Macmillan Rural Palliative Care Pharmacist Practitioner Project

Final Report

October 2016
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This work was undertaken by the
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INTRODUCTION

Background

The Macmillan Rural Palliative Care Pharmacist Practitioner Project (MRPP) was a demonstration project to inform national policy and aimed to have direct impact on the delivery of pharmacy services within NHS Scotland, as outlined in ‘Prescription for Excellence’ (1). This opportunity gave NHS Highland access to the expertise developed through the previous NHS Greater Glasgow & Clyde Macmillan Facilitator project (5, 6) and allowed the University of Strathclyde team to evaluate the project and develop the evidence base for clinical practice within this area, as well as focus on developing rural pharmaceutical care capacity through the use of a community pharmacy-based practitioner.

The MRPP project piloted the role of one full-time Macmillan Rural Palliative Care Pharmacist Practitioner (MRPP) in the Skye, Kyle & Lochalsh area, with a view to supporting service resilience and developing an interface role between primary and secondary care services to improve patient palliative pharmaceutical care. This required a joined-up service approach and consistent service provision through implementing appropriate care planning models and integrating the community pharmacist into the multidisciplinary team. The project would test the ability of a community based pharmacist to:

- Develop community pharmacy capacity to effectively, efficiently and safely support the needs of those in this rural community with cancer and palliative care needs regardless of care setting
- Improve service provision/co-ordination of services ensuring opportunities are developed for training and peer support
- Provide quality information to support practice.

This project considered issues relating to equity of service provision within a rural area, providing continuity of care and access to pharmaceutical services as part of multidisciplinary care input.

The MRPP team comprised of: 0.3wte service lead and 1wte MRPP. The service also benefited from the support and direction of a steering group and the University of Strathclyde were commissioned to evaluate and inform on key initiatives.

AIMS AND OBJECTIVES OF PROJECT

The project key aims are to:

- Develop community pharmacy capacity to effectively, efficiently and safely support the increasing PC needs of those with cancer and life-limiting illness in the rural community.
- Improve the provision and co-ordination of primary, secondary and tertiary services, ensuring opportunities are developed for training and peer support.
• Engage with the wider primary care health and social care team (HSCT) integrating the community pharmacist to provide quality information and tools to support best PC practice as well as improve the quality, safety and cost-effectiveness of prescribing.

The University of Strathclyde provided evaluation services to the Project between Feb 2013 and Dec 2014, the phases and outputs of which will be referenced throughout this report (7, 8):

To deliver on these aims, a variety of quality improvement and engagement activities were being driven across the project locale, engaging community pharmacy and the wider primary care HSCT. Aligned with the direction of travel for health and social care in Scotland, and informed from the learnings and recommendations from the pilot project, the programme focused on 3 key work areas (Figure 2):

**KEY ACTIVITIES AND CURRENT (2016) PROGRESS**

*Education & Training*

Figure 3 illustrates an amalgamation of the activities identified in the Phase 2 report (published Jan 2015) against Education & Training and their current status as of February 2016: completed; in progress, or; activities from which to learn lessons.
## Completed Activities

### Multi-professional training (local and national)

After initial training in 2014, materials were shared with Macmillan Nurses and practice pharmacists, and new care home staff were trained. The sessions were introduced at Macmillan Patient and Carer Living with Cancer days and to the Alzheimer’s’ group. Additional training sessions on other topics were developed. Training roll out is now planned with lay carers / the public.

The Sunny Sessions content informed the NES Online Palliative Care training package for all health and social care support staff, available nationally via an online platform from Autumn 2016. The national Macmillan Cancer Support ‘Foundations in Palliative Care for Care Homes’ Support resource has been made accessible to Macmillan Nursing staff and Primary Care Practice Pharmacists across NHS Highland.

### Support staff in their knowledge of medicines with medicines information sheets

Information sheets on off-label medicines use included in Highland Palliative Care Information Pack. Other resources developed (e.g. Top Ten Tips on medicines)

### Roll-out and testing of Materials Developed

Test currently deployed materials like the “Ask 3” cards and medicines information cards.

### MSP visits and Parliament Motions

Following MSPs Dave Thomson, Rhoda Grant, Dave Stewart and Mary Scanlon visits, MSP motions were raised in the Scottish Parliament to support the model of service provision and the successful outcomes achieved for patient within remote and rural locations. More visits are planned.

### Deliver tailored GP talks on request

Discussions have been led within GP practice meetings on desired topics.

