Health and Social Care

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REVIEW AND RECOMMENDATIONS FOR NEW MODELS OF PRESCRIBING

Dietitian led direct ordering of oral nutritional supplements for care home residents

July 2022


HSC
Dietetic Ordering of ONS in care homes
April – June 2021 Highlights
A number of pilot projects were initiated to explore the processes, governance and policy frameworks required for new models of prescribing (NMOP).
One of the pilots tested a dietetic led ordering of ONS for residents in six care homes in three Health and Social Care Trusts in Northern Ireland, without the need for generation of a GP prescription. Monthly stock orders for the care home residents were raised by the dietitian rather than individual resident orders.
92%
of stakeholders felt dietitian-led ordering of ONS on stock order benefit residents
> 79%
compliance with NI Formulary. Prior to the pilot, this was 64%
96%
of stakeholders happy for dietitian-led ordering of ONS for care home residents to continue
100%
of residents reviewed within the timelines specified in their care pathways
Reduced Costs
The net average reduction in cost per month across the 6 participating homes was £3621. This could be extrapolated to over £43K annually.
40%
time taken for the community pharmacy supply route reduced by at least 40%
96%
Of stakeholders felt the project supported the delivery of care pathways that can be delivered by a dietitian
Increased ONS Compliance
Better compliance was recorded after the pilot, with a full serving being taken for 93% of items and no items being refused completely
Reduced workload
For GPs and CPs associated with the prescribing/supply of ONS in the new process released capacity to other clinical duties
Care homes more informed
with respect to "food first" approaches, food fortification and ONS
Excellent collaboration
of key stakeholders at each stage of the project
"There are benefits for patients, care homes, GP practices, dietitians, community pharmacists and economic benefit to the HSC"

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
Paula Cahalan	AHP Lead (Chair until Sep '21)	BHSCT
Andrea Linton	NMOP Co-ordinator (Chair from Oct '21)	HSCB[1]
Mo Henderson	AHP Consultant	PHA
James McAuley	NMOP Project Manager	HSCB[1]
Emer McLean	PMMT Pharmacy Adviser	HSCB[1]
Lucy Hull	Trust Dietetic Head of Service	BHSCT
Jill Curry	Trust Dietetic Head of Service	NHSCT
Anne Gormley	Trust Dietetic Head of Service	WHSCT
Siobhan McCaffrey/ Warren Edwards (From August 2021)	Acting Assistant Dietetic Manager Community Team Lead Dietitian	
Monique Kritzinger	Trust Dietitian	BHSCT
Jemma Jackson (until June 2021) / Elizabeth Armstrong (from June 2021)	Trust Dietitian	NHSCT
Linda Trimble/ Laura Drumm (until August 2021)/ Louise Roulston (from August 2021)	Trust Dietitian	WHSCT
Brenda Rushe	Representative for Independent Health and Care Providers	RCN
Rachel Lloyd	Pharmacist Inspector	RQIA
Ciara Haughey	General Practice Pharmacist	GP Federation
Dr Stephen Bradley	General Practitioner	GP
Peter Rice	Community Pharmacist	CPNI
Jonathan Semple	Head of Logistics	BSO PaLS
Ruth Balmer	Policy Officer	BDA

[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): Dietitian led direct ordering of oral nutritional supplements for care home residents' 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 the MOIC report.

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 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 working at interfaces to prescribe medication directly to the patient. Care home residents who are assessed as having additional nutritional requirements should have a management care plan that aims to meet their complete nutritional requirements. To supplement the first step of fortified food measures, oral nutritional supplements (ONS) are often prescribed by GPs, usually on the recommendation of a dietitian. At the time of the project dietitians did not have prescribing rights. Whilst changes to legislation were announced in April 2022 which introduced the possibility of enabling supplementary prescribing of medicines in secondary care by advanced dietitians, the ability to prescribe is not relevant for the

majority of nutritional products as they are not Prescription Only Medicines. Regardless of prescribing ability, dietitians already have the skills and expertise to assess and monitor patients for nutritional needs, recommending and stopping nutritional products as clinically indicated and it would be reasonable to propose that the clinical responsibility for ordering these items could sit with them.

