Macmillan Pharmacist Facilitator Project

Year 3 (2012) Final Report

1st February 2013

This report presents work undertaken by the NHS Greater Glasgow and Clyde Macmillan Pharmacist Facilitator Project Team. The Strathclyde Institute of Pharmacy and Biomedical Sciences, University of Strathclyde reviewed and provided advice on the report.

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Executive Summary

Introduction

A 3 year project in NHS Greater Glasgow and Clyde, funded by Macmillan Cancer Support, aimed to explore a new service model in the four participating community health and social care partnerships to support and improve pharmacy services for the increasing numbers of patients with palliative care needs in the community. The first two years of work were subject to formal evaluation by the University of Strathclyde, with a report completed and distributed early in 2012. This final report details the work undertaken during the final year of project activity (2012) and summarises key outcomes over the project duration.

Aim

To share the outcomes and learning from the final year of a quality improvement programme, and make recommendations for widening the benefits across and beyond the Health Board and future service development.

Methods

Project activity during the final year largely comprised completion and refinement of the work in the first two years, with recommendations from the Evaluation Report informing priorities. Changes within the Project Team inevitably led to the need to adapt the work plan, but a short period of funding extension until February 2013 approved by Macmillan allowed a renewed focus on work within the individual localities.

Results

Much of the focus has been on promoting the operation of a cohesive network across all pharmacies, and developing the concept that all pharmacies should be providing a core service responsive to the needs of palliative care patients and their families/ carers, with the palliative care network pharmacies providing an enhanced level to support the overall service. Work to integrate pharmacists more closely into local teams delivering palliative care has continued but been limited by the team capacity. Learning from incidents has continued to drive new initiatives.

Key service developments during the final project year were:

- Access to palliative care training for pharmacy support staff, recognised as critical to service quality and responsiveness to patient and carer needs, widened to staff across the whole of NHS GG&C, with an e-learning resource developed in conjunction with NES accessible nationally
- Development of an electronic version of the Community Pharmacy Resource folder to assist longer term sustainability
- An intensive programme of pharmacy visits within project CH(C)Ps demonstrating the benefits of a face to face approach, but also continuing to identify a mix of good practice and areas for improvement
- Visits to all pharmacies in NHS GG&C open on Sundays capturing new information on the nature of the Sunday workforce and their training needs
- Identification of the need for greater engagement with GP Practice Managers
- Continuing liaison with OOH service to learn from significant events
- Development of EMIS short codes to promote safe and cost-effective prescribing of anticipatory palliative care medicines
- Prescribing data analysis demonstrating a greater percentage of prescriptions for the preferred formulations of injectable palliative care medicines, but a continuing need for further improvement
- Establishing the information and training needs of care home staff in relation to palliative care medicines
- Liaising with NHS Inform and the Macmillan Cancer Information and Support Service @ Glasgow Libraries to commence addressing the previously identified information and support needs of patients and carers
- Promoting service improvements via conference poster presentations and publications in palliative care journals

Conclusion

The facilitator model evolved through the project activities, and described in the Evaluation report, has effectively supported development of the contribution of community pharmacists and their staff to improving palliative care provision in the community.

Key outcomes from the 3 year project are:

- Improved person centred care through establishing the information needs of patients and carers and developing training for community pharmacy support staff
- Increased capacity to provide regular training to enhance the skills of pharmacists participating in the Community Pharmacy Palliative Care network
- Increased effectiveness and efficiency of the service from community pharmacies through provision of regularly updated information resources and face to face visits to share information, provide support and facilitate learning from incidents
- Tools for the multidisciplinary team developed to support appropriate prescribing, reduce wastage, release time to care and decrease clinical risks from medicines used in palliative care
- Contributing to equitable and timely provision of palliative care to support care in the community, including care homes, and prevention of inappropriate admissions, through promotion of anticipatory prescribing and improving awareness of systems for promptly accessing palliative care medicines

Following confirmation of funding, the service improvements achieved in the past three years are to be rolled out across the Health Board. Recommendations to inform and shape progression to a Board wide service are detailed in the full version of this report. Continual adaptation to change and a vision for the future will be required to sustain momentum.

Abbreviations

CDs	Controlled Drugs
CH(C)P	Community Health (and Care) Partnerships
CHI	Community Health Index
CMS	Chronic Medication Service
CPD	Continuing Professional Development
CPDT	Community Pharmacy Development Team
CPPCN	Community Pharmacy Palliative Care Network
GP	General Medical Practitioner
LCP	Liverpool Care Pathway
MCN	Managed Care Network
NES	NHS Education for Scotland
NHS GG&C	NHS Greater Glasgow and Clyde
NPSA	National Patient Safety Agency
OOH	Out of hours
PIL	Patient Information Leaflet
PMR	Patient Medication Record
PPSU	Pharmacy and Prescribing Support Unit
PRISMS	Prescribing Information System for Scotland
SPPC	Scottish Partnership for Palliative Care
SPCPA	Scottish Palliative Care Pharmacists Association
TIPS	Tailored Information for the People of Scotland

Purpose of the report

The purpose of this document is to report on the final (3rd) year's activity of the Macmillan Pharmacist Facilitator project (Jan 2012 – Dec 2012). Project activity during this time period has largely comprised completion and refinement of the work in years 1 and 2, with recommendations from the Evaluation report (January 2012) informing priorities.

The work undertaken from January 2010 – December 2011 is described in the Project Baseline[1] and Evaluation Reports[2].

Background

The Macmillan pharmacist facilitators were originally appointed during October/ November 2009 on 3-year fixed term contracts. A project administrator, originally appointed for 2 years, had her contract extended to 3 years to support the team during the final year. The University of Strathclyde, who had been commissioned to provide independent evaluation of the project work over the first 2 years, retained contact with the Project Lead in an advisory capacity in year 3 and to submit articles for publication in peer reviewed journals.

Changes in three of the four pharmacist facilitators' availability during year 3 (maternity leave, a move to a permanent specialist palliative care post, and reduced working hours due to other professional commitments) impacted significantly on the team's ability to complete some aspects of the planned work. Rationalisation of the workplan and priorities was undertaken.

Responding to interest in the local workforce to become involved in the project work, a decision was taken to advertise for and recruit additional facilitators to fill the gaps; delays in the recruitment process unfortunately resulted in the 3 new postholders not being appointed until August-October 2012.

An approach was made to Macmillan Cancer Support to retain the project underspend (mainly an underspend on salaries) to sustain progress until February 2013 and continue service improvement; this was approved in October 2012. There are therefore

a few elements of work still in progress which will be reported separately or as appendices to this report. Meanwhile, discussions were underway with Macmillan and within the Health Board to seek further funding to roll out the project work across the whole of NHS Greater Glasgow & Clyde to provide an equitable quality service to all patients with palliative care needs and their carers.

1 Pharmaceutical Care: Transfer of information from GP practice to community pharmacy when a patient is added to palliative register, to improve pharmaceutical care

1.1 First CH(C)P pilot

Background:

A local health needs assessment undertaken 2005-2007 identified that community pharmacists were not normally informed of a patient's inclusion on a GP practice palliative care register. Community pharmacists were rarely involved in multidisciplinary team discussions about individual patient care, limiting their ability to intervene appropriately, give advice and optimise pharmaceutical care.

A questionnaire completed by GPs in the four project CH(C)Ps in 2010 showed 90% were willing to share, with patient consent, information about patients on their palliative care register with the patient's regular pharmacy.

A questionnaire to community pharmacists in West Glasgow who were part of the Community Pharmacy Palliative Care Network in 2010 showed that only 46% of them were regularly contacted by GPs about palliative care patients. 100% stated they would find it useful to know when patients are put onto the register and that this information would improve their service to these patients.

A questionnaire (for details see Project Evaluation Report 2012) carried out during the Macmillan Project showed that community pharmacists were not confident dealing with aspects of symptom management in patients with palliative care needs, with a significant decrease in confidence when dealing with issues other than pain management.

Aim:

To determine if the transfer between GP and Community Pharmacy of information about patients on the GP Practice Palliative Care Register would improve pharmacists' ability and confidence to provide clinical and supportive services to these patients and

their families.

Method:

A pilot was initiated in West Glasgow and an experienced Community Pharmacist participating in the pharmacy palliative care network recruited. The pharmacist was also a Prescribing Support Pharmacist at the local GP practice; it was thought this would aid accessing the relevant information and transferring it to the Pharmacy records. The Macmillan pharmacist facilitator held meetings with the GPs, Practice Manager and Pharmacist. A protocol was drawn up for the pilot and agreed by the parties involved. A patient consent form, letter and carer consent form (Appendices 1-3) were drafted by the facilitator and a potentially suitable patient identified from the palliative care register.

The protocol involved the following steps:

- The community pharmacist during his normal GP practice visit (in his role as a prescribing support pharmacist) accessing the practice palliative care register
- Recording which patients on the register were regular patients at his pharmacy (had a current Patient Medication Record (PMR) and not known to be regularly using another pharmacy for monitored dose box or other services). If this information was not recorded on the GP computer, Practice staff were to add the regular pharmacy details
- Letter and consent form posted by GP practice to identified patient; timescale agreed for Practice Manager to make contact with patient if no response received
- Use of an agreed recording form including the patient's name, address, date of birth and CHI number to ensure information transfer to the correct PMR in the pharmacy. The patient's status would be documented including diagnosis and prognosis if available and any relevant clinical information such as uncontrolled symptoms
- Information obtained to be held in a secure place in the Pharmacy and added to the PMR with an automatic prompt to highlight the patient as palliative whenever the PMR was accessed
- An initial pharmaceutical care assessment to be carried out by the pharmacist

using the NHS Education for Scotland (NES) Palliative Care Plan (incorporating a Pharmaceutical Care Needs Assessment Tool)[3] developed for use with the Chronic Medication Service, with a copy given to the practice to put in the patient's notes

- Prescriptions or queries received by the pharmacy for this patient to be assessed for pharmaceutical care issues by the pharmacist on duty, with any interventions recorded on the care plan. It was intended that a record of all interventions would be kept and peer reviewed at the end of the pilot
- Practice staff/GP or District Nurse agreed to contact the pharmacy if the patient's condition changed and/or the patient's details needed updated, e.g. if patient admitted to hospital or hospice, if syringe pump needed or started on Liverpool Care Pathway (LCP), or new medication commenced
- Pharmacists, GPs and DNs to be interviewed at the beginning and end of the project to determine if the transfer of information had improved the care provided by the pharmacy to these patients.

The pilot was scheduled to run for 3 months from December 2011 to February 2012 inclusive.

Results:

Two GPs who were initially asked their views about what might be achieved from the transfer of information gave overall positive responses and considered it would improve patient care if pharmacists had this information.

