REVIEW AND RECOMMENDATIONS FOR NEW MODELS OF PRESCRIBING

A Mental Health Home Treatment Team Prescribing Pilot

December 2022

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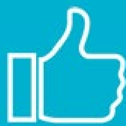
NMOP: Mental Health Home Treatment Team (HTT)

May 2021 – September 2021 Highlights

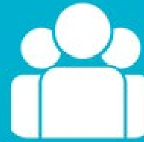
NI lacks a mechanism to allow many prescribers working at interfaces to prescribe medication directly to the patient.

A pilot project ran in 2021 in Belfast Trust involving Mental Health Home Treatment Team medical prescribers.

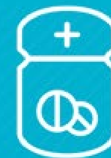


100%
patients/carers surveyed thought the HTT prescribing should become a permanent service

84%
compliance with NI Formulary

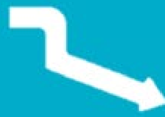


Stakeholders agreed that the HTT prescribing pathway provided patients with a greater opportunity to access the right medicines at the right time from the right person



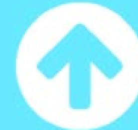
176
medicines were prescribed during the pilot period

Reduced need for hospital admission

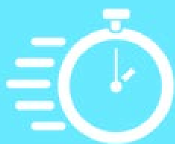


75-91%
Reduction in time taken for entire process

of patients/carers surveyed stated that patients benefited from obtaining prescription in this way



Improved relationship between patient and clinician



Reduction in length of time patient may experience distressing symptoms

Excellent collaboration of key stakeholders at each stage of the project

"It is a vital support at a time when it is much needed for patients and carers"

Task and Finish Group

A task and finish group was set up to oversee the implementation of the pilot project. Membership is detailed in table below:

Task and Finish Group Membership

Name	Title	Organisation
Claire Erki	Lead Community Mental Health Pharmacist	BHSCT
Andrea Linton	NMOP Pharmacy Co-ordinator	HSCB[1]
James McAuley	NMOP Project Manager	HSCB[1]
Stephen Guy	Trust Lead Mental Health Pharmacist	BHSCT
Dr Ashling O'Hare	Clinical Director, Acute Mental Health Services	BHSCT
Agnes Dee	Operations Manager, Home Treatment and Unscheduled Care	BHSCT
Dr Carla Devlin	GP	GP
Siobhan Harney	Community/ICP Pharmacist	Fortwilliam Pharmacy
Marisha Barclay	Senior Nurse Practitioner	BHSCT
Martin Daly	Peer Advocacy Lead	BHSCT
Sharon Casement	Manager, Home Treatment House	BHSCT

[1]On 31 March 2022 the HSCB was closed and its staff and functions migrated to the Strategic Planning and Performance Group (SPPG) of the Department of Health on the 1st April 2022

Introduction

This report summarises the evaluation of the New Models of Prescribing (NMOP): Mental Health Home Treatment Team (HTT) prescribing pilot project. It includes the outcomes from the project and recommendations based on the evaluation results and learning from the development of new processes.

The full report and evaluation data are available from MOIC Report and MOIC Appendices.

Executive Summary

The number of healthcare practitioners in Northern Ireland (NI) who are eligible to prescribe continues to increase each year. In addition to the more traditional medical prescribers, appropriately qualified nurses and pharmacists have been able to prescribe independently since 1997. Additional professional groups such as podiatrists, optometrists and physiotherapists have more recently joined this list of authorised non-medical prescribers. Traditionally, prescribers have worked in either primary or secondary care, and mechanisms to facilitate prescribing are largely reflective of these two environments.

The Covid-19 pandemic has presented unprecedented challenges for the planning and delivery of HSC services, and a Strategic Framework for Rebuilding Health and Social Care Services has been developed which sets out the approach to restoring services as quickly as possible, taking into account examples of innovative approaches to service delivery, developed in response to the pandemic. Related initiatives such as the No More Silos – Urgent & Emergency Care Review, and the Primary Care Multi-disciplinary Teams Programmes further emphasise the increasing requirement for cross sector prescribing across the interface.

NI lacks a mechanism to allow many prescribers, medical and non-medical, working at interfaces to prescribe medication directly to the patient. This report describes how processes to enable HTT prescribing were implemented, tested and evaluated.