A DoH led nutrition pilot in 2019, involving eight care homes in SEHSCT locality, identified that ONS waste over a 3-month period in care homes was 24% of the prescribing costs. A key recommendation for improvement suggested by the care homes, GP practices and community pharmacists, was the direct input of dietitians to the ordering process.

This New Models of Prescribing (NMOP) project tested the concept of dietetic led ordering of ONS for residents in care homes in Northern Ireland without the need for generation of a GP prescription. The evaluation report describes how processes to enable dietitian-led direct ordering of oral nutritional supplements (ONS) for care home residents were implemented, tested and evaluated. Monthly stock orders for the care home were raised by the dietitian rather than individual resident orders. Two supply mechanisms were tested as outlined below:

- ONS supplied by community pharmacy contractor who normally supplies medicines to the care home
- ONS supplied by Business Services Organisation Procurement and Logistic Services (BSO PaLS)

The project was supported by collaborative working involving Health and Social Care Board (HSCB), Public Health Agency, HSC Trusts, Business Services Organisation' (BSO) Procurement and Logistic Services (PaLS) and Family Practitioner Services (FPS), Community Pharmacists (CPs) and General Practitioners (GPs). All key stakeholders were represented on a Task and Finish Group and the project ran from April to June 2021 in three Health and Social Care Trusts. Six care homes and 6 dietitians participated.

Process maps were completed at baseline and end of pilot. Audits were completed to capture detailed information on ONS supplied to residents. Costs of ONS supplied before and during the project were compared. Qualitative evaluation included

recording of resident journeys, stakeholder satisfaction surveys and multi-disciplinary focus groups.

Positive outcomes from the project included:

- A reduced delay in accessing ONS via the CP supply route
- 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
- Reduced dispensing activity of community pharmacists due to stock order model rather than individual resident prescription approach, thereby increasing their capacity for other duties
- Involvement of dietitians in the ordering process released care home staff capacity to other duties important in the care of residents
- Improved nutritional care of residents due to earlier access to dietetic intervention
- Implementation of robust governance systems and standardisation of processes which resulted in improved time management and avoidance of process duplication
- Residence access to specialist care which led to improved adherence with ONS
- Reduced risk of inappropriate ONS being supplied as transcription of a recommendation was no longer needed
- A reduced spend on ONS as a result of dietitians being involved in the ordering process, leading to increased compliance with NI Formulary choices and a reduction in waste
- Care home staff were more informed with respect to "food first" approaches, food fortification and ONS.
- Encouragement of professional autonomy, clinical responsibility, and increased professional standing leading to increased job satisfaction.

Challenges included:

- Limited range of products available via the BSO PaLS supply route
- Commencing the pilot during the COVID pandemic given the related pressures on care homes

- Reluctance of some care homes to move to ONS deliveries on a monthly basis
- Managing the change due to multi-disciplinary and multi-agency nature of project
- Residents remaining under dietetic care for a longer period of time meaning that additional dietetic resource is required.

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 stock ordering process for care home residents should be streamlined into business as usual across all Trusts in a phased manner commencing with one locality per Trust.
2	Benchmark outcomes of any proposed future model with redesigned services in other regions e.g. Tayside and Rotherham health authorities [1,2]
3	Consider carefully the design of any new care plan to avoid the introduction of a two-tier system (with respect to dietetic waiting times) leading to inequity of nutritional care to residents.
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	A pre-requisite of the model should be that care homes must adhere to a 4 weekly ordering cycle and undertake to provide sufficient storage space for 4 week supply of ONS products
7	Determine appropriate professional fees for CP contractors supplying against stock orders and consider payment process

8	Encourage dietitians to review, rationalise and provide a narrower range of products in line with evidenced based recommendations
9	Regular and frequent training for care home staff on good nutritional care is fundamental to the success of any wider expansion

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

10	Determine the training needs for care home staff on the operation of the In-healthcare digital system
11	Expansion of dietetic involvement in ordering of ONS for care home residents should be via the CP supply route
12	Keep documentation to a minimum and further explore digital systems to support ordering

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

13	Share learning with ENCOMPASS programme
14	Identify future plans to enable wider access to necessary IT hardware and software for care homes
15	Standardise communication processes to GPs from dietitians

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

16	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
17	Develop, test and implement robust processes to communicate with GP practices via Electronic Document Transfer

