NHMC

National Homecare Medicines Committee

Lessons Learnt: Homecare Medicines Services COVID-19 Response

Purpose

The purpose of this paper, written by the NHMC chair, is to document the actions and decision-making process of the National Homecare Medicines Committee (NHMC) and members of the National Clinical Homecare Association (NCHA) during the response to the COVID-19 pandemic.

This paper does not document the details of the issues raised but will provide a summary of the main issues, successes and barriers encountered during the first wave of the pandemic. A comprehensive list of topics that were considered can be found in the presentation in Appendix 1. The expectation is that this paper will be reviewed by the Pharmaceutical Market Support Group (PMSG) and may be referred to as a source of useful information if similar events occur in the future.

NHMC carried out a lessons learnt survey to NHS and NCHA members. The full results of this survey can be found in Appendix 2.

Introduction

The NHMC chair was asked by NHSEI CMU to provide the NHS leadership to the homecare market by moving to a 'voluntary' full-time role for an initial period of 6 weeks (mid-March to early May) this was extended until the end June as the measures required for the pandemic progressed. The NHMC chair was also supported by a NHSE Clinical Fellow from the beginning of March until May who efficiently provided the liaison between NHSE Specialised Commissioning and NHMC. The NHMC chair provided a weekly Situation Report (SITREP) for the All England Chief Pharmacists network in order to facilitate communication to NHS hospitals.

Links with the NCHA proved vital through the pandemic, NHMC and NCHA members have forged good working relationships with each other and with the ABPI homecare group members over the past few years. Those relationships proved to be essential to maintaining patient safety during the pandemic. The NHS and industry NCHA members demonstrated their commitment to patients and to each other and were able to have open, honest and transparent conversations about various issues throughout this unprecedented time.

Summary

Communication network

A Regional Homecare Specialist also supported and deputised for the chair during the pandemic which proved invaluable especially if the chair had been unable to perform the necessary duties at any time. Having a full-time NHS homecare expert and deputy was essential for maintaining effective communication between homecare providers and NHS hospitals in England, Scotland, Wales and Northern Ireland. In regions where there was a Regional Homecare Specialist communication of developments and adaptations for safety was easier than in the regions where no role exists.

From 6th March NHMC chair held Microsoft Teams meetings with all NCHA members. Meetings switched to twice weekly during June and continue to be held once a month. Depending on the pertinent topics for discussion other stakeholders were invited to join or separate calls were held with the NHMC chair. Additional participants included members of the CMU homecare contract stakeholder groups for HPN, LSD, PH, Immunoglobulin and hereditary angioedema (HAE) experts.

The NHMC and NCHA chairs also attended 2 meetings with the ABPI homecare group during the pandemic. These meetings helped clarify the approach, ensure that there was sufficient stock of medicines for homecare patients, highlighted the importance of good communication between the pharmaceutical manufacturer and contracted or other homecare providers and also gave a clear message to ABPI members that the NHS was extremely busy and so not to expect much contact until the pandemic was either under control or over. ABPI

members were very supportive and were keen to find out in June how they could support the NHS in the recovery phase.

All information and guidance issued to patients and staff during the pandemic aligned with the guidance from Public Health England, DHSC and NHSE&I at all times.

Learning - Communication with and feedback from NCHA members, ABPI, the homecare specialists in the devolved nations and NHS hospitals was positive with regards to communication, the regular meetings were of particular value and aided good communication between all stakeholders. Improvements that could be made for future resilience would be to have a more permanent NHS lead for homecare services and Regional Homecare Specialists in every region of England as well as designated pharmacy homecare teams in every hospital.

Existing homecare services

There were 372,000 patients receiving homecare medicines services at the time of the pandemic and there were 36,000 clinical interventions by homecare provider nurses in patients' homes each month. During the pandemic these services continued to function with very few disruptions or changes to treatment schedules or deliveries. Some patients however were changed from receiving multiple visits each day to just once a day (24-hour infusions and feeding regimes were instigated) to reduce the number and frequency of interactions with people outside of their household. Other patients took drug holidays either on the recommendation of their clinical team or by their own decision. On occasion patients' treatment regimes were altered to a different day to accommodate nurse absence in a particular geography, but these interventions were minimal. All patients were kept safe and all services continued to be provided to existing patients.

Services to existing patients were maintained during the pandemic with only 2 homecare providers not being able to accept new patients in certain therapy areas for short periods of time.

Homecare providers completed Operation Dashboards on a regular basis which continue to be updated as necessary. Homecare providers were asked to submit the document weekly then monthly in addition to each time their internal situation changed. The operational dashboards were update frequently at the beginning of the pandemic but as the situation settled, the frequency submission of these dashboards reduced considerably. These dashboards were used to identify areas of weakness and also provided reassurance to NHSEI that homecare medicines services remained safe for patients.

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Learning – Homecare providers carry out due diligence before taking on new services. All homecare providers have effective Business Continuity Plans (BCP) in place. This provides reassurance to the NHS that services are robust. Homecare providers will document their vulnerabilities for the NHMC and will accept support from other homecare providers through the joint NCHA BCP.

