Palliative Care Pacesetter

ABMUHB

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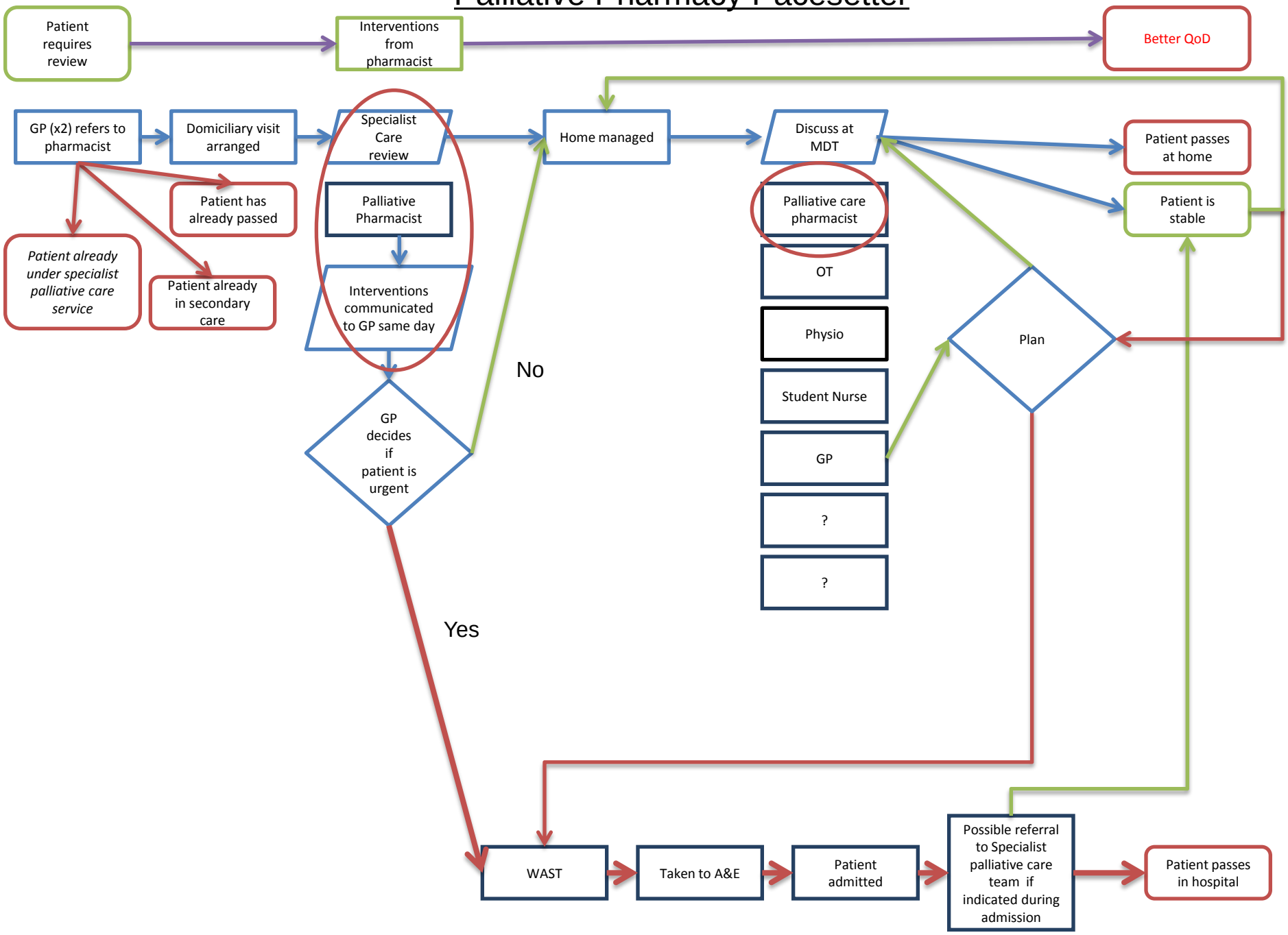
Summary of the Project

Aim: Develop & Improve Quality of Care for Palliative Patients by providing –

- support to the GP workforce to improve care for palliative patients and deliver better outcomes for both cancer and non cancer palliative patients, ensuring their needs are met in an environment that suits them.
- A specialist care review provided at an earlier stage in their palliative care journey to try and alleviate problems and concerns when the patient is nearer end of life.