HTT is an acute community mental health team based in the Belfast Health and Social Care Trust (BHSCT), providing a multidisciplinary approach to care for adult patients with acute mental illness. The team operates 24 hours a day 7 days a week and bridges the gap between community services and inpatient care for those with acute

mental illness. HTT enables patients to avail of psychological support and intensive medical intervention quickly, with an overall aim of preventing the requirement for inpatient care and supports patient recovery in their home setting. HTT also has a facility known as Home Treatment House (HTH), a 6 bedded unit licensed with Regulation and Quality Improvement Authority (RQIA) which meets nursing home standards. Suitable patients from the HTT caseload may be offered a place in this unit for several weeks to undergo a period of continuous monitoring and more intensive intervention. All patients remain under the care of their GP whilst they are involved with HTT including those staying in the HTH and as a result, supply of prescriptions and medicines are managed in primary care.

At the time of the pilot, there were 4 consultants working in HTT and 4 trainee medical staff consisting of a registrar, one speciality doctor, one core trainee and a locum F2 doctor. The multidisciplinary team consists of community psychiatric nurses, social workers, occupational therapists, community and peer support workers and a mental health pharmacist non-medical prescriber. There are approximately 720 admissions to HTT annually with a caseload of around 55 patients, however the caseload can fluctuate significantly and can reach as high as 80 during times of increased pressure on mental health services. Following medical review of a patient, the psychiatry doctors may advise changes to the patient's psychotropic medicines. They may also advise on prescribing of medicines for physical health if they relate to the management of their mental health e.g. an antiemetic for nausea following a change to psychotropic medicine. This advice is communicated to the patient's GP practice using a hard copy Belfast Trust Treatment Advice Note, and at the GPs discretion, a HS21 prescription is supplied to the patient. This process can present the following challenges to medication management for patients, for example:

- Urgent changes to dose or initiation of a new medicine may occasionally be required at very short notice due to changes in the patient's mental state and presentation. On occasions these requests may be directed to the GP out of hours services, however given the high demand on this service this adds additional pressure and, on occasion, there are no medical prescribers to issue a HS21 prescription
- HTT currently relies on the good will of GP practices expediting these requests

- Changes to dispensing frequency- e.g. moving to twice weekly dispensing. Such changes are used to manage risk and may need to happen quickly.
- Home Treatment House - patients staying in the HTH are often some of the most unwell patients being managed outside of hospital. Patients' GP surgeries may be located anywhere in the BHSCT area, and this can cause delays to receipt of medicines.

This New Models of Prescribing (NMOP) project facilitated the issuing of HS21s for medical prescribers working at the HTT base. Unfortunately, the pharmacist independent prescriber (IP) was unable to participate. One of the barriers to the pharmacist prescriber's ability to engage fully with the project was the uncertainty regarding regulatory clarity in the Professional Standards (Standards and Guidance for Pharmacist Prescribing April 2013 (psni.org.uk)) to facilitate remote prescribing by the Pharmacist IP. The standard states that remote prescribing should only take place in "exceptional circumstances and not for convenience".

Prescribing was permitted in the following circumstances:

- Urgent items that need to be commenced the same day or the following day e.g. supportive medication in crisis, initiation of new medication, dose change, medication to manage side-effects associated with psychotropic medicines
- Short supplies of medicines that require review, titration, tapering by HTT prescriber until the GP can issue prescription for ongoing management

It was agreed that up to a maximum of 7 days treatment would be prescribed to the patient, and that the quantity would be determined by the length of treatment course, the time/day of the week in which the prescription needs to be commenced and any instalment dispensing requirements.

The project was supported by collaborative working involving Health and Social Care Board (HSCB), HSC Trust, Community Pharmacy and General Practitioners (GPs). All key stakeholders were represented on a Task and Finish Group and the project ran from January to October 2021 in BHSCT with five prescribers participating.

Process maps were completed at baseline and at the end of the pilot. Baseline and end-point audits were completed to capture medicines prescribed, deprescribed and

changed. Patient satisfaction was measured using questionnaires. Qualitative evaluation included recording of patient journeys, stakeholder satisfaction surveys and multi-disciplinary focus groups.

Positive outcomes from the project included:

- Excellent collaboration of key stakeholders at each stage of the project
- Displacement of prescribing activity from the GP thereby increasing their capacity for other clinical duties
- Rapid access to acute medicines and reduced length of time that the patient may experience distressing symptoms
- Reduced need for hospital admission
- Improved data quality, reduced paper-load, more timely communication and comprehensive audit trails
- Patient access to specialist prescribing which led to faster stabilisation of patient's condition and management of side-effects
- Improvement in patient-clinician relationship
- High level of patient satisfaction with the new pathway being welcomed by families as changes to medication could be implemented on the same day
- The development of a mechanism to digitally share an electronic treatment advice note with GPs via electronic document transfer. This would reduce the risk of transcription errors
- Implementation of robust governance systems and standardisation of processes which resulted in improved time management and avoidance of multiple contacts with GPs to ensure urgent scripts are issued
- Facilitated timely changes to medication following therapeutic drug monitoring
- Practitioner has more scope to intervene in an appropriate and timely way leading to increased job satisfaction.