Gaining patient consent was a major difficulty encountered with the pilot. No response to the consent letter was obtained within a month of posting to the one identified patient. On prompting by the facilitator it was agreed to meet with the District Nurses and ask them to gain consent from the patient. It was agreed with the GP who maintained the palliative care register that any new patients added to the register would be asked consent to share information with their regular pharmacist, and to extend the project to other pharmacies in the area to increase potential participant numbers; some patients however used pharmacies outwith the Macmillan project area. The completion date of the pilot was extended. A further meeting between the

facilitator, Practice Manager and community pharmacist to highlight the pilot was held, but no patients were recruited. Unfortunately no patient consent was gained and hence testing of the transfer of information and pharmaceutical care plan documentation could not proceed. At this stage, the facilitator left the Macmillan project to take up a new permanent palliative care post.

Discussion

There were a number of factors contributing to the pilot's lack of success:

- Time frame – the pilot commenced in December 2011, a busy time for the practice and ideally should have been started at another time of year
- Time pressures – all participants involved were very busy and this was an addition to their roles. The facilitator found managing this element of the project difficult due to other concurrent initiatives
- Differing priorities – it was difficult to engage with the participants to reinforce the importance of the pilot and the benefits which it could bring to all involved, particularly the patient.

On reflection, although the whole team required to be informed, there was no-one with overall responsibility for action and hence perhaps a lack of ownership. Review of palliative care patients was not a priority at that time on the workplan for this CH(C)P's prescribing support pharmacists, with some concern being expressed about the team's capacity to undertake these reviews if there were more than a few. District Nurses on the Project Steering Group had advocated that their professional group would readily be able to seek consent from housebound patients, as they were the ones frequently visiting and who had a close working relationship with these patients. An approach to do this should, however, have included engagement at a senior level with the Lead Nurse within the CH(C)P.

It was agreed to try an alternative approach in another project CH(C)P area.

1.2 Second CH(C)P pilot

Method:

Paperwork developed for West CH(C)P pilot was utilised and customised for West Dunbartonshire CH(C)P.

One of the Dumbarton GP practices and one of the local community pharmacies participating in the palliative care network were identified to potentially test this system. In conjunction with the practice, 8 patients were identified as currently being registered on the palliative care register but only 2 of these used the selected community pharmacy. The patients were contacted by telephone by the prescribing support pharmacist who already worked within the GP practice, outlining the pilot and to obtain consent to being involved. The prescribing support pharmacist then sent the patients the relevant consent paperwork. Once consent was obtained the practice pharmacist planned to undertake a review of the patients, resolve any identified pharmaceutical issues using the NES Palliative Care Plan and then forward this to the community pharmacist for follow up and continued review.

Results:

One of the patients was admitted to hospital the next day; however, this information was relayed to the community pharmacist thus promptly stopping further dispensing of her Monitored Dosage system. This was therefore regarded as a positive outcome of the intervention to improve communication and care. The second patient, although verbally happy to participate, did not complete the necessary paperwork. Disappointingly in the short timescale the pilot did not progress.

2 Support staff training

Background

Prior to and during the project, sustaining training of pharmacists within the network was found to be hampered by the regular movement of pharmacists causing a lack of continuity of the network service. This led the project team to develop training opportunities for pharmacy support staff i.e. counter assistants, dispensing assistants and technicians. These staff members are thought to be more static in their jobs and some, particularly counter assistants, interface directly with the public; they could signpost pharmacists to information resources in addition to providing information and support to patients and carers themselves.

Three different approaches were employed: face to face training sessions, in-house sessions in some larger pharmacies, and an electronic interactive resource (e-resource) accessed via the NES website, the latter designed to contribute to the CPD needs of pharmacy technicians, who became Registered Professionals with the General Pharmaceutical Council as from July 2011.

2.1 Face to face training sessions

Background

Training sessions for community pharmacy support staff were developed and delivered in the project CH(C)Ps during the earlier phases of this project, to provide a broad awareness of palliative care, and improve the ability of staff to identify and support patient and carer needs. Details of the training programme development, the collaboration with NES, and feedback from the sessions delivered during 2010-11 are detailed in the Project Evaluation Report. Widening the training opportunity to staff across NHS GG&C during 2012 is reported below.

Aim

To open the education and training programme previously offered to pharmacies in the 4 project CH(C)Ps to support staff working in all community pharmacies across NHS GG&C, to address the gaps in service delivery relevant to pharmacy support staff

identified in Phase 1 of the project.

Methods

Since staff who had not previously attended one of the project palliative care trainings were being targeted, a similar format and content to previous sessions, which had evaluated well, was used.

Education sessions were promoted through the distribution of flyers to all pharmacies via existing communication mechanisms. Each Facilitator followed up this distribution within their CH(C)P with phone calls or during visits to pharmacies to increase awareness and potential attendance.

All sessions were supported by the NES National Co-ordinator for Pharmacy Support Staff Educational Development, and featured a multi-disciplinary approach with input from district nursing staff or palliative care nurse education facilitators, Macmillan pharmacist facilitators, a palliative care pharmacy technician and presentations/workshops from education facilitators from local hospices. Participants were issued with a certificate of attendance. Network pharmacies were reimbursed £50 for each staff member in attendance. This could be used to cover the cost of replacing the staff member. Light refreshments were provided at the events.

Results

Four education sessions were held during 2012, with different venues used to encourage attendance. Each session ran for two and half hours in the evening.

Topics addressed based on the feedback from previous sessions included:

- Role of Community Pharmacy Palliative Care Network (CPPCN)
- Resource Folder
- Courier Service
- Difficult conversations
- Communication skills
- Syringe pumps

Numbers of participants in the 2012 series of education sessions are outlined in Table 1.

Table1. Participants at the pharmacy support staff education sessions

Session	Technicians	Dispensers	Counter staff	Total
7th February 2012 *(Watermill Hotel, Paisley)*	12	6	6	24
1st March 2012 *(Campanile Hotel, Glasgow)*	15	12	1	28
26th September 2012 *(Holiday Inn, Glasgow)*	3	3	0	10*
2nd October 2012 *(Sherbrooke Castle Hotel, Glasgow)*	4	4	2	16**

**plus 1 pharmacist & 3 pre-registration pharmacists*

***plus 3 pharmacists & 3 pre-registration pharmacists*

Feedback from participants was sought, and confirmed that these sessions were highly valued and would support their work in daily practice:

"Learning about the syringe driver and seeing how it works helps us understand it and deliver a better service."

"Have I said the right thing?" [session on difficult conversations] *this session was the most relevant and has given me confidence. I shouldn't say the wrong thing."*

"..... learnt a lot about patients and family and carers."

"The workshop was very informative. It was very good to hear ..... how you can make the process a lot easier for everyone involved."

"Where to find information to help patients and carers because I feel pharmacies don't

have this information but now have a better insight on how and where to direct them."

"Very informative and inspiring."

"Everything discussed was ..... relevant in our daily pharmacy duties."

"Getting to share stories with other pharmacies, all in the same 'boat'."

Despite efforts to publicise the events it remained a challenge to get good attendance, but it appears from visits to pharmacies by the facilitators late in 2012 that information on training opportunities is not reaching many of the relevant staff who would be interested in attending.

2.2 In-house training on community pharmacy premises

Aim

To deliver training in selected community pharmacies where numbers of support staff were sufficient to make effective use of facilitator time, to enhance their understanding of the role their pharmacy played for individual palliative care patients and in the effective operation of the pharmacy network.

Method

Two sessions, with a different cohort of staff each time, were delivered in one network pharmacy open 7 days and which also had a care home hub. Each session lasted about one hour, the amount of time the pharmacy agreed could be accommodated; the Area manager for the company concerned attended one session.

The session content was based on the Community Pharmacy Palliative Care Resource folder, with additional folders being made available by the facilitator for those present to look at.

Introductory topics covered included:

- An overview of the pharmacy network, how it should work, and how selection of the participating pharmacies had been decided
- Consideration of the geography of the local area, nearest network pharmacies and

a Sunday rota operating nearby

- Explanation of the importance of the service at weekends and their shop's contribution
- Awareness of palliative care not just being about end of life, and considering whether patients/ families gave them information e.g. 'been diagnosed with cancer' which could be brought to the attention of the pharmacist and if appropriate, documented on PMR

Specific sections highlighted from the folder were:

- Customising the front page with local contact details for quick reference (questioning the staff about the information showed that in general, they did not know the required details)
- The role of technical and support staff to know where the folder was kept and direct locum/ relief pharmacists to it
- Getting to know the drugs on the stock list to help recognise palliative care prescriptions
- Availability of the courier service and transferring stock between pharmacies when needed or short dated
- Using stock check sheets to ensure drugs maintained in date

Staff were encouraged to ask about the urgency of prescription items they didn't have in stock, whether presented at the counter or via a phone call from the surgery asking if they had a medication – then establishing how quickly they could obtain it to prevent the caller having to try somewhere else.

A syringe pump and subcutaneous cannula were demonstrated to increase understanding of how the injectable medicines were administered, with brief mention of the Liverpool Care Pathway and palliative care registers to increase understanding of systems in use.

Results

The facilitator phoned the pharmacy manager following the first session to obtain feedback on how it had been received and was informed "Palliative care is all they

[staff] are talking about, there is a real buzz about it". Similarly, the Area manager who attended the second session commended the approach and content.

Discussion

The approach in this pharmacy resulted from discussions following an incident at a weekend, and demonstrates learning following incident review. The approach is under consideration by other facilitators for use in other selected pharmacies where gaps in knowledge and awareness have been identified and/or requests for training have been received.

2.3 E-learning resource

Aim

To develop an electronic interactive resource for Pharmacy Technicians on the subject of Palliative Care.

Methods

The e-resource was commissioned by NES, and developed by one of the Facilitators in collaboration with the NES National Co-ordinator for Pharmacy Support Staff Educational Development, and the IT department at NES. The module was edited and peer reviewed by three Specialist Palliative Care Technicians and two Specialist Palliative Care Pharmacists.

The e-resource was considered an appropriate format as NES had found that a similar resource available for epilepsy had been well received.

Results

The basis of the resource was the NES Distance learning pack 'The Pharmacist in Palliative Care', covering common symptoms, with additional practical information on

- Patient and carer support
- Communication within the multidisciplinary team
- Community pharmacy palliative care networks
- Return of medicines after death

There are twelve activities in the resource including tasking technicians to produce a list of local palliative care contacts and watching the film '20 Takes on Death and Dying' produced by the 'Good Life, Good Death, Good Grief Alliance'[4].
The format is very intuitive to use. An electronic format can also be readily updated.

