NHS
Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative

Community Urgent Care

Workshop for safe and efficient prescribing
Virtual Wards/Hospital at Home

10th September 2024

Agenda

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Time	Item	Lead
0830-0915	**Arrival** Tea and coffee will be available on arrival from 0830 – 0900	
0915-0945	**Introduction and context** Community urgent care and MHLDC provider collaborative Prescribing on VW / Hospital at home	Tony Mayer Michelle O'Neill
0945-1000	**Energiser** Go to slido.com and type in code #2039940	Emma Danton
1000-1100	**Workshop: Safe prescribing principles** Table 1: Admission onto a virtual ward Table 2: Whilst on a virtual ward Table 3: Discharge from virtual ward *(participants to spend 20mins on each table)*	Emma Danton Michelle O'Neill Ipsita Chatterjee
1100-1130	**Break** Tea and coffee will be available from 1100 – 130	
1130-1200	**Feedback** Facilitator from each table to feedback views on the principles and long list of priority actions	Emma Danton Michelle O'Neill Ipsita Chatterjee
1200-1230	**Agreeing Priority Actions** Participants to vote on priority actions via Slido	Emma Danton
1230-1300	**Summary and close** Summary of next steps and close	Michelle O'Neill

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Welcome

Tony Mayer, MHLDC Provider Collaborative Director

Programme Overview (what we do)

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Virtual Wards	UCR	Falls	IV@ Home	DOS
We will develop general virtual wards. Based on feedback from VW site teams, and other ICBs, we will move away from disease-specific pathways and broaden the access criteria into VWs. Formally integrate virtual wards with UCR services, bringing about a more streamlined access process Implement singular clinical leadership across VWs and UCRs to develop and enhance clinical engagement and knowledge of community urgent care services	We will engage with NWAS and Paramedic leaders to develop clear, consistent referral pathways from 999 & 111 into all UCR services Develop clearer referral pathways from care homes into UCR services **and** develop targeted communications with care homes to raise awareness of UCR services Develop standard self-referral pathways and easy access for high intensity users	Develop UCR and falls teams' pathways to provide an urgent response to patients following falls as well as future falls prevention inputs to patients at risk. Work with Chief Pharmacists on reducing polypharmacy and known correlation with falls.	Expand the scope of the IV Elastomeric project to incorporate all OPAT IV services and all C&M Places Improve access to OPAT services by improving clinical awareness and referral pathways.	Work with providers to develop their DOS profiles into an accurate description of service acceptance criteria, opening times etc. Where possible, facilitate digital referrals to services based on DOS profiles and ITK links Develop community urgent care hubs, linked to DOS profiles, that set out clear information about the community offer in each place and offer referring clinicians a single point of access to community urgent care services

Outcomes (why we do it)

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Outcomes	Enabled by
We will treat more people in their normal place of residence	By increasing the volume of activity in VW, UCR, Falls and OPAT services, we will be able to treat more people in the Community either in or closer to their normal place of residence By increasing volume of activity and awareness of community alternatives to ED, such as UCRs and other community services in local DOSs, we will enable reduced conveyances to acute hospitals by emergency ambulances and keep people well in their homes or communities instead.
Colleagues across the system will have improved awareness of community urgent care services and how to refer to them	We are already working with NWAS to develop stronger clinician-to-clinician relationships and awareness of clinical alternatives to ED. We will continue to do this and expand the reach of our message. In addition, we will improve information available in the DOS.
We will reduce risk aversion	By strengthening awareness of community alternatives to ED and improving the DOS, partners will be clear regarding timeliness of accessing community services, increasing their confidence to refer to those services in the future. By closely monitoring the scaling up of community services, we will be able to generate a renewed confidence in the timely availability of community services
We will increase acceptance rates	In all of our initiatives, we will closely monitor and proactively reduce the occurrence of rejected referrals. We will develop an ethos of “no bad referrals” and encourage a strong clinical feedback loop for rejected referrals that are inappropriately directed to Emergency Departments.