Challenges included:

- Inability of pharmacist IP to participate due to limitations in the professional standard relating to pharmacist prescribers working remotely
- Prescribing criteria being considered too restrictive by some of the HTT prescribers

- Occasional issues with GP practices accessing and prioritising treatment advice notes digitally due to the large volume and lack of differentiation in terms of degree of urgency
- Prescription security standards preventing removal of HS21s from base

Enablers identified to support the key principles of NMOP (established during the scoping phase of the project):

Overarching principle: *New Models of Prescribing should provide a robust governance framework to deliver equitable care for all patients in Northern Ireland*

1	Access to HS21s for medical and non-medical prescribers should be streamlined into business as usual across community mental health teams
2	Benchmark outcomes of any proposed future model with redesigned services in other regions
3	Monitoring arrangements should be implemented to provide assurance that prescribing is within professional prescribing parameters
4	The learning should be applied at Trust level to inform Trust Governance frameworks/ policies

Principle 1 *Regional models of prescribing are required*

5	Share outcomes and learning of the evaluation with key stakeholders including budget holders and policy makers
6	Establish regular prescribing update training for medical prescribers working at interfaces with primary care
7	Update pharmacy Professional Standards to permit pharmacist IPs to prescribe remotely, in order to provide patient centred care, while maintaining appropriate safe standards of practice to protect the public
8	Commission a regional service to ensure adequate resource

Principle 2 ***Simplified and clear prescribing and supply pathways***

9	Implement electronic treatment advice notes to simplify the process
10	Standardise communication processes to GPs from Trust prescribers with better demarcation of prescription urgency
11	Keep documentation to a minimum

Principle 3 ***Contemporaneous recording and communication of prescriptions***

12	A technical solution to enable printing of HS21s by medical and non-medical prescribers working at the interface between primary and secondary care is fundamental to NMOP realising its full potential. This will require significant investment and collaborative ownership with colleagues working in digital healthcare
13	Resource software and hardware needed to enable remote access to records
14	Raise awareness of interface prescribing with community pharmacists and GPs

Principle 4 ***Patient's GP practice will be the host of the complete prescribing record***

15	Involve key stakeholders to facilitate GP prescribing record as the complete prescribing record i.e. GPC representatives, eHealth Project Manager, Trust Clinical Information System leads
16	Develop, test and implement robust processes to communicate with GP practices via Electronic Document Transfer

Principle 5 ***Remote access to records***

17	Ensure community medical prescribing is included within electronic prescribing programme
18	Share learning with ENCOMPASS programme
19	Enable remote access to decision support software for Trust prescribers

Principle 6 *Prescriber's role should be clinical*

20	Determine the appropriate skill mix and clinical pharmacy resource needed to enable professional autonomy and to support further
21	Consider how access to HS21s could be utilised more fully by other specialist community teams working at interfaces with primary care e.g. acute care at home teams

Principle 7 *Medicines policy and legislation should enable new models of prescribing and supply*

22	Consider impact of any Medicines Adherence policies on Trust prescribing
23	Share outcomes and learning of the evaluation with budget holders and policy makers
24	Align further expansion with DoH policy in relation to prescribing and supply of medicines at interfaces with primary care

Specific recommendations identified for the future are:

Stakeholder engagement

1. Stakeholder ownership at regional and local level is key
2. Share outcomes and learning of the evaluation with key stakeholders including budget holders and policy makers
3. Manage expectations of key stakeholders in relation to the purpose of any new model implemented

Roll-out new model

4. Access to HS21s for certain community teams should be streamlined into business as usual across all Trusts. Expansion should initially be explored in the areas of integrated and acute care before further expansion to other long-term conditions and disease management that community teams manage within HSCTs

5. Benchmark any proposed future model with redesigned services in other regions
6. Learning from the NMOP pilot should be used at Trust level to inform organisation governance frameworks and policies
7. Solutions to ensure adequate prescription security at offsite clinics should be agreed
8. Clarification of prescribing criteria for community mental health teams to ensure it is measured and not too restrictive
9. Establish a process for Trust-employed medical prescribers to register as a medical prescriber and obtain a prescribing cipher