Distribution

The e-resource went live on the NES website in September 2012, and is freely accessible[5].
It has been advertised in the NES Pharmacy Autumn newsletter and will be promoted at future pharmacy palliative care training events in NHS GG&C.
The Scottish Palliative Care Pharmacists' Association (SPCPA) have endorsed the resource and commented that it could be used for other professional groups including Pre-registration Pharmacists and Junior Doctors.

A poster presentation detailing the approach and collaboration with NES to develop palliative care education for pharmacy support staff was presented at the NES Pharmacy Conference "10 years back; 10years forward" in November 2012.

3. Self directed training for pharmacists

Background

It is a requirement of the Service Level Agreement for participants in the CPPCN that the key pharmacist in each pharmacy commits to specified training, including attendance at an annual update day's training. The invitation to attend is extended to other pharmacists, pre-registration pharmacists and technicians/dispensers regularly working in a network pharmacy. Specific training for pharmacy support staff has more recently been developed and is detailed above.

At the trainings for pharmacists run in early 2011, it was suggested by the Specialist Palliative Care Pharmacists to the attendees that for 2012-13, they identify their own CPD needs in relation to the service, and spend a day in practice with one or more other professionals providing palliative care; locum costs would be reimbursed. This appeared to be positively received by those present.

There were several reasons for this approach:

1. One of the main aims of the Macmillan pharmacist facilitator project has been to improve the integration of pharmacists into local multidisciplinary teams, and it was considered this would increase pharmacists' appreciation of others' roles and vice-versa.
2. Pharmacists as registered professionals are required to identify and address their own CPD needs.
3. Some of the pharmacists providing the service have been doing so over many years and providing training suitable for them and those relatively new to the service may not be adequately developing the former.
4. In addition to gaps in the facilitator posts, impending maternity leave and retirement respectively for the two Specialist Palliative Care Pharmacists with overall responsibility for leading the network and providing training were constraints to delivering face to face sessions.

Aim

To support pharmacists in the palliative care network to identify an appropriate

training opportunity in conjunction with other local providers of palliative care, to detail learning objectives, and reflect afterwards on how it would influence their practice and patient care.

Methods

Participants at the trainings in early 2011 were asked to note ideas as to what they might elect to do, and the learning they hoped to achieve, on a postcard and place it in a self addressed envelope. In January 2012, the cards and envelopes were posted out, and a letter sent to all pharmacies in the network reminding them of the training requirement in the SLA, and asking them to ensure all pharmacists including locums providing the service were made aware of the training opportunity. Although the initial request was to undertake training by end March 2012, this was subsequently extended throughout 2012-13 financial year when ongoing funding was confirmed. Each pharmacist was requested to submit a form with the following details, for approval by a Specialist Palliative Care Pharmacist:

- Proposed professional development opportunity(ies)
- Name and title of person or team they would spend time with
- Date of proposed session
- Aims and learning objectives

A further form for submission after the session was included; this requested details of learning achieved and the impact on their practice. It would also generate payment of the locum fee to the pharmacy contractor.

Results

The initial letter to pharmacies generated a considerable number of telephone calls to one of the specialist pharmacists. Some callers were very positive and looking for confirmation as to whether their proposals were acceptable, and this provided a useful opportunity for discussion and refinement of plans. Others were less positive, unsure what they could do or how they could arrange it, or considered they lacked appropriate contacts e.g. with District Nurses.

" ....[name of specialist pharmacist], it was easier when you just told us to come along on a certain date..." (network pharmacist)

Several requested an opportunity to shadow a specialist palliative care pharmacist at a hospice; although this would have provided some learning opportunities, the specialist pharmacists were already stretched to capacity, and it was considered that the clinical interventions in a hospice did not reflect the majority of the situations community pharmacists would commonly encounter.

The number of pharmacists completing training and submitting their evidence was, however, low. By November 2012, only 14 proposals had been received, with 7 completed reflections on training undertaken submitted (Table 2).

Table 2: Summary of pharmacists' self-directed training.

Date undertaken	Learning opportunity identified	Learning outcomes	Reflections from pharmacists on their learning
21st & 29th February 2012	Attending team meeting at local hospice to gain understanding of patient related issues in those cared for in a hospice. Visiting palliative care patients with District Nurse to gain appreciation of care issues when in their own home.	Now aware of wide scope of the holistic approach to care, irrespective of whether patient cared for at home or in hospice	*"It was an eye opener as to how the patient was dealt with……A totally holistic approach looking at home circumstances or in hospice, family, monetary, nothing was outwith the scope of help. Can we take some of this approach and utilise it in the pharmacy?"*
6th March 2012	Shadowing District Nurse on visits to patients with advanced cancer to learn more about assessing and managing pain with opioids, including dose calculations/ increases, opioid toxicity and care planning (detailed learning objectives identified).	Applied learning from background reading well. Took structured patient history using method from symptom management textbook; included relatives in discussion. Identified discrepancies between primary and secondary care plans, and patient confusion on how to take breakthrough medication. Worked with GPs to review management of patients; liaised with hospital and hospice teams to optimise pain control and address patient's inability to sleep.	*"The patient was rationing her breakthrough medication. I took time to explain how this medicine works…. The district nurse reported that my explanation had a real impact and the patient felt much more confident using this appropriately. I have assumed that patients have a clear understanding of the slow release and breakthrough meds because of secondary care input. I can now see the benefits of reinforcing the message for all my patients."*
	Background reading including SIGN 106 and two of reference books in network pharmacies (PCF4 and Symptom Management in Advanced Cancer)		Following a dose increase where the previous dose was a little vague, and having read about opioid toxicity: *"I discussed the common signs and symptoms of opioid toxicity with the patient and his wife. The patient felt much more confident taking the medication as a result of the information and his wife more reassured and less concerned."*

19th March 2012 **(2 pharmacists from one pharmacy)**	Shadowing nurse working with Care Homes Medical Practice and speaking to specialist palliative care nurses working with the homes.	Better understanding of processes for palliative prescribing by medical practice serving care homes in the city area and the complementary role of nurse prescribing.	*"If nurse notices if anything has been missed by GP from Liverpool Care Pathway, she will do Rx's for these items."*
		Ideas on how to reduce problems with palliative care Rx's and secure timely supply discussed, with suggestions for actions by both nursing and pharmacy teams. The challenges of nursing home staff being confident in dealing with syringe pumps.	*".....how we can improve on both sides* [nursing and pharmacy] *e.g. one way was for urgent Rx's to be marked as such so we know to do them asap as a lot of Rx's are done in advance."*
22nd March 2012	Visit to Beatson oncology centre to learn about: 1. different treatment pathways and side effects/ contraindications relevant to community pharmacy 2. Macmillan support	Discussed medications used in palliative care. Better understanding of patient progression through treatment following visits to wards, clinic areas and pharmacy department.	*"I found this study day very useful.....I now have a better understanding of patient progression through treatment and how to deal with prescriptions received in our pharmacy."*
May 2012	Visit to Macmillan Cancer Information and Support Service drop-in centre at Easterhouse	Better understanding of services available at drop in centre which will enable pharmacist to advise patients on where to go and what to expect when they go to the centre; also aware of wider rollout in Glasgow of this Macmillan service.	*"An invaluable experience and ...would recommend more people to do it."*
May 2012	Shadowed District Nurse visits to several patients	Learnt about processes in patient's home for preparation of medication for syringe pump and associated documentation including Liverpool Care Pathway. Recognition of District Nurse role in identifying palliative care status of patients.	*"Now when I dispense a palliative care Rx I know what happens when the drugs are at home and how the syringe drivers are prepared and given." "...having now seen palliative care patients in their home I will perhaps be able to relate better to their circumstances." "Having seen the role of the district nurse I can appreciate the challenges they face...."*

4 Network information and resources

4.1Network leaflet

Background

The leaflet detailing pharmacies participating in the CPPCN and the list of medicines held in stock was previously revised in October 2010. A couple of additions to the medicines stocked had recently been made in response to reported difficulties accessing medicines being recommended by specialists. The pharmacy details also required to be updated to reflect changes in ownership and opening hours.

Aim

To provide current information on the network and tips for healthcare professionals on medicines commonly used in palliative care.

Methods

The project administrator collated information and ideas from the team on the details to be changed, and suggestions for improving the leaflet layout, and discussed these with the graphic designer.

The project administrator obtained the latest Pharmaceutical List from the Community Pharmacy Development Team (CPDT) for details of pharmacies including name, address, telephone number and opening hours.

Detailed checking of proof versions was undertaken by the project administrator and two facilitators to ensure accuracy.

Results

Following incidents involving difficulties accessing medicines out-of-hours, resulting either in not being able to obtain the required medicine, or families travelling longer distances than needed to have a prescription dispensed, clearer highlighting of pharmacies open extended hours was considered important. Key points emphasising the importance of prescribing the correct strength and formulation according to the listed medicines were revised, to reduce delays in accessing urgently required medicines. Prompts, to improve

safety when prescribing and dispensing opioids, were also included.

A revised leaflet was completed in September 2012, with 5000 copies printed. It has been distributed to all community pharmacies, district nursing teams, GP practices, GP performers (includes GPs working out-of-hours), the GG&C out-of-hours service and hospital on-call pharmacists. Distribution included the Glasgow Care Homes Medical Practice and nursing team, with distribution to other care homes managed via the CH(C)P Lead pharmacists, as there is no central distribution process for these.

During the visits in late 2012 to Sunday opening pharmacies (see section 5.2), it was found that one of the network pharmacies detailed in the leaflet was closed. Although contractors are not formally obliged to notify the Health Board of changes to opening hours out with model hours, advance notification would improve the accuracy of information available to professionals and the public. This illustrates the difficulties of maintaining information resources up to date.

Discussion

Throughout the project, a lack of awareness of the leaflet and the information within it has been encountered, despite having been previously distributed through the above channels. The facilitators have consistently promoted the leaflet and distributed copies within the project CH(C)Ps, but it remains a challenge to promote the information across NHS GG&C. A pdf version is included on the CPDT section of the Pharmacy and Prescribing Support Unit (PPSU) section of Staff Net, the NHS GG&C intranet site

4.2 Community pharmacy resource folder

Background

A palliative care resource folder for every community pharmacy in NHS GG&C was initially produced in January 2011, and a commitment made to updating on a regular basis. An update was produced in August 2011, with two further updates (April and September) in 2012.

