**Appendices**

# An Evaluation of New Models of Prescribing (NMOP):

Mental Health Home Treatment Team

November 2022

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## Appendix 1: Terms of Reference and Task and Finish Group Membership

**New Models of Prescribing –**
**Mental Health prescribing at the interface: HTT**
**Task and Finish Group**
**Terms of Reference**

### 1.0. Background to New Models of Prescribing

Northern Ireland lacks a mechanism to allow many prescribers working at interfaces between primary and secondary care to prescribe medication directly to the patient that can then be dispensed in the community. This can result in duplication of work, with the original prescriber needing to work through the patient's GP to ensure that the required medicines are prescribed.

A transformation project involving extensive stakeholder engagement was established to scope out the arrangements that need to be in place to enable prescribers working at the interface to work in a more effective and autonomous way. The project considered new and transformative processes to allow prescribers to prescribe directly to patients, rather than going through a third party, and proposed mechanisms to enable new models of prescribing (NMOP). A Change Request has been developed and sets out a proposal to invest in the development of an technical solution to enable the production of HS21 prescriptions at interfaces between Primary and Secondary care. Northern Ireland currently has no technology solution to enable the printing of HS21 prescriptions at these interfaces. The proposed ECR solution will enable qualified medical and non-medical prescribers working in for example, Outpatient Clinics, and Intermediate Care Units, to issue prescriptions directly to patients rather than relying on the patient's GP to implement the recommendations.

A number of pilot projects will be initiated to test process, governance and policy frameworks required for NMOP in a small number of sites. One of the pilot projects will focus on medical and non-medical prescribing within the HTT located within BHSCT.

### 2.0. Background to Prescribing

HTT (HTT) is an acute community mental health team based at the Mater hospital site in Belfast, providing a multidisciplinary approach to care for adult patients with acute mental illness. The team operates 24 hours a day 7 days a week and bridges the gap between community services and inpatient care for those with acute mental illness. HTT enables patients to avail of intensive medical and psychological intervention quickly, with an overall aim of preventing the requirement for inpatient care and supports recovery in their home setting. HTT also has a facility known as Home Treatment House, a 6 bedded unit licensed with RQIA under nursing home standards.

Suitable patients from the HTT caseload may be offered a place in this unit for several weeks to undergo a period of continuous monitoring and more intensive intervention. All patients remain under the care of their GP whilst they are involved with HTT including those staying in the Home Treatment House. Supply of prescriptions and medicines are managed in primary care.

There are 4 consultants working in HTT and 4 trainee medical staff which currently consists of a registrar, one speciality doctor, one core trainee and a locum F2 doctor. Patients are admitted to the caseload under the care of a consultant and staff are aligned to each of the consultants in clusters to provide continuity of care. The multidisciplinary team consists of community psychiatric nurses, social workers, occupational therapists, community and peer support workers and a mental health pharmacist non-medical prescriber.

There are approximately 720 admissions to HTT annually with a current caseload of around 55 patients. HTT is staffed to manage a maximum capacity of 55 patients, however the caseload can fluctuate significantly and can reach as high as 80 during times of increased pressure on mental health services.

As described earlier, patients continue to obtain their prescriptions and medicines supply in primary care, including those patients staying in the Home Treatment House.

Following medical review of a patient, the psychiatry doctors may advise changes to the patient's psychotropic medicines. They may also advise on prescribing of medicines for physical health if they relate to the management of their mental health e.g. an antiemetic for nausea following a change to psychotropic medicine. This advice is communicated to the GP practice using a Belfast Trust Treatment Advice Note and at the GPs discretion, an HS21 prescription is supplied to the patient.

**Challenges –** the current request to prescribe system can present the following challenges to medication management for patients on the HTT caseload:

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

GP surgeries may be located anywhere across Belfast, and this can cause delays when requesting prescriptions.