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

18	Enable remote access to In-healthcare digital platform

19	Share learning with ENCOMPASS programme

Principle 6 *Dietitian's role should be clinical*

20	Determine the appropriate skill mix and dietetic resource needed to enable professional autonomy and to support further expansion based on one locality per Trust, in the first instance. This should include consideration of future roles for dietetic support workers and administrative support

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

21	Consider how recent amendments to the Health and Personal Social Services (General Medical Services Contracts) (NI) Regulations 2004 (the GMS Contracts Regulations) and The Health and Personal Social Services Pharmaceutical Services Regulations (Northern Ireland) 2022 (the 1997 Regulations) may influence future supply pathways of the ONS to care home residents
22	Share outcomes and learning of the evaluation with budget holders and policy makers
23	Align further expansion with DH policy in relation to prescribing and supply of medicines at interfaces with primary care

1. NHS Tayside ONS Service for Care Home Patients
2. Rotherham Nutrition Prescribing Project

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

Roll-out of new model

3. Prepare a business case to secure recurrent funding on an "invest to save" basis linking with the SPPG Pharmaceutical Clinical Efficiency programme
4. Benchmark any proposed future model with redesigned services in other regions

Supply mechanisms

5. Expansion of the dietetic involvement in ordering of ONS for care home residents should be via the CP supply route
6. A pre-requisite of the model should be that care homes must adhere to a 4 weekly ordering cycle and undertake to provide sufficient storage space for 4-week supply of ONS products

Workforce and resources

7. Determine the appropriate skill mix and dietetic resource needed to enable professional autonomy and to support further expansion based on one locality per Trust, in the first instance
8. Determine appropriate professional fees for CP contractors supplying against stock orders
9. Identify future plans to enable wider access to necessary IT hardware and software for care homes

Training and guidance

10. Regular and frequent training for care home staff good nutritional care is fundamental to the success of any wider expansion
11. Determine the training needs for care home staff on the operation of the In-healthcare digital system
12. Review ONS product use across the pilot care homes to develop guidance to optimise prescribing in line with NI Formulary choices and good nutritional standards

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 via 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) 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 NMOP (Figure 1).