Communication

10. Encourage HSCTs to agree a regional eTAN rather than specific Trust eTANs
11. Consolidate current communication interfaces between Trust community services and GP practices and ensure that existing NMOP interfaces are considered by the ENCOMPASS team

Workforce and resources

12. Firm commitments and clarity will be needed around Trust prescribing budgets
13. Determine the appropriate skill mix and clinical pharmacy resource needed to enable professional autonomy and to support further expansion
14. The ability to prescribe via virtual consultations requires further exploration and will require electronic prescribing to be enabled
15. Liaise with professional regulator for pharmacists to permit pharmacist IPs to prescribe remotely in a safe and appropriate manner
16. A technical solution to enable printing of HS21s by those prescribing at the interface between primary and secondary care is key to NMOP realising its full potential. This will require significant investment and collaborative ownership with colleagues working in digital healthcare

Training and guidance

17. Regular prescribing update training for prescribers is fundamental to the success of any wider expansion

18. Medical prescribers should be encouraged to prescribe in line with evidenced-based recommendations e.g. NI Formulary choices
19. Monitoring arrangements will need to be in place to provide assurance that prescribing is appropriate and safe.

Following a pause to this prescribing model being implemented in BHSCT, it is anticipated that the pathway will recommence during December 2022. Further consideration to this service aspect becoming “Business as Usual” will be taken by the BHSCT’s Drug and Therapeutics Committee in March 2023. Further expansion to other Trusts or additional service areas is dependent on commissioning arrangements being agreed regionally and the commissioning of a technical solution to enable printing of HS21s by prescribers working at interfaces.

Based on the NMOP pilot project recurrent funding has now been made available from the Department of Health to establish an Integrated Prescribing Programme within the SPPG. This will include the scaling up of NMOP based on the recommendations outlined.

The experience of this NMOP project can serve as an example of the capacity and commitment required to deliver NMOP in other areas. Learning will be taken forward to new clinical areas and across the region.

Overview of New Models of Prescribing project

Northern Ireland lacks mechanisms to allow some prescribers working at interfaces between primary and secondary care to prescribe treatments directly to their patients. This means that there may be duplication of work, with the original prescriber needing to work through the patient’s General Practitioner (GP) to ensure that the required treatments are prescribed.

In order to address these issues, a transformation project, led by the Health & Social Care Board (HSCB) and involving extensive stakeholder engagement, was established to scope out the arrangements that need to be in place to enable prescribers working at the interface to work in a more effective and autonomous way. The stakeholder engagement established key principles to enable New Models of Prescribing (NMOP) (Figure 1).

