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SBAR: Diabetes Insulin Patient Safety Cluster Review Tower Hamlets Community Health Services

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Situation:

- We have identified that the majority (nearly 80%) of Patient Safety Events (PSE) involving Primary Care reported by East London NHS Foundation Trust (ELFT) Community Health Services (CHS) staff in Tower Hamlets are medicines-related. The most commonly reported medicine involved in these events is insulin (around 70%).
- Diabetic housebound patients on insulin often have several co-morbidities and are at the end of their life. NICE recommends we adopt an individualised approach to diabetes care that is tailored to the needs and circumstances of adults with type 2 diabetes, taking into account their personal preferences, comorbidities and risks from polypharmacy, and their likelihood of benefiting from long-term interventions. Such an approach is especially important in the context of multi-morbidity*.
- However, in Tower Hamlets presently there are housebound patients on insulin where oral medication has not been optimised and the patient has not been given sufficient education about their diabetes and self-management.
- Insulin changes are not always communicated effectively to community teams, who do the administration for this group of patients, causing a delay and potential risk of harm when insulin has been stopped or reduced due to side effects such as hypoglycaemic episodes and falls. These complications from insulin can lead to input from Urgent Community Response, NHS 111, 999/LAS, A+E attendance and in-patient care.
- Housebound patients are often discharged from hospital on insulin without a discussion with the patient about suitability for self-management.
- Due to financial viability across NHSE and a 5% local cut in budget for ELFT TH CHS there is a financial pressure across all services, including the Community District Nurses, to review caseloads and identify those families, carers and patients who could safely self-manage their insulin without visits from a nurse.
- Diabetes and related medicines safety has been recognised as a priority across North East London; Improving insulin safety across the interface is a key NEL Medicines Safety & Quality Group (MSQG) system priority for years 24/25 under the “Safe transition of care and information across the interface” work stream.

Background:

Dr Alex Harborne started a GP Communication QI project in early 2022 to address a local community health service need to improve communication with GP teams. The project team tested several change ideas including a new website page, podcast series and updating the electronic GP referral form. A group including both ELFT and Bart’s Health CHS was established to understand why GP referrals were lacking vital information such as NOK, risk assessment and reason for referral. With help from the Clinical Effectiveness Group (CEG) who have the contract for the EMIS templates in Tower Hamlets, several changes were made to improve the functionality in the electronic referral template. A small team tested and discovered that the previous EMIS template had been dysfunctional leading to blank GP referrals and delay in patient care.

The group published a new functional EMIS template into all GP practices in December 2023. Community teams were pleased to see their GP referrals improve– however the group were curious why this problem had not been detected previously and wondered how many other interface issues remained unresolved. They realised there was no clear process in place to share patient safety events and learn together with primary care.