## 3.0. Aims and Objectives of the HTT Prescribing Pilot Task and Finish Group

The aims of the pilot will be to:

- Facilitate the issuing of HS21s by a qualified medical non-medical prescriber (pharmacist) working in the BHSCT HTT.
- Explore existing barriers in policy and legislation to medical and NMP in this setting and work closely with the Policy and Legislation Task and Finish group to overcome these barriers
- Develop robust governance arrangements to ensure safe and effective prescribing practice
- Work closely with Trust Pharmacy leads to make changes to Trust Policies and Procedures as required
- Develop prescribing processes that address existing logistical challenges re: communication with primary care, timely updating of clinical records, interface with community pharmacy.
- To establish an effective funding mechanism, which is not directly linked to a GP Cipher code, to permit medical and NMPs working within HTT to prescribe at the interface

The objectives of the pilot project are to:

- Establish potential volume of prescribing activity that can be shifted to HTT prescribers
- Identify benefits in relation to access to medication and reducing pressure on GPs
- Support and enhance the delivery of tailored HTT interventions to patients, maximising professional skills at the point of care delivery
- Support the delivery of care pathways that can be delivered by a HTT prescriber
- Reduce delays in patients accessing medication - greater opportunity to access the right medicines, at the right time, from the right person.
- Support a reduction in the amount of unnecessary health care appointments and hospitalisations and promote faster recovery and self-caring.
- Support improvements in patient / client concordance with taking prescribed medicines.

### 3.1. Chair

The Mental Health Prescribing at the Interface pilot task and finish group will be chaired by Claire Erki, Community Mental Health Pharmacist, BHSCT.

### 3.2. Frequency of Meetings

The pilot task and finish group will meet monthly, however may meet more frequently in the first instance to launch the pilot.

### 3.3. Pilot Locations

The pilot will run across BHSCT for an initial three month period. The Trust area has been selected based on the submission of a project proposal to NMOP Programme Board and their willingness to participate in the pilot project.

## 4.0. HTT Prescribing Pilot Task Membership

The proposed membership is as follows:

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

## Appendix 2: Analysis plan

### Analysis Plan

**Overview of project aims and objectives:**

This pilot will focus on medical and non-medical prescribing within the HTT located within BHSCT.

The overarching aim was to complete an evaluation of the HTT pilot through joint working between MOIC and Health & Social Care Board (HSCB).[1]

The objectives were to:

**Objective 1** Establish potential volume of prescribing activity that can be shifted to HTT prescribers

**Objective 2** Identify benefits in relation to access to medication and reducing pressure on GPs

**Objective 3** Support and enhance the delivery of tailored HTT interventions to patients, maximising professional skills at the point of care delivery

**Objective 4** Support the delivery of care pathways that can be delivered by a HTT prescriber

**Objective 5** Reduce delays in patients accessing medication - greater opportunity to access the right medicines, at the right time, from the right person.

**Objective 6** Support a reduction in the amount of unnecessary health care appointments and hospitalisations and promote faster recovery and self-caring.

**Objective 7** Support improvements in patient / client concordance with taking prescribed medicines.

In addition: to evaluate

- whether or not the aims and objectives of the project have been met using various data collection methods e.g. surveys, audits, patient stories, correspondence and a stakeholder workshop.

**Data/info sources to consider:**

- NMOP Audit data:
    - Baseline data
    - Final data
- Prescribing data
- Stakeholder Feedback Session – Mentimeter
- Stakeholder Feedback Survey
- Patient survey
- Patient stories
- Process maps
- Supplementary information (exit survey)

**Analysis mapped to aims and objectives:**

| Objective | Suggested analysis | Data processing to completed to perform analysis |
|---|---|---|
| Robust governance arrangements in place to ensure safe and effective prescribing | Qualitative thematic analysis of Stakeholder survey and stakeholder workshop discussion | Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimater ratings to be summarised by MOIC.<br><br>Stakeholder survey data to be analysed and themed by HSCB. |

| | | |
|---|---|---|
| | | MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. |
| To understand the prescriber and patient cohort | Quantitative analysis of care home data and summary of patients | MOIC to analyse and summarise prescriber and patient data into suggested results tables.<br><br>HSCB to collate and summarise care home data and summary of patient's data in excel spreadsheet. MOIC to analyse data and populate suggested results tables. |
| Establish potential volume of prescribing activity that can be shifted to HTT prescribers | Qualitative thematic analysis of Stakeholder survey and stakeholder workshop discussion<br><br>Quantitative analysis of care home data and summary of patients<br><br>Quantitative analysis of baseline and final audit data<br><br>Analysis of process map steps | Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimater ratings to be summarised by MOIC.<br><br>Stakeholder survey data to be analysed and themed by HSCB. MOIC to review |