The initial presentation of the folder was hard copy, in response to feedback from pharmacies that this was the preferred medium with computers generally tied up in the

dispensing process. A decision was taken early in 2012 by the project lead to also develop a pdf version for several reasons:

- moving resources to an electronic platform for longer term sustainability was a recommendation in the earlier Project Evaluation report
- requests had been received from a few pharmacies for electronic copies of some of the contents
- the hard copy updates were proving very time consuming and costly to prepare generating uncertainty over whether they could be sustained beyond the life of the current project team
- it was recognised that a pdf version would permit speedy updating when important.

Similarly, card versions of a Patient Information Leaflet (PIL) became obsolete, but were still in circulation across the Health Board, when the supplier of one unlicensed medicine changed. It was decided these should be available only in an electronic version to be printed as required and given to patients by professionals.

Aim

To identify twice a year contents requiring updating and relevant additional material, and issue an updating package to network and non-network pharmacies.
To develop a pdf format for the resource folder.

Method

Pages requiring revision and new topics were noted throughout the year. Timing of each update was influenced by the urgency of communicating new material or removing obsolete material, but also by the other commitments of the project team. When information needed to be communicated immediately to community pharmacists, a letter was initially sent out by the specialist palliative care pharmacist, asking recipients to make an interim update to their folder.

Meetings between a facilitator, project administrator and the graphic designer to agree amendments and discuss format were followed by further revision and proof checks. An instruction sheet was prepared to be included with each set of update pages, following the

format in place by NHS Scotland for the 'Unscheduled Care folder', detailing which pages to replace and the reason.

The graphic designer produced a partial test version of an interactive pdf format which was completed and refined following feedback.

Results

Updates in 2012 included:

- Details of additional medicines stocked by network pharmacies in response to national palliative care guidelines and specialist recommendations
- New drug monographs including clinical and ordering information for unlicensed medicines
- Electronic version of PIL for levomepromazine 6mg tablets to replace original card format following change in supplier; folder contains the website link to the leaflet
- Information on OOH community nursing teams added
- NES Pharmaceutical care needs assessment tool included (with permission from NES)
- Update to courier service information
- Updated stock check list for network pharmacies

Distribution in the project CH(C)Ps was undertaken by the Macmillan pharmacist facilitators, providing an opportunity to highlight changes and discuss any palliative care issues with both network and non-network pharmacies. Distribution to pharmacies outwith the project CH(C)Ps was via courier. The pdf was posted onto the CPDT section of Staff Net; wider posting is under consideration, but needs to take account of security issues surrounding medicines. The potential for core material to be accessible across NHS Scotland is also being discussed.

A finding by the facilitators during their visits that some pharmacies could not find their resource folder, and others were either missing earlier updates, or had not used them to update their folders, is of concern. Further investigation and discussion is in progress;

more detail is included in Table 4 (in section 5.1) of this report.

Cost differences between the updates for the hard copy and pdf versions are noted to be significant, with the latter much less expensive.

5 Locality work

5.1 Visits to community pharmacies by new pharmacist facilitators Sept – Nov 2012

Aims

As newly appointed facilitators the priority was to forge relationships with the pharmacies in the respective CH(C)Ps whilst familiarising themselves with their new roles, the geography and the workings of differing CH(C)Ps. Across the CH(C)Ps covered there is a mix of network and non-network pharmacies (Table 3).

Table 3: Pharmacy numbers in project CH(C)Ps

CH(C)P	Network	Non-Network	Total
West	9	32	41
South	7	24	31
West Dun	6	16	22
Inverclyde	4	15	19
Total	24	89	113

The facilitators aimed to visit the pharmacies twice in the time frame, initially on a fact finding mission regarding awareness and availability of resources. Having established these relationships, and revisiting, it was hoped to use this as a platform to gain and share information, highlight the support and role of the facilitator, and address any issues arising.

Method

A visit template supplied by the previous facilitators to standardise the facilitators' approaches was updated to suit the current work plan and used (Diagram 1). A body of work to take to individual areas was agreed whilst distributing the new updates for the Palliative Care resource folder in person to the pharmacies.

Diagram 1: Section of template used

D	E	F	G	H	I	J	K	L	M	N
May 2012 updates in folder	Aug 2011 updates in folder	Levo 6mg letter update PIL	Quality practice audit	Network/drug list staff awareness	new courier code staff awareness	PCF4/Syringe driver 3rd	NEWT	Training	Stock list	COMMENTS
?	?	?	X	?	?	X	X	X	X	Have been unsuccesful in speaking to regular staff
Y	Y	Y	X	Y	Y	X	X	X	X	Updates received, covered changes to stocklist and highlighted headings as discusssed
Y	Y	Y	X	Y	Y	Y	N	N	Y	Updates received, covered changes to stocklist/ highlighted headings as discusssed. Network training not claimed, made suggestions, passed on info and trained locum, supplied guide and extra network leaflet. ?patients consent
Y	Y	Y	X	Y	Y	X	X	X	Y	Round corner from network pharmacy. 2nd visit locum. Supplied extra leaflets and pocket guide for locum and covered headings, stocklist etc as per headings
Y	Y	Y	X	Y	Y	Y	N	N	Y	Network pharmacy. 2 new managers, worked thro headings, highlighted headings, made aware of training. Sunday opening. Informed would be visited at weekends
Y	Y	Y	X	?	?	X	X	X	X	Updates supplied but regular staff unavailable then too busy on 2nd visit
Y	Y	Y	X	Y	Y	X	X	X	X	Don't do palliative care! Not regular pharmacist, have spoken to locum and support saff re various headings
Y	Y	Y	X	Y	Y	X	X	X	X	Initially spoke to locum(supplied pocket guide and leaflet) and dispenser and covered role of network etc. 2nd visit new manager and re-enforced previous info and headings
Y	Y	Y	X	Y	Y	X	X	X	X	Folder ok. 2nd visit spoke to locum and explained network, stock list and courier info and supplied copy of pocket guide,network leaflet
Y	Y	Y	X	Y	Y	X	X	X	X	Dispenser on Mat leave, no regular staff member, left info. 2nd visit re highlighted key points with locum, left info and extra for locum
Y	Y	Y	X	Y	Y	Y	N	N	Y	Updates received, diamorphine swapped, highlighted training. May have weekend visit

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Results

<u>Pharmacy Visits</u>

Across the CH(C)Ps the level of interest and knowledge appeared to be dependent on:

- links with local surgeries and nurses
- the pharmacist's individual CPD
- the business throughput of recognised palliative care scripts
- whether the store was a network pharmacy or not
- the staff on duty.

The number of relief managers or locums encountered was commented on by all facilitators.

Over the period from October – November 2012, 19 out of 41 pharmacies in the West CH(C)P had the same staff on different visits, i.e. 22 pharmacies were manned with either locums or reliefs or had new managers. In West Dunbartonshire, Inverclyde and the South CH(C)Ps, the numbers were reported differently but each facilitator recorded 5 locum pharmacists in each respective area with no numbers for relief managers.

Highlighting the training nights for support staff, whilst supplying locums with the Pocket version of the Palliative Care guidelines and their own copy of the network leaflet was the approach all facilitators took. Problem solving of supply issues, script irregularities and service delivery varied across the areas with more intense effort being made by those individual pharmacists with the strongest links with others in the healthcare team or a personal interest in this area.

All facilitators noted that the network pharmacies did not have a copy of the NEWT guidelines; there appears to have been a problem with the distribution of this resource which may need to be investigated further by the Community Pharmacy Development Team.

Courier Service

There appeared to be a distinct lack of knowledge of instances where this service could be used by network and non-network pharmacies. All facilitators illustrated various scenarios in individual pharmacies where this service could be used for patient benefit. With a holiday period imminent at the time of the visits, awareness of the CD requisition forms and the courier service within all areas should have helped to facilitate prompt supply.

Sunday Visits

These are detailed in section 5.2.

Stock

Varying levels of stock were noted across the CH(C)Ps dependent on the frequency of use of the drugs and how often the network service was accessed. Some pharmacies had not yet ordered glycopyrronium, added to the list earlier in 2012, and not all were completing the date check/stock sheets. The facilitators were unsure how to deal with this as the Service Level Agreement had been signed in these pharmacies. This has been referred to the Community Pharmacy Development Team for their consideration.

Resource Folders

Each CH(C)P had pharmacies who had misplaced this resource, or several updates for it (Table 4). Whilst attempts were made by all facilitators to address this, new folders need to be supplied to various pharmacies. The Community Pharmacy Development Team will co-ordinate this, with an appropriate charge being levied to cover the cost.

Table 4: Missing palliative care resource folders & updates

CH(C)P	West	South	West Dun	Inverclyde	Total
Missing Folders	2	3	3	3	11(10%)
Complete Folders	33	21	13	10	77(68%)
Missing Updates	6	7	6	6	25(22%)
Total	41	31	22	19	113

Conclusions

Overall, network pharmacies had a good awareness of all aspects of the service. The CH(C)Ps that had been served with regular facilitator input had better knowledge than the CH(C)P which had no facilitator for most of 2012. With facilitators now in the four project areas, a more even distribution of knowledge should be seen.

Recommendations

The pharmacy visits proved to be a valuable tool for the sharing of information and should be continued into the next phase of Board-wide rollout.

Recognition of palliative care seems limited to malignant conditions and work could be done in the next phase around COPD, Heart Failure, Parkinson's or Dementia.

With the nature of the pharmacy workforce varying over all areas, the policy of encouraging the training of support staff within pharmacies is crucial to maintaining the knowledge of the palliative care network. Continued training evenings and highlighting

NES distance learning packs and e-learning opportunities are recommended.

5.2 Visits to pharmacies in NHS GG&C open on Sundays

Aim

The Macmillan pharmacist facilitator visit undertaken during October – November 2012 was used to assess if any of the 27 pharmacies in NHS GG&C which operate on a Sunday were experiencing any particular problems when dealing with out of hours palliative care prescriptions. The visit also assessed the level of palliative care service provided by these pharmacies and highlighted the resources available to them in out of hours situations.

Method

A series of questions were used to assess:

- the level of knowledge pharmacists had of the palliative care network
- whether dispensary staff were aware of the purpose of the network and what to do when working with locums or relief pharmacists with limited network knowledge.

Results

33% of pharmacists encountered during the visit were regular base pharmacists; the remaining 67% were locums. Of the network pharmacies visited, 60% employed locums on Sundays.

Locums and relief pharmacists had a clear disadvantage compared to regular base pharmacists. 88% of the regular pharmacists encountered had attended a palliative care training day; only 11% of locums had. This impacted greatly on the level of palliative care service likely to be provided – 78% of locums did not know about the courier service, 22% were completely unaware of the existence of the palliative care network and only 22% had looked at the palliative care folder contents. Many found it difficult or not appropriate to take time within their working day to read the folder. In many instances the palliative care folder was not obvious in the dispensary.