## Activities in Progress…

### Further distribution of mouse mats, mugs and any other educational materials across NHS Highland

Interest in materials was shown from across NHS Highland and elsewhere across Scotland. Additional external funding was sought to share materials wider which was unfortunately not achieved. The project lead continues to seek additional resource.

### Access to medicines information materials in non-clinical settings

Stands were placed in Boots Pharmacy, Portree, Glenelg, Sleat and Broadford GP practice reception areas. It was not possible to display them in the local library because of other Macmillan Information Library projects to prevent overlap or duplication.

## Lessons Learned…

### Use of twitter account and hashtag to enable non-direct contact with patients (#SkyeLochPharm)

It was not possible to set up a separate twitter account for the project, however the hashtag was enabled. Difficulties with connectivity meant that it was difficult to maintain a weekly update of activity by the MRRP. Connectivity remains a major challenge within remote and rural areas.

### Developing Top Tips for using medicines sheets for care home staff

Distribution was not achieved prior to the close of the project.
Integration of the MRPP

Figure 4 demonstrates an amalgamation of the activities identified in the Phase 2 report against Integration of MRPP and their current status: either completed; activities from which lessons can be learned.
## Completed Activities

### Community Pharmacy Involvement in Gold Standards Review Meetings

The MRPP attended GSR meetings to provide insight into palliative medication related issues in patients in Kyle, Broadford (Includes Sleat practice), Carbost, Dunvegan, Portree and Glenelg practices. Community pharmacists from Broadford and Portree are regularly invited and attend GSR meetings, with Skype/teleconference access to commence in 2016. Issues from Highland Hospice calls are now on the agenda at GSR meetings.

*Top Ten Tips* guide for healthcare professionals for conducting GSR Meetings completed and included in Highland Palliative Care Information Pack, and shared with practices.

### Provide continued advice and support to Macmillan Nurses relating to palliative care medicines

The MRPP became an integral point of contact with the Macmillan nurses in relation to palliative medicines enquiries. The co-ordination skills of the MRPP enabled wider access to team skills on issues which the nurses may not have initially identified.

### Support Community Pharmacists across the project area in providing teach-back experience for patients’ improved understanding of medicines

Peer support was provided to Community Pharmacists by the MRPP for teach-back implementation.

### Access to patient hospital admission and discharge information, including Immediate Discharge Letters (IDLs) as well as more advanced information for Community Pharmacists

IDLs are now to be available to all Community Pharmacies across NHS Highland. ECS access is used in Broadford with patient consent and has enabled appropriate treatment provision from pharmacy and identifying ‘red flag’ issues for referral.

## Lessons Learned...

### Raising ethical issues in the quarterly Palliative Care Model Schemes Newsletter

Nov 2014- Feedback request & answers would also feature in following quarterly newsletter. Ethical issues included in quarterly newsletter from August 2014, however due to low feedback this was temporarily suspended.

### Conduct a follow-up audit of CD prescribing

A formal follow-up audit of CD prescribing was not carried out. A major problem was not identified in the baseline (2013) audit other than the adherence to prescription writing requirements for discharge prescriptions from the hospital medical staff. This position improved following training, but lapsed on staff changes indicating that training required to be delivered on a regular cycle. It was noted that although the mouse mats containing information were distributed throughout the hospital, these did not remain in the prescribing environments and alternative solutions may need to be sought as prompts.

The community pharmacies developed labels to attach to prescriptions highlighting deficiencies to prescribers. Ease of access of the hospital staff to the pharmacy meant this was not an insurmountable problem delaying patients but remained a low grade procedural issue.

### Support Community Pharmacists in developing and hosting drop-in clinics or independent prescribing clinics

Prescribing clinics require investment from community pharmacy for training. The MRRP was supportive of the “teach and treat” model from NES and was prepared to support clinic development. Clinics conducted in GP Practices or during domiciliary visits yet placed a time constraints on other project developments.