Project Plan

Palliative Pharmacy Pacesetter



Support practices to achieve Gold Standard Framework for End of Life Care in Primary Care by implementation of 7 key tasks:

- Communication
- Co-ordination
- Control of symptoms
- Continuity of care
- Continued learning
- Carer support
- Care in the dying phase

Handouts:

- GP satisfaction questionnaire
- Patient / Carer satisfaction questionnaire
- Educational needs questionnaire & evaluation form
- Supportive Care Medication Review Form

Why it was chosen

- **'Together for Health –Delivering End of Life Care' document was launched by WAG and all Health Boards to provide palliative care plan up to 2016**
- Most GP practices hold a palliative register but these do not reflect predicted numbers of palliative patients; non-cancer patients are under-represented on registers.
- GSF advocates that all disease states should be provided with palliative care where needed
- GP specialist knowledge is often lacking in this area of care. ABMUHB palliative care conference 2015 was well attended and highlighted a further need for palliative care education and service development.
- A specialist pharmacist is ideally placed to support GPs in Primary Care
- The Gold Standard Framework (GSF) indicates that there are approximately 20 death per GP per year or per 2000 patients per year.

What would Success look like?

1. Practices working to Gold Standard Framework for EOLC in Primary Care, focusing on 7 GSF key tasks for both cancer and non-cancer patients

2. Each palliative patient reviewed to have a tailored record sheet that records all symptoms, problems and issues, with carer comments

3. All interventions, recommendations, advice given will be recorded and communicated in the MDT.

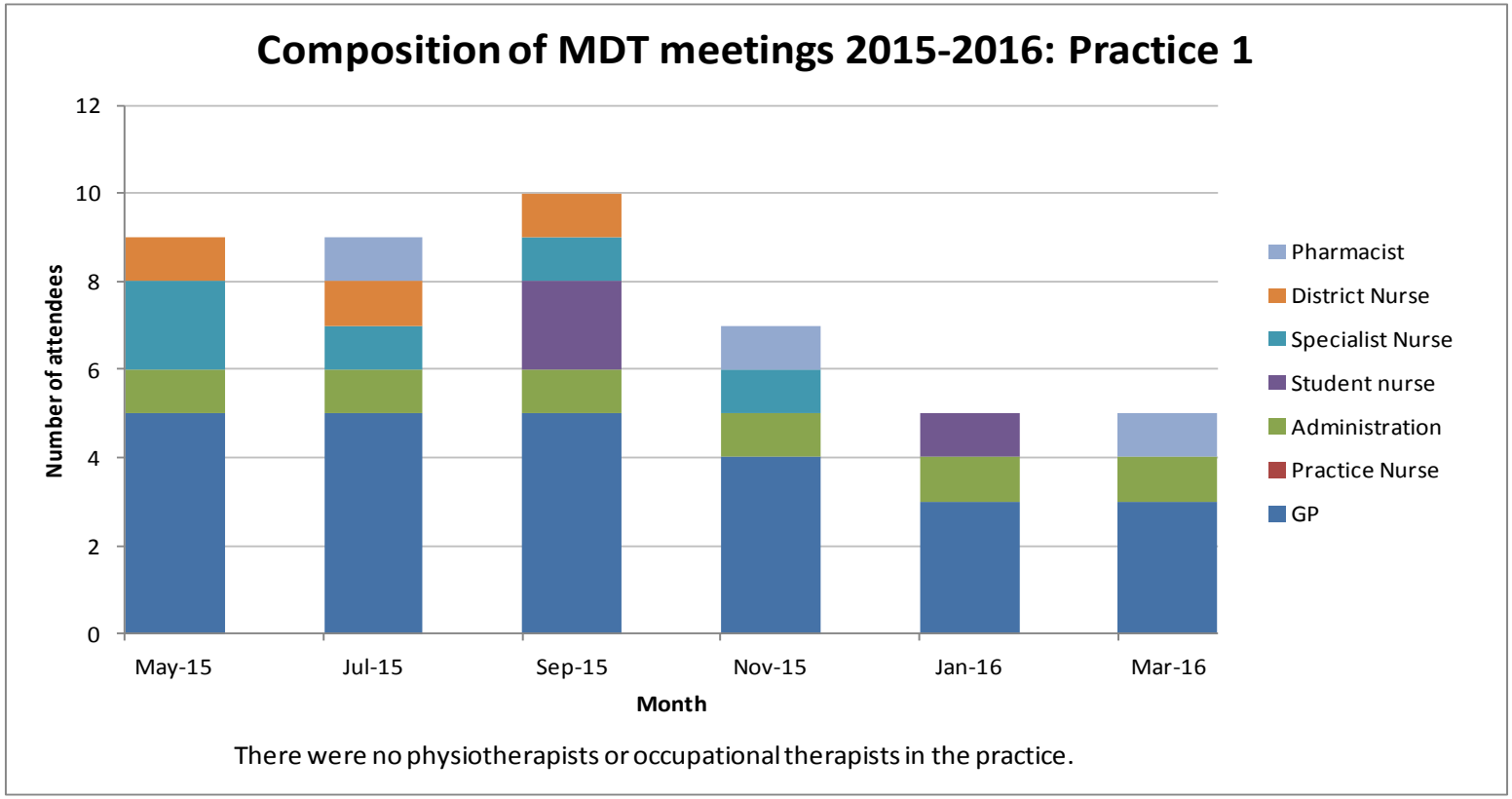
What are the Process Measures?