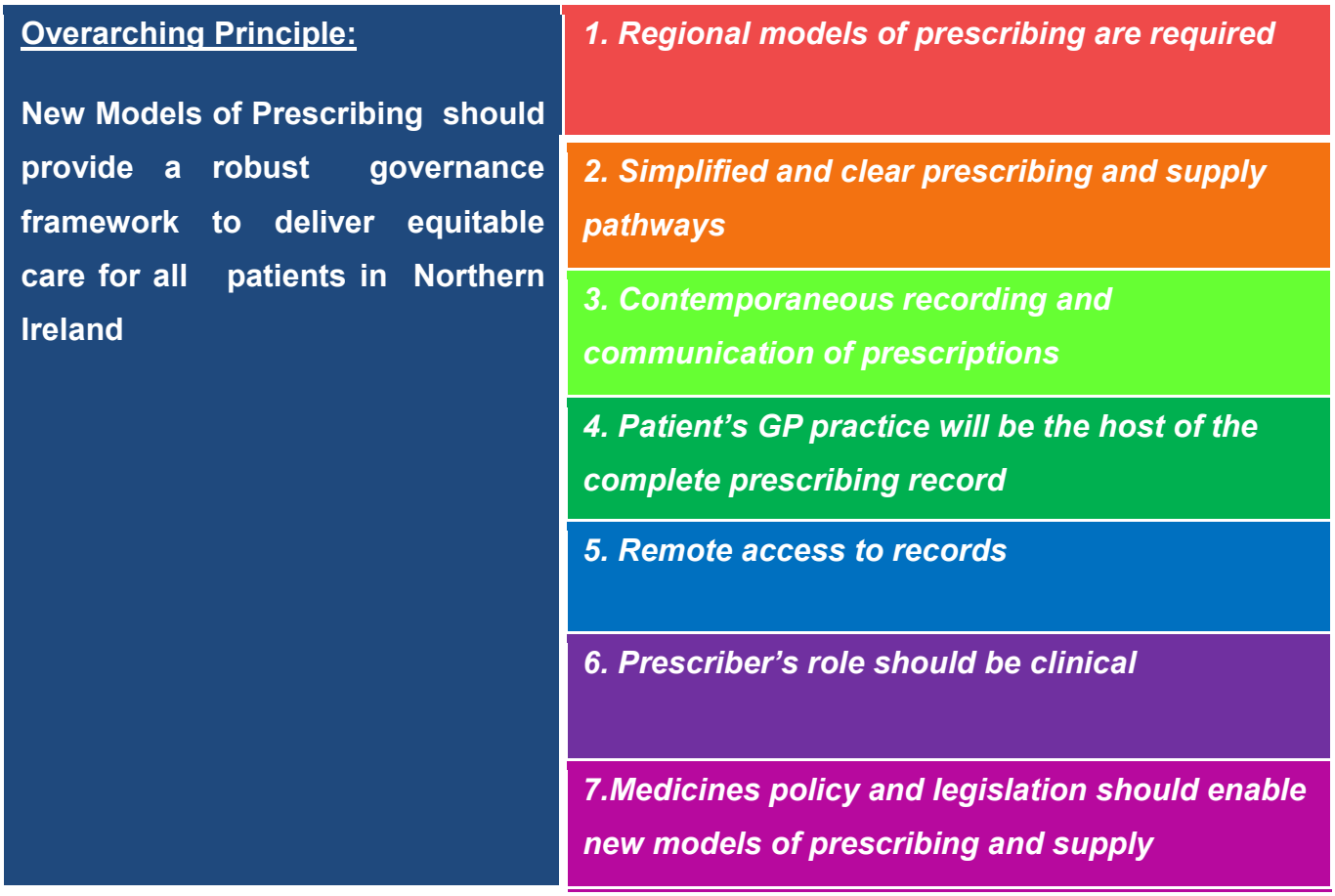

Figure 1 - Agreed NMOP Principles

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 dietitian-led ordering of ONS for care home patients. This report will describe the evaluation of and recommendations from that pilot.

Context

Care home residents, who are assessed as having additional nutritional requirements, should have a management care plan that aims to meet their complete nutritional requirements. To supplement the first step of fortified food measures, oral nutritional supplements (ONS) are often prescribed by GPs, usually on the recommendation of a dietitian. Whilst changes to legislation were announced in April 2022, which introduced the possibility of enabling supplementary prescribing of medicines in secondary care by advanced dietitians, the ability to prescribe is not relevant for the majority of nutritional products as they are not Prescription Only Medicines. At the time of the project dietitians did not have prescribing rights. However dietitians already have the skills and expertise to assess and monitor residents for nutritional needs, recommending and stopping nutritional products as clinically indicated and it is reasonable to propose that the clinical responsibility for ordering these items can sit with them.

A MORE nutrition pilot in 2019, involving eight care homes in South Eastern Health & Social Care Trust (SEHSCT) locality, identified that waste of ONS products over a 3-

month period in care homes was 24% of the prescribing costs. A key recommendation for improvement suggested by the care homes, GP practices and community pharmacists, was the direct input of dietitians to the ordering process.

NHS Tayside has successfully implemented a dietetic led stock order service for care homes in the Dundee area. The service has demonstrated improved management of residents and, prescribing savings mainly achieved from reduced wastage due to inappropriate prescribing. Additional savings have recently been identified as a result of an NHS managed supply process.

This pilot tested a similar concept through dietetic led ordering of ONS for residents in care homes in Northern Ireland, without the need for generation of a GP prescription. Monthly stock orders for the care home residents were raised by the dietitian rather than individual resident orders.

Two supply mechanisms were tested as outlined below:

- ONS supplied by community pharmacy contractor who normally supplies medicines to the care home
- ONS supplied by Business Services Organisation Procurement and Logistic Services (BSO PaLS) (a similar approach to NHS Tayside supply model)

Between April and June 2021, six care homes from three Health and Social Care Trusts in Northern Ireland participated in the Dietetic ONS NMOP Pilot.

