NEW MODELS OF PRESCRIBING: IMPLEMENTATION OF HS21 PRESCRIBING BY FOYLE HOSPICE COMMUNITY PRESCRIBERS

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Acronym List

Acronym	Full term
CPNI	Community Pharmacy Northern Ireland
CPO	Chief Pharmaceutical Officer
EDT	Electronic Document Transfer
GP	General Practitioner
JICB	Just In Case Booklet
MOIC	Medicines Optimisation Innovation Centre
NIECR	Northern Ireland Electronic Care Record
NIGPC	Northern Ireland's General Practice Committee
NMP	Non-Medical Prescriber
OOH	Out of Hours
T&F	Task and Finish
PHA	Public Health Agency
SOP	Standard Operating Procedure
SPC	Specialist Palliative Care
SPCN	Specialist Palliative Care Nurse
SPPG	Strategic Planning and Performance Group
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent
WUC	Western Urgent Care

Contents

1. Introduction

Specialist palliative care (SPC) is targeted to those individuals with progressive life-limiting illness causing complex, unresolved symptoms and more challenging care needs that cannot be optimally managed by generalist palliative care services. SPC not only focuses on physical symptom management, but holistic support including complex psychosocial, end-of-life and bereavement issues. Often, people with life limiting conditions wish to have their palliative care needs met in the community, which is provided in partnership by a range of clinicians. This includes general practitioners (GPs), district nurses and voluntary and independent sector teams such as hospices with dedicated SPC nurses (SPCNs) and specialty doctors. Outside of normal working hours and at weekends/bank holidays, continuity of generalist and specialist palliative care is supported by out of hours (OOH) services.

Timely access to medicines both within and outside of normal working hours remains challenging due to workforce pressures and the lack of process to enable voluntary and independent sector medical and non-medical prescribers to issue HS21[1] prescriptions in the community. They therefore rely on GPs or OOH services to implement their prescribing recommendations. Despite extensive arrangements to improve medicines access such as 'just in case' boxes, establishment of a consultant support care advice line, enhanced transport arrangements and availability of stock within OOH, challenges persist, particularly in the OOH setting.

There are a growing number of qualified non-medical prescribers (NMPs) working in the community setting. However, the process to support both hospice-employed medical and non-medical prescribers to issue HS21 prescriptions in the community continues to be limited. It is essential that additional prescribing models are considered and developed to ensure the needs of the SPC patient population are adequately met and maximise capacity as far as possible within existing resource. A pathfinder was established in 2024 to address these challenges by facilitating hospice-employed SPCN and specialty doctor prescribers to issue HS21 prescriptions to patients living in their own homes or a care home.

The primary aim was to improve access to prescription only medicines for individuals with SPC needs and reduce pressure across the primary care and OOH systems.

Specific objectives of the pathfinder included:

- Reduce pressure on GPs to issue urgent HS21 prescriptions for palliative medication in-hours;
- Reduce pressure on the system out of hours by decreasing the reliance on community pharmacy palliative care rota and the number of contacts with the Trust pharmacy emergency service rota;
- Support proactive management of symptoms and improve the patient experience;
- Make recommendations on regional expansion of the pathfinder model to other hospice organisations following evaluation.

[1] HS21 is the prescription form used by prescribers employed in Northern Ireland's Health and Social Care system to prescribe medicines for individual patients. The items prescribed will be dispensed by a community pharmacist.

2. Methodology

A Task and Finish (T&F) group, comprising all key stakeholders, was established to oversee the development of accountability processes and standard operating procedure (SOP), which detailed both governance frameworks and training and competency arrangements for the pathfinder (summarised in Appendix 1). Stakeholders included representation from the Foyle Hospice, the Strategic Planning and Performance Group (SPPG), the Public Health Agency (PHA), Northern Ireland General Practitioners Committee (NIGPC), the Western Health and Social Care Trust (WHSCT), the Medicines Optimisation Innovation Centre (MOIC) and Community Pharmacy NI (CPNI). Terms of reference were drafted and regular meetings were scheduled for the duration of the pathfinder.

The pathfinder was launched by SPPG in collaboration with the PHA and Foyle Hospice, an independent sector charity providing vital palliative care services and support for the local community in the Western Health and Social Care Trust area in Northern Ireland. HS21 prescribing was introduced for members of the Foyle Hospice community team with a medical or non-medical prescribing qualification on 9th September 2024, following a period of baseline data collection.

The Foyle Hospice cipher number for prescribing inpatient discharge medications was used alongside HS21 triplicate prescription pads for the purposes of the pathfinder. Further information relating to the use of HS21 triplicate prescriptions in the community is detailed in the pathfinder SOP (Appendix 1).

2.1. Evaluation Methodology

The evaluation of the pathfinder was led by the regional MOIC. A mixed methods approach was used to gain both quantitative data and qualitative feedback from all key stakeholders.

Baseline data was collected by 2 prescribers (specialty doctor and SPCN) and 3 non-prescriber SPCNs using a bespoke data collection form (Appendix 2). This assessed the current process and gave insight into the number of steps and time required to access medications. This data was collected between June and September 2024.

Upon initiation of the pathfinder, 2-week periods of midpoint (28th October 2024- 10th November 2024) and endpoint (27th January 2025- 9th February 2025) data collection were completed to assess any changes to the process as a result of the pathfinder. The data collection form used for midpoint and endpoint data collection is in Appendix 3.

The main outcome measures from qualitative data collected at baseline and at the midpoint/endpoint periods included:

- Prescribing decision/action taken by Hospice staff following a homecare visit (including out of hours);
- Number of new HS21 prescriptions requested/written and where available, indication of urgency;
- Wait times for new HS21 prescription issue and collection;
- Where possible, examples of case studies and feedback received which demonstrates the impact of HS21 prescribing in the community.

Due to the sensitive nature of palliative homecare consultations, formal feedback from patients and/or their families/carers was not actively sought. Furthermore, some timeline data could not be fully completed, as follow up was not appropriate.

All data collected was independently evaluated by MOIC.

Qualitative feedback from Foyle Hospice staff was obtained from in-person interviews/focus groups conducted in January and February 2025. Staff were divided into the following 3 groups:

- Prescribers (Medical x2; Non-medical SPCN x1) – individual interviews;
- Non-prescriber SPCNs (x3) – focus group;
- Hospice Managers (Medical Director, Director of Nursing and Community Team Manager) – individual interviews.

All potential participants of the interviews/focus groups were provided with an information sheet (Appendix 4) and given the opportunity to ask questions about the evaluation. All participants provided informed, voluntary, written consent (Appendix 5) to take part in the evaluation. Each interview/focus group was hosted by a MOIC Programme Manager and a Professional Adviser from SPPG. The Programme Manager facilitated the discussion whilst the Professional Adviser facilitated the recording, made notes and encouraged participant involvement. An interview guide, adapted for each group (Appendix 6), was used to ensure consistency between groups and provide a framework for discussion. The discussions were audio recorded and transcribed in full using Microsoft Teams. Transcripts were then accuracy checked and key themes identified by the Programme Manager. All directly identifiable information was removed from the transcripts and the contents were subsequently verified by the Professional Advisor. Once the transcripts were verified, the audio recordings were deleted.

An online feedback survey (Microsoft Forms) was circulated via email in February 2025 (Appendix 7) to capture the views of key stakeholders from the pathfinder T&F group, as well as wider stakeholders from both the community and primary care likely to be indirectly affected by the pathfinder. The online survey was open for 21 days to collect responses from these stakeholders.

Quotes of interest from individual participants were selected for illustrative purposes throughout the qualitative evaluation. To maintain anonymity, responses from Foyle Hospice staff were denoted by Manager ‘M’, Prescriber ‘P’ and non-prescriber SPCN ‘N’ followed by an assigned number e.g. M1, M2 etc. Other stakeholders were denoted by professional title e.g. GP, District Nurse, Pharmacist etc.

3. Results

3.1. Foyle Hospice staff participation and data completion

There was one Specialty Doctor i.e. medical prescriber (0.2 whole time equivalent; WTE) and one NMP SPCN (0.8 WTE) employed by the Foyle Hospice participating in the baseline data collection. Additionally, three non-prescriber SPCNs (two x 1.0 WTEs; one x 0.8 WTE) also contributed to data collection throughout the pathfinder.

OOH homecare consultations were defined as those taking place on Saturdays, Sundays and bank holidays (if applicable). OOH homecare consultations were only attended by SPCNs, with the NMP SPCN working one weekend in five at the time of the pathfinder. The medical prescriber also provided cover one weekend in five to the inpatient unit only.

It was initially anticipated that three prescribers would issue HS21 prescriptions when the pathfinder officially commenced, however one medical prescriber (0.4 WTE) decided not to participate further in the pathfinder for reasons discussed later in section 3.6.1.2. Due to this change and also staff working patterns, there were less total prescriber data available for evaluation in comparison to total non-prescriber data.

During the 11-week period of baseline data collection, records were completed for 275 out of 548 homecare visits (50% completion rate). This included a pilot phase from 17th June until 28thJuly 2024 to familiarise staff with the data collection form and to ensure the form was fit for purpose. Any necessary adjustments to the form or clarifications regarding the data to be collected were made accordingly.

Midpoint and endpoint data were subsequently collected by the participating prescribers and non-prescriber SPCNs during two separate 2-week periods from 28th October - 10th November 2024 and from 27th January – 9th February 2025, respectively. These two focused periods of data collection, at midpoint and endpoint, had completion rates of 100% (n=107 homecare visits) and 95% (n=90/95 homecare visits), respectively.

3.2. Pathfinder process for accessing medicines

HS21 prescribing was introduced for Foyle Hospice staff with a medical or non-medical prescribing qualification in September 2024 and baseline data was collected prior to this. An outline of the process for obtaining a new HS21 prescription at baseline and upon introduction of the pathfinder is shown in Figure 1.

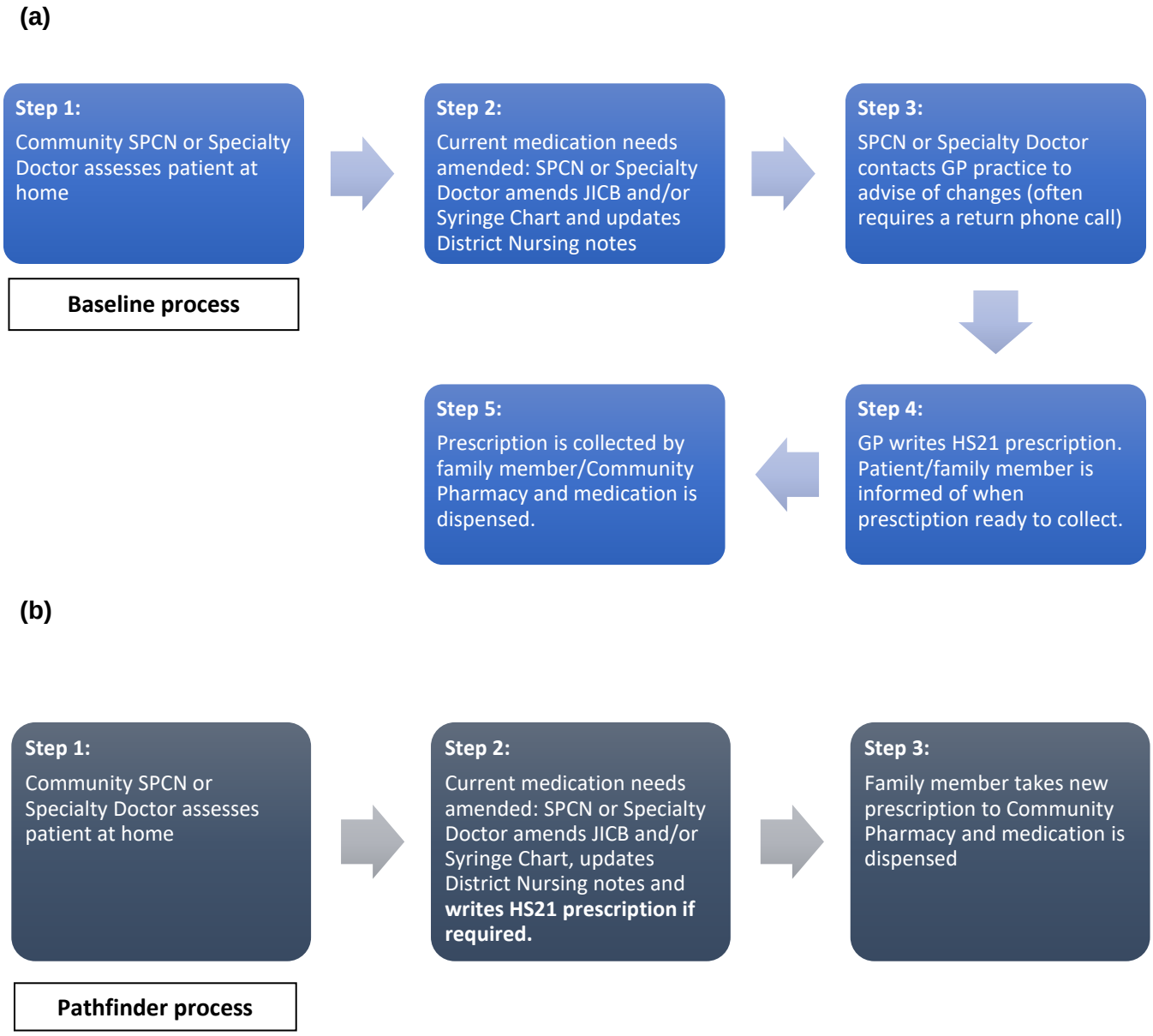


Figure 1. (a) The baseline process for accessing medicines following a homecare visit from a Specialist Palliative Care (SPC) prescriber (nurse or doctor) in the community. (b) The new pathfinder process for accessing medicines following implementation of HS21 prescribing by SPC prescribers from Foyle Hospice in the community.