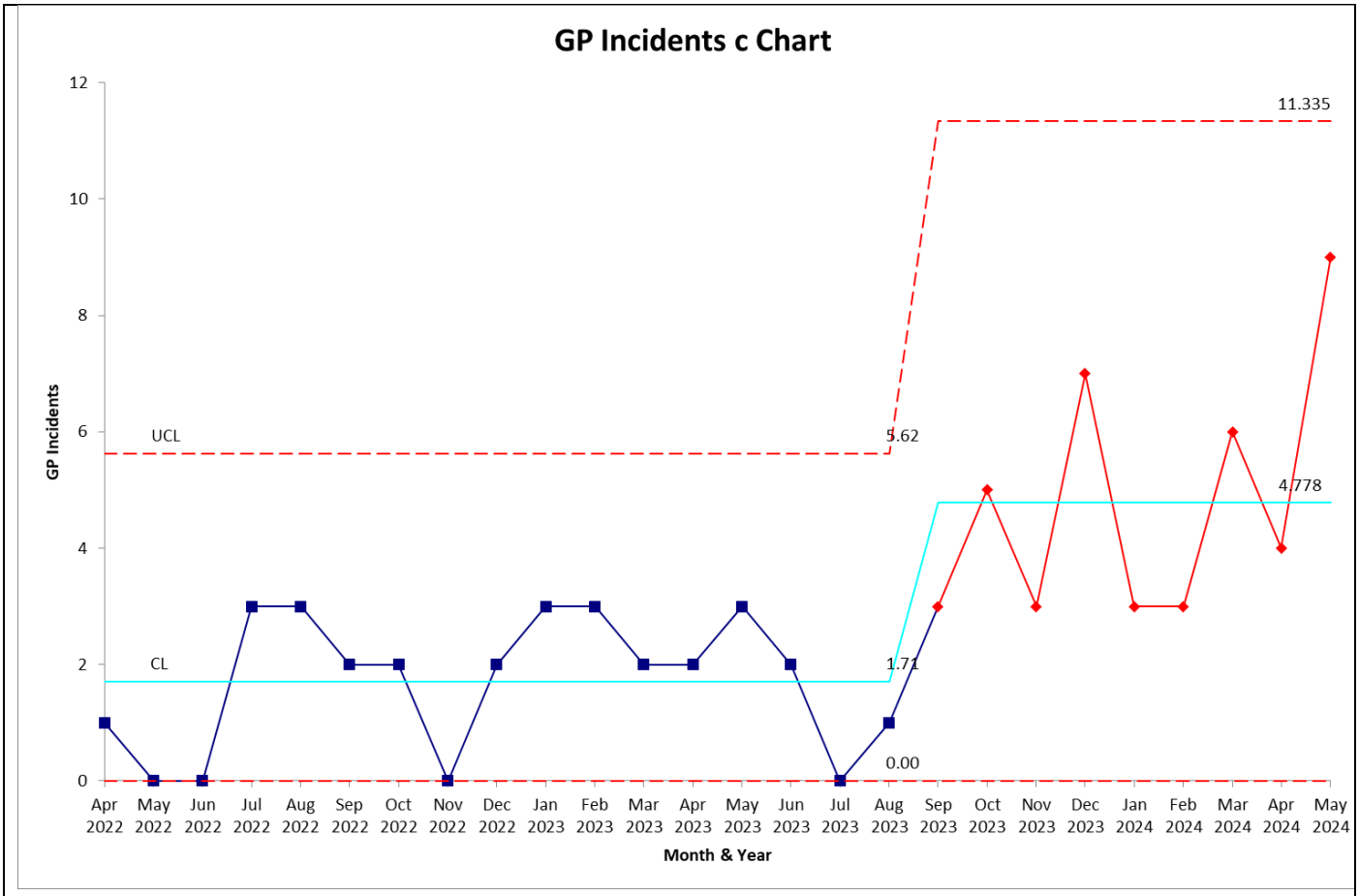
The ‘Learning Together’ group including all system partners developed a local process to share and learn together from patient safety events and interface issues with a core membership including primary care, ICB, ELFT and Bart’s quality teams. Patient Safety issues were reviewed in a quarterly review for the first time in June 2024.