New services for vulnerable patients

COVID-19 caused increased numbers of sick patients to be admitted into hospital for extended periods of time and therefore the hospital environment was a location of risk, in particular, for vulnerable patients. Hospitals aimed to reduce footfall by starting new homecare services, either via new services for the same drugs or by carrying out intravenous to subcutaneous medicine switches, by moving infusion clinics to 'COVID free' zones and by arranging delivery of medicines to patients homes directly from their out-patient dispensing departments (OPD or in-patient pharmacy).

At the beginning of the crisis the extra homecare capacity available to the NHS was unknown. Homecare providers requested that NHMC ensure that hospitals only sent requests for new homecare services to one homecare provider at a time. This was to avoid the often practiced and inconvenient 'scattergun' approach to requesting new services that wastes valuable time and resource within homecare provider organisations, which would have been especially disruptive during the pandemic.

It was also important to ensure that all hospitals and therefore all patients had access to any extra capacity in a fair and transparent manner. Public Health England (PHE) issued a statement which indicated that transplant, cancer and patients suffering from chest/respiratory conditions would be the most vulnerable. NHMC co-ordinated requests for new homecare services using national templates adapted from the South West region and the PHE list was used to guide decisions as to which requests to send to the homecare providers on a weekly basis.

Templates for specialist therapy areas were also designed to aid homecare providers in their decision-making processes as the forms contained fields for additional essential information from the outset. A flow chart to aid hospitals with switching patients between Immunoglobulin IV to SC therapy was also designed and improved during the pandemic. These templates could have been improved as hospitals completed the information concerning patient numbers in a variety of ways that was difficult to collate. This meant that homecare providers could not determine if patients would be referred as a cohort or whether they would be onboarded as few each week/month.

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Learning - The national assigning process led by the NHMC has been extremely helpful in monitoring the NHS demand for homecare and the capacity available in the market. The process can be further refined for improvement and to minimise burden on all stakeholders involved. There is the potential for homecare providers to reserve capacity for a defined time period only, so that if hospitals do not refer their patients in the agreed time period, that capacity could be offered to a different patient cohort.

New patients

During the first twelve weeks of the pandemic, homecare providers were asked to take on new services for more than 20,000 patients in 765+ new service set ups. Homecare providers were able to accept these patients and NHS hospitals will continue to refer these patients over the next 6 months. Time has revealed that some requests were sent to homecare providers as a precautionary measure only and in fact these new services have not been implemented. It will be possible to assess the true number of new patients referred to homecare in December 2020, once all new services have been implemented and patients onboarded.

Learning – Only a single homecare provider could not accept new patients onto some existing services and no new service set-ups for a six-week period. Although this was inconvenient other homecare providers were mostly able to fill that gap. Pharma funded homecare services where that provider was the sole provider caused some challenges. Manufacturers were able to introduce alternative arrangements but some of these arrangements needed NHMC support to set up which was time consuming and the new arrangement did not always fulfil the NHS expectation. Where patient numbers are significant, this episode highlighted the benefits for manufacturers to contract with more than one homecare provider.

Homecare service resilience

There is a finite number of homecare providers, of which the vast majority are members of NCHA. Some of these providers are 'nurse only' organisations who are sub-contracted by the homecare providers for nursing support and other associated care of NHS patients in their own homes. A few homecare providers specialise in

the fertility market, which meant that during the pandemic this fertility capacity could be used to provide other services.

Homecare providers managed to increase their patient capacity at short notice during the pandemic. The 'on-boarding' of new patient cohorts was slow but steady due to a variety of factors (SLA set-up, NHS new patient referral speed etc). The ability of homecare providers to obtain new or additional medicine stock from the pharmaceutical industry was an occasional barrier to speedy on-boarding. The pharmaceutical industry was supportive of the homecare industry in principle, but generally require assurance of financial resilience and regulatory governance before contracting with new homecare providers as a suitable supply chain component. The extra homecare capacity that could have been introduced did not always come to fruition.

Learning – Feedback from NHSEI is that the need for homecare services will continue to grow. Homecare providers managed to increase their capacity at short notice during the pandemic but for the system to be more resilient there is a need for more homecare providers and for current homecare providers to increase their capacity. The NHS also needs to examine 'patient spread' to ensure that, in the case of one or more of the larger homecare providers being impacted negatively, the NHS has a robust (and tested) contingency plan. The financial governance processes that prevent the homecare providers from accessing additional stock at short notice may benefit from review, with the aim of streamlining and improving agility in the market. Homecare providers were able to use virtual platforms for nurse led injection training for some treatments The NHS should promote remote / virtual nurse support where clinically appropriate to mobilise nurse resource to support those who are most in need of a face-to-face support

Repeat prescriptions

In order to relieve the pressure on homecare organisations (NHS and homecare providers), a system for requesting repeat prescriptions 8 weeks prior (as opposed to the usual 5 weeks prior) to the delivery date was set up.