- Communication - ***Measure:*** numbers on registers and discussed at MDT
- Co-ordination – ***Measure:*** attendance sheet at MDT
- Control of symptoms - ***Measure:*** interventions recorded, fed back to MDT.
- Continuity of care – ***Measure:*** record any communication – *this is a problem for this project as pharmacist not available consistently for patients to access.*

Support practices to achieve Gold Standard Framework for End of Life Care in Primary Care by implementation of 7 key tasks:

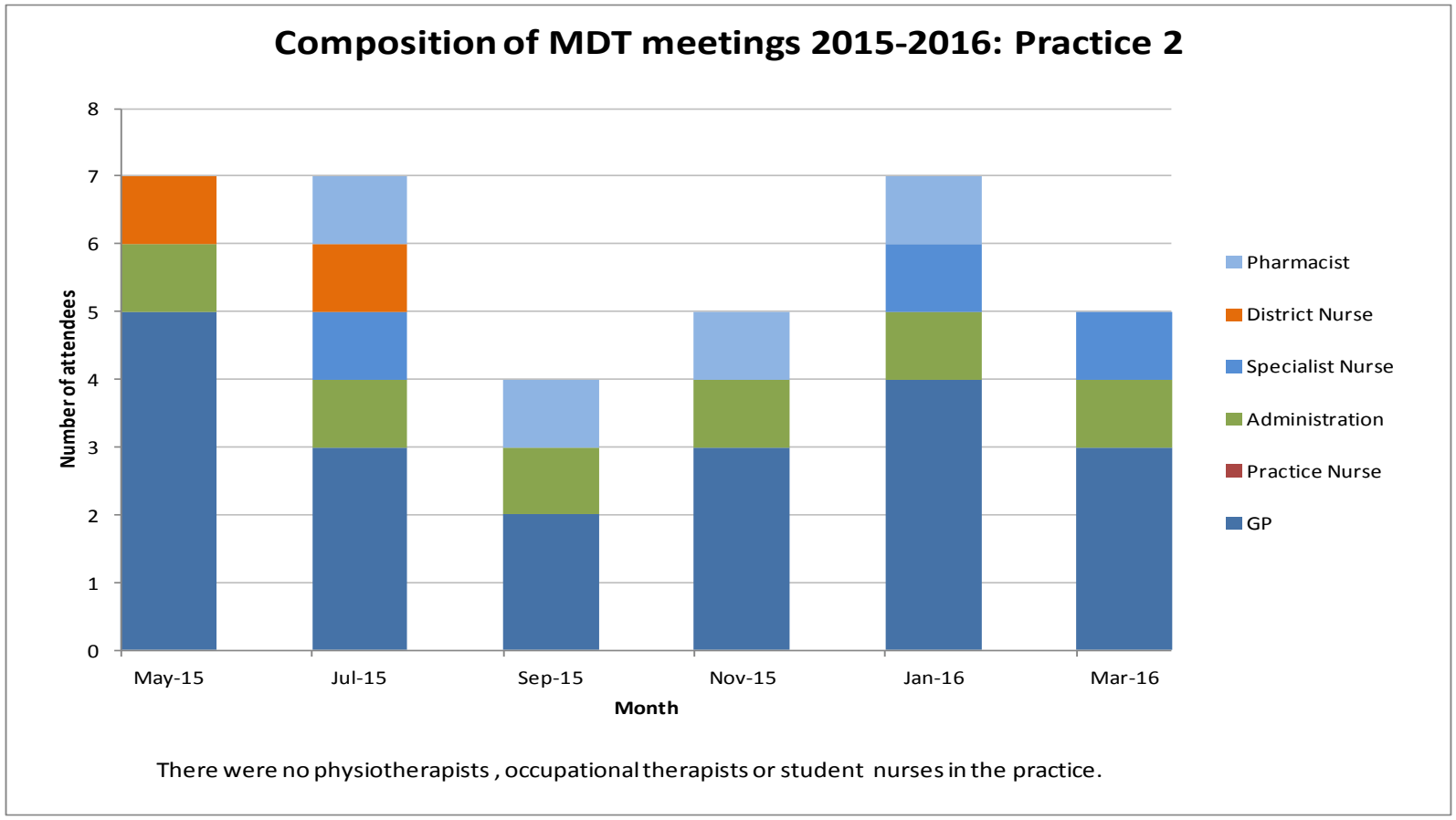
- ✓Communication
- ✓Co-ordination
- ✓Control of symptoms
- ✓Continuity of care
- ❖Continued learning
- ❖Carer support
- ❖Care in the dying phase