Drop-in Clinics – Experience showed that set times for clinics do not work well in rural areas. The Clinic / Pharmacist would have to be available during variable times during opening hours.
Tools, Resources, Publications, Presentations & Awards

Figure 5 provides a logic-based overview of the variety of tools and resources developed over the lifespan of the project against the completed / in progress activities and current palliative care relevant strategies in Scotland. The figure also includes a summary of the various publications, presentations and awards associated with the service.
Figure 5: Logic model of tools, resources and outputs
Service Impact

The successful implementation of the MRPP project can be evaluated using the following categorisation of outcomes (Figure 6) (9):

**Implementation outcomes**
- Acceptable
- Adopted
- Appropriate
- Within Cost
- Feasible
- Remained loyal to
- Penetrating
- Sustainable

**Service outcomes**
- Efficient
- Safe
- Effective
- Equal
- Patient-centred
- Timely

**Client outcomes**
- Service satisfaction
- Service function
- Patient symptomatology

Figure 7 illustrates each of these three levels and provides evidence supporting the associated factors. A traffic light system is used to indicate whether or not these factors associated with successful implementation were realised within the current project.
**Implementation Outcomes**

- Acceptability
- Adoption
- Appropriateness
- Cost
- Feasibility
- Fidelity
- Penetration
- Sustainability

**Service Outcomes**

- Efficiency
- Safety
- Effectiveness
- Equity
- Patient-centredness
- Timeliness

**Client Outcomes**

- Satisfaction
- Service Function
- Symptomatology

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"I think [the MRPP] breaking down those barriers [around the role of the Pharmacist] have been absolutely great." (Key Service Lead)

Project and role designed to be flexible to fill relevant gaps in project area

Project funded for pre-defined time period with full-time and part-time staff allocated to roles.

Project aim to improve service capacity and access to care through MRPP post adhered to.

Impacts of the project felt locally and nationally (i.e. National training development, IDLs available across NHS Highland, motions in Scottish Parliament).

Evaluation team, developed a phased approach towards handing over responsibility of service from MRPP to the Pharmacist

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"[The MRPP’s] going round all the [care] homes at the moment doing a lot of education which for me is hugely beneficial...we can prevent a lot of symptom management problems later on." (Nurse)

NES National Online Palliative Care training Package Pilot

Community Pharmacies have access to Immediate Discharge Letters (IDL) across NHS Highland

Community Pharmacy presence at GSF meetings across whole project area

"Since I have had access to SCI store [through the project], I feel I have been able to advance my practice and be able to provide patients with a better service." (Community Pharmacist)

Operational during the release of several key strategies for palliative care, including: **Prescription for Excellence (1); Transforming Urgent Care (2); The Strategic Framework (3); and Beating Cancer (4).**

"[The MRPP] was quite helpful in looking carefully at the medication [my husband] was on and making suggestions ... [the MRPP] gave me the confidence that I was doing the right thing." (Carer)

"[This patient’s] medicine was trying to keep sort of symptom control...[the MRPP] was able to [phone] the company that was producing it, as well as talk to other pharmacists for advice." (GP)

"The project ended in February 2016. At the time of this report (2016), although individual symptom management improved as a result of interventions (see prescribing comments) not enough time has passed to observe any population realised outcome on the symptomatology of patients.

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*Adoption and Cost were success factors that were not included d in the current project evaluation as the funding was obtained by the service provider for a defined program.
Implementation Outcomes

Once the concept was understood, implementation was well accepted and the service seen as a feasible option to support enhanced utilisation of existing services and integration into the health & social care team. Staff were welcoming and all agencies worked well together. Sourcing equipment proved challenging through NHS purchasing systems. Gaps in professional and patient / carers knowledge were filled as previously unmet need was identified.

Service Outcomes

The following realised activities provide evidence to support that the service implementation had positive impacts on service efficiency, safety, effectiveness, equity of service provision, was patient-centred and was implemented in a timely and time-relevant manner.

The development, roll out and expansion of multidisciplinary training (e.g. Sunny Sessions training and the NES Online Palliative Care Training Series)

At the time of the Phase 2 evaluation (published January 2015), ongoing activities included the development and roll-out of the Sunny Sessions care home training, with a view to making this a national resource in the future. Improving access to other palliative care training materials that would be of value to care home staff was also ongoing.

Through the development of the NES Online Palliative Care Training Series for health and social care support staff (through collaboration with NHS GG&C, NHS Education for Scotland and Macmillan Cancer Support), the Sunny Sessions content was amalgamated with NHS GG&C Webinar training and will be available in this format at a national level online from Autumn 2016. The launch of this training has also impacted on the wider healthcare professional planned outcomes beyond the lifespan of the project, by facilitating local multi-professional team training and improving access to training through the use of IT. The NES training package is also available for community pharmacy and GP reception staff, addressing the Phase 3 planned outcome of addressing the training needs of other health and social care support workers, with a view to adapting or adding to the training to cater to other staff and service user groups (e.g. care at home and patients). As this training resource is available online, it can be accessed in non-clinical settings, however at the present moment the training is not accessible to patients but tailored modules could be in the future.