3.3. Prescribing decision following homecare visits

During all data collection periods, around 50% of the homecare visits did not require a medication change, as shown in Figure 2. For the remaining consultations, an intervention was required either as a change to the syringe pump chart/just in case booklet (JICB), a new HS21 prescription, or both if medicines were already available in the patient's home.

There were only two documented incidences of a prescribing recommendation not being accepted by the patient's GP following a new HS21 request during the baseline data collection period. In these instances, the GP did not agree with the request from a non-prescribing SPCN

to commence a patient on oral pain relief and anticipatory medication, respectively. Further reasoning for either decision was not documented.

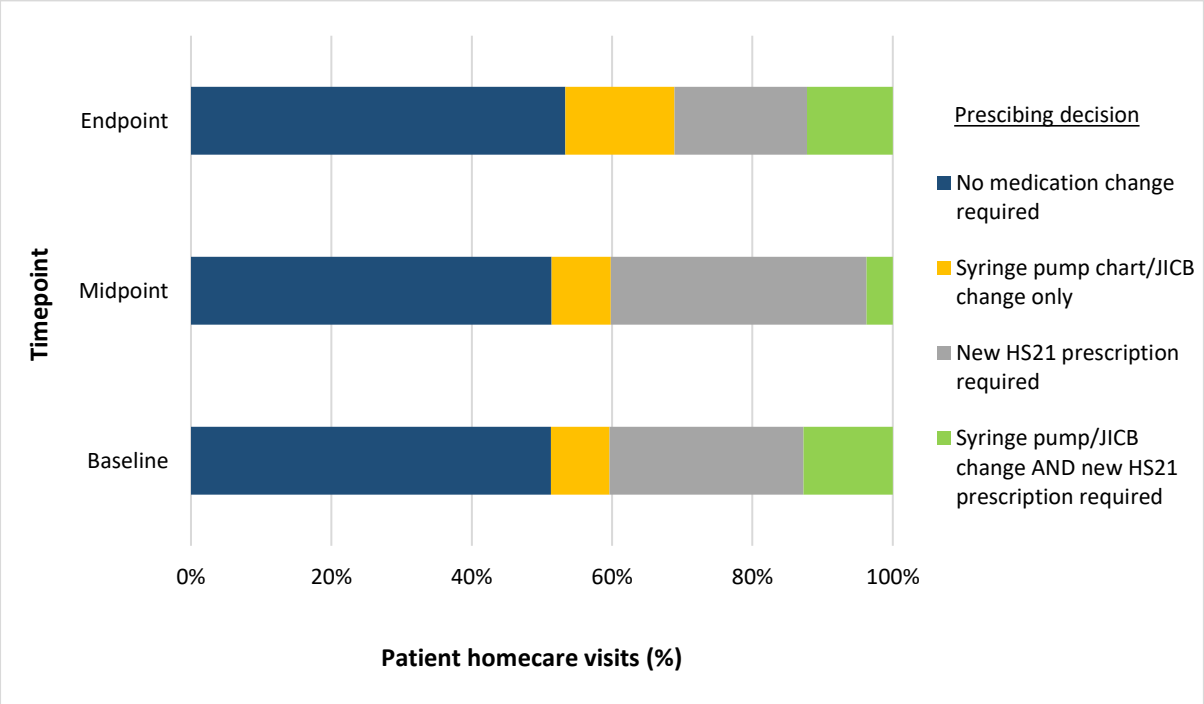


Figure 2. A percentage breakdown of patient homecare visits at baseline (total n= 275), midpoint (total n=107) and endpoint (total n=90) is shown according to prescribing decision by Foyle Hospice community team staff (medical prescriber, non-medical prescriber SPCN and non-prescribing SPCNs). A medication intervention was required for 49% of homecare visits during baseline and midpoint periods and for 47% of homecare visits during endpoint data collection.

Foyle Hospice staff also attended homecare visits OOH at weekends during the baseline (Table 1), midpoint (Table 2) and endpoint (Table 2) data collection periods. Due to weekend shift patterns, the SPCN NMP attended OOH homecare visits during the baseline period only, as shown in Table 1. New HS21 prescription requests OOH were made via Western Urgent Care (WUC) by both prescribers and non-prescribers during the baseline phase of data collection. A medication intervention was required for 61% of OOH homecare visits at baseline and for at least 50% of OOH homecare visits recorded during the midpoint and endpoint periods (attended by non-prescribing SPCNs only).

Table 1. Prescribing decision by Foyle Hospice staff following out of hours homecare visits during baseline data collection**.**

	Out of hours home care visits (n)		
Prescribing decision (baseline data)	**Non-prescriber**	**Prescriber**	**Total**
Patient does not require any medication changes	12	2	14
Syringe pump chart/JICB change only	4	3	7
New HS21 prescription required	9	0	9
Syringe pump/JICB change AND new HS21 prescription required	6	0	6
Total	**31**	**5**	**36**

Table 2. Prescribing decision by Foyle Hospice staff following out of hours homecare visits during midpoint and endpoint data collection. All out of hours homecare visits during these periods were attended by non-prescribing SPCNs.

	Number of out of hours homecare visits attended by non-prescribing SPCNs (n)		
Prescribing decision	**Midpoint**	**Endpoint**	**Total**
Patient does not require any medication changes	3	1	4
Syringe pump chart/JICB change only	2	0	2
New HS21 prescription required	1	0	1
Syringe pump/JICB change AND new HS21 prescription required	0	2	2
Total	**6**	**3**	**9**

3.3.1. Syringe pump chart/JICB changes only

During some homecare visits, the patient required an amendment to the syringe pump chart or JICB without the need for a new prescription i.e. the medicines were already available in the patient's home. This prescribing decision accounted for 8% of total homecare visits during baseline (n=23) and midpoint (n=9) data collection and 16% of total homecare visits during endpoint (n=14) data collection.

Prior to the pathfinder, prescribers routinely amended syringe pump charts and JICB when necessary. This continued throughout the pathfinder where these changes were required (baseline n=14; midpoint n=3; endpoint n=4). In these instances, changes could be implemented immediately during the home visit, meaning that new syringe pump charts and amended JICBs did not have to be collected from GP surgeries or WUC at a later time.

Non-prescriber SPCNs cannot action these changes and therefore any amendments must be requested via the Patient's GP or other prescriber from the Foyle Hospice or WUC, as shown for the data collection periods represented in Table 3.

Table 3. Sample data showing the type of prescriber contacted by non-prescribing SPCNs to implement a syringe pump chart/JICB change only following a patient home visit.

	Number of home visits by non-prescribing SPCNs requiring a syringe pump chart/JICB change only (n)		
Prescriber contacted	**Baseline**	**Midpoint**	**Endpoint**
Patient's GP (in-hours)	6	3	9
Hospice Prescriber (in-hours)	0	1	1
Hospice Prescriber (out of hours)	1	2	0
Western Urgent care (out of hours)	2	0	0
Total	**9**	**6**	**10**

3.3.2. New HS21 prescription requests at baseline

During the baseline data collection period, there were 111 new HS21 prescription requests made by Foyle Hospice prescribers (n=36) and non-prescriber SPCNs (n=75) either alone or in addition to a syringe pump/JICB change (Figure 3a). Of the 75 new HS21 prescription requests from non-prescriber SPCNs, 20% (n=15) were made OOH, as shown in Figure 3b. OOH prescriptions were requested via WUC. Throughout the duration of the pathfinder, the patient's family collected the prescription from the GP surgery/WUC in the majority of cases.

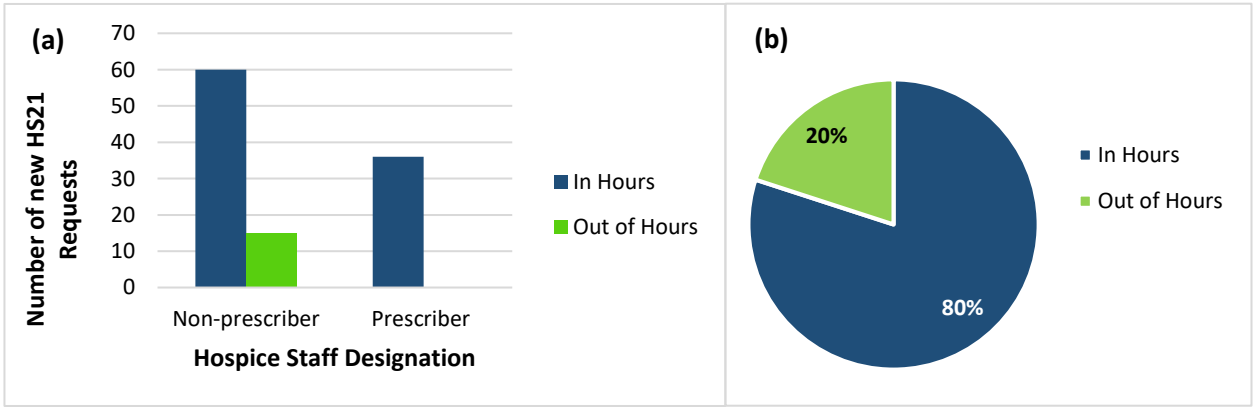


Figure 3. (a) The total number of new HS21 prescription requests by Foyle Hospice staff during the baseline data collection period for prescribers (n=36) and non-prescriber SPCNs (n=75). **(b)** Percentage of new HS21 prescription requests made by non-prescriber SPCNs in normal working hours (n=60) and out of hours (n=15).

3.3.3. New HS21 prescriptions issued by prescribers (midpoint and endpoint)

Upon commencement of the pathfinder, Foyle Hospice prescribers were able to issue HS21 prescriptions, where necessary, in line with the pathfinder prescribing criteria and procedure detailed in Appendix 1. During the pathfinder, a total of 125 HS21 prescriptions (n=64 medical; n=61 non-medical) were written by Foyle Hospice staff over a 6-month period. The number of prescriptions written were fewer than originally anticipated due to the limited availability of a medical prescriber to the pathfinder (1 day per week). The new process allowed prescribers

to issue a HS21 prescription directly to the patient/patient's family in their home, without the need to request and collect via the GP as previously shown in Figure 1. Prior to introduction of the pathfinder, Hospice prescribers would make the majority of new prescription requests to the patient's GP via telephone call. Baseline data available showed that it often could take two (median) instances of communication or attempted communication for these requests to be received appropriately and in some cases up to three attempts. Reasons for this included failed telephone calls and follow up emails.

Sample data collection periods at midpoint (n=11 new HS21 prescriptions) and endpoint (n=9 new HS21 prescriptions) show that most HS21 prescriptions issued by Hospice prescribers were urgent in nature (Table 4). Urgent, in this instance, was defined as a situation where medication needs to be commenced or titrated as soon as possible to achieve better symptom control (e.g. via syringe driver) within 72 hours. Furthermore, any delay in access to medicines would be detrimental to the person's physical and mental wellbeing. Previously, urgent requests would have been made via telephone request to the patient's GP. Fewer HS21 prescriptions were written during the endpoint data collection period as NMP availability was reduced for one week due to preceding weekend shift patterns.

Table 4. The number of new urgent and non-urgent HS21 prescriptions issued by Foyle Hospice prescribers during the midpoint and endpoint data collection periods. All home visits requiring new HS21 prescriptions during the data collection periods were within normal working hours.