No members of dispensary staff working on Sunday had been to a palliative care training evening for pharmacy support staff. Of all dispensary staff encountered, 52% worked only

on Sundays and 20% were pharmacy students.

Network pharmacies in some areas appeared to receive the majority of palliative care prescriptions whereas others in the vicinity received few.

The main problem encountered was incorrectly written CD prescriptions. All regular pharmacists had no hesitation in dispensing (once checked) a palliative care prescription which contained a wording error. Locums gave mixed responses.

Conclusion

It is critical that information about palliative care is made available to the out of hours workforce. Awareness about training events and folder contents with regard to the support available for out of hours situations and the level of service expected for palliative care needs to be improved.

Recommendations

Area managers of the large multiples and supermarkets should be encouraged to raise locum awareness of training dates and to support the Health Board's method of reimbursement for this training. The importance of relief pharmacists attending should also be highlighted.

Similarly for support staff, communication from the pharmacy managers needs to be encouraged in respect of training evenings and the importance of involving all staff in the communication chain. Use of e-learning opportunities should be considered and promoted.

Pharmacies which service large care homes would benefit from the addition of an extra palliative care resource folder in the care home hub.

The reasons why some pharmacies reported seeing a higher volume of palliative care prescriptions than others in the same area remains unknown and warrants further investigation. There appears to be a continuing need to promote the locations of all network pharmacies open out of hours, especially to non-pharmacy staff.

6 Engagement with Practice Managers

Background

A practice manager baseline questionnaire was undertaken in Inverclyde in spring 2010. Feedback indicated that there was very little awareness of the network amongst the 30% of practice managers who returned the questionnaire.

In February 2011, GP practices in Inverclyde reported that they had not received the new version of the pharmacy palliative care network leaflet circulated in December 2010. The Macmillan pharmacist facilitator undertook GP practice visits in spring 2011 and handed copies directly to the practice managers. This visit provided an opportunity to give a brief overview of the service and the importance of GPs prescribing in line with the palliative care guidelines. Less than half of practice managers were available during visit times.

The Inverclyde Practice Managers Forum invited the Macmillan pharmacist facilitator to their quarterly meeting on 1st October 2012 to provide a ten minute update on the project. Key points included:

- Reports of delays in accessing palliative care medicines had reduced with incidents generally occurring during out of hours and weekends
- GPs and nurses communicating the urgency of prescriptions for palliative care medicines and time required to the community pharmacy would further support improvements in timely access
- Resources have been developed to support community pharmacists and GPs, including a pharmacy folder, network leaflet incorporating good practice points, and a prescribing aide memoire for GPs
- Prescribing errors unfortunately still occur and any help that the practice managers could provide in raising awareness of prescribing in this area would be much appreciated.

Actions

Practice managers indicated they would like further copies of the GP aide memoire to circulate to GPs and would encourage them to carry the aide at all times. New GPs and GP

locums would be targeted.

Reflection

The practice managers have an essential role in supporting effective communication between GPs and community pharmacies especially in highlighting services provided.

Updates on the project had generally been provided via the CH(C)P Lead pharmacist to GP networks locally and it is difficult to meet with practice managers without appointments. On reflection it would have been more helpful to have attended the practice manager forum in the first year to discuss the baseline report and subsequently to have utilized their skills and experience in the development of communication pathways and GP resources.

7 Out of Hours (OOH)

Background

Incidents involving access to medication during OOH periods were reported to the Macmillan pharmacist facilitators and specialist pharmacists throughout the project duration, and came from a range of professionals. Some included significant delays in accessing medicines urgently required for patients at end of life, some in care homes and others in their own home, with carers sometimes trailing round several pharmacies to obtain the required medicines, pharmacies trying to contact prescribers to clarify or amend incorrect or illegal prescriptions, and GPs spending several hours phoning a range of sources from hospital pharmacies to hospices in an attempt to source Controlled Drugs (CDs), such as low strength diamorphine injection. Whilst each incident was followed up locally, it was agreed that one facilitator would have further discussions with the pharmacist working one day a week at the NHS Greater Glasgow & Clyde OOH hub although a good working relationship already existed with the full time specialist palliative care pharmacists.

Aim

One of the Macmillan pharmacist facilitators met several times with the pharmacist who works within NHS GG&C OOH team to highlight palliative care prescribing issues e.g. incorrectly written Controlled Drug prescriptions, prescribing of non-preferred strengths of midazolam injection.

Significant events such as appropriate direction to or direct contact with community pharmacies in the palliative care network were also discussed.

Result

The pharmacist working at the OOH hub had ensured that all supporting material for correct prescribing was available to prescribers working OOH within Greater Glasgow & Clyde but issues still remain, e.g. in one of the more rural areas within one of the project CH(C)Ps difficulties can arise at weekends if advance contact is not made with the community pharmacy providing a Sunday Rota service to check if they stock certain medication. Unfortunately there seem to be difficulties / barriers in resolving these issues with prescribers.

One recent significant event that involved two palliative care network pharmacies on a Sunday has however resulted in two education sessions (details in section 2.2) being delivered 'in house' to one of the pharmacies (over 12 members of staff attended) and palliative care is now high on the agenda within this pharmacy.

Discussion

Further work with the OOH service is required to identify and resolve system failures which contribute to medication related incidents in palliative care. It is hoped that once Just in Case boxes are rolled out across the Health Board in 2013 to support anticipatory prescribing that many of the incidents involving urgently needed medicines for symptom control at end of life will be prevented.

8 Prescribing support and data

8.1 Development of EMIS shortcodes

Background

GPs already had access on computerised prescribing systems to short codes for common therapeutic categories to promote safe and cost-effective prescribing. Following a move to EMIS as the system in common use by GP practices, links were made through the CH(C)P lead pharmacists to the central Prescribing Support Team to develop codes for palliative care.

Aim

To prompt appropriate prescribing of medicines and formulations in line with palliative care guidelines and the list of palliative care medicines stocked by pharmacies in the community pharmacy palliative care network.

Method

Work was undertaken with the central Prescribing Support Team to develop short codes. Initially it was hoped that short codes that would encompass several situations for various symptoms could be developed e.g. Use of Liverpool Care Pathway (for both normal and reduced renal function), and anticipatory medication for Just in Case boxes.

It was subsequently realised that this would be fairly complex as several of the guidelines and documentation currently in use were not completely aligned with regard to choice of drugs, dosages, frequency of administration and terminology used. It was decided that initially short codes for 'Just in Case' would be developed and tested before expanding this work.

Result

Short codes for 'Just in Case' medicines have been developed and approved in collaboration with the central Prescribing Team and were being distributed during January 2013 to GP practices for incorporation into GP prescribing systems.

8.2 Prescribing trends and cost effectiveness

Background

Difficulties encountered by prescribers in selecting the most appropriate strengths and formulations of injectable palliative care medicines were identified earlier in the project. Pharmacists appeared to lack the knowledge or confidence to query prescriptions for formulations not on the list of medicines stocked in the Community Pharmacy Palliative Care Network. Tools and training to assist prescribing and dispensing of the preferred formulations were developed. Incidents where inappropriate formulations had been prescribed continued, however, to be reported to the project team, mainly for midazolam.

Initiatives arising from the Living and Dying Well Action Plan which were expected to increase prescribing of medicines to control symptoms at end of life, e.g. education on the Liverpool Care Pathway and Advance/ Anticipatory Care planning, were underway across NHS GG&C.

Aim

To assess trends in the prescribing of end of life medicines and the effectiveness of interventions during the project in improving appropriate prescribing.

Method

Primary care prescribing data in NHS GG&C from October 2009-October 2012 was analysed via the Prescribing Information System for Scotland (PRISMS), for injectable medicines recommended for consideration for anticipatory prescribing in people approaching end of life, and included in the LCP drug algorithms. The injections reviewed were diamorphine, levomepromazine, midazolam and specific anti-secretory medicines.

A more detailed review of formulation and cost data for midazolam and the anti-secretory medicines included comparison with other Scottish Health Boards for the period November 2011 – October 2012.

Results

Prescribing trends

Data analysis indicated an upward trend in the volume of prescriptions dispensed for the above medicines. The outcome is expected to be better symptom control in the community, thus reducing the risks and costs of out of hours call outs and hospital admission.

The following data are for prescriptions dispensed in NHS GG&C (all preparations are injections; it is assumed that this prescribing is for palliative care):

- Prescription items for diamorphine 5mg, the strength likely to be prescribed for an opioid naive patient, showed a steady increase from around 80 items per month in late 2009 to around 150 per month in late 2012
- Levomepromazine 25mg/1ml - prescriptions numbers increased from around 70 items per month in late 2009 to around 150 per month in late 2012
- Prescriptions dispensed for midazolam injection almost doubled from 135 items per month in late 2009 to 250 in late 2012
- Anti-secretory medicines:
    a. Hyoscine butylbromide (currently recommended[6] as first line and the most cost-effective agent) – substantial increase from 30 items per month in late 2009 to around 160 per month in early 2012
    b. Use of glycopyrronium (recommended as second line) was minimal throughout this period
    c. Hyoscine hydrobromide (recommended as third line but previously the most commonly used anti-secretory agent) - prescription numbers showed a reduction from 60 items per month in late 2009 for 400mcg/ml to 40 in late 2012, with a few prescriptions still for 600mcg/ml which is not on the list stocked by the community pharmacy network; the hydrobromide is much more expensive and has a poorer side effect profile than the butylbromide.

Midazolam

The overall prescribing rate in NHS GG&C between Nov2011-Oct2012 for the midazolam formulation used in palliative care, i.e. 5mg/ml, 2ml ampoules, was 72% of all prescriptions for midazolam. This is a significant improvement on the rate of 50% found

early in the project for June2009-May2010. Rates across the other Scottish Health Boards between Nov2011-Oct2012 ranged from 60% to 84%.

Although prescribing of the 5mg/ml, 10ml ampoule reduced from 6% of the total number of midazolam prescriptions in November 2011 to 3% in October 2012, it accounted for 28% of the annual cost (£7582). Prescribing rates across the other Scottish Health Boards ranged from zero to 14%. The 10ml ampoules contain a dose considerably in excess of that used for the majority of palliative care patients, and are likely therefore to be wasteful and pose a clinical risk.

Other strengths (2mg/ml and 1mg/ml) accounted for 20-30% of midazolam prescriptions. These strengths are not on the pharmacy network list and therefore not readily available; they are generally too dilute for bolus subcutaneous injections and pose volume limitations in syringe pumps.

Copies of a small card in a 'business card' format detailing the preferred strength of midazolam and the rationale for using this strength have been printed in January 2013 to encourage appropriate prescribing.