This training package has been piloted on a variety of staff members in both NHS GG&C and NHS Highland health boards, providing the opportunity to give feedback which will shape the final version of the training. The impact the Sunny Session training had has gone beyond care home staff working in the project area, extending to a wider variety of support staff across Scotland and potentially beyond.

Community Pharmacy Access to Immediate Discharge Letters (IDL) across NHS Highland

The Caldicott Guardian approval for community pharmacy access to SCI store had been obtained for this project. The Director of Pharmacy supported a bid for a new business request to extend this
access. It was accepted by both the Clinical Governance and Information Governance Committees that this approval was appropriate for all community pharmacies for all patients. A brief meeting with eHealth and clinical leads enabled the project to move forward. A multi-disciplinary implementation group were drawn together to take the plan forward under the chair of the project lead.

Defining the key areas for community pharmacists to use data and the governance issues and required systems have been clarified, e.g. access approval processes, monitoring processes, removal from the system processes, access by locums etc. Enabling independent pharmacies is straightforward on the network however greater difficulties remain with pharmacies belonging to multiples, specifically in overcoming firewall restrictions. Additional challenges remain within the Argyll and Bute Integrated partnership area because patients from this area use hospital and laboratory services in NHS GG&C. Engagement with governance groups within NHS GG&C is required prior to enabling these pharmacies as they would access NHS GG&C SCI store.

Community Pharmacy Presence at GSF Meetings

Input from a medicines-perspective to the meetings has enabled pharmaceutical aspects to be identified and has facilitated the tailoring of medicines related solutions to meet patient needs. The MRRP contributed a greater awareness of alternative formulations, unlicensed uses of medicines and how to obtain and use these to assist patients and practitioners with delivering improved patient symptom management. This could minimise delays in commencing treatments. The MRRP input provided a springboard for invitations to be issued to the local community pharmacy to attend meetings as the contribution was recognised and valued. By providing peer support at meetings the community pharmacists developed confidence in this environment and strengthened relationships and communications with the wider multidisciplinary team.

Being able to leave the pharmacy at times may not always be possible. Teleconferencing was a possibility however it was felt for this to work well, good relationships needed to be established face-to-face. Connectivity and availability of technology has presented barriers, but the implementation of NHSmail2 which includes Skype may enable this.

Client Outcomes

As seen in Figure 7, service users (including patients, carers, GPs and key service leads) expressed their satisfaction with the service at an anecdotal patient story level, feeling that the MRPP and enhanced service was valuable in the safe, effectively and timely care of palliative patients in this community which faces unique challenges relating to its rurality. Unfortunately no reliable documentary evidence was collected relating to patient satisfaction or improvement of symptomatology as a result of the project. Upon project completion, the Lead was provided with a model for successful handover following the post of MRPP ending which sought to ensure the project function would continue beyond the lifetime of this intervention. Due to limited resources and time lapsed since the end of the project, it has not been possible to provide further quantifiable evidence on client outcomes, beyond the qualitative data provided on user satisfaction.
Forward Planning Activities

Forward planning has been integrated through the 2 key strands of work both in the context of: sustainability of tools and resources developed within the project, and; in capacity and capability building, particularly in the community pharmacy and home care setting. The challenge remains as to the resource alignment for changing roles within community pharmacy and the provision and access to specialist pharmaceutical palliative care expertise within rural areas.

A further strand of activity identified as part of the program, as yet not progressed, is the need to explore patient education on opioid use and more generally patient literacy. This involves challenging the misconceptions around opioid use within the patient and carer population and also ensuring patient appropriate resources to support understanding of their medicines. The forthcoming NES online training package could be a potential vehicle, developing additional modules on: common myths and concerns around opioid use, and; patients making sense of medicines information.