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|---|---|---|
| | | themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data.<br><br>MOIC to analyse and summarise prescriber and patient data into suggested results tables.<br><br>MOIC and HSCB to analyse and baseline and final data into suggested results tables.<br><br>Process maps steps to be compared from baseline to final. |
| Identify benefits in relation to access to medication and reducing pressure on GPs | Qualitative thematic analysis of Stakeholder survey and stakeholder workshop discussion<br><br>Analysis of Process map steps | Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimater ratings to be summarised by MOIC.<br><br>Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to |

| | | |
|---|---|---|
| | | be reached between MOIC and HSCB on Themes and categorisation of data.<br><br>Process maps steps to be compared from baseline to final - Change in number of steps on pathway to be identified. |
| Support and enhance the delivery of tailored HTT interventions to patients, maximising professional skills at the point of care delivery | Qualitative thematic analysis of Stakeholder survey and stakeholder workshop discussion<br><br>Quantitative analysis of care home data and summary of patients<br><br>Quantitative data analysis of baseline and final audit data | Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimater ratings to be summarised by MOIC.<br><br>Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data.<br><br>MOIC to analyse and summarise prescriber and patient data into suggested results tables. |

| | | |
|---|---|---|
| | | MOIC and HSCB to analyse and baseline and final data into suggested results tables. |
| Support the delivery of care pathways that can be delivered by a HTT prescriber | Qualitative thematic analysis of Stakeholder survey and stakeholder workshop discussion<br><br>Quantitative data analysis of baseline and final audit data<br><br>Analysis of Process map steps | Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimater ratings to be summarised by MOIC.<br><br>Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data.<br><br>MOIC to analyse and summarise prescriber and patient data into suggested results tables.<br><br>MOIC and HSCB to analyse and baseline and final data into |

| | | |
|---|---|---|
| | | suggested results tables. |
| Reduce delays in patients accessing medication - greater opportunity to access the right medicines, at the right time, from the right person. | Qualitative thematic analysis of Stakeholder survey and stakeholder workshop discussion<br><br>Quantitative data analysis of baseline and final audit data<br><br>Analysis of Process map steps | Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimater ratings to be summarised by MOIC.<br><br>Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data.<br><br>MOIC and HSCB to analyse and baseline and final data into suggested results tables. |
| Support a reduction in the amount of unnecessary health care appointments and hospitalisations and promote faster | Qualitative thematic analysis of Stakeholder survey and stakeholder workshop discussion<br><br>Quantitative data analysis of baseline and final audit data | Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. |

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| recovery and self-caring. | | Mentimater ratings to be summarised by MOIC.<br><br>Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data.<br><br>MOIC and HSCB to analyse and baseline and final data into suggested results tables. |

**Suggested results table templates**

Table 1. Patient and Prescriber Characteristics

| | **Baseline** | **Final** |
|---|---|---|
| | **N** | **N** |
| Total Number of Prescribers | | |
| Total Number of Clusters | 4 | 4 |
| Total Number of Patients | | |

Table 2. A table summarising the total number of prescription changes including recommendations to prescribe, reduce, increase or deprescribe medication

| | **Baseline** | | **Final** | |
|---|---|---|---|---|
| Total | **n** | % | **n** | **%** |

| | | | | |
|---|---|---|---|---|
| Total no of prescription changes<br><br>No of medications prescribed<br><br>No of medications reduced<br><br>No of medications increased<br><br>No of medication de-prescribed | | | | |

Table 3. A summary of medications prescribed organised by name of medication

| | **Baseline** | | **Final** | |
|---|---|---|---|---|
| Total | **n** | % | **n** | **%** |

Table 4. No of instances which resulted in one, two or three medications prescribed

| | **Baseline** | | **Final** | |
|---|---|---|---|---|
| Total<br>One medication prescribed<br>Two medications prescribed<br>Three medications prescribed | **n** | % | **n** | **%** |

Table 5: MDT/ face to face etc.

| | **Pre-pilot** | | **Post-pilot** | |
|---|---|---|---|---|
| Total | **n** | % | **n** | **%** |

Table 4. A summary of patient diagnosis

| | **Baseline** | | **Final** | |
|---|---|---|---|---|
| Total | **n** | % | **n** | **%** |

Table X A summary of the actions taken

| | **Baseline** | | **Final** | |
|---|---|---|---|---|
| Total | **n** | % | **n** | **%** |
| Letter of recommendation made to GP | | | | |
| Supply requested from OOH | | | | |
| Supply from Hospital Pharmacy | | | | |
| HS21 issued by HTT | | | | |
| Date of issue on ECR | | | | |