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An introduction to the MHLDC Team

- Tony Mayer, Director
- Ipsita Chatterjee, Interim Medical Advisor
- Val McGee, Strategy Director
- Michelle O'Neill, VW Lead Pharmacist
- Emma Danton, Head of Transformation
- Qazeem Faniran, Project Manager
- Diane Nolder, Project Support
- Liane Thorley, Project Support

Setting the Scene – Patient Story

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PATIENT BACKGROUND

- 80-year-old female
- Prolonged admission
  - Cycle of IV fluids, fluid restriction, IV diuretics, AKI
  - Multiple complications and hospital acquired infections
- Clinical frailty score 7
- GSF registered – prognosis thought to be last 12 months
- Patient wish to be cared for at home
- PMH: HF, PD, CKD 4-5, T2DM, asthma, paroxysmal atrial flutter, angina
- Current problem - IECOPD
- Medication: Aspirin, co-beneldopa, famotidine, linagliptin, bisoprolol, lantus, sertraline, folic acid, furosemide (IV), apixaban, fostair nexthaler, salbutamol MDI

Priority: Wishes to reduce medication burden.

ON ADMISSION TO VW

- Switch IV to oral furosemide
- TTOs inc supply of oral abx

WHILST ON VW

- Review at daily MDT
- Structured medication review (SMR): *Stop aspirin, apixaban (? Benefit and CrCl < 15ml/min), stop folic acid, switch nexthaler to MDI with spacer*
- Advanced clinical management plan: *GTN for chest pain, oxycodone for breathlessness to avoid hospital admission*
- Day 2 – wheeze and SOB: *Continue on antibiotics, commence steroids; Identified GTN missed off TTO*
- Communication of prescribing information/medication changes

ON DISCHARGE FROM VW

- Communication of medication changes
- Adequate supply of medication
- Follow up
  - Furosemide tapering in light of CKD/risk of AKI
  - Asthma review
  - Referral for post-discharge SMR: *Review famotidine, antidiabetics (HbA1c 55), sertraline*

Setting the Scene – Medicines Use on VW/H@H

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- **NHS England VW Guidance**
  - Stage 1: Assessment
    - Medicines related admission
  - Stage 2: Admission
    - Prescription and/or administration of medication for pain or symptom relief
    - Rapid access to appropriate medical treatments, including ability to deliver via parenteral routes (subcutaneous and intravenous), as required
    - Medicines reconciliation
  - Stage 3: Assessments and monitoring
    - Medicines optimisation assessment – structured medication review
  - Stage 4: Discharge and transferring care
    - Communication and medicines reconciliation of changes

- **Challenges**
  - Varying services available across the region
  - Multiple clinical systems in use
  - Limited interoperability
  - Data sharing inconsistent
  - Wards and specialities developed in isolation
  - EPS not widely implemented
  - Varying routes of medicines prescribing & supply
  - Pharmacy resource
  - Functionality within clinical systems
  - Timeliness of medicines supply
  - Trust medicines policies applicability to VW/H@H
  - Communication of medicines changes and transfer of care
  - Clarity of prescribing responsibilities

Pharmacy Teams – VW/H@H

Post	Lead Provider	Pharmacist
Principal Pharmacist		Michelle O'Neill
Senior Clinical Pharmacist	LUHFT	Sheeba Bibin
Senior Clinical Pharmacist	MWL (STHK and S&O)	Rachel MacDonald (+vacancy)
Senior Clinical Pharmacist	WHH & EC	Georgia Jordan
Senior Clinical Pharmacist	WUTH & COCH	Dominique Davies
Senior Clinical Pharmacist	MC	Sally Griffiths
Senior Clinical Pharmacist	COCH H@H	Kate Spark

- **Additional expertise and clinical input to the MDT**
- **Expanding skill mix within teams**
- **Governance**
  - Medicines use and safety
- **Routes of prescribing/supply – EPS**
- **Antimicrobial stewardship**
- **Medicines optimisation**
  - Medicines reconciliation
  - SMRs (triage for priority patients)
  - Holistic and proactive approach
- **Domiciliary visits**
- **Support for communication of medicines information on transfer of care**

Prescribing Principles – What has been agreed already?