FUTURE DIRECTION

The current service funding ended in 2016. Moving forward, the overarching aims of the MRPP project are fully aligned with the current direction for PC and Urgent Care in Scotland and the depth of experiential learning gained should be invaluable as the NHS and the Scottish Government are poised to deliver on the new Strategic Framework for Action on Palliative and End of Life Care (SFA) (3) and implement recommendations from Transforming Urgent Care for the People of Scotland (2) (TUC). Figure 8 includes a proposed approach for sustainability, building on the model outlined in the Phase 2 report which illustrated a roadmap from design, through development to a maintenance position. The addition of a sustainability domain puts in context the current policy/funding drivers and key actors necessary for delivery of an effective transition for patients and their carers in need of pharmaceutical palliative care services. The three elements of this sustainability domain are:

- Policy/Funding - a range of potential funding streams / bodies who could be approached to financially aid the transition between Step 2 and Step 3
- Community pharmacy - the support required from the pharmacy contractor, in this instance Boots Company PLC to facilitate handing over of responsibilities from the MRPP to services within the community
- NHS Highland - the support to facilitate handing over of responsibilities from the MRPP to services within the community

Progress is already being made; transition of some services using the locally negotiated model of pharmaceutical palliative care service specification has been implemented. Community pharmacists are now recognised as having a place within the multidisciplinary team and at Gold Standard Framework meetings, which is a lasting legacy. The future ambition is for a 2 day-per-week co-ordinator role for an agreed geography to maintain and evolve service continuity including extension of education and training programmes and improved integration across health and social care, not currently included within the community pharmacy contract. Continual development is restricted without funding as community pharmacists find it difficult to leave the premises to deliver any
additional services which may bring value for patients and their families, e.g. visiting and supporting patients and family carers in their own homes. Opportunistic access to the MRPP role (e.g. while physically present in the community out with the community pharmacy premises, in between visits etc.) is also limited at this time; this informal access to the post holder played a more critical role for patient and carer access than initially realised or intended.

Although prescribing clinics held in GP surgeries and during domiciliary visits played a large part of the Phase 3 project work, the time constraints placed on the MRPP to deliver these impacted on the ability to monitor and implement other development. However, the benefits of the domiciliary visits were that patients were more relaxed and could be observed partaking in their usual activity and in their own home environment.
MODEL FOR SERVICE SUSTAINABILITY

Potential Funding Streams to Aid Sustainability
1. Teach & treat
2. Prescribing clinic fund
3. Macmillan
4. Operational Units
5. Boots Company PLC
6. Prescription for Excellence

MRPP Role in Step 2 - 3 Transition
- Contractor Pharmacy Support Required for:
  - Community Pharmacist
  - Specialist in Palliative Care
  - Palliative Care Leadership
  - Training for care home services
  - Drop in clinics, advice/information centres
  - GP Liaison – Boots framework Gold/Silver across Scotland
  - Community Pharmacist mentorship
  - Roll-out of the Boots-Macmillan partnership: communication training, knowledge skills training, and tools
  - Prescribing clinic support

- NHS Highland Support Required for:
  - Advance Care Planning and service co-ordination (Gold Standard’s Framework meetings)
  - Hospice liaison for virtual hospice/hospice outreach
  - Palliative prescribing support
  - Hospital clinical review/admission-to-discharge liaison
  - Care at home involvement: Education for carers (lay & SVQ), HCP and some patients
  - Leadership support: Locality mentor (pharmacy peer support), model scheme, peer review etc.
  - Dispensing practice involvement and support
  - Service development & implementation
  - Integration & liaison

Figure 8: Step Diagram of Project Phases for Sustainability of Service
CONCLUSION

This project addressed areas of activity under two main headings: education & training; and integration of the MRPP. The project success and effectiveness has been well documented and celebrated. The service funding ended in 2016. Moving forward the overarching aims of the MRPP project are aligned with the current direction for PC and Urgent Care in Scotland and will be invaluable to the NHS and the Scottish Government in delivering on the new Strategic Framework for Action on Palliative and End of Life Care (SFA) and implement recommendations from Transforming Urgent Care for the People of Scotland (TUC). Transition of some aspects of the service, using the locally negotiated model of pharmaceutical palliative care service specification, has been implemented, with community pharmacists now recognised as key members of the multi-professional team.

A number of lessons have been learnt over the lifespan of the project, including the feasibility of drop-in clinics within community pharmacy and the limits a lack of time and resource have on the development of work areas and resources. Furthermore, the expected versus preferred and actual route of access to the MRPP and the services they facilitated provided insight into the needs of the community i.e. a more hands-on, person-focused and convenience-based service seems most suitable for this remote community.

Although Macmillan funding for this service has since ceased and continuation of the service, modelled on a single person or persons in a role is no longer operational, the impact of the service being felt in the community is in part being sustained due to the variety of training tools and resources developed and now widely distributed. The project lead has developed a model of service sustainability should resource become available to further develop the service and instil the importance of palliative care at all service levels.
REFERENCES