**Appendix 3: Stakeholder feedback in relation to each objective: Themes and direct extracts**

| Statement | Key theme | Supporting extracts |
|---|---|---|
| **Robust governance Arrangements** | Prescription security | • Governance arrangements were very tight e.g. prescription security (cannot remove scripts from base)<br>• Delivery of scripts by courier to incorrect location. |
| | Unable to print scripts | • Only able to handwrite scripts |
| | Remote prescribing | • Qualified pharmacist prescriber in HTT unable to prescribe due to regulatory limitations on remote prescribing. This needs to be addressed before Pharmacist IP in HTT can contribute |
| | Cipher application process | • Medics had to obtain cipher via NMP cipher allocation model which was counterintuitive |
| | Multi-disciplinary team approach | • Prescriber must see patient - difficult if trainee assessed patient. Only higher specialist trainee allowed to prescribe<br>• Trainee medics would normally be allowed to prescribe, but not in this case. |

| | | |
|---|---|---|
| | Communication between HTT and GPs | • Communication with primary care - GP actioning eTAN - significant issue - not always actioned in a timely manner.<br>• Patients contacting HTT to say GP not received - staff workload issues |
| | React to therapeutic drug monitoring | • Facilitated timely changes to lithium dosing based on therapeutic drug monitoring<br>• Opportunity for clinicians to intervene to prevent/manage side-effects |
| | CP access to prescriber | • CPs able to raise queries with HTT prescribers - clinical safety net for prescribers |
| **This pilot project provided a greater opportunity to access the right medicines at the right time from the right person** | Out of hours service delivery | • Previously may have had to wait until OOH return call and this may have been when Community Pharmacy was closed. HTT access to scripts means that this hasn't been as big as an issue |
| | Patient / prescriber relationship | • Urgent prescription for patients, professional decision-making, and regular interaction/communication with GP |
| | Patient access to advice | • Patient accessing specialist advice regarding medication prescribed |

| | | |
|---|---|---|
| | Same day resolution to problems | • Family members reporting greater reassurance that changes implemented same day |
| | Facilitated compliance aids | • Easier to implement changes to medication administered via blister compliance aid<br>• Compliance aid issues resolved directly between HTT and CP |
| | Timely access | • Timely access achieved<br>• Permitted prescribers to prescribe in a more timely fashion |
| | Nurse support for families | • Great for patients without family support - nurse practitioners are reassured that patients are getting meds in a timely way |
| **The pilot project maximised the use of professional skills at the point of care** | Pharmacist NMP unable to prescribe | • Qualified pharmacist prescriber in HTT unable to prescribe due to regulatory limitations on remote prescribing. This needs to be addressed before Pharmacist IP in HTT can contribute |
| | Trainee medics excluded | • Trainee medics would normally be allowed to prescribe, but not in this case |
| | Clinical pharmacist support | • CP queries raised with HTT rather than GP |

| | | |
|---|---|---|
| | | • CPs able to raise queries with HTT prescribers - clinical safety net for prescribers |
| | Administrative duties | • GP actioning advice notes - Letter from HSCB to advise on best practice |
| **The pilot project displaced prescribing activity from GP practices** | Efficient interactions across interface | • Reduced need for multiple contacts with GP to ensure script has been issued |
| | Avoid duplication | • Less duplication of effort as GP not required to implement |
| | Designated roles | • During course of pilot opportunity to prescribe for patients in Home Treatment House were limited. Opportunities to increase potential needs to be revisited |
| | HTH medicines prescribed by HTT | • HTT staff know specific patient info e.g. quantity remaining/ required. |
| **This pilot project supported a reduction in the amount of unnecessary health care appointments and hospitalisations and promoted faster recovery** | Avoid hospital admission | • Reduced need for hospital admission |
| | Stabilising symptoms | • Patients symptoms stabilised faster |
| | Timely intervention | • More timely access to medicines vs GP prescribing<br>• Permitted prescribers to prescribe in a more timely fashion |

