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Funded by NHS National Institute for Health Research

ISCOMAT
Improving Safety and Continuity Of Medicines management At Transitions of care

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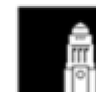
Joint Programme Leader

Joint Work Package 2 Leader



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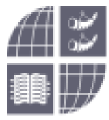

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Background

NIHR major programme grant – in 4 work packages (WP 1-4)

Improve the management of medicines across care transitions

WP 1 & 2 in 4 healthcare economies

WP 3 in 3 healthcare economies

WP4 in 42 acute trusts nationwide

Patient participants:

Heart failure (Moderate/EF<45%)

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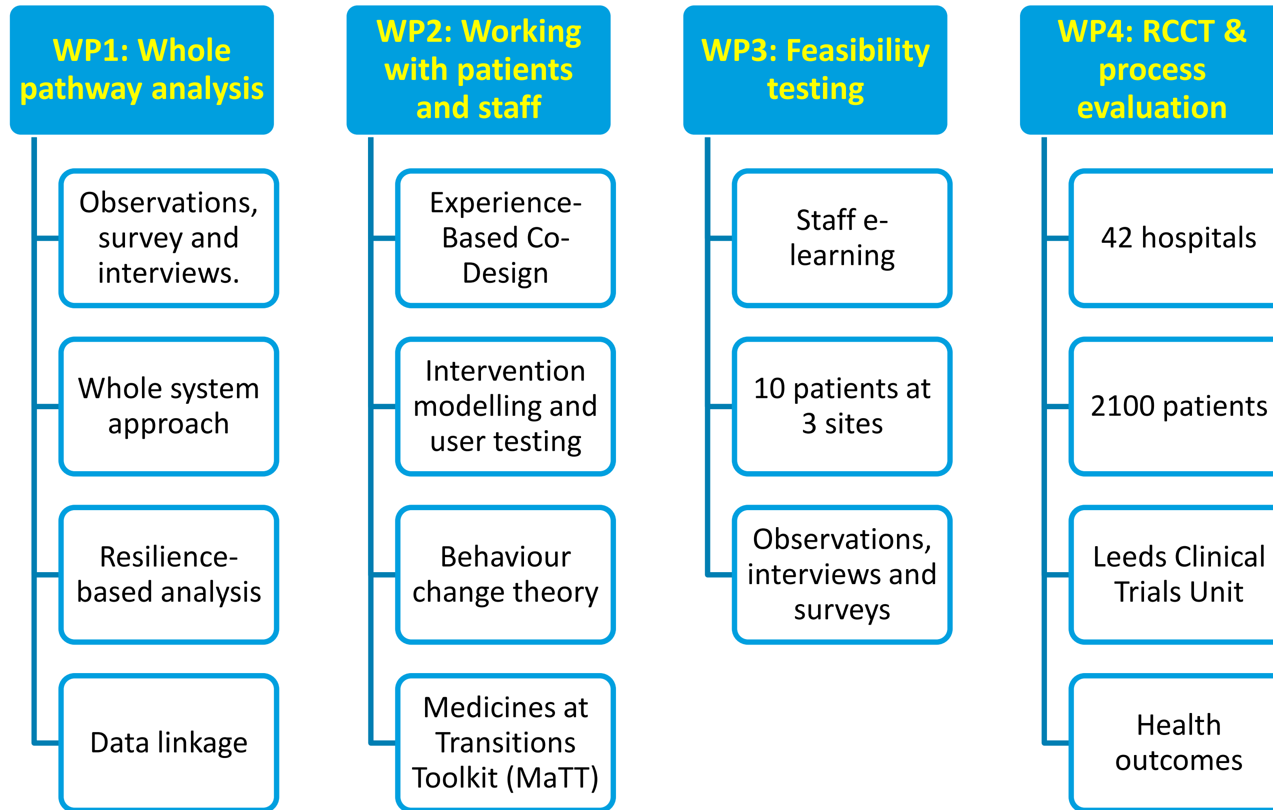
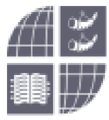
Stages from Intervention development to trial





Work Package 1

Design – WP1

Whole pathway analysis – resilience perspective

Observations in 5 cardiology wards	Patient interviews at three time points (20)	Hospital and primary care staff interviews (n=45)	Documentary analysis – national and local policies	Parallel 'mixed' analysis	Map the patient pathway

WP1 Summary

Areas of good practice but also ineffective processes, poor communication and lack of co-ordination at different levels of care.

