in order to share with the wider table the one difference that mattered to both of the delegates.

At their tables delegates shared the difference identified within their pairs and were asked to write down the two differences that mattered most to the table overall (What matters to us? A3 worksheet).

Responses were summarised and fed back to the room in the afternoon. The A3 worksheets, 1 per table, were collected for more detailed (qualitative) analysis after the event.

Afternoon Session – Levers: change ideas/improvement activities

Delegates were asked to respond to the following question as individuals, and to write as many separate change ideas on separate post-it notes.

Question:

What changes can you make in the next one to four weeks to bring about improvement in medicines safety?

At their tables delegates then grouped/themed the change ideas, based on consensus by the group, with each theme noted on a separate post-it.

Delegates were then presented with 6 key themes that were identified by the SPSP Medicines clinical advisory group as levers for change (see table below). Delegates were tasked with arranging the individual change ideas under the 6 levers for change (A3 worksheet).

Table: Levers for Change, identified by MCAG

Patient knowledge, participation and co-design
Clear staff roles and responsibilities
Attractiveness for staff of medicines safety work
Quality improvement support
IT systems
Effective medicines safety governance structures, locally and nationally

As part of this exercise delegates were also asked to indicate:

- any changes required to the levers and if any additional levers were required, and

- if any change ideas did not fit within the 6 levers for change.

The A3 worksheets, 1 per table, were collected at the end of the session for more detailed (qualitative) analysis after the event.

4. Qualitative analysis:

Hand written feedback received on the day from the morning and afternoon sessions (WMTU and Levers) were typed up by the central team. Where possible individuals were contacted to clarify and words that were not clear.

In order to enhance readability and to identify practical steps that can be taken across the whole system for medicines safety, responses were sub-themed into 'drivers' by two independent reviewers (Aravindan Veiraiah [AV] and David Maxwell [DM]).

For example:

Change ideas / improvement activity	Driver
Share challenges with other "interested" parties. ?Collaborative	Involve staff across the system
Ask the staff in NHS Lanarkshire 'what matters to me' re meds safety	
Engage stakeholders	
What single change can you bring about to improve medicine safety? Ask this question during each professional interaction	

An effort was also made to interpret as many 'meanings' from the feedback provided during the process of analysis rather than a single 'meaning', resulting in some change ideas/ improvement activities having links to multiple drivers.

For example:

Change ideas / improvement activities	Driver
Consider compelling campaign. E.g. #C2C – chance to check.	Promote positive language and focus
	Plan and participate in QI projects
	Enhance & use QI support networks

The draft levers presented on the afternoon session were revised based on feedback from delegates and the types of change ideas /improvement activities identified by delegates.

5. Outcomes:

4.1 Morning Session – What matters to us?

The table below summarises the responses to the question of 'What matters to us?', with each table providing two separate responses.

If things improved dramatically in the context of medicines safety, what are the biggest differences you would see?	
1	Patients own their own medical record with the ability to view and give consent to others easily to access this: their record is singular & is viewed/ amended by necessary professionals.
2	Culture of medicines safety - recognition of risk, harm and improvement to ownership. Better understanding.
3	Medication safety being accepted and acknowledged as everybody's business – not only pharmacy.
4	Development of nationally agreed standards for medicines safety: Prescribing and Administration. "How do you know if you are good?"
5	Medications are regularly rationalised (including over the counter medicines).
6	Everyone makes decisions about medicines based on up to date, complete and understandable information.
7	Ensuring all professionals within the team understand the impact of 'unsafe practice' on the patient. Encouraging colleagues to identify and support areas for improvement across the whole system.
8	Improving IT infrastructure – patient held records.
9	Reliable whole system medicines reconciliation (Primary, Secondary, Pharmacy), with robust data collection processes.
10	Discharge planning improvements: - Time of discharge - Patient's new/changed medicines - Pharmacy processes - Documentation - Onward communication - Information to patients on discharge
11	Patient empowerment
12	Improved medicines safety culture
13	Linking of IT systems for patients and practitioners – will give increased time – stop duplication – allow patients to be educated on medicines.
14	Shared decision making between professional and patients. (Change culture – patients need to take more responsibility).
15	Medicines reconciliation at various interfaces (e.g. Care homes/DCH/Unscheduled care/Primary care/Community pharmacy)
16	Improved discharge (DCH) process
17	Consistent, pro-active medicines support for patients & carers meeting their needs for information in a way they understand so that they have confidence in using medicines appropriately.
18	Polypharmacy review to make things simpler for patients, reduce number of medicines, improve cost effectiveness & safety.
19	Increased access to patients' medicine information to wider professionals group, leading to accurate, timely medicines administration.
20	Access to emergency medications to improve pre-hospital care and/or reduce hospital admissions: - Overdose - Sepsis - Obstetrics - COPD

An initial high level thematic review of the responses to 'What matters to us?' was shared with delegates on the day:

What matters	Differences that will be seen
Patient	• Ownership of data/information. • Shared decision making between professionals and patients. • Accessible information, time to absorb, confidence in using medicines safely
Systems and culture	• Better systems and culture for learning from errors/harm. • Recognition and understanding of harm and effective harm reduction techniques. • Professionals are aware of the impact of unsafe practice on the patient – all contribute to improvement. • Ownership by all, not just pharmacists.
Information and communication	• Everyone makes decisions about medicines based on current, complete and understandable information. • Improve IT infrastructure (better sharing of electronic information).
Reliable actions	• Whole system process for medicines reconciliation (activity). • Structured discharge planning to enhance medicines reconciliation. • Access to support use of emergency medicines in the pre-hospital setting to improve patient care. • Regular rationalisation of medicines, including over the counter medicines.

4.2 Afternoon Session – Levers and change ideas

Delegates identified a combined total of more than 130 change ideas that they could test in the next one to four weeks to bring about improvement in medicines safety, all of which were successfully grouped under the 6 levers for change.

The levers were accepted by the majority of delegates, with following changes suggested:

Levers (MCAG)	Feedback from delegates
Patient knowledge, participation and co-design	*Nil change*
Clear staff roles and responsibilities	Clear staff roles, responsibilities and competencies
Attractiveness for staff of medicines safety work	*Nil change*
Quality improvement (QI) support	*Nil change*
Information Technology (IT) systems	Digital [IT] systems
Effective medicines safety governance structures, locally and nationally	*Nil change*

4.3 Collating the morning and afternoon sessions

Based on the differences identified in the morning session (What matters to us?) and the change ideas identified in the afternoon session, the levers were further revised to the following:

Patient empowerment	**Work processes**
Education	**Recognition for excellence**
QI support	**Digital [IT] systems**

The following drivers linked to the revised levers were identified by the reviewers:

Lever	Drivers	
Patient empowerment	Support shared decision making	Improve patient information
	Ask for patient feedback	Ensure timely access to medicines
	Help patients access & own their data	Co-design with patients
	Improve safety culture for patients	Enhance medication self-use in hospital
Work processes	Improve safety culture for staff	Improve information available to staff
	Clarify roles and responsibilities	Strengthen policies & guidance
	Ensure appropriate staff allocation	Use data to drive improvement
	Ensure regular review of medicines	Promote team problem-solving
	Ensure regular action on medication data	Ensure structured discharge planning
	Involve staff across the system	
Education	Improve medicines safety education	Improve feedback & supervision
	Ensure QI education (capability)	
Recognition for excellence	Promote positive language and focus	Ensure regular celebration events
	Promote recognition in supervision	Provide national benchmarking
QI support	Plan and participate in QI projects	Enhance & use QI support networks
	Create a culture of improvement	
Digital [IT] systems	Inform digital health priorities	Enhance use of other electronic resources
	Implement & improve use of HEPMA	

These findings have been translated into a driver diagram (see next page) as a summary of the outputs from the day.

4.4 Stakeholder Exchange Driver Diagram (Summary of Outputs):

Ambition	Primary Drivers (Levers)	Secondary Drivers	Change ideas
To ensure safer use of medicines (Transitions Omissions & High risk medicines)	**Patient empowerment**	Support shared decision making Ask for patient feedback Help patients access & own their data Improve safety culture for patients Improve patient information Ensure timely access to medicines Co-design with patients Enhance medication self-use in hospitals	To be identified by local teams
	Work processes	Improve safety culture for staff Clarify roles and responsibilities Involve staff across the system Ensure regular review of medicines Ensure regular action on medication data Ensure appropriate staff allocation Improve information available to staff Strengthen policies & guidance Use data to drive improvement Promote team problem-solving Ensure structured discharge planning	
	Education	Improve medicines safety education Improve feedback & supervision Ensure QI education (capability)	
	Recognition for excellence	Promote positive language and focus Promote recognition in supervision Ensure regular celebration events Provide National benchmarking	
	QI support	Plan and participate in QI projects Create a culture of improvement Enhance & use QI support networks	
	Digital [IT] systems	Inform digital health priorities Implement & improve use of HEPMA Enhance use of other electronic resources	

5. Post Event

The summary of the outputs of the day and the process of data analysis were shared with key stakeholders as part of the SPSP Medicines WebEx series on the 19th of April and the draft Outcomes report were shared with the SPSP Medicines Clinical Advisor Group (MCAG).

The MCAG undertook a preliminary survey to inform a view on the ease and impact of the range of improvement activities identified through the analysis of the Stakeholder Exchange. The invitation to complete the survey was extended to key contacts for SPSP Medicines. A summary of the responses are below (n = 20).