Anti-secretory medicines

Prescription items during November 2011 – October 2012 for the first choice agent of hyoscine butylbromide were 70% of the total prescriptions for the anti-secretory injections listed above, but accounted for only 19% of costs. Item rates in other Scottish Health Boards ranged from 8% to 96%.

Although only 28% of prescriptions were for hyoscine hydrobromide, these accounted for 81% of costs at £20,826. Significant savings could be realised from using hyoscine hydrobromide first line rather than the butylbromide.

Discussion

Whilst the increases observed in overall prescribing rates of injectable medicines used in palliative care are thought to have arisen mainly from initiatives involving the multidisciplinary team such as training on Liverpool Care Pathway, and Advance/Anticipatory Care Planning, it is considered that the work of the Macmillan

Pharmacist Facilitator project in conjunction with the specialist palliative care pharmacists will have been the main influence in relation to prescription of the preferred formulations. Tools developed to support appropriate prescribing were distributed across NHS GG&C; further review of PRISMS data at CH(C)P level would help to identify whether promotion of key messages locally by the Macmillan pharmacist facilitators produced greater change in the project CH(C)P areas than elsewhere.

Increased use of these medicines strengthens the need for all community pharmacists to know which formulations/ strengths are appropriate, and be able to give pharmaceutical advice, including drug compatibilities for syringe pumps, or know where to obtain it.

The continuing inappropriate prescription of certain formulations and strengths poses both a clinical and financial risk and requires more intensive work with all prescribers across the Health Board. The EMIS short codes recently developed and inclusion of practice specific data on midazolam and anti-secretory injections used in palliative care in annual GP practice prescribing analysis reports should assist this.

9 Care homes: establishing information and training needs

Background

The Care Commission (now Care Inspectorate) collated data provided by care homes to assess how they were delivering the action points from the Scottish Government Strategy Living and Dying Well. [7] The authors concluded that care homes were making progress in how they delivered good palliative and end of life care. The authors recommended that care homes work closely with GPs and primary health care teams to deliver good palliative care.

The Macmillan pharmacist facilitator post holder working in the Inverclyde CH(C)P met with Inverclyde Care Home Liverpool Care Pathway (LCP) Champions in February 2010. There was little awareness of the community pharmacy palliative care network, which had been in existence since 2001 and included 4 pharmacies in the CH(C)P area. In addition, a number of issues were raised in relation to delays in accessing palliative care medicines. A 'key points' summary was developed to supplement the network leaflet, and both were circulated to all care homes in spring 2010 (Appendix 4). The facilitator visited the local pharmacy dealing with supplies to most care homes in the area to discuss the network and explore how to improve communications. The pharmacy agreed to stock commonly used palliative care medicines.

In spring 2012, a number of reported incidents indicated that there was still a lack of awareness of the network service and of the National Patient Safety Agency (NPSA) best practice guidance on the safe use of opioids and the use of oral or enteral syringes for oral medicines.

Aim

A questionnaire was developed and used to identify the information and education needs amongst care home staff in all types of care home within Inverclyde CH(C)P area.

Methods

The Inverclyde Care Home Pharmacy Technicians hand delivered the questionnaire to all 16 care homes in May 2012 and collected two to four weeks later. The data was analysed by the Macmillan pharmacist facilitator.

Results

Care Homes Questionnaire (n=16)

Knowledge of network	Yes	No
Do you and your staff know about the Community Pharmacy Palliative Care Network?	8 (50%)	8 (50%)
Are you aware that this network keeps an agreed list of medicines used in palliative care (purple leaflet)?	8 (50%)	8 (50%)
Do you have a copy of the NHS Greater Glasgow & Clyde Community Pharmacy Palliative Care Network information leaflet for GPs and district nurses?	2 (12%)	14 (88%)
Sources of information about palliative care medicine		
a) Who do you call if you have a query about palliative care medicines? (respondents asked to circle options below or specify 'other')		
District nurse	9	
General Practitioner	14	
Community pharmacist	6	
Hospice	11	
NHS 24	4	
Specialist palliative care pharmacist	0	
All	1	
a) Please note the information sources on palliative care medicines you refer to		
NHS GGC palliative care guideline	1	
BNF	6	
LCP	3	
Palliative care book	1	
Purple leaflet	1	
Hospice	4	
Pharmacist	1	
GP	1	
Comments: Question (b) may have confused the care home staff as they tended to repeat the answers to the previous questions (no suggested responses were given for question b). The question intended to relate to resources such as books, guidelines or internet		

resources.		
Knowledge of safe administration of liquids via oral and other enteral routes		
Do you always use oral or enteral syringes to measure oral liquid medicines when the dose to be given cannot be measured using a 5ml spoon or graduated medicine cup?	13 (81%)	3 (19%)
Do all staff know that intravenous syringes should not be used to measure and administer oral liquid medicines?	14 1 N/A	1
Do you have a copy of the following?		
a) National Patient Safety Agency Patient Safety Alert 19; Promoting safer measurement and administration of liquid medicines via oral and other enteral routes. 2007. (two care homes did not answer question)	1 (6%)	13 (81%)
b) National Patient Safety Agency Patient Safety Rapid Response Report; Reducing dosing errors with opioid medicines. 2008.	2 (12%)	14 (88%)
Problems with accessing palliative care medicines		
In the last 12 months have you experienced a problem with accessing palliative care medication for your residents? Please give detail over leaf.	3 (19%)	13 (81%)
If the medication is urgent how do you communicate the urgency to your supplying community pharmacy?		
Telephone pharmacy	11	
Fax pharmacy	2	
FAX with urgent letter	1	
Travel to Paisley	1	
No comment	1	
Please note any additional information or support you require in relation to palliative care medication e.g. how to calculate parenteral doses?		
Parenteral	2	
Yes (no detail)	3	
Training in all palliative care medication	1	
The use of breakthrough pain medication, calculating doses	1	
Community and DN's deal with palliative care medications, we do not require training	1	
Greater clarity on who is responsible for checking stocks and ordering medications when it is the community or DN that manage this	1	

Discussion

The questionnaire highlighted a lack of awareness of the community pharmacy palliative care network services and how to access them. This can result in delays in accessing medication for residents. Although copies of the network leaflet were circulated in 2010 to all care homes in Inverclyde, only 12% (2/16) reported having copies in 2012 when this survey was undertaken.

Care homes were found to contact the district nurse or GP more often than their community pharmacist to discuss palliative care medication. Further study is required to identify if the advice aspect of the pharmacy service is being underutilised.

The majority of care homes reported that they did not have copies of National Patient Safety Agency Patient Safety Alert 19: Promoting safer measurement and administration of liquid medicines via oral and other enteral routes, 2007. However 81% (13/16) reported following the recommendations of this document.

There appears to be a gap in the routine circulation to care homes of key information resources including the network leaflet, safety alerts including NPSA alerts and best practice guidance. Ideally this would happen simultaneously with circulation to health care services. Guidance was sought[8] from one of the Pharmacy Professional Advisers to the Care Inspectorate on whether this responsibility should rest with care homes, NHS Boards, GP Practices or community pharmacies providing services to the care home. The Adviser responded that the procedure for dissemination of NHS drug alerts and safety information is via the NHS supply chain as per former Scottish Executive Health Department guidance. Thus for a patient level recall, responsibility for dissemination to a care home would be via the supplying pharmacy (or dispensing GP).
The Professional Adviser also advised that the Care Inspectorate, and formerly the Care Commission, have encouraged care homes to get drug and device alerts directly from the MHRA by email. The Care Inspectorate website contains a link http://www.scswis.com/index.php?option=com_content&task=view&id=7905&Itemid=725#other which then links to the MHRA one-stop resource for care home staff http://www.mhra.gov.uk/Safetyinformation/Healthcareproviders/Carehomestaff/index.h

tm . The advantage of this is that information is received immediately and goes direct to the person's email, rather than relying on someone checking a website. Although NPSA alerts do not carry a formal status in Scotland, their use has been encouraged as good practice where relevant to the service.

Only 19% of care homes (3/16) reported any delays in accessing medication in the previous 12 months and all but two reported that they would contact the pharmacy directly if the medication was required urgently. This is in line with the 'top tips' circulated to care homes in 2010, but there is no comparative baseline to assess whether this is an improvement.

A number of training requirements were reported and will require further investigation by the appropriate bodies.

Actions

Several documents were circulated to all Inverclyde care homes in August 2012 (Appendix 5).

The questionnaire, with minor adaptations, is being repeated in two of the other project CH(C)Ps during December 2012 – January 2013.

Recommendations

Information about the community pharmacy palliative care network should be included as standard in core training for care home staff.

Mechanisms to include care homes in communications relating to drug alerts or good practice in medicines safety are required. Automatic direct notification via established routes such as the MHRA website should be promoted.

Community pharmacies providing dispensing services to care homes should ensure that oral syringes are supplied when appropriate.

The questionnaire could be repeated in other areas of NHS GG&C to identify and address

gaps in knowledge and communication pathways. Ideally there should be a baseline and follow up to assess if necessary change was achieved.

Components of the questionnaire could be incorporated into the Pharmacy Advice Visit provided 3-monthly by community pharmacies supplying care homes to advise them on safe storage and handling of medicines.

Pharmacies supplying care homes should keep injectable medicines commonly used at end of life e.g. those recommended in the Liverpool Care Pathway, in stock.

10. Patient & carer information

10.1 Macmillan Cancer Information and Support Service @ Glasgow Libraries

Aim

To gain an appreciation of the service provided by one of the Macmillan Glasgow Library services, and consider potential links to and from community pharmacies.

Background

Currently there are five libraries across Glasgow which accommodate a Macmillan advice service, with expansion planned to a total of 25 libraries within Glasgow City. These drop-in services based in local communities are run by Macmillan trained volunteers who, through a variety of shifts, allow a service to open two days per week in each library, providing support and advice on a wide range of issues for anyone suffering from the effects of cancer. Each service is manned by approximately three volunteers from 10am until 4pm.

Previously, the manager of the Easterhouse service, which was a pilot site, had contributed to training sessions for the network pharmacists, together with a service user who related her experience of the support received from the service.

Method

Following a meeting between the project lead and the manager of this expanded Macmillan service, one of the recently appointed Macmillan pharmacist facilitators visited the Easterhouse service in December 2012. She explained the purpose of her visit, spoke to the volunteers, and joined in conversations with clients attending the service.

Results

The advice area in the Easterhouse service is in a prominent area of the library, with large displays of leaflets, plenty of biscuits and facilities for coffee and tea. Service users are encouraged to sit and chat. On the day of the Macmillan pharmacist facilitator visit, there were three service users, each with their own story to tell.