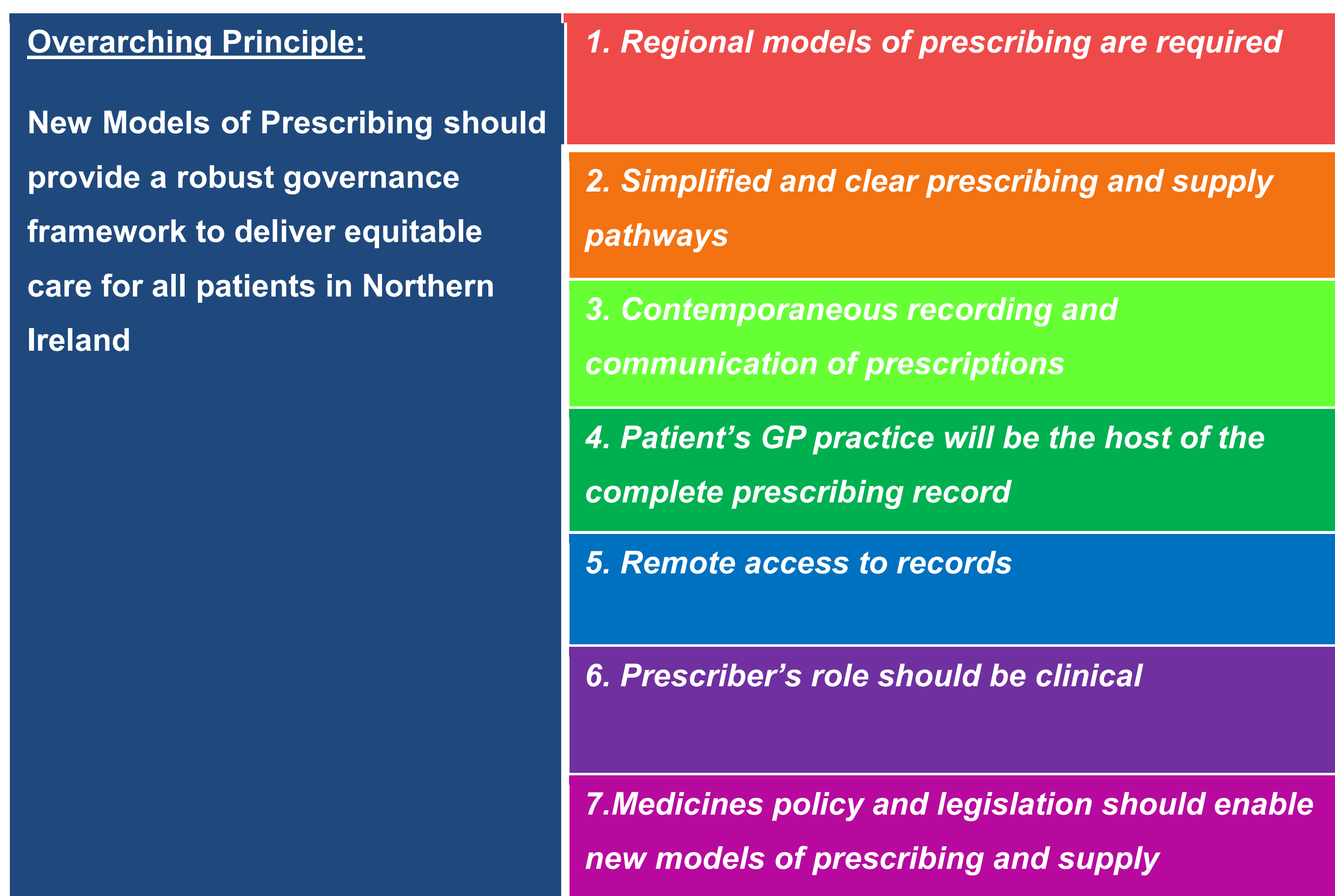


Figure 1 - Agreed NMOP Principles

A number of pilot projects were initiated to explore the processes, governance and policy frameworks required for new models of prescribing (NMOP). The pilots included:

- Dietitian led direct ordering of oral nutritional supplements for care home residents
- Physiotherapist prescribing at the interface: community and outpatients
- Heart failure nurse specialist prescribing at the interface
- Mental Health Home Treatment Team medical prescribers

The Medicines Optimisation Innovation Centre (MOIC) is a regional centre in Northern Ireland dedicated to delivering medicines optimisation to the population. MOIC were tasked with assisting in the evaluation of the NMOP pilot studies.

One of the pilot projects focussed on Mental Health HTT prescribing at the interface. This report will describe the evaluation of that pilot.

Context

HTT is an acute community mental health team based in the Belfast Health and Social Care Trust (BHSCT), providing a multidisciplinary approach to care for adult patients with acute mental illness. The team operates 24 hours a day 7 days a week and bridges the gap between community services and inpatient care for those with acute mental illness. HTT enables patients to avail of intensive medical and psychological intervention quickly, with an overall aim of preventing the requirement for inpatient care and supports patient recovery in their home setting. HTT also has a facility known as HTH, a 6 bedded unit licensed with Regulation and Quality Improvement Authority (RQIA) which meets nursing home standards. Suitable patients from the HTT caseload may be offered a place in this unit for several weeks to undergo a period of continuous monitoring and more intensive intervention. All patients remain under the care of their GP whilst they are involved with HTT including those staying in the HTH and as a result, supply of prescriptions and medicines are managed in primary care. At the time of the pilot, there were 4 consultants working in HTT and 4 trainee medical staff consisting of a registrar, one speciality doctor, one core trainee and a locum F2 doctor. Patients are admitted to the caseload under the care of a consultant and staff are aligned to each of the consultants in clusters to provide continuity of care. The multidisciplinary team consists of community psychiatric nurses, social workers, occupational therapists, community and peer support workers and a mental health pharmacist non-medical prescriber.

There are approximately 720 admissions to HTT annually with a caseload of around 55 patients. HTT is staffed to manage a maximum capacity of 55 patients, however the caseload can fluctuate significantly and can reach as high as 80 during times of increased pressure on mental health services. Following medical review of a patient, the psychiatry doctors may advise changes to the patient's psychotropic medicines. They may also advise on prescribing of medicines for physical health if they relate to the management of their mental health e.g. an antiemetic for nausea following a change to psychotropic medicine. This advice is communicated to the patient's GP practice using a hard copy Belfast Trust Treatment Advice Note and at the GPs' discretion, a HS21 prescription is supplied to the patient.