Supply mechanisms established for pilot

Process	ONS Supply by Community Pharmacy	ONS Supply by BSO PaLS
Who will order ONS?	A Trust dietitian will order ONS for the care home on a monthly basis, following resident assessment, using a stock order form which will be issued to the pharmacy	A Trust dietitian will order ONS for the care home on a monthly basis, following resident assessment, using a stock order form which

	using the secure email address.	will be issued to BSO PaLS via eProcurement.
How will community pharmacy contractor be reimbursed?	The contractor will code the stock order form in the same way as a GP stock prescription and will then submit the prescription to BSO FPS (via a dedicated email address) to process for payment. In order to reimburse the community pharmacists participating in the supply option of the pilot, BSO has agreed to process the order forms for payment in the same way as a GP stock form.	Community pharmacy contractor will be compensated for loss of income.
Trusts	BHSCT and WHSCT	NHSCT
Number of care homes	2 in each Trust (n=4)	2
Dietitian's role	The dietitian will liaise with care home staff and use a digital stock management module along with nutritional requirements of all residents to generate future orders.	The dietitian will liaise with care home staff and use a digital stock management module along with nutritional requirements of all residents to generate future orders during the pilot period.

Aims and objectives of NMOP dietetic ONS pilot evaluation

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

The objectives were to:

Objective 1	Establish potential volume of ordering activity that can be shifted to dietitians
Objective 2	Identify benefits in relation to access to ONS and reducing pressure on GPs
Objective 3	Identify any risks associated with the sustainability of a new model e.g. workforce
Objective 4	Support and enhance the delivery of tailored dietetic interventions to residents, maximising professional skills at the point of care delivery
Objective 5	Support the delivery of care pathways that can be delivered by a dietitian
Objective 6	Reduce delays in residents accessing ONS
Objective 7	Support a reduction in waste of ONS
Objective 8	Support optimum use of technology in processes
Objective 9	Support improvements in resident concordance with taking ONS
Objective 10	To agree measures and collect relevant data to measure the outcomes for residents[2]
Objective 11	To agree and implement measures to capture the experiences of care home and dietetic staff, GPs and community pharmacists, and BSO PaLS.[2]

[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

[2]Achieved in the project set up phase

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.

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

- **Stakeholder feedback**
  - Virtual discussion: 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 analysed using a theming approach. Average agreement ratings from the participants on how the pilot met the project objectives were obtained. All data has been summarised and is presented in this report.
  - 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 mapped against the project objectives.
  - GPPs feedback: General Practice Pharmacists were asked to provide general feedback on the pilot service which has been included in the Stakeholder feedback.
- **NMOP audit activity**: Between April and June 2021, six care homes from three Health and Social Care Trusts in Northern Ireland participated in the Dietetic ONS NMOP Pilot. Assigned dietitians from each care home collated baseline and end of pilot data through clinical audits. Audit activity was collated using Excel. Data was quality checked and re-categorised 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.
- **Supply route process maps**: Clinicians participating in the NMOP pilot summarised the supply route 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 summarised as a flowchart figure. Key findings were summarised.

- **Resident journeys**: Clinicians participating in the NMOP pilot summarised resident journeys which emerged during the pilot. The key findings are summarised in this report.
- **Summary of stock orders and prescribing data**: Average monthly prescribing costs pre-pilot were obtained from prescription payment data collated by BSO Family Practitioner Service (FPS) to facilitate community pharmacy dispensing payment, in conjunction with care home prescribing data systems developed by NISRA. The reported costs may be slightly different to the actual costs due to some limitations with the raw data e.g. NISRA information relies on identification of a care home resident's health and care number from a prescription which has been 2-D bar code scanned; GP practice generated prescription scan rate can vary and is not currently 100%.
    - It was anticipated that the stock order payment system used by BSO FPS would provide the data to analyse the dietetic raised stock orders. This proved challenging due to multiple factors including dates of orders and inconsistencies in submitting forms for payment. A spreadsheet was created instead to collate information from all the stock orders written by the dietitians for each care home to facilitate the cost analysis. March 2021 product price list was used to ensure consistency.
    - BSO PaLS provided costs for product they supplied during the pilot.
    - The time period for costs analysis extended beyond the pilot period to ensure results were as robust as possible; the analysis period was January to November 2021.
- **Audit of Good Nutritional Care Training delivered to care home staff**: An educational package 'Good Nutritional Care in Care Homes' was delivered to the care homes taking part in this project. Outcomes were obtained for these sessions with the use of pre and post knowledge based polls during the sessions.

- **Supplementary information**: Comments were sought from the ONS suppliers (community pharmacists or BSO PaLS), to supplement feedback from the stakeholder workshops and survey, to enhance understanding of the challenges and benefits of the two supply models.

