Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Breaking down barriers

On the front line of patient care in Wales

September 2019

‘It is important to understand the complicated relationship patients have with their medication’

We wanted to evaluate how the Patient and Carer Network (PCN) can work with clinicians in acute hospitals to help patients understand the decisions made about their care. We are especially interested in the area of deprescribing – the process of reviewing and stopping potentially inappropriate medications in order to improve quality of life.[1] Prescription medication is an integral aspect of care for many frail older patients, with some patients prescribed up to 25 different medications at one time. However, we know that there has been little research into how patients feel about deprescribing in hospital, and so we have been gathering information through informed consent and data collection, and a detailed patient questionnaire.

It is important to understand the complicated relationship patients have with their medication. How do they cope with taking medication at home after leaving hospital? What are the psychological effects of being prescribed multiple medications? Are they keen to make decisions themselves about their medication? Particularly interesting from the clinical point of view, we wanted to explore whether the patient feels that the doctor is giving up on them if a medication were to be stopped.

The most positive aspect of the project has been the opportunity for the PCN to engage with patients, doctors and nurses, as these relationships are core to the role of the PCN. Deprescribing – especially in our target group of those with capacity and over 65 years old who are taking more than one medication – has been welcomed by patients who are eager to learn more, despite it being a potentially controversial subject. The level of support from the research and development team at Aneurin Bevan University Health Board has been outstanding; they have provided guidance for the project and arranged access to clinical settings where necessary. Furthermore, the ward staff have been exceptionally inviting and accommodating, despite working in a busy environment.

The logistics involved in obtaining permission for a PCN member to enter the ward environment was an obstacle, but we have learned from the process and hope it will be more streamlined for future projects. We are keen to share the learning through our networks and committees in Wales, and by presenting at conferences, and we hope to use this as a pilot for a larger project to be run on a national scale, ideally though our PCN members.

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Case study

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‘We were encouraged to challenge outpatient referral habits’

Reform of the outpatient system is needed – demand for outpatient review continues to rise, while the system is increasingly affected by a shortage of clinical staff, and there is patchy uptake of technology which is designed to improve efficiency. This has resulted in increased waiting times for those at greatest clinical need, despite recognition of the large burden of unnecessary appointments for those who could be better managed elsewhere. The Wales Audit Office review of outpatient management in 2015[2] encouraged clinicians to challenge outpatient referral habits, and recommended that clinical leaders take managed risks to ensure services offer timely review for those at greatest clinical need.

In 2014, the rheumatology team at ABMU (now Swansea Bay University Health Board) designed a project to look at outpatient capacity and demand. Thirteen per cent of new patients were waiting for over 26 weeks (the Welsh government target) and 1,624 patients exceeded their target waiting time for follow-up appointments. We initially undertook a detailed evaluation of referral pathways during a facilitated event attended by clinicians, managers and waiting list booking staff. We focused on referral prioritisation, guided by prudent healthcare principles,[3] with the aim of reducing new patient waiting times and addressing the excessive waiting times for our existing follow-up caseload.

We designed criteria for accepting new patient referrals using national guidelines defining appropriate rheumatology caseload. Inappropriate referrals were redirected to other services such as physiotherapy / chronic pain or returned to the referrer with tailored investigation/management plans. Letters were sent directly to patients, explaining the rationale behind these decisions.

By March 2015, new patient waiting times had fallen to 4–6 weeks across all sites in the health board. We were able to convert new patient clinics to follow-up activity with a significant reduction in the number of patients waiting longer than their target date from 1,624 in March 2014 to 253 in January 2016. Subsequent work in 2018 showed that, of 474 patients whose referrals were returned between June 2015 and May 2016, only four were later diagnosed with inflammatory disorders, having been re-referred with new features.