There was interest in the facilitator visit from both the volunteers and the service users. The volunteers are confronted daily with many medically related questions and currently direct service users to the Macmillan helpline. No one knew of the Boots Macmillan partnership, with some pharmacists working in Boots stores being trained to provide support and information to people with cancer and direction to other services. Similarly no volunteer had heard of the community pharmacy palliative care network within NHS GG&C.

Discussion

There would appear to be potential benefits from the pharmacist facilitators and community pharmacies linking with this developing service:

- Providing the volunteers with training on pharmacy services, and the types of questions e.g. medication side effects, that pharmacists could respond to could help direct patients/ carers when appropriate to pharmacy advice and increase their awareness of the range of pharmacy services available
- Pharmacies could display flyers for the library service, and advise patients and carers seeking information or identified as in need of support of the locations of nearby library services.

Network pharmacists attending the NHS Greater Glasgow & Clyde annual update training days have already received some training in communication skills, and further training would be beneficial so they could be better prepared for any future referrals.

10.2 NHS Inform

Aim

To consider the NHS Inform website, including the Palliative Care Zone, as an appropriate medium to post information on pharmacy services in response to findings from the patient/ carer focus groups run during phase 2 of the project (see Evaluation report for details).

Method

Following an initial meeting with the project lead, the Macmillan National Tailored Information Programme (TIPS) Manager was invited to the project Steering group meeting in November 2012 to share information on the work underway to improve the information on NHS Inform for people in Scotland with cancer. The material is being developed in such a way that it can be tailored to individuals' needs, and given to them a step at a time as they need it.

Result

It was agreed that much of the information advising patients and families on pharmacy services would be applicable across Scotland. It was agreed to ask the Scottish Board of the Royal Pharmaceutical Society to consider developing relevant information, and this request is currently under consideration. There is the potential on the NHS Inform site to supplement this with links to local information.

11Dissemination of Project learning and resources

11.1 Evaluation report

The evaluation report prepared for Macmillan Cancer Support, completed in January 2012, was widely distributed within NHS GG&C and to relevant parties and organisations within Scotland.

Distribution within GG&C included:

- CH(C)P heads, clinical directors and lead pharmacists
- Palliative care MCN
- Lead nurses, GPs, community pharmacists, and associated professional committees
- Prescribing Management Team
- Hospices

National circulation included:

- Scottish Government
- Royal Pharmaceutical Society
- NHS Education for Scotland
- Directors of Pharmacy
- SPCPA

11.2 Macmillan Cancer Support

The Project Lead was invited to present the project outcomes and learning to Macmillan's Healthcare Programme Management Group in London in September 2012. Widespread interest had been generated within Macmillan by the project, with consideration being given as to how the model could be developed across the UK. It was sensed that the organisation recognised the potential for greater engagement with pharmacy across the range of services available and consideration of what could be achieved by better utilising pharmacy expertise.

Discussions were also held with the Macmillan employee leading the partnership between Boots and Macmillan to provide information support for people with cancer in Boots pharmacies. Their approach has been to use Boots pharmacies to signpost the public to

sources of support and information.

An invitation to the project lead to contribute to a pharmacy workforce mapping workshop in February 2013 has been accepted.

11.3 Scottish Palliative Care Pharmacists Association

A presentation to members of the SPCPA in April 2012 summarising the project work, and the evolved model and capacity plan, was positively received. NHS Highland had already recruited to a part-time pharmacist post in Argyll & Bute CHP, modelled on the project facilitator model; the post has been 'adopted' by Macmillan Cancer Support.

11.4 Scottish palliative care conference

A poster entitled 'What does it take to get it right each time and.....is the picture complete? Providing an effective palliative care service from community pharmacies' was displayed at the Scottish Partnership for Palliative Care (SPPC) Annual Conference in October 2012[9]. It depicted aspects of the project work all aimed at securing an effective service through improving knowledge and skills, communication, information, and anticipating needs, with the pharmacist facilitators delivering change through local clinical leadership as advocated by Audit Scotland[10].

12. Future direction

Following the positive evaluation report, discussions with Macmillan were opened to establish whether further funding and support for the next 3 years would be considered to rollout the work to date across the whole of NHS Greater Glasgow & Clyde to provide an equitable service. Response to the initial Expression of Interest submission to Macmillan early in 2012 was positive, but indicated that matched funding from the NHS organisation would be required.

A full Case of Need was prepared and submitted to Macmillan, with a business case developed and discussed within NHS GG&C, including the palliative care Managed Care Network (MCN). The CH(C)P Directors agreed to match the offer of funding from Macmillan.
Final confirmation of funding has been received in January 2013.

The capacity plan developed during the project evaluation phase has been refined to introduce a skill mix of pharmacists and pharmacy technicians, as it was considered that technicians could ably undertake aspects of the work including medicine supply issues, network awareness and some of the training; the refined model will also introduce staffing cost efficiencies.

Further service development to address areas identified for improvement, including care homes, training for other professionals e.g. GP practice managers, receptionists, District Nurses, and communication between sectors of care will be incorporated in the rollout phase. It is intended that the work will continue to be guided by a multidisciplinary steering group; a number of criteria for ongoing evaluation, including patient/carer outcomes, will be identified and their suitability discussed with the MCN.

13. Recommendations

The recommendations drawn from the work undertaken in phase 2 have been updated to reflect progress in year 3, but are largely still applicable, and are presented below as a guide to inform and shape discussions for the Board wide rollout of the work.

Information resources

Patients / Carers

- Encourage community pharmacies to inform patients on changes in their medicines and work to raise patient and carer expectations of pharmacy services
- Develop a written, easily accessible resource (to supplement verbal information) educating palliative care patients and their carers on accessing their medicines and information from their community pharmacy
- Identify and promote a list of validated and reliable web-based patient information resources
- Develop links between community pharmacies and services provided by other professionals (health and social care) or voluntary providers e.g. the Macmillan Cancer Information and Support Service at Glasgow libraries, to direct patients/ carers to appropriate sources of support and information.

Community Pharmacy / Multidisciplinary Team

- Promote the sharing of resources generated through the ongoing work as tools to support best practice, through existing local and national networks
- Continue to assess the feasibility to move resources developed to electronic platforms to facilitate resource sustainability
- Continue to develop guidance for medicines used in palliative care, to support patient care
- Monitor prescribing data for palliative care medicines used at end of life to assess the effectiveness of initiatives
- Increase awareness of the palliative care needs of people with non-malignant conditions.

Communication and networking

- Continue to establish and strengthen communication strategies across the CH(C)Ps and sectors of care, both within pharmacy and across the multidisciplinary team as appropriate, and between health and social care
- Assess how communication strategies can become more system dependent rather than person dependent, to facilitate sustainability
- Continue to build an understanding of the information, communication and support needs for care home staff to improve pharmaceutical palliative care for their residents
- Ensure effective clinical leadership in the ongoing development of pharmaceutical care services for palliative care to ensure communication between service teams and alignment of work with local/national frameworks.

Skills development

Pharmacists / Pharmacy support staff

- Continue education sessions for pharmacists and pharmacy support staff across NHS GG&C to sustain core skills and develop enhanced skills within community pharmacy; these should be aligned to support registration requirements with the General Pharmaceutical Council
- Investigate alternative methods to communicate training opportunities to all staff who wish to engage in training, including locums and staff working at weekends
- Encourage experienced community pharmacists to engage in cascading training to promote local sustainability
- Future education sessions for pharmacy staff should be shaped by local educational needs assessment and key national priorities e.g. anticipatory care, supplementary/independent prescribing
- Identify any specific palliative care information and training needs of pharmacies supplying care homes and develop training packages; pharmacies supplying care homes outwith the Health Board area may pose additional challenges
- Continue to develop e-learning tools for pharmacy support staff education modules with the support of NHS Education for Scotland

- Field test the designed pharmaceutical care plan with community pharmacists and establish the information technology steps necessary to support this through the evolving CMS

Multidisciplinary team

- Widen awareness within primary and social care teams, including specifically GP Practice managers and receptionists, of the community pharmacy palliative care network and its operation
- Continue to link with OOH service providers to raise awareness of the full range of pharmacies stocking palliative care medicines which are open extended hours
- Promote continuing use of the patient's usual pharmacy whenever possible for palliative care prescriptions, supported when needed by the palliative care network pharmacies

14. Reflections on the project

Discussion of the project methodology, successes and challenges, and detailed evaluation of the work strands is included in the evaluation report. Continuation and refinement of work in the third and final year is described above, with a high level of detail to facilitate continuity at handover to a new service lead and team for Board-wide rollout.

The following present a personal reflective account through the eyes of the Project lead who championed the project from inception to delivery over the past 3 years. It is hoped that this provides a helpful insight to those who will continue to strive to improve the services to patients and carers requiring palliative care services.

Audit Scotland estimated that 42,000 people per annum in Scotland have palliative care needs. This equates to around 10,000 patients per annum (and similar numbers of carers) who are likely to access community pharmacy services within NHS GG&C.

The overarching aim of this work has been to establish an effective way to improve the consistent delivery of safe, effective and efficient pharmaceutical palliative care to people with cancer and other life-limiting conditions living in the community, and to support their carers. The main drivers were recognition of the impact on patients, families and professionals when care was not of the quality expected, difficulties sustaining knowledge and skills in a very mobile community pharmacy workforce, and a desire to identify and share examples of good practice, which were less likely to be reported than system failures. Just recently, a letter from a family to a community pharmacy, and a personal communication, have both highly praised the service they received towards the end of life of a family member; it would be great for this to become the norm.

Audit Scotland identified:

- That palliative care had not been a priority for Community Healthcare Partnerships
- That local clinical leadership is important in driving change
- The importance of developing skills of generalists

The pharmacist facilitators have delivered local clinical leadership by working 'on the ground' with community pharmacists and support staff, nurses, and GPs and their staff.

Their work has focused on developing the knowledge and skills of generalists through personal contact and discussion, development of resources, provision of training opportunities and improving communication channels. In addition, some have contributed to the evolving CH(C)P palliative care groups and agenda, and generally acting as advocates that "good palliative care is everyone's business".

In addition, the facilitators enabled us to identify the root causes of some of the problems reported around prescribing, dispensing, supplying and administering palliative care medicines, putting us in a better position to find solutions. Whilst it is frustrating that we still hear of problems, many with a direct and immediate impact on patients and their families, the facilitators' presence increases the chance of incidents being reported and utilised for reflection and learning to continuously improve care more widely. It is viewed that as anticipatory prescribing becomes more common, supported by the introduction of Just in Case boxes, that fewer clinical incidents relating to urgently needed palliative care medicines should arise.