- **Comms issued December 2023:**
  - Following discussion with Primary Care representatives in Cheshire and Merseyside, it has become apparent that further clarity is required about the clinical responsibility of patients whilst they are under the care of the Virtual Ward team.
  - The Virtual Ward Team is responsible for the oversight of all care while the patient is on the Virtual Ward. Clinical care includes the management of new problems or an exacerbation of a known condition, even if it is unrelated to the reason for admission to the Virtual Ward.
  - Suitable assessment and management will be dependent upon the urgency and severity of the new problem.
  - If the new clinical problem is non urgent, it may be appropriate to handover care to the patient's usual primary care team upon discharge from the Virtual Ward for further assessment and management.
  - The position with regards to repeat prescribing and prescribing for known conditions unrelated to the reason for admission to the virtual ward is still being discussed with the relevant stakeholders. Virtual ward teams will continue to work to the model that they have already agreed with their local teams for prescribing and supply of medicines at this time.

Energiser

- Go to slido.com and type in code #2039940
- Familiarise yourself with Slido – we will be using it later to vote on priority actions

Safe Prescribing Principles

- **We would like the group to agree on some DRAFT principles for safe prescribing in virtual wards**
- **To get the conversation started, we have given some draft ideas**
- **Groups will be rotated so everyone will have an opportunity to input into all three tables. In your groups, please consider:**
  - Do these principles look right?
  - What good practice have you already implemented/what is working well?
  - What challenges have you faced?
  - Is there anything we have missed?
  - What actions would we need to take to implement these principles across C&M?

- Table 1: Admission onto a virtual ward
- Table 2: Whilst on a virtual ward
- Table 3: Discharge from virtual ward
- *(participants to spend 20mins on each table)*

Principles

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Table 1: admission onto a virtual ward	Table 2: whilst on a virtual ward	Table 3: discharge from a virtual ward
• All patients admitted to a C&M virtual ward will have a full medicines reconciliation performed within 24-48 hours of admission. • Medicines reconciliation can be performed by suitably trained and competent clinicians, this is not solely a pharmacy responsibility. Training will be made available to all teams across C&M via the joint pharmacy team. • Step-down admissions: at least 28 days of medication will be provided on discharge to patients being discharged to a virtual ward. Trusts should have processes in place to ensure these patients are flagged to pharmacy prior to discharge to ensure pharmacy teams know why a different quantity on discharge is required.	• Patients/carers must be informed that they are on a virtual ward, what this means and that VW clinicians are responsible for their care whilst on the ward. They should not contact their GP practice outside of this as this may pose a risk to the patients care. • Clinical issues not related to the admission that arise whilst the patient is on the virtual ward should be risk assessed by the VW clinicians and if an urgent need is identified then the VW team may need to involve or liaise with other clinical teams for support and advice. • All C&M virtual wards are to use a clinical system that is EPS enabled if FP10s are the primary route for prescribing. • Prescribing for the acute condition related the VW admission is the responsibility of the VW prescribers. Primary care must not be asked to prescribe on behalf of the service. • Whilst under the care of the VW, if patients need their routine medication prescribed then this is up to the VW prescribers to resolve and prescribe what is needed, even if this condition is not related to the reason for the acute admission.	• Standard discharge information must include the same information that would be provided if the patient had been discharged from an inpatient bed. The same principles apply for primary care to be provided with enough information to be able to understand what drugs have stopped, started, changed and the rationale for these changes along with any plans for follow-up.

Feedback, Actions and Close

- Group member and facilitator from each table to feedback views on the principles and long list of priority actions
- Participants to vote on priority actions via Slido
- Summary of next steps and close