ADDRESS BY ANDREA JENKYNS MP

THE TRUE COST OF MEDICATION ERRORS

"Patient safety is an issue very close to my heart having lost my father to MRSA due to poor care and lack of cleanliness after a routine operation to treat a lung infection. Sadly, my family is not an isolated case - earlier this month I hosted a patient safety conference where I heard some devastating stories about the impact on people lives when things go wrong in our beloved NHS.

THE CONFERENCE HELD IN WESTMINSTER focussed on the impact of medication errors and brought together representatives from a number of leading hospital Trusts. This included Great Ormond Street Hospital (GOSH), pharmacy automation specialists Omnicell UK, Diabetes UK and the Royal College of Nursing. Attendees discussed ways to work together to help reduce errors and support our stretched NHS workforce.

A staggering 237 million medication errors occur every year in the UK, causing 712 deaths. The sheer number of patients and the ever-increasing complex regimes of our population are helping increase the risk of errors.

Delegates all agreed there was no one magic fix to reduce these errors. However there is so much more that could be done now with the technology and best practice that already exists.

Please read on for more detail about some of the thinking and initiatives that came to light during the

Health Summit. Patient safety is so important - behind every statistic is someone's life. It is always someone's son, someone's father, someone's daughter. That's why we need to continue to work together and speak openly to find a way to reduce the risks of mistakes being made and to learn from them for the future."

Andrea Jenkyns, Conservative MP for Morley and Outwood and Chair of the All Party Parliamentary Group for Patient Safety.

MEDICINE AND NURSING IS A SAFETY CRITICAL INDUSTRY

Guests at the Health Summit on 5th February heard some truly heart-breaking accounts of the real impact of medication errors. One story included 51-year old lung cancer patient Phillipa, who despite warning healthcare professionals six times of her allergy, was administered penicillin causing her to suffer a cardiac arrest and tragically pass away three days later.

Her partner of 30 years Roy encapsulates perfectly the horror and true personal cost of these errors;

"The impact on the family as a victim of a mistake is enormous – of having someone snatched away from you needlessly is appalling. We did not have time to say goodbye."

There was agreement from the Summit panel and attendees that much more could be done to reduce medication errors. Initiatives such as moving towards 'closed loop prescribing and administration' where automation and software is integrated within hospitals to ensure the right patient is administered the right dose of the right drug at the right time is readily available.

Paul O'Hanlon, Managing Director of Omnicell UK & Ireland went on to concur that such solutions already existed and were being used across many hospitals. He explained that Omnicell was successfully campaigning for the 'closed loop' approach to become a recognised standard of care within the UK's health

landscape, having seen the benefits for both patients and healthcare professionals alike.

"At Omnicell we are committed to ensuring all Trusts are aware of the technology that already exists to help prevent medication errors and it's been great for us to do that alongside other key organisations and MPs.

I would like to thank all our MP partners, patient group representatives and customers for being here today and for taking part in the panel discussion."

Another important area of focus was around safe staffing levels and learning from mistakes, rather than adopting a culture of blame. Yinglen Butt, Associate Director of Quality and Regulation at the Royal College of Nursing gave a passionate speech outlining the impact of medication errors on the nursing profession. Approximately 40% of nurses' clinical time is spent on administering medications, translating to 12-16 hours in any given working week.

She comments; *"The workforce impact of these medication errors is monumental, including psychological trauma, loss of confidence, disciplinary action and in a few extreme cases, even suicide. Nurses are the 'second victims' of these tragedies."*

Yet to even contemplate moving forward and adopting learnings, there needs to be a cultural shift and change to improve the reporting of medication errors without fear of repercussions.

There was consensus among those in the room that the NHS needs to get better at sharing best practice and they need to adopt a one system approach. Steve Tomlin, Chief Pharmacist at Great Ormond Street Hospital, discussed how the National Health Service needed to be more 'national' by reducing variation and standardising systems to drive patient safety forward. He explained that embracing technology 'put the rationalisation into decision making'. At Great Ormond Street Hospital, 34 medication administration cabinets are already in place, making it easier to locate and select the right medication for the right patient quickly. Looking to the future, Steve Tomlin aims to ensure that an Omnicell cabinet is on every ward at GOSH by the summer of 2019. This will mean nurses have more time by the bedside, attendees were told. These will integrate with an electronic prescribing system to 'close the loop', which will help to drive patient safety.

Steve Tomlin added; *"Medical professionals transfer and rota to different hospitals and in each setting, often different medication systems are used. This can be complicated and confusing for staff. A standardised system is needed across hospitals in the UK to improve patient safety, act as a vital safety net for staff and drive much needed cost efficiencies."*

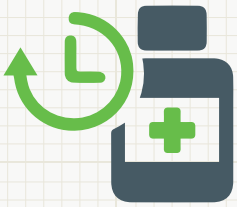
THE IMPACT OF MEDICATION ERRORS ON THE NHS

237 MILLION MEDICATION ERRORS OCCUR AT SOME POINT IN THE MEDICATION PROCESS PER YEAR.

£98m

per annum

THE ESTIMATED COST OF MEDICATION ERRORS TO THE NHS.



MORE THAN ¾ OF MEDICATION ERRORS IN SECONDARY CARE HAPPEN DURING ADMINISTRATION.

IT IS ESTIMATED THAT MEDICATION ERRORS IN THE NHS HAVE CAUSED 712 DEATHS AND CONTRIBUTED TO 1,708 DEATHS DURING HOSPITALISATION.

850,000

ADVERSE DRUG EVENTS IN ENGLAND HAVE PREVIOUSLY BEEN ESTIMATED TO COST £2BILLION IN ADDITIONAL BED DAYS.

IN NOVEMBER 2017, JUST 35% OF ACUTE TRUSTS AND LESS THAN 12% OF MENTAL HEALTH ORGANISATIONS HAD INTRODUCED THE NECESSARY ELECTRONIC MEDICATION SYSTEMS.