	Number of new HS21 prescriptions issued by Hospice prescribers (n)		
Urgency of HS21	**Midpoint**	**Endpoint**	**Total**
Urgent	9	9	18
Non-urgent	2	0	2
Total	**11**	**9**	**20**

During the midpoint data collection period, there were instances (n=3) where the prescriber requested the new HS21 prescription via the patient's GP, rather than issuing it themselves. This was because the required medicines were not within the defined pathfinder prescribing parameters. The patient's GP was contacted on six occasions by prescribers (outside of routine notification of new HS21 prescription issue as per pathfinder SOP) during the midpoint (n=5) and endpoint (n=1) data collection periods. Reasons stated for this included:

- The prescription request was not within the prescribing parameters of the pathfinder (n=2);
- To provide a verbal update on changes (n=2);
- The patient was dying (n=1);
- To discuss the patient's current home situation and multi-agency involvement (n=1).

3.3.4. New HS21 prescription requests by non-prescriber SPCNs (midpoint and endpoint)

The process for non-prescriber SPCNs (n=3) to obtain a new HS21 prescription for a patient during the pathfinder remained largely unchanged to the standard process and therefore the majority of new HS21 requests were still made via the patient's GP, either alone or addition to syringe pump chart/JICB changes (Figure 4). The pathfinder did however permit non-

prescriber SPCNs to utilise the prescribing ability of their colleagues to obtain a new HS21 prescription, where appropriate. There was one instance of this during the endpoint data collection where following discussion of case management between Hospice colleagues, an urgent increase in medication was agreed and planned for the patient. The Hospice prescriber subsequently issued the HS21 prescription for the homecare patient that the SPCN was due to visit later that morning. A small proportion of new HS21 requests during midpoint (n=1; 3.4%) and endpoint (n=2; 10.5%) data collection periods were made OOH (Saturdays and Sundays) via WUC.

All recommendations to change medication made by non-prescribing SPCNs during the midpoint and endpoint data collection periods were accepted by the corresponding prescriber and prescriptions duly issued.

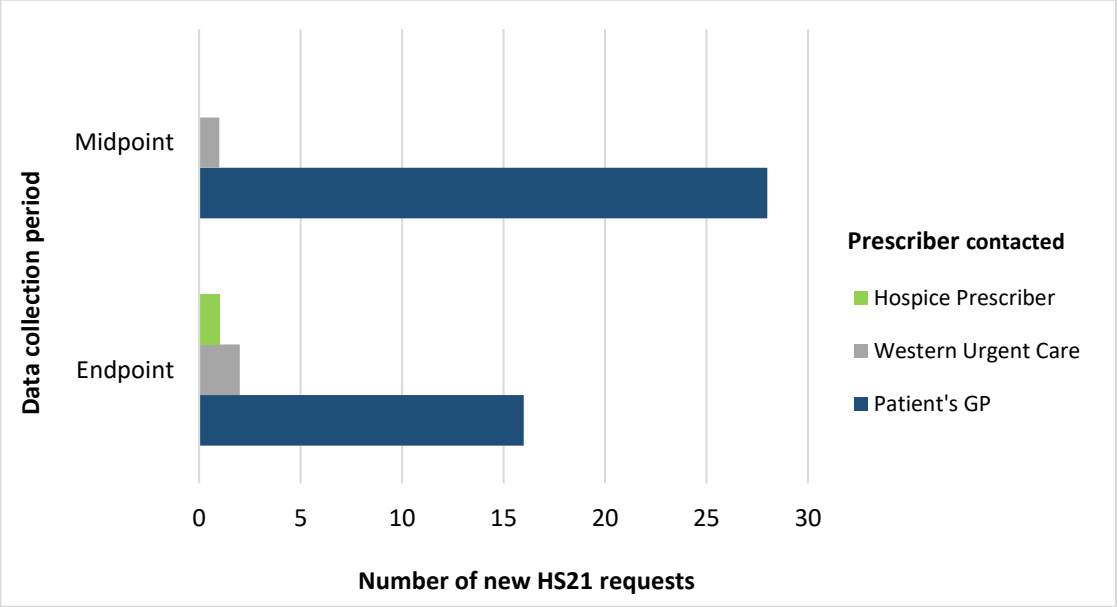


Figure 4. The number of new HS21 requests made by non-prescriber SPCNs during midpoint and endpoint data collection periods. SPCNs requested new HS21 prescriptions either from the patient's GP (midpoint n=28; endpoint n=16), Western Urgent Care (out of hours service; midpoint n=1; endpoint n=2) or a Hospice prescriber (endpoint- n=1).

Similar to the Hospice prescribers, the most common method by which non-prescriber SPCNs contacted the patient's GP for prescriptions requests was via telephone, with a return call often required. This was consistent throughout all pathfinder data collection periods. Table 5 shows the number of times a non-prescriber SPCN was in contact, or attempted contact, with the patient's GP/WUC following a homecare visit to request a new HS21 prescription (by email or telephone). In some cases, it took up to 4 telephone calls (or email exchanges) to communicate the request. Reasons for this included not being able to get through to the GP telephone line in a timely manner or having to go through OOH triage processes.

Table 5. Pathfinder data showing number of times non-prescriber SPCNs were in contact or attempted contact with the patient's GP/Western Urgent Care per new HS21 request.

	Number of homecare visits (n)		
No. of times SPCNs in contact with GP surgery/WUC per new HS21 request	**Baseline**	**Midpoint**	**Endpoint**
1	15	15	6
2	54	10	9
3	3	1	0
4	2	1	2
Total recorded responses (% data completion rate)	74 (99%)	27 (100%)	17 (94%)
Median (n)	**2**	**1**	**2**
Mode (n)	**2**	**1**	**2**

3.4. Time wait for new HS21 prescription requests

Foyle Hospice staff were asked to record timings, where possible, during the homecare visit to estimate timelines for new HS21 prescriptions requests and subsequent acquiring of medicines. Due to the sensitive nature of patient consultations, this data was only collected if deemed appropriate by the staff member and in doing so did not add undue workload burden regarding follow up of timelines. As a result, data completion rates reduced as the timeline progressed, as shown in Table 6.

For homecare visits attended by Foyle Hospice prescribers at baseline, the median wait time from the start of the homecare visit until the new HS21 prescription was ready for issue to the patient was 2 hours 50 minutes. Furthermore, it took a median time of 4 hours for the prescription to be collected from the GP surgery/WUC, usually by the patient's family. On 2 occasions it was not available until the following day (urgency not known). Upon introduction of the pathfinder, the new HS21 prescription was issued to the patient/patient's family in a reduced median time of 30 minutes (midpoint) and 32 minutes (endpoint), as shown in Table 6. This allowed the patient's family (or carer) to directly collect the medicines from a community pharmacy within a 2 hour timeframe (median) from the beginning of the homecare visit, negating the need to collect the prescription first from the GP surgery. From the data available at midpoint and endpoint, a time saving of over 2 hours was demonstrated from the beginning of the homecare consultation to obtaining new medicines from the pharmacy. All medicines were obtained on the same day as the homecare visit during these data collection periods.

Given that the process for obtaining a new HS21 prescription for non-prescribers did not change since the beginning of the pathfinder project, no significant change to wait times was anticipated in comparison to the baseline data. The median wait time from the start of the homecare visit until the prescription was available for collection from the GP surgery/WUC ranged from 2 hours 5 minutes at baseline to 3 hours 7 minutes at midpoint and 2 hours at endpoint. A range of data was reported during all three data collection periods, including multiple instances of the prescription not being available until the following day at baseline (n=8; urgency data not available) and midpoint (n=3 non-urgent; n=1 urgent).

The median time from the start of the homecare visit until the new prescription was actually collected from the GP surgery was also recorded, where reasonably possible. From available

data, the median time for this parameter at baseline was 3 hours 30 minutes (n=7 not collected until day after prescription available for collection) and 4 hours at midpoint (n=1 non-urgent prescription not collected until day after prescription available for collection). From the data available during the endpoint data collection period, 50% of prescriptions were not collected from the GP surgery until the following day or later (n=1 urgent), resulting in a median time of 12 hours 48 minutes.

Insufficient data was available to calculate the time from the start of the homecare visit until the medicines were collected from the pharmacy for visits attended by non-prescribing SPCNs during all data collection periods and prescribers at baseline.

Table 6. Wait times for new HS21 prescriptions requested by Foyle Hospice prescribers and non-prescriber SPCNs during baseline, midpoint and endpoint data collection periods. Times are shown as median values (n= number of wait times recorded; % data completion rate).

	Time (median) from the start of the homecare visit until:		
	The HS21 prescription was ready for issue to the patient	*The HS21 prescription was collected from the GP surgery*	*The medicines were collected from community pharmacy*
Prescribers [a] (**Baseline**)	2 hours 50 minutes (n=27; 75%)	4 hours (n=19; 53%)	Insufficient data
Prescribers [b] (**Midpoint**)	30 minutes (n=11; 100%)	N/A	2 hours (n=11; 100%)
Prescribers (**Endpoint**)	32 minutes (n=8; 89%)	N/A	1 hour 55 minutes (n=8; 89%)
Non-Prescribers [c] (**Baseline**)	2 hours 5 minutes (n=64; 85%)	3 hours 30 minutes (n=57; 76%)	Insufficient data
Non-Prescribers [d] (**Midpoint**)	3 hours 7 minutes (n=20; 68.9%)	4 hours (n=14; 48%)	Insufficient data
Non-Prescribers [e] (**Endpoint**)	2 hours (n=13; 68%)	12 hours 48 minutes (n=10; 53%)	Insufficient data

[a] n=2 HS21 prescriptions not issued on same day as home visit (n=1 request made same day; n=1 request made following morning); n=2 HS21 prescriptions not collected from GP until following day. Urgency data not available at baseline.
[b] n=1 prescription not collected from GP until the following day (urgent).
[c] n=8 HS21 prescriptions not issued on same day as home visit; n=14 HS21 prescriptions not collected from GP until the following day or later. Urgency data not available at baseline.
[d] n=4 HS21 prescriptions not issued on same day as home visit (n=1 urgent); n=4 HS21 prescriptions not collected from GP until following day (n=1 urgent).
[e] n= 5 HS21 prescriptions not collected from GP until the following day (n=1 urgent).

3.5. Example case studies and feedback

Foyle Hospice staff recorded details of particularly notable cases which exemplified how processes affecting timely access to medicines impact on patients and their families. Feedback from other healthcare professionals involved in the patient's care was also received following implementation of the pathfinder.

3.5.1. Baseline- example case study

One complicated OOH case (Sunday) was attended by a non-prescriber SPCN. The patient required a syringe pump change and a new HS21 prescription. The SPCN made multiple calls to the Hospice inpatient unit regrading symptom control. A new syringe pump chart was written by the inpatient doctor on weekend duty (0.2 WTE Specialty Doctor) and taken to the patient's home by the SPCN at 11:30. The patient was unsettled, actively dying and multiple subcutaneous stat doses were required. A new prescription was needed for extra drugs for overnight management. The OOH doctor was contacted at 14:23 via telephone and the medicines were ready for 14:55. The Hospice was then informed that the patient sadly died at 15:10, before the medicines could be collected.

3.5.2. Midpoint example case study

On one occasion, a Foyle Hospice prescriber attended a homecare visit at 14:40. The patient was actively dying and a new syringe pump was required. Following the appropriate procedure, as per the pathfinder governance arrangements, the prescriber wrote a new HS21 prescription for the required medicines at 15:15. The patient's family were able to immediately collect the medicines from the community pharmacy at 15:30. The district nurse was called and advised that the medicines would be available in the patient's home within 30 minutes. The district nurse was able to schedule a visit to arrive between 15:50-16:10 to set up the syringe pump for the patient.

3.5.3. Endpoint example case study

The Foyle Hospice prescriber attended a homecare visit at 11:35am. The patient had multiple stats overnight and required a new syringe driver chart and switch of anti-secretory medication. The patient had two new syringe drivers erected; the original driver was altered and a new second driver was required for secretions & fluid overload. The new HS21 prescriptions were written and given to the family at 12:30, which they took to the pharmacy. The two syringe drivers were changed and put in place by the district nurse at 12:55, who had also come out to the home at 12:30 for the syringe driver change. The district nurse who had attended praised the current system of new models of prescribing. He was happy to be quoted saying *"that was a great system"* and he was *"so glad to have had such quick and easy access to medications with no delay to commencement of drivers- great for patients".*

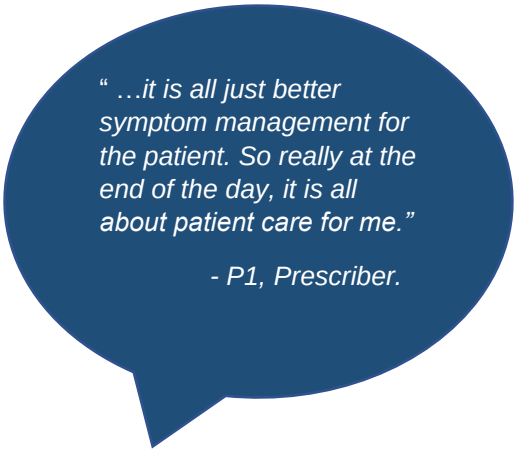
3.6. Qualitative feedback from Foyle Hospice staff

Foyle Hospice staff were interviewed as previously described in section 2.1 to gain valuable feedback and insights across a range of topics concerning the delivery of the pathfinder.