**Appendix 4: Stakeholder feedback session: Positives of the pilot: Themes and direct extracts**

| Key theme | Supporting extract |
|---|---|
| Job satisfaction | • Sense of satisfaction in contributing to something positive for patients<br>• Practitioner more scope to intervene in an appropriate and timely way<br>• Patient accessing specialist advice regarding medication prescribed<br>• Improved patient/specialist relationship<br>• Less duplication of effort as GP not required to implement<br>• Fewer queries from GPs regarding medication |
| Project management | • Project management<br>• Clinical pharmacist support |
| Training | • Training of prescribers key |
| Clinical pharmacy support | • Clinical pharmacist support<br>• Clinical pharmacists able to raise queries with HTT prescribers - clinical safety net for prescribers |
| Patient access to specialist advice and timely interventions | • Improved access to medicines for patients<br>• Great for patients without family support - nurse practitioners are reassured that patients are getting meds in a timely way |

| | |
|---|---|
| | • Patients symptoms stabilised faster<br>• More timely access to medicines vs GP prescribing<br>• Assisted with changes to medicines for patients using blister packs<br>• Particularly beneficial on Friday<br>• Welcomed by families that required changes to medication can be resolved same day<br>• Nurses assist patients/families in identifying extended hour community pharmacies<br>• Avoids need for multiple contacts with GP practice to ensure urgent script is issued |
| Patient/clinician relationship | • Improved patient/specialist relationship |
| Management of side-effects | • Facilitated timely changes to lithium dosing based on therapeutic drug monitoring |

**Appendix 5: Stakeholder feedback session: Negatives/ challenges of the pilot: Themes and direct extracts:**

| **Key theme** | **Supporting extract** |
|---|---|
| Development of electronic treatment advice note (eTAN) interface | • Can only handwrite scripts<br>• PARIS development work - ECR only updated once daily (after midnight) - item issued may be missed if e.g. A&E / GP attendance same day |
| Duplication of eTAN and HS21 | • Dual process of writing eTAN plus HS21 - something can be missed e.g. patient presenting at A&E before all records updated<br>• Duplication of medication by GP as GP had not received eTAN (timing) and not showing on ECR. Window where there is a gap in info due to time taken to update<br>• eTANs not always actioned by GPs |
| Regulatory limitations to remote working | • Qualified pharmacist prescriber unable to prescribe due to restrictions within professional standards relating to remote prescribing<br>• Unable to prescribe remotely<br>• Additional requirement on staff time to bring script from mater base to patient's home |

| | |
|---|---|
| Prescribing restrictions | • Criteria for prescribing too restrictive<br>• Only higher specialist trainee allowed to prescribe<br>• Relying on GP OOHs. Could be faced with situations where no medical staff to write scripts.<br>• Big change from service provided during the week. Large on-call medical staff with no access to HS21s. So weekend service delivery very different if no GP OOH medical cover. Requires further consideration on how to resolve<br>• No qualified Nurse prescribers in HTT at present<br>• On call w/e cover not necessarily on site |
| Off-site prescription security | • Governance arrangements were very tight e.g. prescription security (cannot remove scripts from base)<br>• Security of scripts and printers<br>• Unable to remove scripts from base |
| Prescription form delivery | • Delivery of scripts by courier to incorrect location |

**Appendix 6: Stakeholder feedback session: What will be required for roll out? Themes and direct extracts**

| **Key theme** | **Supporting extract** |
|---|---|
| Technical | • Technical side of PARIS - not easy - letter generation has number of restrictions, which is difficult to address. PARIS is an old product<br>• Include IT on T&F group - fortuitous that new developer was in place and timing worked out / planning<br>• IT enabler - electronic solution at start<br>• Access to patient records when working remotely<br>• Prepopulate some data fields on eTAN to save time<br>• Develop useful stock phrases for eTANs<br>• More streamlined IT interfaces with other systems to save time<br>• Electronic solution from start |
| Administrative resource | • Practical - access to support for Chair with admin and data collection.<br>• Co-opt more support to T&F group<br>• Communication strategy - would have improved ability to adhere to tight timelines<br>• Preparation and planning<br>• Enable printing of scripts |
| Less restrictive prescribing criteria | • Very restricted in SOP - include all doctors in HTT if starting again |

| | |
|---|---|
| | • Enable remote prescribing following MDT discussion |
| Non-medical prescribers | • Enable remote prescribing following MDT discussion<br>• Training of prescribers key<br>• Prescriber identification important<br>• Arrangements to allow to have scripts out with you in community/closer to care of patient<br>• access to patient records when working remotely |
| Adequate clinical pharmacy support | • Crucial to ensure good governance<br>• Remain tight on governance and managing risk as we transition from pilot to business as usual. Important doesn't slip. Key to provide support for prescribe |
| Communication strategy | • Communication strategy<br>• Assurance that eTANs are actioned by GPs in a timely manner<br>• Manage expectations of GPs |
| Process for medics to obtain prescribing ciphers | • Medics had to obtain cipher via NMP cipher allocation model which was counterintuitive |
| Out of hours access to service | • Other Trusts Weekend / OOHs Access to HS21s for on-call medical staff<br>• Relying on GP OOHs. Could be faced with situations where no medical staff to write scripts |