Variation in practice for managing discharges at individual and organisational levels.

Safety is inbuilt but there are temporary fixes and safety gaps.

Policy should explore training for staff across the pathway and involving patients in improving the system.

Work Package 2

- Experience based co-design (EBCD)
- Working in 4 sites (Yorkshire & the Humber)
- Patient and staff groups jointly agreeing priorities and developing solutions
- Activities framed by a ‘trigger film’ summarising the emotional touch points found in WP1
- Normally, EBCD is carried out in 1 site
- We were running the process in parallel across 4 sites and integrating the outputs

EBCD priorities from WP2

PRIORITIES

Site A

Communication between various professionals needs improving

Site B

Better explanation in hospital about tablets and condition before day of discharge

Site C

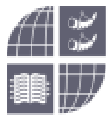
Need to make sure patient knows what will happen after discharge

Site D

Clear communication about plan at home – who does what and when

Work Package 3: Feasibility Study

- Complex intervention
- Cross pathway
- Three sites
- 30 patients
- Follow-up – interviews, surveys, focus groups



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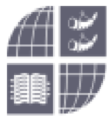
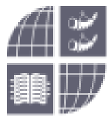
Work Package 3: Feasibility Study

- Refine intervention
- Staff training
- Deliver intervention
- Patients: Health resource use and QOL surveys at follow-up
- Staff survey
- Staff interviews (approx 3-6 in each site)
- Observations on wards
- Patient follow-up interviews (20 in total)



Work package 4

- Cluster randomised controlled trial
- 21 control and 21 intervention areas
- Main sites are Acute Trusts
- Patients with moderate LVSD
- Training provided about medicine safety at transitions of care
- Intervention delivered by Cardiology Ward staff:
  - Improving communication in the pathway
  - Providing information about medicines
  - Arranging follow up in the community



WP4: outcome monitoring

- 12-month follow up post-discharge
- All-cause mortality & heart failure readmission
- Prescribing of key medicines
- Patient experience & satisfaction with care
- Quality of life (EQ-5D)
- Resource use (for economic evaluation)

- Using patient questionnaires and where possible routine data (e.g. NICOR audit)

Trial progress to date

- n=42 sites randomised
- 1207/2100 patients registered
- 2040 patients approached about ISCOMAT
- 5359 patients screened for suitability

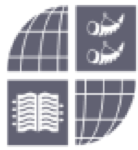
- Intervention is suitable for all patients meeting the inclusion criteria – registered or not
- Recruitment has generally been slower than planned or expected
- Lots of variation between sites

Lessons learnt (about care)

- Care pathways are complex and not many people have end-to-end understanding
- Specialist nurses are key professionals but may lack capacity in some areas
- For patients, medicines taking and disease management are social processes
- Better information is needed for all those involved
- Heart failure is one example of a complex, common and chronic disease
- The intervention we have developed is intended to have wider applications

Lessons learnt (about research)

- There are lots of competing pressures in frontline patient care (we did know this!)
- Intervention was feasibility tested, nevertheless, systems and processes vary lots between trusts
- We are assessing ‘fidelity’ to the intervention – different places have different problems
- It’s hard to maintain a clear distinction between recruitment to the trial & intervention delivery
- More flexible intervention components may be needed – but this raises the issue of internal validity (what would we be testing)



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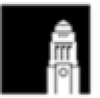

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Any questions?

Thank you for listening!