Results

Detailed results of the evaluation undertaken by MOIC and NMOP project team can be found at the following link: evaluation report

Discussion

Discussion points emerging from the analysis were formulated.

Benefits to care home residents:

Stakeholder feedback and dietetic audit confirmed **a reduced delay in accessing ONS via the CP supply route**. Residents were likely to receive ONS within 2 days of dietetic assessment. The process mapping exercise verified this, indicating that the revised model reduced the number of steps from 10 to 6. Furthermore, the time taken for the entire process (initial dietitian assessment to receipt of ONS via CP) reduced from >2 weeks to 24-72 hours.

Prior to the pilot four care homes indicated that they routinely followed up with GPs and CPs when ONS prescribed had not been received. Following introduction of the new process, this type of intervention was only required by one care home. The pre-pilot process was further complicated by the need for different ordering mechanisms across different GP practices. The introduction of the new approach, with one dietitian per care home, led to a more consistent and less complex system.

Due to the complexities of the BSO PaLS supply route a reduction in the time between ordering and supply of ONS was not evident from stakeholder feedback, process mapping, and audit activity. Time taken for supply via this route exceeded 7 days following assessment.

Improved resident compliance with ONS product was a positive outcome of the dietitian's direct involvement in the ordering process. Stakeholders reported that this was as a result of an awareness of, and promoting access to, a wider range of flavours,

facilitating trials of product, and timely modification of ONS if resident was non-compliant to the trial ONS. Pilot development of an ONS record sheet and subsequent audit activity confirmed this improvement in resident compliance.

The care home residents also benefited from **improved access to a specialist** with almost twice as many residents being under dietetic care by end of the pilot period than at its outset. The improved access led to earlier dietetic intervention, and subsequently a reduced risk of residents receiving an inappropriate ONS product. Audit data showed fewer discrepancies with ONS supplied i.e. more likely to match dietetic recommendation and improved compliance with IDDSI recommendations and timely implementation of change to a more appropriate product. These benefits were further evidenced by resident journeys with a number resulting in discontinuation of inappropriate ONS products.

Improved nutritional care was delivered to residents of all six care homes who were more likely to be assessed and reviewed within the current timelines specified in dietetic service care pathways. A greater variety of snacks with improved nutritional density and modified textures were introduced into some care homes.

A key outcome of recorded resident journeys was **reduced risk of harm to residents** e.g. potential harmful outcomes as a result of aspiration and obesity were avoided following the interventions made by the dietitians.

Benefits to healthcare system:

The audit activity data and resident journey examples indicated **a reduced spend on ONS** as a result of dietitians being involved in the ordering process. Analysis of the prescribing and stock order data confirmed the reduction in spend; the average monthly expenditure across the six care homes was reduced by £3621 during the pilot period, a potential efficiency of more than £43K annually across the six care homes. Product choice saw an increased alignment with those recommended in the Northern Ireland Formulary during the pilot period and dietetic intervention supported the Regional Medicines Optimisation Policy. This is likely to be due to increased access to a dietitian, and the reduced range of products being prescribed. The model also had the advantage of allocating only one prescriber of ONS to each care home i.e.

one dietitian, compared with the previous model which involved multiple GP prescribers. **This improved the continuity and consistency of recommendations and resulted in reduced waste of ONS.**

The revised model of care was designed to **ensure improved communication and partnership working** across the stakeholders through the development of robust processes and documentation. Stakeholder feedback confirmed that this had been achieved and indeed this was clearly depicted in one resident's journey where the resident had the potential risk of an adverse aspiration-related outcome removed through timely dietetic intervention and liaison with speech and language therapy colleagues.

More efficient processes were particularly evident in the CP supply route with number of steps and time taken for supply reducing. Care home staff reported their reduced need to intervene in chasing the supply of ONS products for residents. The pre-pilot process was complicated by the need for different ordering mechanisms across different GP practices. The new pilot process removed this complexity with one dietitian being responsible for the orders in each care home.
The use of email to transmit stock orders to the CP to submit stock orders to BSO FPS for processing and payment was more efficient than hand delivery by representatives or couriers.