Initial reservations regarding the potential personal liabilities of misdirected referrals were overcome by agreeing to collective responsibility for the project with regular feedback. The introduction of electronic referral prioritisation facilitates timely and effective electronic dialogue with referrers and we would strongly recommend this approach. We have also been able to demonstrate that the principles underpinning the project are robust and support the reduction of inappropriate variation through evidence-based approaches.

Dr Usha Srinivasan
Consultant physician in rheumatology
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Andrea Mills
Service manager for rheumatology
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‘I am proud to say that intermediate care in Wales is emerging as a specialty within a specialty’

In 2007, we began our journey to design a pioneering collaboration between health and social care services in Gwent. Our aim was to deliver the best possible community care for older people and for any adult struggling with clinical frailty – 12 years on, the Gwent Frailty Programme has evolved and transformed into one of the UK’s most respected and recognised services, and the model of care has been emulated by several centres across England and Scotland. Wales has led the way in making this programme a reality – many other parts of the UK have struggled to do the same.

The journey has, at times, been arduous. As the programme developed, patient needs kept altering, due to rapidly changing demographics in Gwent and across the country. It often still feels like hitting a moving target. The key to staying relevant has been our ability to adapt and respond to change. Being subjected to scrutiny and regular evaluations has helped the programme to stay viable and find its place among the core services of Gwent.

Community resource teams are the nerve centres of the Gwent Frailty Programme. They are made up of multidisciplinary team members, from therapy staff, social care and voluntary sector workers, to a rapid response arm supported by senior medical and nursing staff. The team’s resource and skills are designed in accordance with the needs of frail and older people with complex needs and multiple comorbidities. Employees are paid from a pooled health and social care budget.

Referrals into the service are from primary and secondary care via a single point of access. The focus of the teams is to prevent unnecessary admissions into hospital, allow early supported discharges, and support re-enablement and falls prevention. Comprehensive geriatric assessment[4] is the cornerstone on which care plans are built and developed. Access to therapists, social care and consultant-led rapid medical services are fundamental in providing our community-based response, which, in turn, delivers care closer to home in line with the Aneurin Bevan University Health Board Clinical Futures programme.[5]

Patients are extremely satisfied with the service. Unexpected mortality is very low, thanks to clear lines of governance and rigid surveillance in the community by the clinical teams. The cost of the programme is being evaluated via a multicentre randomised controlled trial and the results are imminent. Integration, wellbeing and the use of new technologies are all on the agenda for the future. We are also developing community frailty units which are capable of delivering enhanced nursing and medical care. I am proud to say that intermediate care in Wales is emerging as a specialty within a specialty.

Dr Jaideep S Kitson
Consultant physician in geriatric medicine
Clinical director for intermediate care
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‘This has been an amazing project to be involved with’

Wales has the highest prevalence of diabetes in the UK. Almost 200,000 people now live with diabetes, or 7.4% of the adult population – and the numbers are rising every year. If current trends continue, it is estimated that 311,000 people in Wales will have diabetes by 2030. The disease costs the NHS in Wales approximately £500 million a year, of which 80% is spent on managing complications, most of which could be prevented.[6]

Delivering appropriate advice and support to such large numbers of people with type 2 diabetes is both essential and a considerable challenge. Audit data from 2015 showed that less than 1% of this group had ever attended a validated education course in Wales.[7] We needed a new way to reach out to the many thousands of people who have diabetes and aren’t receiving the support they deserve to manage their disease properly – especially those living in rural, isolated areas, perhaps feeling socially isolated, perhaps economically deprived.

We started thinking about ways to support and empower patients with chronic conditions. We put together a working group which includes: Diabetes UK Cymru; the Diabetes Research Unit Cymru; patient groups; and eHealth Digital Media Ltd. Our goal was not only to develop content, but also to think about how we could distribute that content. We decided to create a series of digital education films which focused on behavioural change in patients with diabetes.

Our media company partners put together around 10 films about type 2 diabetes for us and we approached two GP surgeries, especially one with a huge list of people who had been referred in for an education package for diabetes, but there no was no education package available. We received immediate feedback through the system, which helped us to develop films on other topics, and the national diabetes lead for Wales secured us some all-Wales funding. The links can be sent out through text message directly to a mobile phone and accessed on the move.