3.6.1. Pathfinder engagement

3.6.1.1. Motivation

Motivation for Foyle Hospice staff to participate in the pathfinder was mainly attributable to the anticipated benefit to patients, including quality of care and better symptom management due to more timely access to medicines. Both prescribers and managers had previous experience of the challenges encountered in the community regarding the logistical pressures of requesting new prescriptions via the GP, which on occasion have led to medication delays for the patient. Working as a local GP, one prescriber described how the challenges in the community became apparent upon taking up the role as a Hospice Specialty Doctor, stating "*I didn't understand, as a GP, [the challenge of] trying to get through to a GP on a phone on the other side."* Managers and non-prescriber SPCNs were also motivated by the opportunity to evaluate the benefits of a new initiative, which would be setting the precedent for community-based HS21 prescribing in Northern Ireland. For some non-prescriber SPCNs, participation was encouraged by management. Other motivating factors for managers included utilisation of NMP skills and the positive benefits already experienced through the NMP/Specialty Doctors amending syringe pump charts and JICBs prior to the pathfinder.



3.6.1.2. Barriers to pathfinder engagement

One medical prescriber decided not to participate in the pathfinder prescribing. Exploring the reasons for this, the main barrier to participation was safety concerns in relation to the handwriting of prescriptions. These concerns included no previous experience of handwriting prescriptions as a GP, the anticipated paperwork burden of handwritten prescriptions and the ability to access all of the relevant patient information to inform prescribing decisions. Concerns were also expressed about the flow of prescription information back to the patient's GP in a timely manner, the risk of deskilling GPs and distancing GPs from their palliative patients. This prescriber also indicated that, in their opinion, families are usually content to collect prescriptions from the GP and stated "*I think electronic would be better*" in relation to future HS21 community prescribing sustainability.

All Hospice managers expressed staff participation and engagement as an initial barrier to the pathfinder. There was initial reluctance and resistance amongst some of the team to change current practice, as one manager stated "*not everybody likes change...*" Managers also felt

that the wider benefits of the pathfinder were not obvious to some team members in the early stages and there was a lack of awareness of the pathfinder amongst wider Hospice staff such as those in the inpatient unit. Reassurance and motivation from management was necessary to overcome this.

> *"They didn't realise the importance of what it was going to be. So that was a big challenge."*
>
> *- M1, Manager.*

> *"It's a busy team. So a lot of acceptance of this was required on the team's behalf."*
>
> *- M2, Manager.*

Operationally, the pathfinder required getting all staff on board, including administrative staff and non-prescribing SPCNs. This was not anticipated prior to launch of the pathfinder and therefore representatives from these staff groups were not included in project scoping discussions. Hands on support was required from all levels of management to make the pathfinder a success, although sometimes it was difficult to find time for project meetings. All participating Hospice staff acknowledged the vital importance of whole team commitment to successfully implement the new prescribing process, to ensure team cohesion and instil confidence in the value of the pathfinder.

A further barrier was that two managers were new to post at the start of the pathfinder. This was a challenge as they were not involved at the early stages and it took time for them to get orientated with the pathfinder and to determine how best to support participating staff. Managers agreed that governance arrangements put in place allayed early safety concerns in relation to prescribing criteria and the logistics of communicating changes to the GP. One manager suspected that different interpretations of an 'urgent medication' amongst clinical staff may have influenced attitudes towards the value of community HS21 prescribing. This was evident from feedback given by non-prescriber SPCNs, who amongst themselves had differing views on the necessity of community prescribing and perception of medication urgency. Furthermore, different experiences of making contact with GPs in the community added to the varying opinions, with one SPCN stating *"I don't really see that it had been a barrier*" whilst another stated "*I'm definitely having to, at times, ring back again, make a couple of calls… I haven't always got a GP."* Despite differing views on the issues with current practice, all SPCNs agreed that prescribers writing syringe pump charts and JICBs was very useful, particularly at weekends and bank holidays.

All non-prescriber SPCNs felt that they needed a prescriber to be present on homecare visits to fully benefit from the initiative, as SPCN processes for obtaining a new HS21 prescription in the community had not changed. Only some of the SPCN team had the opportunity to see the prescribing in practice during a joint homecare visit with the medical prescriber. Prescribers emphasised the importance of peer support during the implementation period and proposed that SPCNs have the opportunity to witness the impact of NMP prescribing in practice to encourage this. Prescribers and managers recognised that the culture change of having a practicing NMP in the team meant it took time for SPCNs to utilise the option to request prescriptions from their colleagues, rather than always via the traditional GP route. Likewise, SPCNs expressed it took time "*getting used to it*". This is supported by data presented in

Figure 4, showing that SPCNs predominantly requested prescriptions via the GP, however, by endpoint, there was one example of an SPCN consulting a hospice colleague instead.

An additional concern communicated by the SPCNs was the confidentiality risk for prescribers leaving their mobile number on the prescription due to lack of individual cipher numbers. Cipher numbers are unique codes usually assigned to individual prescribers and their practices. However, due to lack of process to obtain multiple ciphers in a timely manner, one cipher was used for all prescribers during the pathfinder. This meant that prescribers were required to provide contact details on the HS21 form as part of the pathfinder governance arrangements.

For prescribers specifically, there were a considerable number of barriers or concerns to overcome. Initially, the main concern was about handwriting prescriptions. A safety concern also shared by Hospice colleagues. For the NMP, this was '*very much new learning'* as it was the first opportunity to issue prescriptions in practice as a qualified prescriber. Wary of the professional responsibility and the legal implications, the NMP had to learn and practice writing controlled drug prescriptions as well as establishing their own reference materials. The NMP stated that the familiarisation process was '*a learning curve'* however, confidence developed with practice. Similarly, the medical prescriber, as a GP, was used to prescribing electronically and found the transition to handwritten prescriptions for controlled drugs slightly daunting in the initial stages of the pathfinder. Both prescribers felt that the project leads made assumptions regarding the level of initial training and support required for this, especially with the medical prescriber who "*had to relearn again*."

Prescribers believed that the perception of added workload pressures influenced acceptance of change within the team, which was raised as a concern by both managers and SPCNs. The novelty of setting the scene for Hospice community prescribing in Northern Ireland "*felt like a huge amount of weight you're putting on your shoulder*" according to one prescriber. Moreover, being the only full-time prescriber within the Hospice community team was an added pressure for the NMP**.**

3.6.1.3. Enablers to pathfinder engagement

Hospice management agreed that the guidance and support provided by the project leads was an enabler in addition to the regular T&F group meetings which were "*an open forum"* for discussion. The defined prescribing criteria set out at the beginning was also of vital importance for addressing safety concerns. Communication and awareness of the pathfinder amongst local pharmacies and GPs assisted with acceptance of the new prescription forms and reporting of any potential issues back to the Hospice. Positive existing working relationships with primary care colleagues such as district nurses and the GP service was useful. Managers stated that typically, "*the GP service here is very proactive"* and *"they already have that trust in the [Hospice] team and what they do… they would be held in high enough regard out there."* Further to this, the real world experience of the Hospice medical prescriber as a GP was beneficial.

All managers recognised that the outstanding enthusiasm and commitment of the Hospice prescribers was critical to the success of the pathfinder. One manager took encouragement from this stating "*they wanted it to work and that's what spurred me on."*

Prescribers felt enabled by their own skills and knowledge in the palliative care field. SPCNs also expressed trust in the skills of their colleagues and felt that the established practice of

amending syringe pump charts/JICBs assisted with the transition to HS21 prescribing. Finally, the NMP was reassured by the support provided by the medical prescriber and team manager.

> *"I think it is a great asset… I'm quite confident and competent and I'm quite happy doing it..."*
>
> *- P1, Prescriber.*

3.6.1.4. Stakeholders

Patient-facing Hospice staff described how the pathfinder has influenced their engagement with various stakeholders. Prescribers explained how the dynamic with primary care colleagues has changed since introduction of the pathfinder, with communication being of a less urgent nature than before. As part of the governance process, prescribers are now contacting GPs to inform of changes, rather than making treatment recommendations. Prescribers felt that communication with GPs and district nurses has increased, however "*the urgency is gone…you can go ahead to the end of your day, get everything else finished, and then that communication can happen."* Response from GPs has been positive and supportive so far.

SPCNs believed that there was now less co-ordination required between various stakeholders to organise a prescription for a patient, requiring less phone calls to be made by the SPCN/Specialty Doctor to GP surgeries, patient families and community pharmacies.

> *"… It's a totally different pressure at a different time because the patient has already got the script..."*
>
> *– P2, Prescriber.*

3.6.2. Pathfinder outcomes

3.6.2.1. Pathfinder benefits

Managers and non-prescriber SPCNs felt that the pathfinder has had a positive effect on relationships with primary care colleagues, assisting with the GP workload and enabling better co-ordination of medication changes with district nurses. Prescribers agreed that the new service is a good support to GPs and response so far has been positive. There has also been a shift in dynamic with district nursing colleagues, as they are increasingly engaging with the NMP regarding medication changes. An example of positive district nursing feedback is detailed in section 3.5.3. The hospice medical prescriber described the advantages from a GP perspective, stating it not only saves time and energy but also improves relations with patients and their families due to quicker medicines access.

> *"I think it's because I have a foot in both camps, I can see 100% how it helps me as a GP, as a working GP, if I know the patient is cared for, looked after, scripts are done, the kardex is done and I trust the people doing it on the other end."*
>
> *– P2, Prescriber.*

Managers, prescribers and non-prescriber SPCNs agreed that the main outcome benefit of the pathfinder has been more timely access to medicines for patients. This benefits the patient in terms of better symptom management, facilitates earlier review and forward planning within the community team, particularly at weekends and bank holidays. The condensed process also eases the pressure on patient families during a distressing time, meaning families are not taken away from their loved one at home for as long in order to collect a prescription. A Foyle Hospice manager explained the effect on patients and their families:

> *"None of these prescriptions are being done on well people. These are sick people who might not be in the last days of life, but they're definitely within the last months. So you have a vulnerable patient. You have a very vulnerable family. They may show that in various ways or not show it at all, whose lives are going to change. I mean, it already is changing for them. So to take away any of that pressure… We're out there to try and make this easier. Yes, we're trying to make sure the patient is not pain and all that. But on top of that, this is the worst thing they are going to go through. The whole point of all our services is to try and make a terrible thing as easy as possible, and if we can hand somebody a new syringe pump chart or a new just in case booklet or a prescription for symptoms that can all be in place within one hour as opposed to five hours, six hours… They have enough to deal with and if have we can shorten that one aspect with regards to changes in prescribing that makes a massive difference to them." - M2 (Manager).*

Prescribers detailed multiple outcome benefits to HS21 prescription writing in the community throughout the pathfinder including dealing with rapid complex changes and assisting their SPCN colleagues during weekends and bank holidays, reducing the need to use OOH services such as WUC. Prescribers also felt that communication has improved between the OOH service and the Foyle Hospice as a result of the pathfinder governance arrangements.

During one unprecedented event resulting from red alert adverse weather conditions, the NMP was able to write prescriptions for colleagues when GP surgeries were required to remain closed. This enabled service continuity and provided an opportunity for SPCN colleagues to experience the benefit of non-medical prescribing.

Similarly, the medical prescriber was able to write prescriptions for a patient who was in-between GP practices on New Year's Eve. This made the transition from one GP surgery to the new surgery seamless, with the necessary medications in place on the same day. The prescriber indicated that due to the upcoming bank holiday and temporary hiatus in practice ownership, the extremely ill patient would have ended up in the Emergency Department had it been pre-pathfinder.

A non-prescriber SPCN recounted one experience, where during a joint homecare visit with the medical prescriber, two syringe drivers were arranged and in place for a dying patient within one hour. This was particularly beneficial as the patient lived in a different locality from the GP surgery, which saved time and actions for the family, hospice staff and the district nurse.

