Breakout groups notes – Cheshire and Merseyside DRD event 2018

PHI Public Health Institute
LIVERPOOL JOHN MOORES UNIVERSITY

COPD/Respiratory Care

Main issues
COPD impacts between a third to a half (from screening at addiction clinic). Approximately 48% of those screened required further testing for COPD – large cohort.

It also impacts younger demographic 40-50 years.

It is common in those with a history of smoking drugs – Occurrences in prison due to high level of NPS use.

A combination of prescribed medications, drug and alcohol use caused respiratory depression. There is a link between opiates and COPD.

Access to treatment is currently complex.

Hard to work in a joined up way due to funding and expensive to bring screening into services if not commissioned together.

Discussion around the reluctance to treat / support if still smoking tobacco. Difficult to engage. Reluctance to change. Still feel there is a lack of education/knowledge around smoking.

Achievable aims (short to medium term)

- Need clear effective pathways and screenings – spirometry.
- Need specialist nurses to facilitate.
- Screenings in service, e.g. COPD6. Study on co-location required (likely to have a better uptake if delivered within services).
- Use quality of life scores to show impact and evidence.
- Use motivational interviewing particularly in prisons.
- Identifying links in other services, e.g. flu vaccine offer.
- Learn from other work, e.g. Hep-C treatment which is offered in-service treatment and required a lot of engagement work but is proving effective.
- Identifying if have a COPD nurse within prison settings.
- Psychological assessment to assess willingness to change.

Longer term

- Normalisation of spirometry at entry to service.
- Review by respiratory specialist on a yearly basis.
- Joint prescriptions for COPD and MAT.
- Joint commissioning – putting heads together and working together.

Hostels

Main issues

Problems associated with control of prescribed medication, including methadone. Not knowing what residents have been prescribed, possibility that meds get stockpiled/diverted/shared?

Some discussion about prescribing: Liverpool YMCA have methadone scripts delivered by a mobile pharmacy and dispensed on site (7 days a week); this process is better controlled and also helps residents to stay in treatment.

Main points from YMCA centred around establishing links with MerseyCare (Brook Place) and Addaction.

Talked about links with drug service, and also harm reduction work with Addaction, NSP and Naloxone are provided by Addaction Outreach. Discussed pragmatic approach regarding harm reduction, people are not evicted for drug use on site – supported with treatment instead. YMCA staff have been trained and carry naloxone.

Questioned whether experience of problems with hostels being targeted by the police, but were told this wasn't a problem in Liverpool with police being generally supportive.

St Helens have set up a dedicated (Salvation Army) substance misuse worker, and a nurse from drug treatment service within hostels.

Achievable aims (short to medium term)

- Provide support to hostels regarding prescribed medication
- Provide support to hostels for health related issues faced by homeless population

Discussed whether there are any other service providers where links might need to be established. Mentioned already having contact with GP's and dedicated nurse at Brownlow Practice. Also have outreach at A&E and working with Waves of Hope.

Palliative Care

Main issues

- Late presentation of disease and diagnosis
- Palliative (end stage) patients being referred by hospital – treatment service unable to provide a service as they are too sick and patient may subsequently pass away shortly after being referred
- Need better links with palliative services at different stages of disease and treatment
- Prescribing complications for patients who have severe diseases such as COPD
- Some hospice day services are not set up for this cohort of patients
- Identification of who is end of life and the right access to palliative care pathway – hard to identify
- Poor access to primary care

Current work taking place

- Links with Marie Curie service to provide joint training
- Some services have end of life pathway but not all and need clear previous stages such as palliative care
- Brownlow practice have a good provision for homeless and hostels – forward thinking
- Service provider in St Helens attends GP MDT's and can discuss palliative care
- Easier to link in if an NHS organisation
- Palliative care team monitor doses and combination of drugs

Achievable aims (short to medium term)

- Single point of contact in substance misuse service and CCG for homeless population's access to palliative care
- Better links and training for care homes, also availability of suitable care homes for younger people who may be end of life
- Inviting palliative care provider to DRD panels
- Sharing good practice and contacts across all areas
- Areas linking up with their local hospice provision
- Better identification of service users with advanced stages of disease or complex health issues to seek palliative care pathways
- Education for all staff working in treatment services on the gold standard framework and referral pathways
- Improving links with Primary Care
- Better identification of service users; end of life, palliative care and making them the appropriate offer of support available

Meds Management

Main issues

- Multiple people prescribing – GP, hospital, mental health
- Multiple pain-killer prescribing
- Lack of information sharing
- Lack of medication reviews and responsibility from pharmacies (as pharmacists are the experts on medications and dosage); however individuals use several pharmacies
- High physical/mental health co-morbidities which require medication
- Medication costs – individuals may not have a choice
    - Cost of buprenorphine has increased considerably, which has touted a shortage; therefore methadone prescribed which may not be what the individual wants
    - Also low stocks of diamorphine which has led to individuals going out and using heroin as an alternative

Achievable aims (short to medium term)

- Co-working with other services e.g. Hep C, respiratory
- CCGs are probably the drivers for change
    - CCGs can carry out audits and needs assessments (looking at costs/outcomes) – obviously they want to save money, so they don't want people on multiple medications unnecessarily
    - There is a national dashboard which highlights prescribing 20+ medications to individuals (looks at pharmacies across the country)
- Involve families in reviews of deaths