**Appendix 7: Stakeholder survey: Do you feel this pilot benefits the patient?**

| **Please provide further details** |
|---|
| provides more rapid access to acute medicines without waiting for the GP to prescribe from an e-tan |
| Quick access to medication and treatment |
| Yes 100% benefits the patients |
| The electronic communication arrived with dozens and dozens of other routine electronic communications from the trust.<br>The GP and practice based pharmacist were often unaware of any medication changes until the patient was on the phone frustrated that there had been delay in issue. This included urgent same day medication changes.<br><br>The practice based pharmacist or admin team had to sit for many hours looking at many different electronic communications trying to find the urgent one that required action due to irate patient - this caused actually more work for the GP admin/pharmacy team. |
| The methods of communication between HTT and primary care need to be altered and agreed so that patient's care is not delayed/missed. |
| Delays in patients receiving prescriptions for new meds/dose changes etc. as electronic communication not forwarded to GPP in timely manner. GP practice admin staff unable to sort through the sheer volume of electronic documents on top of current daily roles, leading to a backlog of electronic communications. No way to easily identify urgent letters/documents, therefore important medication changes can be easily missed/delayed. |
| This benefits patients as it means that they can receive their medication in a timely fashion therefore reducing the time that they may be experiencing distressing symptoms. |

| There was a clear benefit to patients. This allowed patients to receive urgent medication in many cases within a few hours of review. This contributed to alleviating of distress and improvement in symptoms in a quicker fashion than would otherwise have been possible. |
|---|

**Appendix 8: Stakeholder survey: Do you feel that the electronic communication to GPs was beneficial?**

| **Please provide further details** |
|---|
| important for info to be shared with GP |
| If they sent it to the GP and was actioned on time - Yes |
| The electronic communication had no identifying features to show that this was urgent/important communication that required same day action.<br><br>The GP receives hundreds of this type of communication every day from the hospital which include DNA letters/non urgent pieces of communication.<br><br>This was discussed a number of times at our clinical governance meetings as there was concern that important urgent prescription requests could easily be missed. |
| EDT may be useful for sending documents but needs to be properly set up at primary care level. We are overrun by EDT files from various sources (DNAs, hospital letters, TANs, etc.) not just this pilot and we are without the staffing levels to be able to constantly monitor EDT and prioritise the correspondence. It can be weeks of correspondence before admin members have a chance to look at EDT. A priority system or a system that medication changes go straight to practice based pharmacist, or an email alert to let us know a change needs actioned and can be accessed through ECR. Personally I have never seen EDT nor have any access to EDT so anything coming this route, I relay on practice staff sorting and sending via DOCMAN. This has not worked at all as admin staff are needed to deal with the other primary care pressures -phone lines/appointments/patients etc. |
| Electronic communication was unable to be actioned by practice admin staff efficiently, due to large volume of documents coming through, on top of regular methods of communication (such as post, letter drop off by hand by patient/representative, email etc). Staff felt it was an "additional" workload, to try to manage yet another route of communication. |
| no, poor information, needs to come through to surgery as a priority request, this urgent request from MH comes through as low priority then need follow up phone call etc., it’s a mess |

| Yes this was an efficient use of Home Treatment staff time whilst ensuring that clients/patients received their medication in timely fashion therefore reducing time that they may have experienced distressing symptoms. |
| --- |
| Automatically populated advice notes, with less chance of transcription errors. Less workload on secretaries regarding need to email/phone GP practices etc. |