> *"100% I find it brilliant giving it [HS21] to the patients straight away. We can get everything set up much faster… I think it's just become part of the service now where we're able to give it to them there and then. We have multiple instances where drivers can be set up far faster than they were before, especially with district nurses already there. They would be floating about and they can be in almost as soon as the medication has been delivered back. And you can have the pump up before you're even leaving the house, which would be unheard of before…"*
>
> *– P2, Prescriber.*

Despite initial resistance, managers felt that the change in practice has been good for the team and have noticed a transition in attitudes and morale as the benefits of prescribing have become apparent. Both managers and non-prescriber SPCNs acknowledged that community HS21 prescribing has enabled prescribers to plan their work in advance of patient homecare visits and according to SPCNs it is "*handier for everyone"* and "*a smoother transition",* particularly in emergency scenarios

The NMP has noted an increase in job satisfaction and confidence as prescribing skills have developed, giving an increased sense of professional autonomy. The pathfinder has also provided the opportunity for specialist practice students to learn from the NMP during homecare visits and observe prescribing in practice. Referring to medical and nursing students, the NMP stated, *"I don't think they ever realised before that we were able to do things like that."*

3.6.2.2. Outcome barriers

The main barrier from the perspective of prescribers was the logistics of the governance procedure, specifically in relation to delivery of the triplicate prescription form to the patient's GP surgery. For the medical prescriber working at the Foyle Hospice one day per week, this was particularly challenging. The triplicate prescription pad also caused difficulties as the carbon copies sometimes did not transfer clearly. Prescribers felt that the method of writing a triplicate prescription was "*outdated*" but understood it was necessary for the pathfinder. A further difficulty that prescribers encountered was alerting the GP to medication changes that the hospice had uploaded to the Northern Ireland Electronic Care Record (NIECR), as sometimes it was not possible to get through on the telephone, in which case an email would be sent instead. At weekends, the NMP cannot action changes on NIECR until Monday morning, as these are uploaded by administrative staff. Managers and non-prescriber SPCNs also acknowledged that that there was increased workload for the hospice staff.

Handwriting prescriptions and the additional time this takes was a further barrier experienced by prescribers, expressing that sometimes it can be "*just quite stressful*" juggling a distraught family at the same time as concentrating on writing a prescription for multiple medications. Prescribers described how the dynamic of the patient consultation changes when they need to remove themselves from potential distractions e.g. to another room or the car, however they are still ascertaining the best approach. The additional paperwork burden and longer patient

consultations "*definitely adds time*" however despite this, prescribers felt that it was worth it for the patient benefit. Prescribers suggested that, where possible, it would help if the referring GP could have some anticipatory medicines in place upon patient referral to hospice care.

Some SPCNs did not have the opportunity to see their colleagues prescribe in practice during a homecare visit and felt this was a barrier to experiencing the potential benefits of the pathfinder. This was mainly due to reduced medical prescriber availability than originally anticipated and lack of joint visits with the NMP. SPCNs therefore expressed a preference to continue using the standard new medication request process via the GP. Prescribers and managers also felt this was a barrier, however as time progressed, the culture began to gradually change.

A barrier specific to Hospice management included two managers being new to post, which they both felt was challenging at the start of the pathfinder. A further issue mentioned by management was systems access, as independent sector organisations have limited access to patient information systems that are available within Health and Social Care Trust organisations. At the time of the pathfinder, this included difficulties with accessing Epic Care Link.

3.6.2.3. Outcome enablers

Managers and non-prescriber SPCNs believed that the enthusiasm and commitment of the Hospice prescribers was the most significant outcome enabler. Managers also considered the regular T&F group meetings and project team support to be an enabling factor, as well as the peer support between medical prescriber and NMP, with one manager stating "*I think they supported one another.*" It was also particularly helpful that the medical prescriber works as a GP in the local area, with links to GP colleagues and an open communication channel with primary care. Managers and prescribers thought that adherence to defined prescribing criteria and parameters was also an essential enabler.

> "*I kind of thought if we stick to what we do, that the likelihood of any major issue would be very low… we know our palliative group of drugs."*
>
> *– M3, Manager.*

Prescribers believed that joint visits with a SPCN colleague was an outcome enabler as it assisted with consultation flow, allowing the prescriber time and space to concentrate on prescription writing whilst the SPCN continued engaging with the patient and family.

There were no significant issues raised with the prescribers by community pharmacy in terms of prescription requirements and legibility throughout the duration of the pathfinder. Both prescribers were contacted by a pharmacist on one occasion each, where queries were immediately addressed and medicines subsequently dispensed. This was possible because the prescribers wrote their contact phone number on all prescriptions. Although Hospice colleagues had raised the issue of confidentiality as a concern, especially for the medical prescriber who does not have a work phone, both prescribers stated they had no concern with this and personal preference was that they would rather be contacted immediately if there was

an issue. Likewise, prescribers stated communication with pharmacies regarding stock availability prior to issuing a prescription was also an enabler in the process.

Non-prescriber SPCNs also observed that prescriber preparation to glean all relevant information required for prescribing enabled successful outcomes.

3.6.3. Pathfinder impact

3.6.3.1. Sustainability and scale within Foyle Hospice

In order for the Foyle Hospice to sustain and scale community HS21 prescribing, common themes were identified amongst all participating staff. All groups agreed that electronic resources and support for prescribing would be the gold standard approach. This would include technological support for homecare visits to access relevant patient information systems, replacing the triplicate form and streamlining the governance process. Prescribers also suggested a prescribing template similar to the JICB, with pre-populated options. In relation to electronic means of prescribing and governance, the medical prescriber said *"risk would go down, error would go down, and having it there would be fantastic."* Additionally, resolving issues with access to information and communication systems such as Epic Care Link would facilitate safer transitions of care between the interface of the independent sector and secondary care services. Funding to update current IT facilities in the hospice will also likely be required to support Encompass systems.

Other common themes arising for prescribing sustainability were ongoing managerial support and increased prescriber availability, both medical and non-medical, on a full-time basis to future-proof the service. A potential barrier to this for the Foyle Hospice is the future funding uncertainty for Specialty Doctors, which is not guaranteed. Managers mentioned the importance of encouraging culture change and promoting awareness within the primary care setting to future scale and sustainability efforts.

Prescriber and managers strongly felt that community HS21 prescribing should be scaled throughout the Foyle Hospice to other areas such as Day Case (outpatients) and the Inpatient Unit. This would assist with faster titration and earlier review of response for symptom management which benefits the patient when their condition rapidly changes and ensures continuity of care. Both groups also recognised that individual prescribing ciphers would assist with future audit and traceability as well as cultivating a sense of ownership.

Prescribers recommended SPCNs also attend initial joint homecare visits with the NMP, where possible, in order to overcome the barriers previously discussed and provide the opportunity for a shared learning experience and peer support.

Finally, managers and prescribers recognised that job descriptions would need to be amended to reflect prescribing requirements in the future.

3.6.3.2. Non-medical prescribing

Hospice managers felt that more SPCNs attaining their non-medical prescribing qualification would assist in the sustainability and scale of HS21 community prescribing that has been established by the pathfinder. Prescribers would also encourage other SPCNs to gain their

non-medical prescribing qualification due to the potential for career development and progression for the nursing profession. Prescribers and managers felt that with an effective communication and awareness strategy, more NMPs in a supportive role would be welcomed by primary care, where the GP remains the main provider of care. The ability of the NMP to write syringe pump charts and amend JICBs also means that these important documents can remain in patient's home at all times.

All groups agree that the increased sense of responsibility, workload and time commitment may deter more nurses from doing the non-medical prescribing course in the future. For those that do want to proceed, all agreed that pay scales/remuneration should be reflective of the extra workload and responsibility in order to future-proof the qualification. A further potential barrier raised by SPCNs is the limited number of opportunities within teams to gain a suitable job post to utilise prescribing skills. At present, SPCNs feel there is not much professional incentive to undertake a non-medical prescribing qualification, although do acknowledge that the profession is progressing in this direction and if all nurses were NMP-qualified, then the workload would be shared equally.

"When you come out, you need to be able to use your qualification."

- N3, Non-prescriber SPCN.

"It's just a harder, more specialised job than would have been done here. And I think maybe if you add the weight to it and the weight sometimes has to be the recognition of banding and change and monetary value."

– P2, Prescriber.

3.6.3.3. Regional spread and implementation

All groups articulated the positive aspects to regional spread of HS21 prescribing in Northern Ireland, particularly in terms of anticipated patient benefits and support to primary care colleagues. According to the medical prescriber, the current workforce crises in general practice means there is a risk of deteriorating doctor-patient relationships due to increased pressures on the service.

"I think where it comes into its own is when you are out in the house of someone who is in the final 24 hours and you can just get it all sorted…. So I think rolling it out would seem like a really, really useful thing to do all around…"

– M3, Manager.

Despite the strong endorsement from Foyle Hospice staff for regional spread, there are a number of potential barriers and recommendations that need to be considered based on the experience gained during the pathfinder. Prescribers supposed that resistance to change is likely to be the main barrier to regional spread. From a managerial perspective, this included a small risk of potential resistance from primary care. On this subject, SPCNs and managers

believed there would be no risk of deskilling either GPs or district nurses, as the hospice services are advisory and supportive, specifically within the SPC field. SPCNs and managers both expressed concerns about the lack of technical capability and prescribing support in the community, especially in terms of accessing patient information systems. The importance of appropriate prescribing was also identified by one SPCN.

To assist the successful spread of community HS21 prescribing throughout Northern Ireland, prescribers strongly suggested training or induction sessions for both doctors and nurses (NMPs) to become familiar with controlled drug prescription requirements and provision of reference materials to support this. Furthermore, managers expressed the importance of strong leadership and staff commitment stating, "*You have to commit to it. Everyone has to give 110%."* Finally, utilising existing NMP-qualified staff such as pharmacists could also assist with scale and regional implementation.

3.6.4. Pathfinder improvement

Foyle Hospice staff made a number of recommendations for pathfinder improvement. A summary of these include:

- Early engagement of all participating staff groups from the outset during the planning and scoping activities to achieve whole team commitment and support. All staff groups played an important role in implementation and therefore should have been represented on the T&F group, especially the non-prescriber SPCNs. An introductory in-person meeting or event would also have been beneficial.

- Training on the data collection forms at all stages of data collection.

- More training from the outset for prescribers, as assumptions were made as to the level of support required.

- A replacement solution to the triplicate form and a decreased governance workload, preferably assisted with electronic support, where possible, and means to access patient information systems whilst in the community.

- Raise greater awareness of community HS21 prescribing amongst key stakeholders, wider hospice senior management/executives and clinical staff to increase support for prescribers.

3.6.5. Encompass

Regional implementation of the Health and Social Care Northern Ireland Encompass programme, which uses Epic software, is currently underway in Northern Ireland. At the time of the pathfinder, uncertainty about how this will affect current ways of working, training needs and access to IT systems was a concern expressed by all staff groups. Foyle Hospice management recognised that this may require updated IT resources to support integration with Epic systems for safe transition of care between secondary care services and the independent sector.

3.7. Stakeholder feedback survey

Members of the pathfinder T&F group not directly involved in the evaluation and wider stakeholders from primary care were invited to complete an anonymous online feedback survey upon conclusion of the pathfinder. Respondents (n=13) represented a range of different stakeholders, including primary care colleagues such as GPs and District Nurses, as shown in Figure 5.

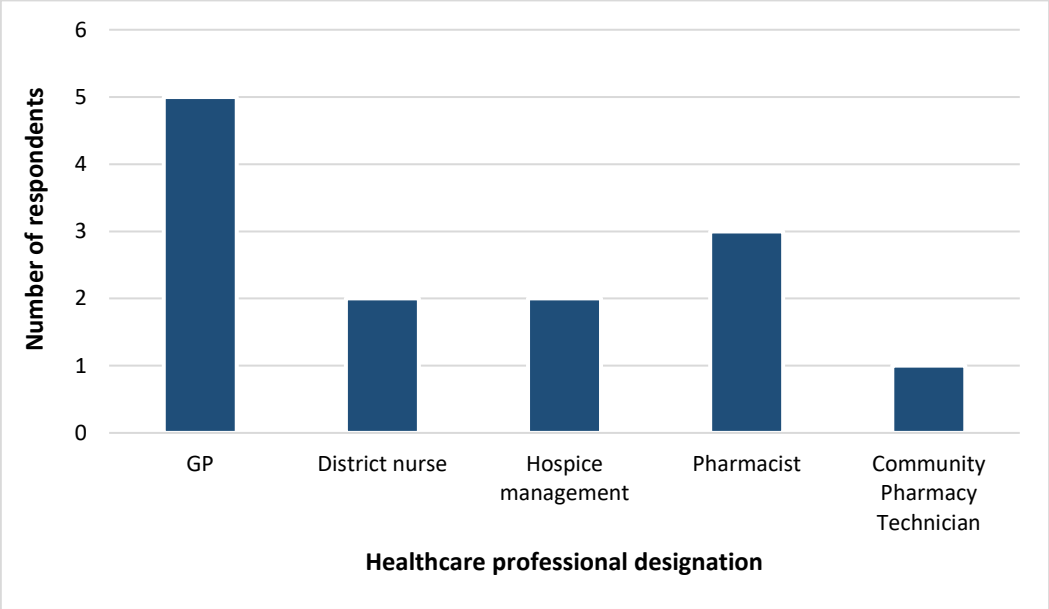


Figure 5. Respondents to the pathfinder stakeholder feedback survey. This included those directly involved in the Task and Finish Group as well as wider stakeholders affected by the introduction of H21 prescribing by the Foyle Hospice in the community.