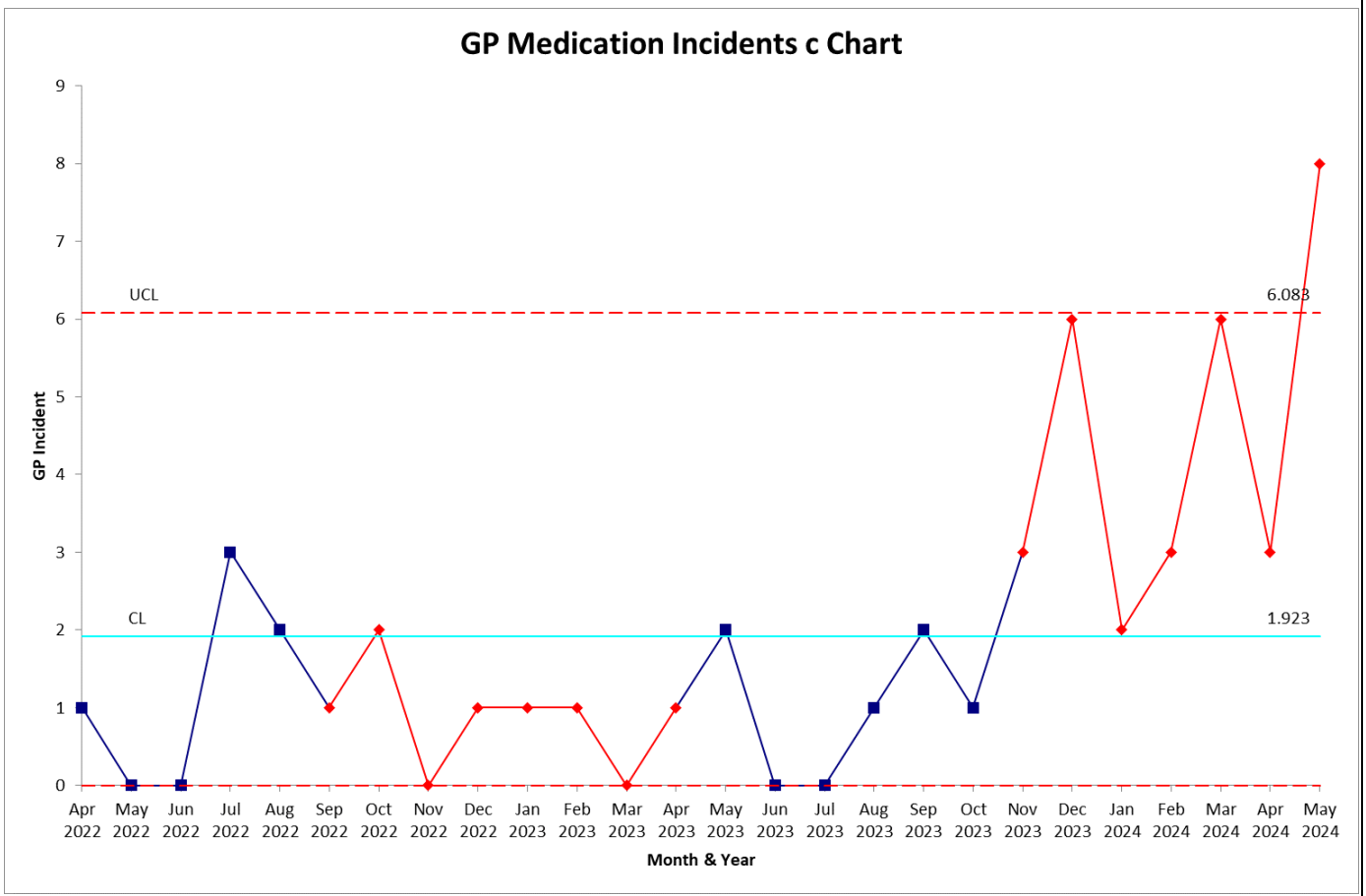
The group quickly identified that the highest reported event in Tower Hamlets CHS was medicines-related and the majority of these involved insulin. They decided to focus improvement in this area.

A Cluster Review was led by Dr Alex Harborne in September 2024 looking in detail at a small number of the Insulin PSE to understand the themes. The Cluster review included colleagues from across ELFT, Bart’s Health, Primary Care and ICB.

Assessment:

The ‘Learning Together To Improve Patient Care In Tower Hamlets CHS /Primary Care’ group reviewed data in the first quarterly review in June 2024 and found out that from December 2023 to May 2024 there had been 28 medication incidents reported and 20 of these were insulin related (over 70%). The most common theme was related to communication – where insulin dose was changed by GP but not communicated to the district nurses or updated on EMIS.





A wider group including staff and quality teams from across Bart's CHS, ELFT CHS and ICB were invited to think about how best to approach the problem. The system partners agreed that it would be useful to look in more detail at a small number of incidents to learn more, so a Cluster Review was arranged to help them better understand the underlying issues and problem. At the second quarterly review in September the data continued to demonstrate that the majority of medicines patient safety events involved insulin.

The Cluster Review system partners met in person in September 2024 and looked in detail at three case scenarios asking each other

- **What are the main themes emerging?**
- **Where do we need to make improvements?**
- **What are we going to do next?**

The three cases included an example where due to miscommunication a housebound patient had 7 days without insulin and this resulted in 111 calls and ambulance call out. It also included an example where insulin had been stopped on EMIS by the GP due to the patient having recurrent hypoglycaemic falls but this had not been communicated to the district nurses who administer in the community - the patient continued to receive insulin placing them at risk.

The group met for a second time in October to look back again at their discussions and agreed on three key themes for recommendations to share with their system partners across Tower Hamlets.

Recommendation:

Self-Management

- Amend EMIS SPA CHS GP referral to include a prompt for self-management
- Attend network / health and wellbeing meetings / MDT and share Diabetes Self-Management story

Communication

- Standard Operating Procedure for Insulin changes and prescribing to be drafted locally then shared with GP teams for comment/input

Insulin Safety

- Review of housebound/frail patients in GP and community caseloads by Primary Care and Community Pharmacy Teams to assess if insulin safe/if oral medications have been optimised
- Amend EMIS SPA CHS GP referral to populate with acute and repeat medications

The Cluster Review team recently met to review progress in these three areas and will be meeting again in 2 months in January 2025. All work is either completed or in progress.

Appendix

* https://www.nice.org.uk/guidance/ng28/chapter/Recommendations#individualised-care