The NHS also pursued clarification on the need for providing 'wet' signatures on EPMA generated prescriptions. NHMC carried out a significant amount of work and research as to the impact of working from home and the difficulties in transferring EPMA prescriptions in homecare services. DHSC, GPhC and NHSX were consulted but unfortunately NHMC was not successful in obtaining authorisation to provide a printed prescription without the 'wet' signature.

Learning -Although NHMC did not succeed in finding a solution for e-transfer of prescriptions, DHSC did provide useful direction as to the conditions under which the pandemic clause of Human Medicine Regulations 2012 Section 226 gives significant flexibility for the homecare pharmacy to make appropriate supplies of prescription only medicines. This will be explored further in due course. The COVID-19 pandemic also raised the awareness of homecare services within NHSX and NHS Digital which will be useful for future engagement.

Medicines shortages

Medicines shortages are not uncommon under usual circumstances so NHMC and homecare providers have an agreed route of communication and mitigating actions that can be deployed.

NHMC Proposal
FINAL v3 HC Shortage

During the pandemic, there were other potential changes to practice that may precipitate a medicines shortage. All of these were dealt with through national decisions in conjunction with the affected pharmaceutical manufacturers. In the majority of cases, homecare providers were able to manage and monitor stock levels by reducing delivery quantities and increasing delivery frequencies of the following groups of medicines for these patient cohorts:

- switches from IV hospital administration to SC formulations via homecare of the same or equivalent treatment
- patients limited to pre-filled syringe devices (low initiation of pens which were in short supply)
- switches from out-patient dispensary (OPD) supply to homecare services

In order to reduce patient footfall in hospital premises during COVID-19, some NHS clinicians considered increasing the quantities of medicines supplied at any one time from out-patient dispensaries (OPDs). This would mean that patients would attend hospital less frequently to reduce their infection risk.
NHMC used the weekly SITREP reports to inform pharmacists and clinicians not to change prescribing and dispensing supply practice which would cause demand surges with subsequent stock shortages. Despite this some HIV medicines did encounter increased demand and associated supply disruption due to OPD dispensing practice changes which could have been avoided.

Learning – The message not to change prescribing habits was well managed by homecare providers but the OPDs did supply HIV medicines in greater quantities which caused national supply issues for a small number of medicines These demand surges had knock on effects on the rest of the supply chain which impacted homecare providers. The messaging from NHMC needs to be more effective and heeded by all hospitals in the future.

Patient engagement

NCHA set up a communications group which 'met' each week with input from various patient groups. The purpose of this group was to ensure that all communications either sent directly to patients or available from the NCHA and NCHA member websites was always accurate and up to date. The NHMC chair and deputy attended this group as often as possible to represent the NHS. There was general agreement that all information would reflect the information from NHSE, PHE and DHSC available in the public domain. This group did not issue disease specific information either; patients were signposted to their own clinical teams if clinical questions were raised.

This communication group also produced an article for publication where the effectiveness of homecare medicines services during COVID-19 was documented.

Learning – The NCHA is a great mediator between the NHS and patients. Patient groups are very willing to help shape communication and to ensure that messaging is consistent and clear. It is essential to hear the patient voice. NHMC will be able to engage with patients via this NCHA group in the future.

Key worker status

Obtaining key worked status for homecare provider staff was essential in order for them to be recognised as an extension of the NHS workforce. This was needed for 3 distinct areas:

- access to PPE
- access to childcare via schools
- access to PCR testing (swab antigen testing) via hospitals

and will be essential for access to the COVID-19 vaccine when this is available.

Access to childcare and swab testing was relatively easy. Schools and hospitals were understanding and once systems were in place, childcare and swab testing was rolled out across the country for homecare providers. Obtaining PPE proved very difficult and ABPI raised concerns with DHSC and the Office of Life Science. The usual supply routes for hospitals were not open for the homecare providers whilst the local community stock was not available in enough quantities for the homecare providers national coverage. Obtaining PPE was extremely challenging in the context of the pandemic and took many weeks resolve. Access to the pandemic stock via NHS Supply Chain was finally granted on 22nd May.

It was not possible for homecare providers to obtain PPE via usual routes of supply as supplies had been reserved for NHSEI only. One homecare provider helpfully sourced PPE and imported masks and aprons from abroad.

Learning – The NHMC perception of the NHSEI system of Cells for crisis management is that the different Cells do not communicate well with each other nor do they understand the nature or complexity of homecare medicines services. NHSEI have stringent data requirements and repeated requests to complete numerous spreadsheets and dataset are a waste of time and effort. In the absence of help from NHSEI homecare providers are resourceful and will support each other.

Conclusion and Next Steps

The NCHA and NHMC work extremely well together to ensure that the NHS and homecare providers collaborate and maintain patient safety system-wide. As an industry the system is self-sufficient but NHMC needs to continue to raise profile of homecare medicines services nationally within the pharmacy and other national teams. It is essential that the importance of homecare medicines services are recognised as serving the NHS in delivering medicines and care to patients' homes.

Appendix 1 NHMC Covid-19 response presentation

2020 NHMC update COVID Response July

Appendix 2 NHMC Lessons Learnt survey results

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