According to stakeholders, common factors which enabled and assisted in the delivery of the pathfinder included:

- Strong communication between stakeholder groups such as the Foyle Hospice community team and primary care colleagues.
- Leadership from the SPPG project team and support for the pathfinder from the Chief Pharmaceutical Officer (CPO). This included frequent meetings and updates between the project team and the Foyle Hospice.
- Promotion of pathfinder anticipated benefits.
- Development of clear guidance and a governance framework.
- Highly motivated and experienced Foyle Hospice staff who had previous experience of the barriers that exist to timely medicines access within the current model.
- Support from district nursing colleagues and joint working.

Only three respondents indicated that they had concerns regarding implementation of HS21 community prescribing. These concerns were in relation to the governance arrangements, so that all relevant services were informed of medication changes and newly prescribed medications in a timely manner. One respondent stated that these concerns were alleviated by the framework implemented by the T&F group. Barriers/challenges experienced during the

pathfinder were reported by three respondents directly involved in the T&F group. Challenges reported included:

- The project team made an assumption that all prescribers would participate in the pathfinder, however this was not the case.
- The project team was unable to recruit a GP Pharmacist to the T&F group, however this was largely offset by the regular attendance of a GP who provided essential input from a primary care perspective.
- Prescription details could not be transferred via electronic document transfer (EDT) to the GP practice- however, this was addressed via the carbon copy triplicate forms and subsequent upload to NIECR with a follow up telephone call where required.
- The additional workload of data collection for the pathfinder evaluation was time consuming for Foyle Hospice staff.

In reference to pathfinder outcomes, one GP found that the pathfinder highlighted *"how good our Hospice team is."* Other outcomes observed by GP respondents were a decrease in prescription requests, a definite improvement in patient satisfaction, less admin and less stress for families who would have to wait on prescriptions from the surgery. For district nurses, outcomes included timely symptomatic relief for patients and better joint working between themselves and the Foyle Hospice community team.

A community pharmacy dispensing technician recognised the benefits to patients' family members and friends, stating that *"the pathfinder has delivered a smoother transition*" for those collecting prescriptions for the patient. Furthermore, *"it is also reducing a lot of waste being brought back to the chemist."*

For pharmacists, the main outcome recognised was once again the benefit to patients and their families in terms of timely access to medicines, enabling better symptom control. Other outcomes mentioned by pharmacist representatives of the T&F group included excellent collaboration amongst stakeholders to address challenges and the potential benefits to GP workload. Finally, as previously discussed in section 3.6.2.1, the pathfinder was able to support service continuity during a recent unprecedented red alert storm when GP practices remained closed.

For representatives of Hospice management on the T&F group, the pathfinder highlighted a lack of access by Hospice staff to Trust services, particularly ICT and clinical systems, in addition to outcomes previously discussed in section 3.6.2.1.

All respondents agreed that the pathfinder was of benefit to patients. Some direct quotes articulating the benefits from the perspective of primary care professionals are shown below:

> *"By assisting GPs through tasks such as completing kardexes, syringe driver charts & prescribing/providing medication scripts whilst in the home, it avoids the need to take up the GP's time, freeing them up to take on other urgent tasks and will also inevitably improve the relationship between carers/patients & their primary care contacts as it will decrease the amount of time loved ones spend trying to engage in an already overstretched primary care system, whilst simultaneously providing prompt physical benefit for the patient." – GP 3.*

"Patients were reviewed in a timelier manner. Holistic care worked in partnership with key worker."

- District Nurse 1.

"Quicker process to getting medications. Less risk of prescribing error as fewer steps in the process."

– GP 2.

Over half of respondents (54%) indicated that they have seen a significant change to practice since introduction of the pathfinder. This included 3 GPs and a district nurse who were not directly involved with the T&F group, but experienced the consequences of the pathfinder in practice. Changes experienced by these primary care representatives included less dependence on the GP and better management of patients in a faster, more efficient process. For those with direct T&F group involvement, changes to practice included stronger relationships between the Foyle Hospice and local OOH/GP services, better job satisfaction and process changes for prescribers and non-prescribers.

Most respondents indicated that they would not do anything differently in relation to the pathfinder process in the future. One district nurse however, would like to use their NMP qualification for palliative patients in the future, stating that collaborative working with the SPCNs will be a "*great asset to the community.*" Most respondents thought that HS21 community prescribing should be sustainable into the future with the following support and/or resources:

- Support from the CPO and SPPG (Integrated Prescribing Oversight Board);
- Education and training for prescribers;
- Electronic prescribing and technology;
- More qualified non-medical prescribers;
- Individual prescriber cipher numbers and scale of prescribing to outpatient clinics.

According to some respondents (n=3), potential barriers to adoption of community HS21 prescribing into standard practice were:

- Ability to communicate with GP practices via EDT;
- Ability to obtain multiple ciphers for each hospice;
- Lack of knowledge from GPs (regarding pathfinder awareness);
- Buy-in from potential prescribers and their supervisors.

In order to support regional adoption, the following supportive measures and resources were recommended by stakeholder respondents:

- Increase awareness amongst GPs and community pharmacies.
- Training and support to encourage engagement with non-medical prescribing courses and increase numbers of active non-medical prescribers.
- Share outcomes and learning from the pathfinder to inform a regional approach to implementation, with policy support from the Department of Health.
- Adequate governance, registration and training processes.

- GP support at a regional level.
- Successful integration with Epic systems for safer transitions of care, including adequate IT/electronic resource and training to support this.

4. Recommendations

4.1. Recommendations for Foyle Hospice

The pathfinder indicated that HS21 prescribing provided timely access to medicines in an efficient manner for patients requiring specialist palliative care. In addition, it reduced pressure on GP and OOH services. As such, to ensure consistency and improve patient outcomes, HS21 prescribing by the Foyle Hospice should be sustained and scaled to other areas within the service.

Steps should be taken by the Foyle Hospice to explore and address solutions to the barriers identified during the pathfinder including:

a. Provision of adequate electronic resources including access to dedicated work mobile phones.

b. Provision of sufficient training, professional support and resources for prescribers in the areas of prescription writing, controlled drug prescription requirements and governance processes.

c. A means to access all relevant patient information systems.

d. Further consideration of how and where prescribers prepare the HS21 is required, as prescribers reported that there were potential distractions when prescribing within the home setting.

e. Consideration of options to enhance the availability of both medical and non-medical prescribers to ensure future service provision and continuity.

4.2. Recommendations for regional adoption

Regional adoption of HS21 prescribing by all hospices across Northern Ireland should be championed, supported with robust governance processes and provision of training to meet the needs of the prescriber(s). The pathfinder highlighted the importance of stakeholder identification, inclusion and engagement, including the wider hospice team, at the earliest opportunity for successful implementation of new processes.

When scaling and spreading there are a number of additional considerations:

a. Existing governance and accountability processes could be strengthened further by individual prescriber cipher numbers on HS21 prescription forms, and the introduction of electronic governance processes, such as printing of prescriptions, should be considered.

b. Communication with primary care services is essential to raise awareness of HS21 prescribing by hospice staff within the community setting.

c. The pathfinder demonstrated a valuable role for both medical and non-medical prescribing in the community setting. Hospice staff with an existing medical/non-medical prescribing qualification can utilise these skills to deliver an enhanced SPC service which benefits patients and supports primary care. SPC nurses who wish to progress towards a non-medical prescribing qualification should be fully supported-however, meaningful opportunities to practice these skills must be made available for the benefits to be realised. Joint visits between prescribers (medical and non-medical) and SPCNs (non-prescribers) could be considered as a learning opportunity for prospective non-medical prescribers and to support successful adoption of HS21 prescribing within community teams.

d. It is recommended that the evaluation is shared with the Palliative Care in Partnership programme to inform future commissioning arrangements. For example, it could be considered as part of the baseline scoping exercise into palliative and end of life care services.

5. Conclusion

Prescribing in the community setting by Foyle Hospice staff was successfully implemented during the pathfinder. A robust governance process and regular update meetings with key stakeholders provided a supportive framework for prescribers to utilise their skills to prescribe critical medication within the patient home or care home setting. Data collected at various stages during the 6-month time frame demonstrated a benefit to patients in terms of quicker access to medicines and therefore more prompt symptom management in the end stages of life. Prescribing by Foyle Hospice staff also reduced pressures on other services such as the GP and WUC. Prescribers and other stakeholders support the sustainability and scale of the service in the future. A number of opportunities to improve the process to support this have been highlighted. It is vital that the learning from this pathfinder is utilised to facilitate the regional adoption of HS21 prescribing by hospices across Northern Ireland so that the benefits can be realised for all SPC patients.

END OF REPORT

Appendix 1

Summary of Standard Operating Procedure for HS21 prescribing in the community

Prescribing criteria and scope

The prescribers will issue prescriptions directly to patients in situations where it is of benefit to the patient to:

• Commence treatment quickly (within 72 hours of contact with the prescriber).

• Titrate medication and have an early review for response and appropriateness.

Prescribing process

A triplicate HS21 prescription will be generated by the prescriber. The top copy will be given to Community Pharmacy, middle to the GP for their records and bottom kept at the Hospice for their records. The prescription will be annotated to distinguish between medic and nurse to allow appropriate entry into controlled drug (CD) registers, and to facilitate any prescription queries with the prescriber.

Prescribers will inform the patient's GP of any medicines prescribed and ongoing monitoring requirements on the same day that the prescription is issued. This will occur by one of 2 routes:

- The prescriber will deliver by hand a copy of the prescription issued to the GP practice on the same day, if they are in the vicinity of the patient's GP practice. On return to the Hospice base the prescriber will upload the medication details to NIECR.

  OR

- The prescriber will upload the medication details to NIECR and follow up with a telephone call to the GP practice to draw their attention to the changes in the patient's medication, with reference to the details contained in the patient's NIECR. When up-loaded to NIECR, the template with the medication adjustments will be found in the "out-patient" section of the patient's notes.

Step 1:

Hospice Prescriber assesses patient at home or care home and determines if a change in medication is required. If no change is required update patient and district nursing notes.

Step 2:

If a change in medication is required then the following processes should be followed.

Syringe Pump Chart/JICB change only (medicines available at patient home)

- Make required changes, update patient and district nursing notes and notify patients GP

(step 4).

New HS21 prescription required to commence treatment quickly (within 72 hours of contact with the prescriber) or to Titrate medication and have an early review for response and appropriateness.

- Issue HS21 script (step 3)

Syringe Pump Chart/JICB change (medicines available at patient home) and new HS21 prescription required required to commence treatment quickly (within 72 hours of contact with the prescriber) or to Titrate medication and have an early review for response and appropriateness.

- Issue HS21 prescription (step 3) and
- Make required changes, update patient and district nursing notes and notify patients GP (step 4)

Step 3

Writing HS21 Prescriptions

HS21 prescription forms can be issued by prescribers in the following circumstances:

- Urgent items that need to be commenced within 72 hours and within the prescriber's usual scope of practice e.g. end-of-life medication.
- Short supplies of medicines that require review, titration, tapering by Interface prescriber prior to recommendation for longer term suitability e.g. analgesia or to titrate medication and have an early review for response and appropriateness.

Staff should refer to Section 7 prescription security of the Hospice NMP policy and to the Guidance-for-non-medical-prescribing-in-general-practice.pdf

https://bnf.nice.org.uk/guidance/prescription-writing.html

The Hospice prescriber should add their contact telephone number to the prescription to enable the community pharmacist to contact them in case of any clinical queries.