	May-15	Jul-15	Sep-15	Nov-15	Jan-16	Mar-16
GP	✓	✓	✓	✓	✓	✓
Administration	✓	✓	✓	✓	✓	✓
Specialist Nurse	✓	✓	✓	✓		
District Nurse	✓	✓	✓			
Pharmacist		✓		✓		✓
Student nurse			✓		✓	
Practice Nurse						



There were no physiotherapists or occupational therapists in the practice.

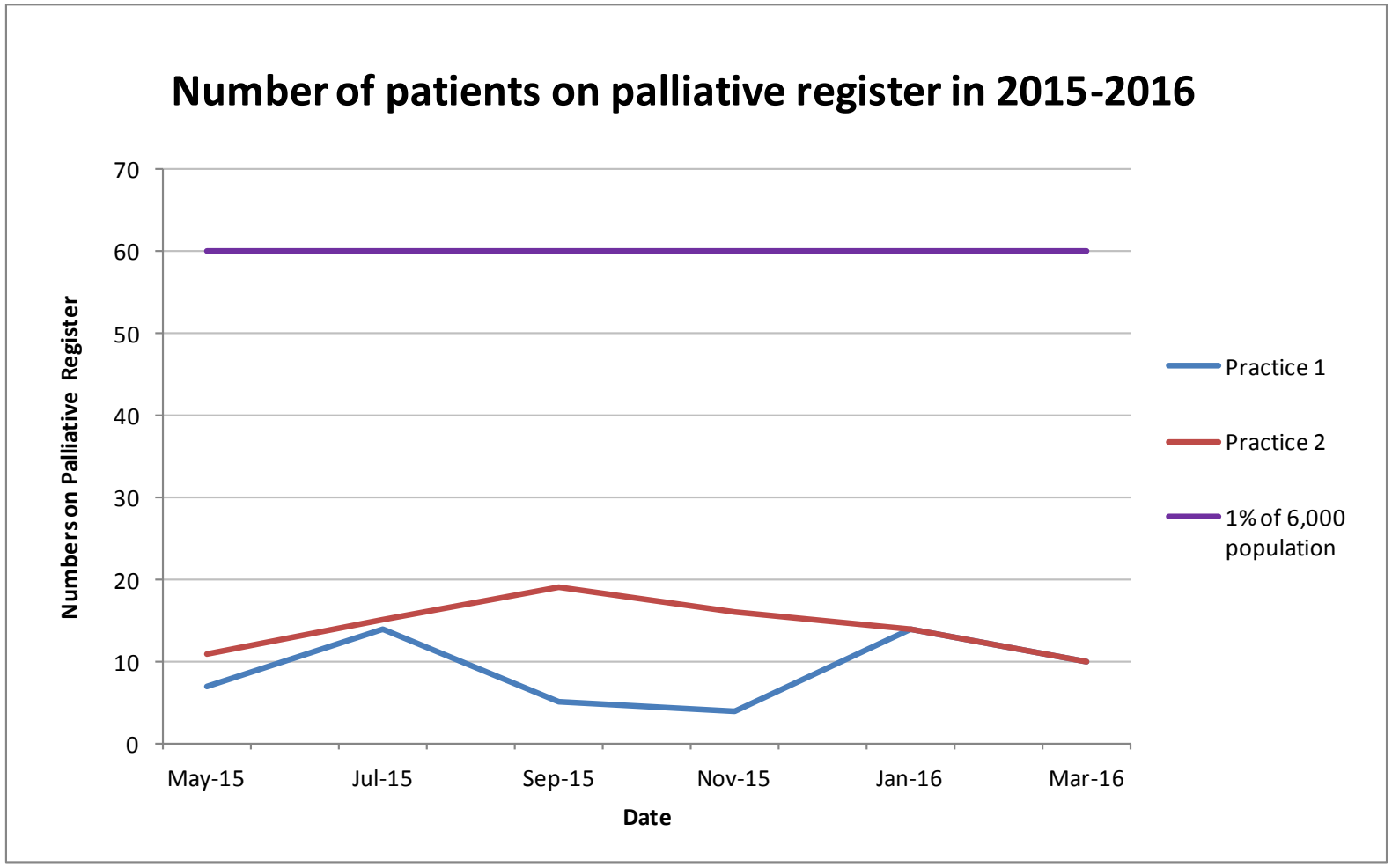
	May-15	Jul-15	Sep-15	Nov-15	Jan-16	Mar-16
GP	✓	✓	✓	✓	✓	✓
Administration	✓	✓	✓	✓	✓	✓
Pharmacist		✓	✓	✓	✓	
Specialist Nurse		✓			✓	✓
District Nurse	✓	✓				
Practice Nurse						