The comments from some pharmacists encountered during the facilitator visits that '*they don't do palliative care'* are worrying; whether this a mistaken perception that all palliative care prescriptions should go to the network pharmacies, or a lack of confidence in dealing with some of the issues, as found in earlier project work, continuing efforts are required to raise the expectation that all pharmacists should be able to deliver palliative care at a generalist level, with support from network pharmacies and specialist teams when needed.

The importance of pharmacists and their staff possessing effective communication skills in their dealings with palliative care patients and carers, and colleagues and other professionals, has been evident throughout the project; also evident was a considerable variation in skill levels. The wide ranging situations faced by community pharmacists dealing with palliative care patients, and the challenges of managing these within the community pharmacy environment, are described in a study by O'Connor et al[11].

Work continuing early in 2013 is showing a very positive impact on service quality of the repeated visits to community pharmacies that the facilitators appointed late in 2012 have undertaken.

A disappointment is not succeeding so far in testing out the NES Pharmaceutical Care Plan/ Needs Assessment Tool designed to support the Chronic Medication Service (CMS) for palliative care patients. Obtaining written patient consent to transfer details of palliative care status from the GP palliative care register to their usual community pharmacy was the stumbling block; this would be better sought either through a face to face visit to the patient or much earlier than the last months of life, ideally when the patient is still able to attend the pharmacy in person. It is likely that as CMS becomes embedded, the required consent will be in place for at least some patients with palliative care needs. It is worth noting that patient and carer views obtained during the course of the project indicated that they tended to already expect pharmacists to know their diagnosis, etc, and they recognised that having such information would improve safety and their care. The scope for community pharmacists to play a greater role in managing cancer pain if they had access to information on diagnosis and changing patient needs, and the barriers, have been explored in a UK study[12].

Disappointment is tempered by the very positive reception to the introduction of training for community pharmacy support staff, supported throughout by NHS Education for Scotland. The invite from NES to develop an e-learning resource for pharmacy technicians was timely, and with free access to this on the NES website, demonstrates the benefits beyond our own Health Board of aspects of the project work.

When the team members were appointed, they were given flexibility around working days to fit with the service needs and their other jobs; this proved beneficial in terms of their ability to attend, for example, CH(C)P palliative care group meetings on a day they did not normally work on the project. Conversely, it made team meetings difficult to arrange, and in retrospect, dates for these should have been set much further ahead. Having the pharmacists based within the CH(C)P prescribing support teams worked well, and helped them to understand and integrate into the CH(C)P structures. The management structure was complex however, with the CH(C)P lead pharmacists providing line management, but the project lead largely directing work, and sometimes this generated uncertainty over responsibilities. It is recommended that the organisational structure is reviewed for the rollout phase, but a focus on working within defined localities and close links with CH(C)Ps

should remain.

The very positive feedback received from Macmillan and from within the NHS on the quality of work and the evaluation report is encouraging. There is no doubt that partnership working with the University of Strathclyde team enhanced the robustness of the methodology, with publication of two papers in palliative care journals[13,14] adding to the evidence base, and conference presentations and posters sharing the learning and ideas across NHS Scotland and more widely.

The enthusiasm of individual team members and their unfailing desire to improve care for patients and their families, and a collaborative approach, learning from one another, have enabled significant progress in raising awareness of the pharmacy palliative care network within the project CH(C)Ps, skilling pharmacy staff across NHS GG&C to improve patient care and medication safety, the latter particularly around use of opioids, and in promoting closer links with others in the multidisciplinary team. The cooperation and contribution of all parties, including patients and carers, who have engaged with the project team, is gratefully acknowledged.

With funding to rollout the work across all the CH(C)Ps within NHS GG&C, and to continue with service improvement, secured, it is hoped that the progress achieved within the last 3 years can be sustained and built on, and an equitable patient-centred palliative care pharmacy service provided to all those who need it.

NHS
Greater Glasgow and Clyde

Glasgow
CITY COUNCIL

Appendix 1

CONSENT TO SHARE PATIENT INFORMATION

Person Name			
Address			
CHI number		**GP name**	

Purpose

This form authorises the practice to share information about you with your regular community pharmacy for the purposes of ongoing supportive care. We will only share the relevant information required to address your needs.

Statement of Understanding & Agreement

- In order to provide appropriate care for me, I understand that information about me may need to be shared with my regular community pharmacy if it is directly relevant to my needs;
- I have had the reasons why information is going to be shared with my named carer explained to me;
- I am aware that I can withdraw my consent at any time and this will not affect the support that I receive after that point;
- I understand I have the right to prevent my information being shared with certain individuals / organisations (noted below in 'Comments' section);
- I understand that my consent to share information will be reviewed at my request, or when considered appropriate.

Based upon information explained to me above, I do /do not consent to information about myself being shared with my regular community pharmacy.

Signed:_____ **Date:**_____

Person / parent / guardian / legally appointed power of attorney (Delete as appropriate)

GP Signature:_____**Date:**_____

Any Additional Comments:

NHS
Greater Glasgow and Clyde

Appendix 2

Dear

This GP practice is involved in a pilot (trial) project regarding the sharing of some health information between GPs and community pharmacists.

You have been identified as a patient who might benefit from being involved in this pilot.

The pilot involves sharing relevant information about your diagnosis, treatment and medication with your regular pharmacist. This information will be recorded in your patient medication record in the pharmacy. Any information shared in this way and stored in the pharmacy will be kept confidential and in strict accordance with the Data Protection Act.

This information is not currently given to the pharmacist and the aim of the project is to show that giving the pharmacist this information will help them to provide more appropriate care for you. In some cases you may be unable to visit the pharmacy in person and it can then be difficult for the pharmacist to ensure that you are receiving proper care, if they are unable to share information with a carer if they do not have your consent.

We have enclosed two forms asking you to give consent for the practice to share this information with the pharmacy, and for the pharmacist to share information with your carer.

If you would like to be involved in this pilot please fill out both forms and return them to the practice within two weeks of receiving this letter.

If you do not wish to become involved in this pilot then you do not need to do anything and you will receive all the care that you normally do.

If you have any questions about the project please contact .....

NHS
Greater Glasgow and Clyde

Appendix 3

CONSENT TO SHARE INFORMATION WITH CARER(S)

Patient Name			
Address			
CHI number		Pharmacist	

Purpose

This form authorises the responsible pharmacist (named above) to share information about you with your named carer(s) for the purpose of ensuring appropriate treatment and advice is given. We will only share relevant information required to address your needs.

Statement of Understanding & Agreement

- In order to provide appropriate care for me, I understand that information about me may need to be shared with my named carer(s) if it is directly relevant to my needs;
- I have had the reasons why information is going to be shared with my named carer explained to me;
- I am aware that I can withdraw my consent at any time and this will not affect the support that I receive after that point;
- I understand I have the right to prevent information being shared with certain individuals (noted below in 'Comments' section);
- I understand that my consent to share information will be reviewed at my request, or when considered appropriate.

Based upon information explained to me above, I do /do not consent to information about myself being shared with named carer(s).

Patient Signature:_____**Date:**_____

Pharmacist Signature: _____**Date:**_____

Named Carer(s) Details:

Name:

Address:

Contact Number:

Relationship to patient:

Appendix 4

NHS Greater Glasgow and Clyde Community Pharmacy Palliative Care Network Key Points for Care Homes

NHS Greater Glasgow and Clyde have an agreed list of drugs commonly used in palliative care that the following pharmacies will stock. This drug list has the backing of palliative care guidance. More details about the service and drug list can be found in the Community Pharmacy Palliative Care Network purple leaflet.

The network pharmacies in your area are:

Insert name, contact details and opening hours	

Aim of Service: To ensure that patients requiring medication for palliative care receive supplies rapidly in an urgent situation, 24 hours a day and that appropriate advice is available on the use of these medicines.

Key points to aid communication and access

- Please display a copy of the Community Pharmacy Palliative Care Network leaflet in an area accessible to all relevant staff.
- Always plan ahead wherever possible.
- If the GP prescribes a drug that is not on this list, this will not be covered by the Pharmacy Network Service Level Agreement and the same day supply cannot be guaranteed. In this circumstance, the GP may have to prescribe an alternative medication to cover any delay.
- When you have a prescription for palliative care medicine, please contact your usual supply pharmacy in the first instance and if required they will link with the network pharmacy and manage the process. Only contact the network pharmacies directly in exceptional circumstance.
- A courier service is available to transport prescriptions and or medication; however this can take up to two hours and the courier service **must be accessed via your usual pharmacy.**
- When contacting your pharmacy please indicate if the drug is required urgently.
- To aid communication fax the prescription to the pharmacy (cover patient identification details) and notify the pharmacy the time the medication is required by.
- If the supply is required Out of Hours, please prompt the OOH service to contact a network pharmacy and use the courier service.
- With patient/welfare proxy consent please inform the pharmacy that the person is at the palliative stage of their life.

Appendix 5

Documents distributed to care homes in Inverclyde, August 2012

1. National Patient Safety Agency Patient Safety Alert 19; Promoting safer measurement and administration of liquid medicines via oral and other enteral routes. 2007
2. National Patient Safety Agency Patient Safety Alert 19; Promoting safer measurement and administration of liquid medicines via oral and other enteral routes. 2007. Questionnaire
3. National Patient Safety Agency Patient Safety Rapid Response Report; Reducing dosing errors with opioid medicines. 2008
4. National Patient Safety Agency Patient Safety Rapid Response Report; Reducing dosing errors with opioid medicines. 4th July 2008 Summary
5. NHS Greater Glasgow & Clyde Community Pharmacy Palliative Care Network information leaflet (2010) for GPs and district nurses.
6. Care Home Key Points about the NHS Greater Glasgow & Clyde Community Pharmacy Palliative Care Network information leaflet for GPs and district nurses. (see Appendix 4).
7. NHS Greater Glasgow and Clyde Palliative Care Prescribing, Sample Prescription.

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12. Savage I, Blenkinsopp A, Closs S, Bennett M. 2012. *'Like doing a jigsaw with half the parts missing': community pharmacists and the management of cancer pain in the community.* Int J Pharm Pract 2012; published online: 9 OCT 2012, DOI: 10.1111/j.2042-7174.2012.00245.x [accessed 17/01/13]

13 . Akram G, Bennie M, McKellar S, Michels S, Hudson S, Trundle J. 2012. *Effective Delivery of Pharmaceutical Palliative Care: Challenges in the Community Pharmacy Setting.* J Pall Med 2012;15:317-321

14. Bennie M, Corcoran E.D, Trundle J, MacKay C and Akram G. *Investigating the medicines and pharmacy information needs of older palliative care patients and their carers receiving care from community pharmacies.* Accepted for publication by Eur J Pall Care.