The project has been extremely effective, and it is relatively low-cost. If current rates of use continue, we are on track for a 30,000 click-through rate in 2019, with diabetes alone achieving 2,000 clicks per month. Usage is steadily growing and has doubled since last year. We’re also expanding into some parts of England using a system developed to cost pennies per patient. Our primary evaluation has demonstrated a statistically significant reduction in average blood glucose levels (HbA_{1c}) in those interacting with the content.[8] The project was previously shortlisted for the NHS England Innovation Awards and the NHS Wales Awards. It received a Quality in Care (QiC) Diabetes Award commendation in 2018 and in 2019, was announced as a QiC Diabetes Award finalist for an animation on insulin safety in collaboration with the Cambridge Diabetes Education Programme.

The films are between 5 and 10 minutes long, depending on content. It works well for people who are in work – if you’ve just received a diabetes diagnosis, there’s no way you’re going to be able to get to an education course which is half a day every week for 6 weeks, even if there is one available in your area. We know the uptake is very poor for these courses. We provide links at the end of the films, signposting patients towards more information, or other learning materials.

This has been an amazing project to be involved with, but like any new way of working, a considerable amount of effort has been needed to promote the new system. At times, it has been difficult to get the healthcare profession to engage with it. Embedding the delivery into standard primary care practice has taken some time, but recent work with primary care IT providers has really helped, and now the diabetes films are officially built into the GP system as part of a diabetes review. The important thing for us now is to raise awareness and get the message out to patients and clinicians.

Following the success of the diabetes films, we have pulled together content for chronic obstructive pulmonary disease (COPD), chronic pain, lymphoedema, heart failure, social prescribing,[9] end-of-life care, cancer survival, and more recently, dementia,[10] some of which are funded by the Welsh government on an all-Wales basis.

‘This is a brilliant film. It shows what living with dementia is really like, which is so much better than reading about it. This film is a real-life example of how people with dementia struggle to focus on a target when surrounded by distracting information. All the observations and ideas in the film fit with the scientific evidence, but such evidence is bit dry to read and it doesn’t really reach the very people who could make the most of this knowledge.’

Professor Andrea Tales, chair in neuropsychology and dementia research, Centre for Innovative Ageing, Swansea University

We are now developing films to support the diabetes remission agenda, as well as producing content in different languages, and we are also working with colleagues abroad to explore ways of exporting the system outside of the UK, especially to India.

We really want to do something similar for obesity. The issue with obesity is that it’s not part of any of existing funding streams, but has an impact on almost all chronic conditions. It would be helpful to top-slice some of the existing funding for chronic conditions because there is no specific money for obesity. Helping people to feel more empowered can only be a positive thing.

Dr Sam Rice, Professor Jeff Stephens and Dr Julia Platts
Consultant physicians in diabetes and endocrinology
Hywel Dda University Health Board

Kimberley Littlemore
Director, eHealth Digital Media Ltd

‘Pharmacists can offer a high-quality specialist service as part of the wider admissions team’

In 2015, the National Institute for Health and Care Excellence (NICE) updated their medicines reconciliation guidance saying that patients should have their medicines reconciled within 24 hours of admission to hospital, and ideally a member of the pharmacy team would be involved. This recommendation really changed the workload for clinical pharmacists.

It is well-documented that harm can be caused when there are problems in the way that information about medicines is transferred between care settings, or when people move between care settings, perhaps from their own home or from a nursing home into a hospital. As a profession, we accepted the new NICE recommendations because they are all about patient safety – but the reality is that most hospital-based pharmacy medicines reconciliation systems are reactive. The pharmacy team are often unable to carry out medicines reconciliation for hours, sometimes days after an admission, when prescribing mistakes have already happened. There is a staggering amount of inefficiency in the current process and it causes an awful lot of rework.