A triplicate prescription will be generated by the prescriber. The top copy will be given to Community Pharmacy, the middle copy will go to the GP for their records and bottom kept at the hospice for their records. The prescription will be annotated to distinguish between the medic and nurse to allow an appropriate entry to be made in the CD register, and to facilitate any prescription queries with the prescriber.

Step 4

Informing GP

Prescribers will inform the patient's GP of any medicines prescribed and ongoing monitoring requirements on the same day that the prescription is issued. This will occur by one of 2 routes:

- The prescriber will deliver by hand a copy of the prescription issued to the GP practice on the same day, if they are in the vicinity of the patient's GP practice. On return to the Hospice base the prescriber will upload the medication details to NIECR.

  OR

- The prescriber will upload the medication details to NIECR and follow up with a phone call to the GP practice to draw their attention to the changes in the patient's medication, with reference to the details contained in the patient's NIECR.

When uploaded to NIECR the template with the medication adjustments will be found in the "outpatient" section of the patient's notes.

Process to follow if HS21 script or changes made to Patient's medication during Home Visit at Weekend or Bank Holiday by Hospice Prescriber.

1. Rota detailing if Prescriber on duty following weekend /bank holidays to be emailed by Hospice staff to Western Urgent Care Monday or Tuesday. (If these days are a bank holiday, rota to be sent to following first normal working day) highlighting when one of the prescribers will be covering home care.
2. At weekend or bank holiday when a Foyle Hospice prescriber issues an HS21 script and or makes changes to a visit to ensure NIECR is updated should that patient later present to OOH or to A and E.
3. Hospice Prescriber contacts Western Urgent Care call centre (028 7186 5195) with the details of the medication changes for Patients.
4. The Call Handlers will mark the call – "Information Only from Hospice Team" and will be advised to double check the medication names and doses with the prescriber and then to close the case on Adastra Western Urgent Care Clinical system as "Information Only".
5. This will close it on WUC system and not require any further intervention so no triage etc. When the case is close the information will then be pushed to the Patients ECR.
6. WUC will issue a reminder each time to our Call handlers so that if they take a call they know what to do.
7. To ensure continuity and as additional governance mechanism, the Carbon Copy of HS21 script should be sent to GP practice and NIECR Hospice Drug Template uploaded on the first normal working day following the weekend or Bank Holiday.

Governance Arrangements

All prescribing practices will be reviewed and managed as per the Hospice governance processes.

All prescribing practices will be reviewed by the prescriber's direct line manager and will be discussed at 1:1 supervision sessions.

BSO send a quarterly report detailing prescribing activity to the Hospice Medical Director which will be reviewed and disseminated to the relevant line manager and discussed at 1:1 supervision sessions with the member of staff.

Risk Management

1. The accountability for prescribing lies with the individual prescriber and prescribers must restrict the prescribing of medicines on HS21 to their own scope of practice.
2. Prescribers must communicate details of the prescribed medicines to the patient's GP as detailed previously and a clear statement indicating when prescribing is likely to be

transferred to the GP.

3. Any medication suitable for repeat issue will be continued by the patient's GP.

In addition to the above currently medicine management within Hospice is monitored on a 6 month basis by both DoH (medicines regulation) and RQIA.

HS21 Prescription Pads scripts delivered to Hospice from DLRS are addressed to the accountable officer and require a signature.

Evidence-based practice

Prescribed medicines should, where possible be those recommended in the Northern Ireland Formulary www.niformulary.hscni.net

Appendix 2

Data collection forms- baseline

Day:	**Date:**	**Time of visit:**
Prescriber ID:	**Patient ID (icare number):**	

Section 1- Action required (Prescriber)

Please select the relevant option:

A. Patient does **not** require any medication changes ☐ (*no further details necessary*)
B. Syringe Pump Chart/JICB change only (medicines available at patient home) ☐ (Fill in **section 2 only**)
C. New HS21 prescription required ☐ (Fill in **section 3 only**)
D. Syringe Pump Chart/JICB change (medicines available at patient home) **and** new HS21 prescription required ☐ (Fill in **sections 2 and 3**)

Section 2- Medicines available at patient's home

Syringe Pump Chart/JICB amended: Yes ☐ No ☐

Time amended: _____

GP informed of changes: Yes ☐ No ☐

District nurse informed of changes: Yes ☐ No ☐

Was medication change made in-hours? Yes ☐ No ☐

Additional comments:

Healthcare professional (HCP) administering medicines:

District Nurse ☐ GP ☐ Other ☐ Please specify: _____

Date & time HCP visit to administer medicines expected: _____/_____

Additional comments:

Section 3- New HS21 Prescription Required

Action: Contact patient's GP

(list each contact / attempt to contact GP)

Date	Time	Method of communication	Comments/ Details

New HS21 prescription issued: Yes ☐ No ☐ If No, please state why:_____

Date & time new HS21 prescription to be ready for collection: _____/_____

New prescription to be collected by:

Patient's family ☐ Hospice / District nurse ☐ Pharmacy ☐ Other ☐ _____

If known, date & time prescription was collected at: _____/_____

If known, date & time medicines were collected or delivered from **Community Pharmacy**:

_____/_____

Healthcare professional (HCP) administering medicines:

District Nurse ☐ GP ☐ Other ☐ Please specify: _____

Date & time HCP visit expected to administer medicines: _____/_____

Please indicate if contact with any of the following was required:

Western urgent care ☐

Trust Emergency Pharmacy Service rota ☐

Community Pharmacy Palliative Care rota ☐

Other ☐ (please specify) _____

Additional comments

Day:	**Date:**	**Time of visit:**
Prescriber ID:	**Patient ID (icare number):**	

Section 1- Action required (non-prescriber)

Recommendation: (select one):

A. Patient does **not** require any medication changes ☐ (*no further details necessary*)
B. Syringe Pump Chart/JICB change only (medicines available at patient home) ☐
C. New HS21 prescription required ☐
D. Syringe Pump Chart/JICB change (medicines available at patient home) **and** new HS21 prescription required ☐

For options B- D, please fill out sections 2 & 3.

Section 2- Contact with GP

Please list each contact / attempt to contact GP. Please detail outcome.

Date	Time	Method of communication	Comments/ Details

Medication recommendations accepted by GP: Yes ☐ No ☐

If applicable, **New HS21** prescribed: Yes ☐ No ☐

If yes, date & time new HS21 prescription to be ready for collection: _____/_____

Prescription to be collected by:

Patient's family ☐ Hospice / District nurse ☐ Pharmacy ☐ Other ☐ _____

If known**,** date & time prescription was collected by patient's family: _____/_____

If known, date & time medicines were collected or delivered from **Community Pharmacy**:

_____/_____

If Syringe Pump Chart/JICB change only, date & time change expected:_____/_____

Additional comments:

Section 3- Medicines Administration

Healthcare professional (HCP) administering medicines:

District Nurse ☐ GP ☐ Other ☐ Please specify: _____

Date & time HCP visit expected to administer medicines: _____/_____

Please indicate if contact with any of the following was required:

Western urgent care ☐

Trust Emergency Pharmacy Service rota ☐

Community Pharmacy Palliative Care rota ☐

Other ☐ (please specify) _____

Additional comments:

Appendix 3

Data collection forms- used at both midpoint and endpoint

Day:	**Date:**	**Time of visit:**
Prescriber ID:	**Patient ID (icare number):**	

Section 1- Action required- Prescribers

Please select the relevant option:

A. Patient does **not** require any medication changes ☐ (*no further details necessary*)
B. Syringe Pump Chart/JICB change only (medicines available at patient home) ☐ (Fill in **section 2 only**)
C. New HS21 prescription required ☐ (Fill in **section 3 only**)
D. Syringe Pump Chart/JICB change (medicines available at patient home) **and** new HS21 prescription required ☐ (Fill in **sections 2 and 3**)

Section 2- Medicines available at patient's home

Syringe Pump Chart/JICB amended: Yes ☐ No ☐

Time amended: _____

GP informed of changes: Yes ☐ No ☐

District nurse informed of changes: Yes ☐ No ☐

Was medication change made in-hours? Yes ☐ No ☐

Additional comments:

Healthcare professional (HCP) administering medicines:

District Nurse ☐ GP ☐ Other ☐ Please specify: _____

Date & time HCP visit to administer medicines expected: _____/_____

Additional comments:

Section 3- New HS21 Prescription Required

New HS21 prescription issued: Yes ☐ No ☐ If No, please state why:_____

Date & time new HS21 prescription written: _____/_____

GP informed of changes: Yes ☐ No ☐

Was HS21 prescription written in-hours (Mon-Fri)? Yes ☐ No ☐

New HS21 prescription: Urgent ☐ Non-urgent ☐ _____

Prescription given to:

Patient's family ☐ Hospice / District nurse ☐ Pharmacy ☐ Other ☐ _____

If known, date & time medicines were collected or delivered from **Community Pharmacy**:

_____/_____

Healthcare professional (HCP) administering medicines:

District Nurse ☐ GP ☐ Other ☐ Please specify: _____

Date & time HCP visit expected to administer medicines: _____/_____

Please indicate if contact with any of the following was required:

Patient's GP ☐

Western urgent care ☐

Trust Emergency Pharmacy Service rota ☐

Community Pharmacy Palliative Care rota ☐

Other ☐ (please specify) _____

Additional comments

Day:	**Date:**	**Time of visit:**
Prescriber ID:	**Patient ID (icare number):**	

Section 1- Action required (non-prescriber)

Recommendation: (select one):

A. Patient does **not** require any medication changes ☐ (*no further details necessary*)
B. Syringe Pump Chart/JICB change only (medicines available at patient home) ☐
C. New HS21 prescription required ☐
D. Syringe Pump Chart/JICB change (medicines available at patient home) **and** new HS21 prescription required ☐

For option B- please fill out section 2 only. For options C & D- please fill out section 3 only.

Section 2- Syringe Pump Chart/JICB change only

Prescriber contacted to make changes:

Patient's GP ☐ Hospice Prescriber ☐ Other ☐ Details:_____

If applicable, please list each contact / attempt to contact GP. Please detail outcome.

Date	Time	Method of communication	Comments/ Details

Syringe Pump Chart/JICB amended: Yes ☐ No ☐

Time amended: _____

Did Syringe Pump Chart/JICB change occur **out of hours?** (After 5pm Mon-Fri OR Sat/Sun)

Yes ☐ No ☐

Western Urgent Care contacted: Yes ☐ No ☐

Healthcare professional (HCP) administering medicines:

District Nurse ☐ GP ☐ Other ☐ Please specify: _____

Date & time HCP visit expected to administer medicines: _____/_____

Additional comments:

Section 3- New HS21 Prescription

Syringe Pump Chart/JICB change required in addition to new HS21: Yes ☐ No ☐

Prescriber contacted: Patient's GP ☐ Hospice Prescriber ☐ Other ☐ _____

***If applicable**, please list each contact / attempt to contact the **patient's GP**. Please detail outcome.*

Date	Time	Method of communication	Comments/ Details

Medication recommendations accepted by GP/ Other Prescriber: Yes ☐ No ☐

New HS21 prescribed: Yes ☐ No ☐

New HS21 prescription: Urgent ☐ Non-urgent ☐

Date & time new HS21 prescription to be ready for collection: _____/_____

If applicable, Syringe Pump Chart/JICB amended: Yes ☐ No ☐ _____

Prescription to be collected by:

Patient's family ☐ Hospice / District nurse ☐ Pharmacy ☐ Other ☐ _____

If known**,** date & time **prescription** collected: _____/_____

If known, date & time **medicines** were collected or delivered from Community Pharmacy:

_____/_____

Healthcare professional (HCP) administering medicines:

District Nurse ☐ GP ☐ Other ☐ Please specify: _____

Date & time HCP visit expected to administer medicines: _____/_____

Please indicate if contact with any of the following was required:

Western urgent care ☐

Trust Emergency Pharmacy Service rota ☐

Community Pharmacy Palliative Care rota ☐

Other ☐ (please specify) _____

Additional comments:

Appendix 4

HEALTHCARE PROFESSIONAL INFORMATION SHEET

Study title: New Models of Prescribing: Foyle Hospice Pathfinder

Invitation to participate in a service evaluation
This service evaluation will examine the New Models of Prescribing: Foyle Hospice Pathfinder project. You have been invited to participate in a focus group or questionnaire because of your participation in this project.

This information sheet describes the evaluation and your role in it. Before you decide, it is important that you understand why the evaluation is being carried out and what it will involve for you. Please take time to read this information and discuss it with others if you wish. If anything is not clear, or if you would like more information, please ask the person responsible for this evaluation. After that we will ask you to sign a consent form in order to participate in the evaluation.