**Appendix 9: Stakeholder survey: Happy for HTT medical prescribing to continue as per the pilot project**

| **Please provide further details** |
|---|
| Scheme has been very successful, helpful, fast action |
| Agreeing to continue this arrangement is creating stress and greater burden of work for GP admin team and practice based pharmacists as the items are not marked urgent/requires immediate action.<br><br>It is equivalent to agreeing that an appropriate way to communicate urgent medication changes with the GP is to post it in a standard trust envelope with no distinguishing features. GP surgeries receives hundreds of these items of post every week. |
| Yes but the communication needs more thought. Too many times changes have been made, but not actioned at a primary care level as the pharmacist's do not get the correspondence from EDT. Eventually when we are contacted by patient/HTT I can then access ECR easily and process but I need to be alerted that something has changed. |
| I personally prefer direct email to the practice, as this would allow for faster redirection to GPP. |
| To ensure efficient use of time for Home Treatment staff whilst ensuring that clients/patients are able to get their medication in a timely fashion and therefore reduce the time period that they may be experiencing distressing symptoms. |
| Clear benefits as above |

**Appendix 10: Stakeholder survey: What do you think were the benefits of this project?**

| **Please provide further details** |
| --- |
| See above |
| Quick treatment for patient<br>Convenient for practitioner to access medication as script can be taken to any chemist<br>Quicker to see benefit of treatment |
| Electronic has the potential to be faster than mail |
| Electronic correspondence is 100% the way to go. Cutting out postal letters etc.. It just needs to work for both sides. |
| None for the practice<br>Nightmare |
| As above<br><br>Patients receiving urgent medication more quickly and with less hassle for both them and carers.<br><br>Less work for secretaries emailing and chasing up GPs. |

**Appendix 11: Stakeholder survey: What were the challenges encountered in the project?**

| **Please provide further details** |
|---|
| None |
| I think there needs to be clear communication on the advice notes to state if medication has been given and for how long intended treatment is for. A lot required telephone calls to confirm details that were missing.<br><br>Also if something is needing urgently it should be highlighted to say this on the EDT<br><br>I have also noticed that if a medication has been discontinued this is also missing. |
| No distinguishing features on the communication to show that this is an urgent same day request to be processed. |
| As above |
| Challenges included the sheer volume of electronic documents, and how quickly a huge backlog of documents can accumulate. Difficult to identify urgent communications from less important documents, making it difficult to prioritise workload. |
| Request lost in a demanding over stretched inbox of hospital requests |
| Getting used to new system although this was relatively straightforward |

**Appendix 12: Stakeholder survey: What changes are required for full implementation across the region?**

| **What do you think were the positives of this project** |
|---|
| Uncertain |
| Ensuring GPs have a robust system in place for someone at admin to receive this request and send it to the clinician to be actioned in the appropriate time frame. |
| Need overhaul of the system to show URGENT /SAME DAY ACTION on the subject line - how the email shows itself in the inbox. This is required so GP admin staff can immediately see and bring this to the attention of the GP /practice based pharmacist |
| As above |
| First need to prioritise these requests much better than at present to continue with this in the same format with GP practices, |

**Appendix 13: Stakeholder survey: Additional Comments**

| **What do you feel were the challenges/negatives of the pilot** |
| --- |
| Please do not continue to send in this way until above addressed.<br>Suggest Speaking to any of the practice based pharmacists. |
| Priority EDT system, medication change alerts that go directly to pharmacist (email), ECR use (pharmacists have access to ECR whereas we don't to EDT) |
| Needs to improve and engage a better system to highlight these request for GP practice. |

## Appendix 14: Patient satisfaction survey: Additional Comments

7 of the 16 (44%) respondents included comments on how the service could be improved upon; these are included in the box below:

| Do you have any other comments or suggestions for the HTT? |
|---|
| A doctor on site with access to medical records could be assessed that same day |
| Excellent and very valuable service which should continue. Even the reassurance of having a 24 hour telephone number immediately reduced our stress. The personnel involved are efficient, supportive and caring. |
| My father flushed his medication down the toilet and the HTT were able to help and he was able to avail of his medication without delay. I am so grateful for their help in this regard. Thank you HTT... |
| Invaluable work from the team. Very much appreciated it would be an extremely essential service to not only extend but to have on a permanent basis which would benefit every person who really needs this service from the team who have in my opinion been simply professional and courteous. I sincerely hope will stay for everyone. Thanks again. |
| Ensure continuity of staff as much as possible<br>It is a vital support at a time when it is much needed for patients and carers |
| This would be a great service to have. We have had weeks of delays with the GP with regards to prescriptions which added to Patient A’s anxiety. |
| It is a good service. It helps people when they need it |