So we thought, what if the pharmacy team was there at the start? What if we did the clerking drug history and we fitted into the process from the beginning? All of us would prefer to be making a positive contribution to patient care, rather than correcting mistakes that we could have prevented. A great deal of our workload is focused on spotting what has gone wrong: if the process were slicker, or certainly if fewer errors were made, it would be better for the patients. It helps out our medical colleagues by taking some of the burden off them, and it meets prudent healthcare principles, being what we are best qualified to do.

Singleton Hospital in Swansea was already pioneering this with pharmacists. So we decided to try it out with pharmacy technicians, as we were confident that they were capable. We think it’s the first example of technicians transcribing a medication chart at the point of admission in the UK, so it’s a relatively novel approach and not at all widespread.

Ordinarily, with adult patients referred to hospital by their GP, when the patient arrives, they are triaged by a nurse and will wait to see a junior doctor, who will clerk them, perform the drug history and write the medication chart, and they’ll be seen later by a consultant physician. They may or may not be admitted at that stage, and if they are admitted, a member of the pharmacy team would see them (hopefully within 24 hours, but almost certainly within 48 to 72 hours) and double-check the drug history and chart transcription carried out by the junior doctor.

During our pilot, once the referral phone call came from the GP, the pharmacy team (usually the technician) would access the patient’s information from their electronic individual health record to start collating the drug history. When the patient arrived, our technicians completed the drug history together with the patient, as well as checking other sources like outpatient clinic records – we always cross-check our data here, which is best practice. We are really proud of our technicians, they are fantastic; everyone who took part in the pilot volunteered.

‘There was good verbal feedback from the juniors. I thought it was excellent because I could read everything, it was very comprehensive – it was far more accurate and up-to-date.’

Consultant physician

Our job was to document the drug history in the medical clerking document, and transcribe the medicines from the drug history to the patient’s medication chart: two tasks that junior doctors would previously have done. Then the clerking document and medication chart would go into a green envelope, which was sealed and a sticker was put on the back to say that only the prescriber was to open the envelope. The prescriber would still check and sign the charts and decide if the medications are appropriate, but now they know they are looking at an accurate drug history list.

New medicines come onto the market all the time, so trying to keep track of them all would be almost impossible for most junior doctors. When we collected our baseline data, in our control group of 16 patients, there were 44 discrepancies on the medication charts written by junior doctors, whereas our pharmacy technicians – some of whom do drug histories all day every day – didn't make any discrepancies when transcribing 25 charts during the pilot. We've since trialled a version of the project in the hospital's emergency department, which is even more high-stress and high-pressure, and it went well.

'It's about providing care in the right place, by the right person, at the right time. When we start writing our next integrated medium-term plans, this project will be included because it would save a huge amount of hassle in the long term.'

Consultant physician

If we wanted to roll this out more widely, we would need investment in the workforce – new pharmacy team members. What we actually found is that almost half of the patients we saw were not admitted, so these were patients that wouldn't normally come into contact with the pharmacy service. But at the same time, we were freeing up junior doctor time by taking on that role, which is a big reallocation of resource. There's also the question of education and extra training for our technicians – this is a way of working which requires them to operate under more pressure than they experience in the current system. It's also crucial to keep lines of communication open and make sure everyone involved is well-briefed – early engagement between different teams is vital. Finally, we don't want to risk de-skilling junior doctors, as the final decision about patient care still rests with the medics.

'It boils down to time. The ideal situation is that you have a multidisciplinary, multiprofessional ward round for every single patient, but that's not feasible. However, by having pharmacy colleagues on the ward, we're co-located, and we can ask their advice about a patient's clinical assessment and management.'

Consultant physician

However, ultimately it's about changing the way that we all think. Pharmacists can offer a high-quality specialist service as part of the wider admissions team. We're not there to get in the way of our medical colleagues – we are there to help and to save time, and improve patient safety.

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