Challenges – this process which relies on GPs issuing a HS21, following assessment by the HTT, can present the following challenges to medication management for patients, for example:

- Urgent changes to dose or initiation of a new medicine may occasionally be required at very short notice due to changes in the patient's mental state and presentation. HTT currently relies on the good will of GP practices expediting these requests
- Access to medication out of hours - including weekends, bank holidays and times that surgeries have reduced hours for staff training. Urgent requests for prescriptions may be directed to the GP out of hours services, however given the high demand on this service, the HTT try to minimise requests where possible.
- Changes to dispensing frequency - e.g. moving to twice weekly dispensing. Such changes are used to manage risk and may need to happen quickly.
- Community Pharmacies will require a prescription with the new frequency to be issued by the GP before the new supply can be made.
- Home Treatment House - patients staying in the HTH are often some of the most unwell patients being managed outside of hospital. Patients' GP surgeries may be located anywhere in the BHSCT area, and this can cause delays to receipt of medicines.

Aims and objectives of NMOP HTT's pilot evaluation

The overarching aim was to complete an evaluation of the NMOP HTT pilot through joint working between MOIC and HSCB[1].

The objectives were to evaluate:

Objective 1	Establish potential volume of prescribing activity that can be shifted to HTT prescribers
Objective 2	Identify benefits in relation to access to medication and reducing pressure on GPs

Objective 3	Support and enhance the delivery of tailored HTT interventions to patients, maximising professional skills at the point of care delivery
Objective 4	Support the delivery of care pathways that can be delivered by a HTT prescriber
Objective 5	Reduce delays in patients accessing medication thus providing greater opportunity to access the right medicines, at the right time, from the right person
Objective 6	Support a reduction in the amount of unnecessary health care appointments and hospitalisations and promote faster recovery and self-caring
Objective 7	Support improvements in patient / client concordance with taking prescribed medicine

[1]On 31 March 2022 the HSCB was closed and its staff and functions migrated to the Strategic Planning and Performance Group (SPPG) of the Department of Health on the 1st April 2022

Evaluation methodology

An analysis plan linking project objectives to the collected data was co-produced by MOIC, HSCB and clinicians participating in the NMOP pilot. Division of tasks under the plan was agreed between HCSB and MOIC (Appendix 2).

In line with the agreed analysis plan, the following outcome measurement and analysis was undertaken:

- **Stakeholder feedback session:** An agenda for a virtual feedback session was co-produced by HSCB and MOIC. Mentimeter software was used to capture quantitative agreement ratings and qualitative commentary from contributors. Qualitative feedback from participants was mapped to the project objectives using a theming approach. Average agreement ratings from the participants on how the pilot met the project objectives, were summarised.

- **Stakeholder survey:** A survey co-designed by HSCB and MOIC was launched via Citizen Space. Descriptive statistics were used to summarise responses. Qualitative feedback from participants was themed and tabulated.
- **Patient Satisfaction Questionnaire:** Patients receiving care as part of the NMOP pilot were invited to complete and submit a paper or electronic Patient Satisfaction Survey in person, via post or email. Descriptive statistics were used to summarise results. Direct quotes were extracted and presented.
- **NMOP audit activity:** Audit activity was collated using Microsoft Excel by the participating prescribers and compiled into a baseline and final database by the Lead Community Mental Health Pharmacist. Data was quality checked and recategorised as necessary. These data were agreed by HCSB and MOIC. Descriptive statistics were used to summarise activity at the start and end of the pilot and results were tabulated. Additional supporting information were summarised in text.
- **Process maps:** Clinicians participating in the NMOP pilot summarised their clinical workflow at the start and end of the pilot. The main steps from the process at the start and at the end of the pilot were extracted from the text and collated in flowchart figure. Key findings were summarised.
- **Patient journeys**: Clinicians participating in the NMOP pilot summarised patient journeys prior to and during the pilot. The full summaries and key findings were presented in text.
- **Prescribing data**: Monthly prescribing data (number of prescribers, number of scripts, number of items, cost of items, average cost of item and average cost of item per prescriber) from the start to the end of the pilot was summarised using descriptive statistics.

Discussion points emerging from the analysis were formulated.

Results

Detailed results of the evaluation undertaken by MOIC and NMOP project team can be found on the MOIC Report and MOIC Appendices.