Voluntary nature of participation
Participation in this evaluation is voluntary. You can withdraw from the evaluation at any time without giving any reason and without there being any negative consequences. If you withdraw from the evaluation or withdraw your consent, your personal data collected for the purposes of the evaluation will be removed.

Purpose and aims of the evaluation
The main goal of this evaluation is to investigate whether the project worked as expected. The specific aims of this interview or focus group are to explore healthcare professionals' views on engaging with the project, practice with regards to prescribing in the community and the impact of this.

Who is organising and funding the evaluation?
The New Models of Prescribing Pathfinder project is organised by the Strategic Planning and Performance Group (SPPG). The Medicines Optimisation Innovation Centre is conducting the evaluation.

What will the participation involve?
<u>Providing consent</u>

- After you have had time to read and understand this information sheet you will be asked to sign a consent form.

<u>During the interview/focus group</u>

- During the interview or focus group, you will be asked some questions regarding your participation in the project.
- We are looking for your honest opinions.
- The researcher(s) may need to take notes during the interview/focus group and will be audio recording the conversation so that we can listen back to it and make more detailed notes.
- The conversation should not last longer than 60 minutes. We will work at a pace that is set by you and you may take a break at any time during this.

<u>Collection and processing of information after the interview/focus group</u>

- Other than the recording obtained during the interview/focus group, no other personal data will be collected.
- All recordings collected during the interview/focus group will be transferred to a password-protected computer that only the staff at SPPG/ MOIC will have access to.
- We will transcribe the recordings and anonymise any identifiable information in the process. Recordings will then be destroyed after use.
- Anonymised findings may be used in further publications or dissemination activities (e.g., in journal articles, workshops and conferences).

Possible benefits of taking part
The evaluation will investigate what worked well in the project and what could be improved in the future. The findings of this evaluation may influence policy regarding community-based prescribing by hospices in Northern Ireland.

Possible disadvantages and risks of taking part
There is no foreseeable risk or disadvantage to you by taking part in this interview/focus group.

Incidental findings
There are no foreseeable incidental findings of taking part in this interview/focus group.

Financial information
Participation in this evaluation will involve no cost to you, other than your time. You will receive no payment for your participation.

Informing about the evaluation results
A written summary of the evaluation will be made available to all participants once completed. Results, including direct quotations may also be published in a report to the funding body, journals, publications and conferences. No participants will be able to be identified from these reports.

Further information
Further information related to the evaluation can be requested from the research team.

Contact details of the researchers / person in charge
MOIC: Dr Rachel Huey Rachel.Huey@northerntrust.hscni.net
Telephone: 028 9442 4942

SPPG: Gillian McCorkell Gillian.McCorkell2@hscni.net

Appendix 5

PARTICIPANT CONSENT FORM

Study title: New Models of Prescribing: Foyle Hospice Pathfinder

Participant declaration

- I have been invited to participate in the above study. The purpose of the study is to evaluate the New Models of Prescribing: Foyle Hospice Pathfinder.

- I have read and understand the participant information sheet. The participant information sheet has provided me sufficient information about the above evaluation, its purpose and execution of the study, about my rights, and about the possible advantages and disadvantages of taking part.

- I have had the opportunity to ask questions about the evaluation and have had these questions answered satisfactorily.

- I have been given sufficient information about the collection, processing, transfer/disclosure and deletion of my responses during the study. I understand that other than voice recordings obtained during the study by staff from MOIC/SPPG, no other personal data will be processed during this study.

- By signing this form, I confirm that I voluntarily consent to participate in this evaluation and that I also grant consent to the processing of my responses for the purposes described in this document.

- I have not been pressurised or persuaded into participation and I have had enough time to consider my participation in the study. I understand that my participation is entirely voluntary and that I am free to withdraw my consent at any time, without providing any reason.

- I also have the right to request the removal of my identifiable personal data in accordance with data protection legislation.

To be completed by the participant

Agreement (please complete the details below to confirm your consent)

Name:	
Date:	
Signature:	

To be completed by MOIC personnel

Please complete the details below to confirm receipt of signed consent

Name:	
Date:	
Signature:	

The original consent signed by the participant will be kept by the research team.

Contact

MOIC: Dr Rachel Huey rachel.huey@northerntrust.hscni.net
Telephone: 028 9442 4942

SPPG: Gillian McCorkell Gillian.McCorkell2@hscni.net

Appendix 6
Interview Guides

Focus of questions	Example interview questions- **Hospice Managers**

Engagement	• What **motivated** you to participate in this pathfinder? What
	• What **barriers or challenges** did you experience in taking part in the pathfinder?
	• Were there any issues encouraging staff to engage with the pathfinder? How did you overcome these?
	• Did you have any concerns about the introduction of HS21 prescribing? Were these addressed/overcome? Did you feel adequately supported?
	• Did you notice any change in how yourself/Hospice Staff interacted with the following key stakeholders upon introduction of the pathfinder (compared to current practice):
	  ○ Patients
	  ○ GPs/Out of Hours/District Nurses
	  ○ Other Hospice Staff
	• Were there any factors that affected your interaction (either positively or negatively) with the project stakeholders?

Outcomes	• From your perspective, describe how the pathfinder has affected **outcomes** for patients and their carers in terms of medicines access? Have you had any feedback from patients/carers? • In your opinion, what factors **enabled** and supported the delivery of HS21 prescribing in the community? • What **barriers** or challenges were encountered in delivering HS21 prescribing in the community and how were they overcome? • Describe any **resources required** to support ongoing HS21 prescribing in the community that are not already in place? • What **benefits** did you as a manager experience as a result of your participation in the pathfinder? • Were there any **unintended outcomes** as a result of the pathfinder? • Did your **practice change** significantly? What changes did you have to implement to facilitate the pathfinder? • Would you do anything differently/ suggest any **changes** to the process?
Impact	• Describe the impact HS21 prescribing has had on patients/ would have on future patients. • Do you think HS21 prescribing for Hospice staff should be **scaled and spread** regionally and **adopted** into standard practice? Do you see any barriers to this? • What support/resources would be required for Foyle Hospice to sustain HS21 prescribing in the community? • Do you feel it is a benefit for SPC nurses to have a NMP qualification? Would you be keen for more staff to have this qualification? • Do you see any barriers to NMP in general for SPC nurses?

	• Thinking about the pathfinder as a whole what did you like and what could be improved?
	• Anything else you would like to add?

Focus of questions	**Example interview questions- <u>Prescribers</u>**

Engagement	• What **motivated** you to participate in this pathfinder?
	• What **barriers or challenges** did you experience in or taking part in the pathfinder?
	• Did you have any concerns about the HS21 prescribing? Were these addressed/overcome? Did you feel adequately supported?
	• What aspects of the pathfinder did you engage with and what enabled you to do this?
	• Describe how introduction of the pathfinder (compared to current practice) has changed your interaction with the following key stakeholders:
	  o Patients
	  o GPs/Out of Hours/District Nurses
	  o Other Hospice Staff
	• Were there any factors that affected your interaction (either positively or negatively) with the pathfinder stakeholders?

Outcomes	• Describe how the pathfinder has affected **outcomes** for your patients and their carers in terms of medicines access? • What factors **enabled and supported** the delivery of HS21 prescribing in the community? • What **barriers** were encountered in delivering HS21 prescribing in the community and how were they overcome? • Describe any **resources required** to support ongoing HS21 prescribing in the community that are not already in place? • What **benefits** did you as a healthcare professional experience as a result of your participation in the pathfinder? • Were there any **unintended outcomes- that is anything that you didn't expect to happen,** as a result of the pathfinder? • Did your **practice change** significantly or do you think that you developed/utilised new skills? • Would you do anything differently/ suggest any **changes** to the process?
Impact	• Describe the impact HS21 prescribing has had on patients/ would have on future patients. • Do you think HS21 prescribing for Hospice staff should be **scaled and spread** regionally and **adopted** into standard practice? Do you see any barriers to this? • **For NMP only**: o Has the pathfinder helped develop your prescribing skills? Would you like to continue utilising these skills?

	○ Do you feel it is a benefit for SPC nurses to have a NMP qualification? ○ Do you see any barriers to NMP in general for SPC nurses? • Thinking about the pathfinder as a whole what did you like and what could be improved?
	• Anything else you would like to add?

Focus of questions	**Example interview questions- <u>Non-prescriber Specialist Palliative Care Nurses</u>**
Engagement	• What **motivated** you to participate in this pathfinder? • What **barriers** or challenges did you experience in taking part in the pathfinder? • Did you have any concerns about the introduction of HS21 prescribing? Were these addressed/overcome? • Did you receive adequate **support** to participate and complete the data collection that was required during the pathfinder? • Describe how introduction of the pathfinder (compared to current practice) has changed your interaction with the following key stakeholders: ○ Patients ○ GPs/Out of Hours/District Nurses ○ Other Hospice Staff e.g. prescribers • Were there any factors that affected your interaction (either positively or negatively) with the pathfinder stakeholders?
Outcomes	• From your perspective, can you describe how the pathfinder has affected **outcomes** for patients and their carers in terms of medicines access? Have you had any feedback from patients/carers? • In your opinion, what factors **enabled and supported** the delivery of HS21 prescribing in the community? • Could you see any **barriers or challenges** that were encountered by your colleagues in delivering HS21 prescribing in the community and how were they overcome? • Describe any **resources you think would be required** to support ongoing HS21 prescribing in the community that are not already in place? • Did you experience any benefits as a result of your participation in the pathfinder? E.g. did you benefit from your colleagues being able to write a prescription during the course of your practice? • Were there any **unintended outcomes- that is anything that you did not expect to happen,** as a result of the pathfinder? • Did your **practice change** at all during the pathfinder? • Would you do anything differently/ suggest any **changes** to the process?
Impact	• Do you think HS21 prescribing for Hospice staff should be **scaled and spread** regionally and **adopted** into standard practice? Do you see any barriers to this? • Do you feel it is a benefit for SPC nurses to have a NMP qualification?

	• Do you see any barriers to NMP/have any concerns in general for SPC nurses? • What support would be required for more SPC nurses to gain their NMP qualification? • Thinking about the pathfinder as a whole what did you like and what could be improved?
	• Anything else you would like to add?

Appendix 7

Stakeholder feedback survey questions

Invitation to participate in a service evaluation

This survey is part of a service evaluation to examine the 'New Models of Prescribing- Foyle Hospice Pathfinder.'

You have been invited to participate in this survey because of your involvement in this pathfinder.

The main goal of this evaluation is to investigate whether the pathfinder worked as expected.

The specific aims of this survey are to explore the pathfinder Task and Finish Group members' views on delivery, impact and future sustainability of the pathfinder.

A written summary of the evaluation will be made available to all participants once completed. Results, including direct quotations, may also be published in a report to the funding body, journals, publications and conferences.

By completing this survey, **I confirm that I voluntarily consent to participate in this evaluation** and that I also grant consent to the processing of my responses for the purpose of evaluation and dissemination of the New Models of Prescribing- Foyle Hospice Pathfinder.

Please do not provide any identifiable information in your responses below. All responses are anonymous. If you would like any further information on the evaluation please contact **Rachel.Huey@northerntrust.hscni.net**

Please submit your response by **14 February 2025**. **Thank you!**
* Required

1. Today's date *

1. What **motivated** you to take part in the pathfinder?

2. What factors **enabled** delivery of the pathfinder?

3. Did you have any **concerns** about the implementation of HS21 prescribing in the community by hospice-employed prescribers? (Yes/No) If yes, please detail.

4. Did you experience any **barriers/challenges** in the delivery of the pathfinder? (Yes/No) If yes, please give detail and how were these overcome?

5. From your perspective, what **outcomes** (intended and unintended) has the pathfinder delivered?

6. Have you seen any **significant changes to current practice** during the course of your job role as a result of the pathfinder? (Yes/No) If yes, please detail.

7. What **resources** were required to deliver the pathfinder?

8. Would you do anything **differently** in the future? (Yes/No) If yes, please detail and why?
9. How **sustainable** is the delivery of HS21 community prescribing by Foyle Hospice prescribers in the future? What further support/resources would be required that are not already available?

10. Do you see any **barriers** to HS21 prescribing (medical and non-medical) being adopted into standard practice at a regional level? (Yes/No). If yes, please detail.

11. What needs to happen in the **longer term** to achieve **scale and spread** of HS21 prescribing in the community (medical and non-medical) at a **regional level** by hospice-employed prescribers? (E.g. in terms of resources not already available, training, support, processes etc.)

12. Is there anything else you would like to add?