**Appendix 15: Patient diagnoses**

| Number of patients<br><br>Diagnosis N (%) | 28 | 16 |
|---|---|---|
| ***One condition diagnosed*** | | |
| Acute schizophrenia like disorder | 1/28 (4%) | - |
| Adjustment disorder, unspecified | 1/28 (4%) | 1/16 (6%) |
| Atypical Anorexia Nervosa | 1/28 (4%) | - |
| Body dysmorphic disorder | 1/28 (4%) | - |
| Bipolar Affective Disorder (BPAD) | 2/28 (7%) | 2/16 (12%) |
| Delusional disorder | 1/28 (4%) | 1/16 (6%) |
| Emotionally Unstable Personality Disorder (EUPD) | 3/28 (11%) | 1/16 (6%) |
| Mania with psychotic symptoms | 1/28 (4%) | - |
| Mania without psychotic symptoms | 1/28 (4%) | - |
| Mixed anxiety and depressive disorder | 2/28 (7%) | - |

| | | |
|---|---|---|
| Moderate depressive episode | 1/28 (4%) | - |
| Paranoid schizophrenia | 2/28 (7%) | - |
| Recurrent depressive disorder, current episode severe without psychotic symptoms | 1/28 (4%) | 1/16 (6%) |
| Schizoaffective disorder unspecified | 1/28 (4%) | - |
| Severe depressive disorder without psychotic symptoms | 1/28 (4%) | - |
| Unspecified psychosis | - | 1/16 (6%) |
| Schizophreniform psychosis | - | 2/16 (12%) |
| Major depressive disorder, recurrent, moderate | - | 1/16 (6%) |
| Schizoaffective disorder, depressive type | - | 1/16 (6%) |
| Major depressive disorder, recurrent severe without psychotic symptoms | - | 1/16 (6%) |
| Hypomania | - | 1/16 (6%) |
| ***Two conditions diagnosed*** | ***Baseline ctd.*** | ***Final ctd.*** |
| Schizophrenia & opioid dependence, in remission | 1/28 (4%) | - |
| EUPD & Adjustment disorder | 1/28 (4%) | - |
| Paranoid Schizophrenia & Harmful use of cannabis | 1/28 (4%) | - |

| | | |
|---|---|---|
| Acute schizophrenia-like psychotic disorder & Acute psychosis secondary to cannabis.<br><br>Postnatal depression – mild depressive episode with prominent anxiety<br><br>BPAD-current episode manic with psychotic symptoms<br><br>Paranoid schizophrenia & EUPD | 1/28 (4%)<br><br>-<br><br>-<br><br>- | -<br><br>1/16 (6%)<br><br>1/16 (6%)<br><br>1/16 (6%) |
| ***Three conditions diagnosed*** | | |
| Paranoid Schizophrenia & Harfuml use of cannabis & EUPD | 1/28 (4%) | - |
| ***Other*** | | |
| Other specified mental disorders due to brain damage and dysfunction and to physical disease; epileptic psychosis NOS | 1/28 (4%) | - |
| No confirmed diagnosis | 1/28 (4%) | - |

## Appendix 16: Process Maps

### Prescribing Pathway at baseline

1. Patient is reviewed by prescriber either via a face to face or telephone consultation, and decision made to change medication in agreement with patient.
2. Prescriber returns to base office and completes a Treatment Advice Note (TAN).
3. TAN is sent to the medical secretary, who telephones the GP practice to inform that a TAN has been written and request email address. Password encryption is provided by secretary to GP practice.
4. TAN is emailed to GP practice
5. Follow up phone call is made to the GP practice to check TAN has been received. Urgency of request is discussed with GP practice
6. GP prescribers assess request and contact HTT if further clarification is required.
7. HS21 is written by GP practice and sent to the nominated pharmacy.
8. Patient or mental health practitioner collects the medication depending on the circumstances.

### Prescribing Pathway at final

1. Patient is assessed by the prescriber and a decision is made to change medication in agreement with the patient.
2. Prescriber returns to base office and completes an HS21 prescription.
3. A corresponding electronic Treatment Advice Note (eTAN) is completed on Trusts Paris system. The eTAN provides the information to the GP on what has been prescribed by HTT along with further instructions on whether or not ongoing prescribing is required.
4. eTAN is sent from Paris to the GP electronic management system through an automated process overnight.
5. HS21 is given to HTT secretary for safe storage and secretary contacts the patient or the MH practitioner to inform that the prescription is ready.
6. Prescription is either collected by the patient/patient representative for dispensing or a HTT practitioner will take the prescription to the community pharmacy for dispensing and deliver to the patient depending on individual circumstances.