Discussion

The HTT prescribing pilot was innovative and flexible and ensured that the patient remained at the centre of prescribing interventions. The multidisciplinary approach involving Trust psychiatrists, pharmacists, nurses, managers, and IT colleagues, and GPs, community pharmacists, and HSCB colleagues enabled the programme to be tailored to individual patient requirements.

The excellent collaboration also facilitated quality assurance at each stage of the project development as regular Task and Finish Group meetings ensured that identification of issues were incorporated within service design and delivery.

Results, both qualitative and quantitative, were very positive. A number of positive outcomes were described as benefits to the patient, health and social care system, and specific disciplines involved in the revised model of care. These are described as follows:

Benefits to patients:

A wide range of patient-perceived benefits were reported via the various data collection methods leading to an improved patient experience. Stakeholder feedback and process mapping highlighted that allowing HTT medics to prescribe on HS21s **reduced the delay in accessing urgent medicines,** which was of great significance in those patients requiring early intervention to manage distressing symptoms and prevent the need for hospital admission. As a result, many patients were able to have their **medication dispensed on the same day as their HTT assessment.** The process mapping exercise verified this indicating that the revised model reduced the number of steps by an average of 2.

Furthermore, the **time taken for the entire process** (initial assessment to receipt of item via CP) **reduced by at least 75%.** The most significant change in process was the reduced need for multiple contacts with the GP to ensure urgent medication is commenced in a timely manner.

Documented patient journeys provided examples of the patient receiving **the right medicine from the right person at the right time.** This access to specialist care led to **improved symptom management** enabling faster stabilisation of patients' symptoms and reduced need for hospital admission. NMOP improved prescription

access for all patients leading to beneficial changes in management of side-effects associated with psychotropic medication.

Feedback from stakeholders, patients and patient's families reported **increased patient satisfaction** with the new pathway enabling access to medication on the same day in urgent situations.

Patient journeys and survey returns provided examples of **benefit in managing acutely ill patients** and removing the stress for patients and families associated with previous difficulties in accessing urgent medication. All patients surveyed thought they benefited from obtaining their medication in this way. In some of these cases, time was saved as a GP prescription was no longer required for urgent medication required for patients of the HTH.

The patient survey provided an assurance that patients found the new process for obtaining medication **straightforward** (94%) and all patients felt that the new model should become permanent.

High levels of compliance with NI Formulary choices (84%) was achieved indicating that prescribing was evidence-based.

Benefits to the healthcare system:

Stakeholders reported that the model owed its success, in part, due to clear, efficient and timely communication between prescribers and other stakeholders. **Robust governance systems and standardisation of processes** resulted in improved time management and avoidance of process duplication.

The development, rigorous testing and deployment of eTANs via Electronic Document Transfer to GP practices resulted in **improved data quality, reduced paper-load, more timely communication and comprehensive audit trails.**

NMOP also enabled more direct and timely communication between the HTT and GP practice. Direct involvement of the HTT prescriber in writing the prescription will therefore have benefits in terms of **reduced costs** associated with duplicated work and contributed to improved multidisciplinary working.

The results from the evaluation of this NMOP highlight the importance of the HTT skill set in managing acutely ill mental health patients e.g. in **reducing need for hospital admissions** to manage distressing symptoms**.**

Stakeholder feedback reported that HS21 prescriptions written by HTT prescribers, on occasions had the potential to **reduce duplication and administrative burden** in GP practices.

A shorter process had the added benefit of potentially reduced costs associated with poor symptom control.

One of the recorded patient journeys concluded that the streamlined processes implemented with the NMOP reduced disruptions to multiple clinicians' time.

Benefits to HTT:

Prescribers participating in the stakeholder feedback session and responding to the survey recorded that NMOP **maximised use of professional skills at point of care** leading to increased job satisfaction. Furthermore, audit activity confirms that NMOP provides a vehicle for clinicians to de-prescribe medications that patient may no longer require e.g. hypnotics.

The NMOP was particularly beneficial **making prescribing processes more efficient.** The evaluation found that there was a reduction in the number of instances that the HTT needed to contact a GP to generate a prescription leading to **better time management** and cost savings.

Enabling patients to access medicines faster resulted in more **efficient management of HTT caseload.**

Participating prescribers welcomed the increased opportunities that the project provided for learning and development and improved relationships with their patients. Those participating showed resilience in progressing with the project despite the pressures faced as a result of the COVID pandemic and difficulties in establishing a digital interface with GP practices.

Benefits to GPs:

Evaluation of audit data found that there was a reduction in the number of occasions GPs were asked to generate a prescription for the HTT patient. As well as **reducing GP administrative burden** this should lead to subsequent cost savings.