5.1 Benefit: Top 10 Improvement Activities (average ranking score: range 1 – 5)

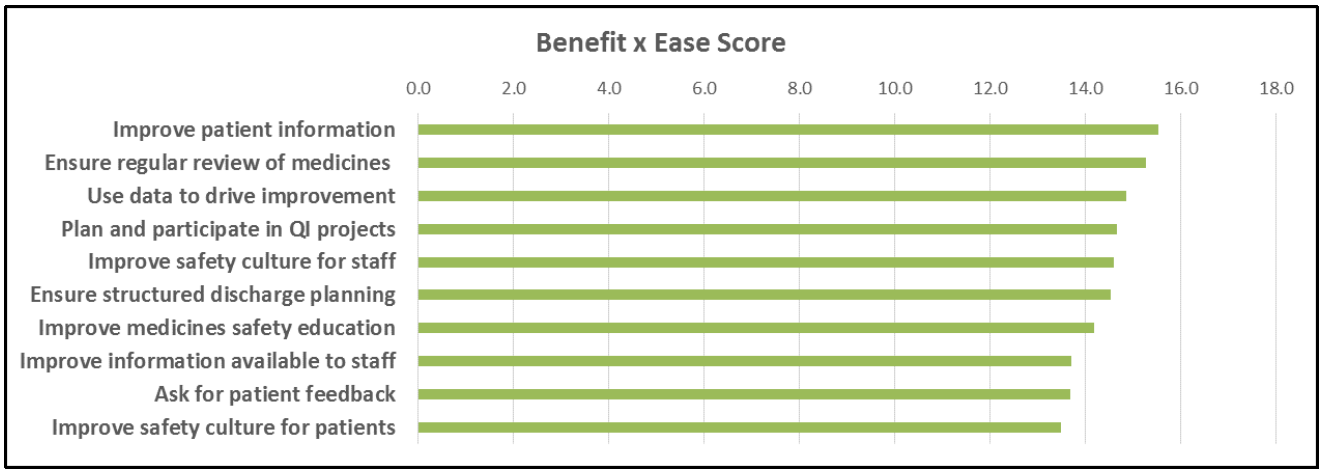
Ensure regular review of medicines*	4.70
Improve safety culture for staff	4.61
Improve safety culture for patients	4.58
Ensure structured discharge planning	4.53
Involve staff across the system	4.47
Create a culture of improvement	4.42
Implement & improve use of HEPMA	4.32
Help patients access & own their data	4.25
Reduce delays for patients	4.25
Use data to drive improvement*	4.21

5.2 Ease: Top 10 Improvement Activities (average ranking score: range 1 – 5)

Ask for patient feedback	3.70
Improve patient information	3.70
Ensure regular celebration events	3.63
Strengthen policies & guidance	3.58
Use data to drive improvement*	3.53
Plan and participate in QI projects	3.53
Improve medicines safety education	3.50
Promote positive language and focus	3.50
Improve information available to staff	3.47
Ensure regular review of medicines*	3.25

*Improvement activity that appears in both top 10 lists of benefit and ease.

5.3 Ease x Benefit: Top 10 Improvement Activities (max possible score of 25)



6. Next Steps

The six key levers and results of the survey will be used to:

- inform the types of activities that that national team could support in 2018 /19

- guide boards and local teams regarding improvement efforts

- identify new types of improvement activities for further development / testing.

All the presentations and resources from the Stakeholder Exchange are available on the SPSP Medicines website, in addition to a supplementary evaluation report.

Appendix 1 – Delegate Agenda

Title:	Date:	Time:	Location:
SPSP Medicines: Stakeholder Exchange	8 February 2018	10:30am to 3:00pm	COSLA Conference Centre, Edinburgh

Reviewing the Prescription: What else can we do to reduce harm from medicines in Scotland?

Aims:

- **share the achievements of the first 2 years of SPSP Medicines,**
- **discuss national and international strategies for achieving medicines safety, and**
- **inform future priorities.**

Stakeholder Exchange Chair:
Joanne Matthews, Head of Safety and Improvement, Healthcare Improvement Scotland

Time	Topic	Room	Lead
10:00	**Registration and coffee in the Caledonian Lounge**		
10:30	Welcome	Caledonian Rooms	**Joanne Matthews (Chair)** **Jill Gillies, Primary Care Portfolio Lead**
10:50	Medicines in a Complex System		**Rhona Moyes, Clinical Nurse Specialist, Marie Curie**
11:05	SPSP Medicines: the first two years		**Arvind Veiraiah** **National Clinical Lead**
11:45	What matters to you……		**David Maxwell** **Improvement Advisor**
12:30	**Networking lunch in the Caledonian Lounge**		
13:30	Feedback from morning sessions	Caledonian Rooms	**Joanne Mathews (Chair)**
13:45	Levers for further change		**Arvind Veiraiah** **National Clinical Lead**
14:45	Next steps		**David Maxwell** **Improvement Advisor**
15:00	**Close**		**Joanne Matthews (Chair)**

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