Benefits to care homes:

At the outset of the pilot project care home staff were offered bespoke good nutritional care training. Care home staff reported that, as a result, they were **more informed** with respect to "food first" approaches, food fortification and ONS.
The audit activity data and a recorded resident journey indicated a **reduced reliance on ONS** to address nutritional deficit in residents by participating care homes highlighting, in particular, that they are now more likely to offer food fortification at main meals. More varied snacks, in terms of both nutritional density and texture, were introduced into some care homes.

Care home staff were pleased that the involvement of dietitians in the ordering process meant that this **released staff capacity** to other duties important in the care of residents.

In the case of those four care homes receiving ONS via the CP supply route the **reduced need for storage space** was a welcome benefit of the new process. However, this was not apparent to the two care homes in the NHSCT area because they had an arrangement for a weekly delivery from their supply pharmacy prior to the pilot.

Benefits to professions:

Dietitians reported that the new model of care facilitated more appropriate **deployment of their professional skills.** They had the autonomy to directly order the products they had assessed as being suitable for residents, rather than having to add steps to request and follow up prescribing by GPs. The importance of those skills to optimise nutritional care and minimise harmful outcomes was evident in the recorded resident journeys.

GPs and CPs stated their **reduced workload** associated with the prescribing and supply of ONS in the new process released capacity to other clinical duties and service delivery. CPs reported time saving benefits from reducing steps in the dispensing process e.g. no need for individual resident labelling on each ONS carton.

CPs and dietitians both valued the new collaborative working processes developed within the pilot; pre-pilot there would have been limited if any contact between the dietitian and CP.

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.

The BSO PaLS supply route was associated with a number of challenges including a **limited range of products** being available for dietitians to order due to the secondary care procurement arrangements; significant lag time between ordering and care home

access to stock; a complicated eProcurement process which required verification by a senior Trust pharmacy manager.

The CP supply route was not without its challenges, particularly in those care homes where established local arrangements around **weekly deliveries** continued, reducing the potential usefulness of the revised ordering arrangements.

Both care home staff and dietitians reported that **inadequate access to IT** hardware and digital software in care homes posed a significant obstacle in implementing the In-healthcare digital system.

Due to the multi-disciplinary and multi-agency nature of the new model, **managing the change** was challenging. Clear and timely communication with the wide range of stakeholders was key in ensuring ownership of the pilot and successful implementation of the multiple new processes.

While engagement with representatives of each of the affected disciplines and those who would be directly involved in each locality was robust, less attention to **clearly communicating the objectives** of the pilot to the wider CP service, in particular, led to some misconceptions. As a result, the project team addressed those misconceptions quickly and robustly to limit their impact on the project's success.

Engagement with representatives of **nutrition companies** was arranged to address their questions around the longer-term plans for redesigning the supply of ONS to care home residents.

While there were many positive consequences of the improved access to dietitians in each care home it also caused some difficulties which will require further consideration, before further expansion of this model. Residents remained **under dietetic care for a longer period of time** which reduced the capacity for dietetic intervention for residents referred to the core service. An unintended consequence of the model was that some care home residents were seen much earlier compared with core service clients which could, in effect, lead to a two-tiered pathway with residents in other care homes or in the community. Care homes, also, did not always use the formal written referral for dietetic services due to the regular contact with the dietitian;

amendment to this pathway may need to be considered in any further roll out to ensure systems allow timely response with robust governance arrangements.

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 recommendations for the future are as follows:

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. Expansion of the dietetic involvement in ordering of ONS for care home residents should be via the CP supply route
4. A prerequisite of the model should be that care homes must adhere to a 4 weekly ordering cycle and undertake to provide sufficient storage space for 4 week supply of ONS products
5. Determine the appropriate skill mix and dietetic resource needed to enable professional autonomy and to support further expansion based on one locality per Trust, in the first instance
6. Determine appropriate professional fees for CP contractors supplying against stock orders
7. Identify future plans to enable wider access to necessary IT hardware and software for care homes
8. Prepare a business case to secure recurrent funding on an "invest to save" basis linking with the SPPG Pharmaceutical Clinical Efficiency programme
9. Benchmark any proposed future model with redesigned services in other regions

10. Regular and frequent training for care home staff on good nutritional care is fundamental to the success of any wider expansion
11. Determine the training needs for care home staff on the operation of the In-healthcare digital system
12. Review ONS product use across the pilot care homes to develop guidance to optimise prescribing in line with NI Formulary choices and good nutritional standards.