Displaced prescribing activity and consultation activity from GPs to HTT was also reported by some stakeholders, and has the potential for further benefits to GPs of any future patients being cared for in the HTH.

Stakeholder feedback suggested that as a result of NMOP **robust communication pathways were established between HTT and GPs** via the development of electronic transfer of treatment advice notes to GP practices. It also facilitated clearer designation of the GP role in relation to managing medication for HTT patients.

Challenges

As well as positive outcomes the pilot provided an opportunity to identify the constraints of the new process and aspects that will require further consideration before any further expansion to the delivery of this new model.

Respondents to the stakeholder survey included GP Pharmacists (GPPs), however, the nature of some of the feedback provided caused doubt as to their direct involvement in and understanding of the new model.

There were specific challenges in implementing the NMOP that could not be measured, but that emerged through stakeholder feedback. Commencing this pilot during the **COVID pandemic** also caused difficulties as there were limitations to prescribing at virtual consultations. Implementation was also affected by staff sickness, shielding and redeployment due to COVID.

Some GPs surveyed, reported occasional **issues with receiving/accessing treatment advice notes.** It was evident that some were not aware of the transmission of treatment advice notes to GP document management systems via EDT. Furthermore, the pilot highlighted a wide variation in systems employed across GP practices to triage and workflow communications from secondary care, particularly those related to medication changes. This was addressed, in part, via local contacts made with GPs from HTT clinical pharmacist and other HTT members and the issuing of a regional letter from HSCB to clarify the roles of both Trusts and general practices in managing communications relating to medication changes. It was hoped that the HSCB correspondence would also improve consistency of processes in both sectors.

At the project initiation stage, considerable time and effort was required to establish a digital interface between the Trust PARIS consultation system and GP clinical systems. While this was challenging, it provided **an early opportunity to identify problems and implement solutions** before the project went live. Further modifications to the interface were required as the project continued and additional shortcomings with the process identified.

Offsite location of HTT staff led to some logistical difficulties with **delivery and transportation of prescription stationery**.

Future considerations and recommendations

The success of this and other NMOP pilots has led to new HSC posts being secured regionally with recurrent funding to the Strategic Planning and Performance Group. The experience of this NMOP project can serve as an example of the capacity and commitment required to deliver a NMOP in other areas. Collective leadership, stakeholder engagement from the outset, capacity to facilitate and attend regular meetings, robust communication strategy and clearly-defined outcomes were all paramount to successful implementation.

Specific considerations / recommendations for the future are as follows:

1. Access to HS21s for certain community teams should be streamlined into business as usual across all Trust. Expansion should initially be explored in the areas of integrated and acute care before further expansion to other long-term conditions and disease management that community teams manage within HSCTs.
2. Share outcomes and learning of the evaluation with key stakeholders including budget holders and policy makers.
3. Stakeholder ownership at regional and local level is key.
4. Learning from the NMOP pilot can be used at Trust level to inform organisation governance frameworks and policies.
5. Determination of the appropriate skill mix and clinical pharmacy resource needed to enable professional autonomy and to support further expansion.
6. Benchmark any proposed future model with redesigned services in other regions.

7. Regular prescribing update training for prescribers is fundamental to the success of any wider expansion.
8. A technical solution to enable printing of HS21s by prescribers at the interface between primary and secondary care is fundamental to NMOP realising its full potential. This will require significant investment and collaborative ownership with colleagues working in digital healthcare.
9. Medical prescribers should be encouraged to prescribe in line with evidenced-based recommendations e.g. NI Formulary choices
10. Firm commitments and clarity will be needed around Trust prescribing budgets.
11. Monitoring arrangements will need to be in place to provide assurance that prescribing is appropriate and safe.
12. Ability to prescribe via virtual consultations requires further exploration and will require electronic prescribing to be enabled.
13. Agree a regional eTAN rather than specific Trust eTANs.
14. Consolidate current communication interfaces between Trusts and GP practices and ensure that existing NMOP interfaces are considered by ENCOMPASS team.
15. Ensure adequate prescription security at offsite clinics.
16. Manage expectations of key stakeholders in relation to the purpose of any new model implemented.
17. Clarification of prescribing criteria for community mental health teams to ensure it is measured and not too restrictive.
18. Establish a process for Trust-employed medical prescribers to register as a medical prescriber and obtain a prescribing cipher.
19. Liaise with professional regulator for pharmacists to permit pharmacist IPs to prescribe remotely in a safe and appropriate manner.

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