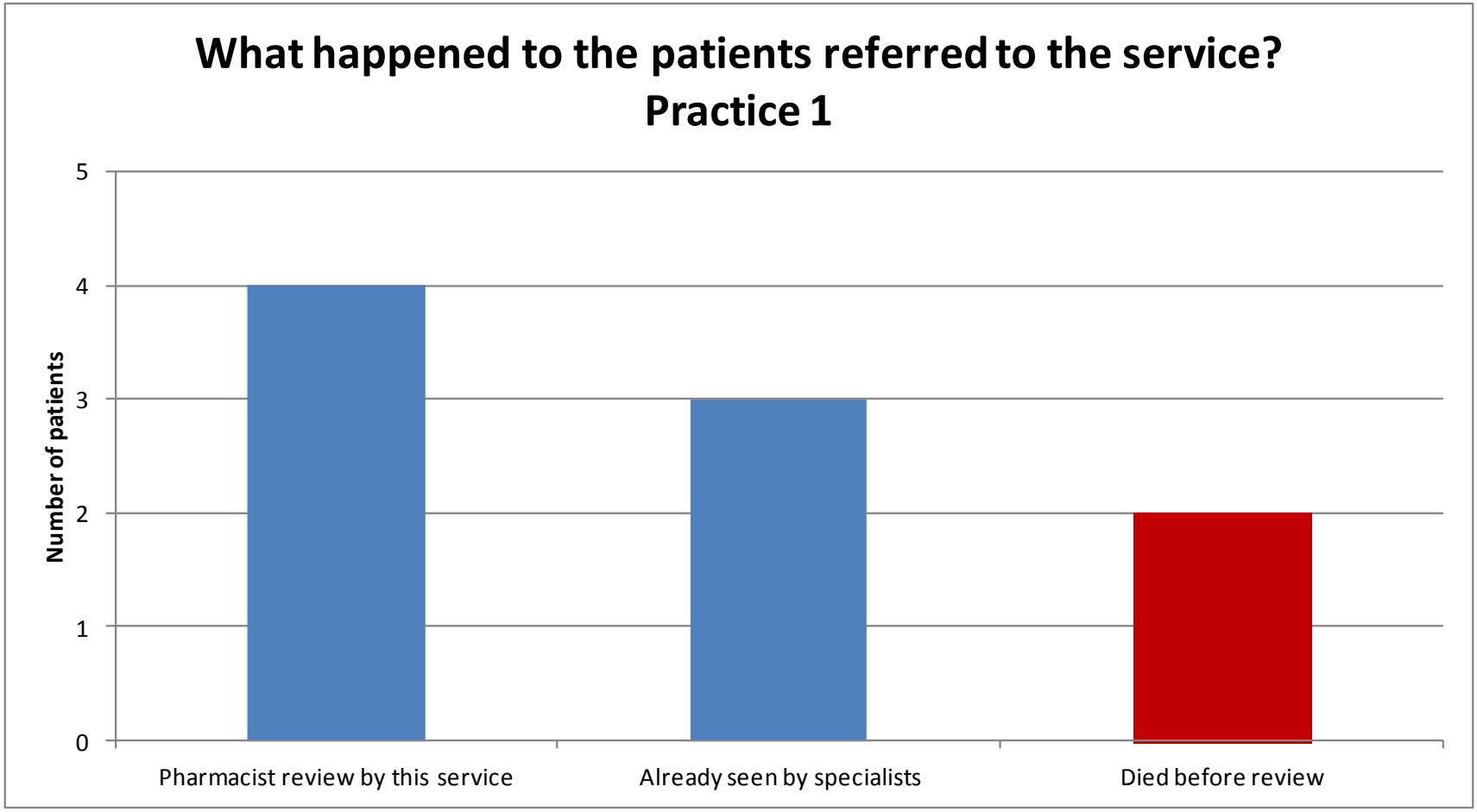


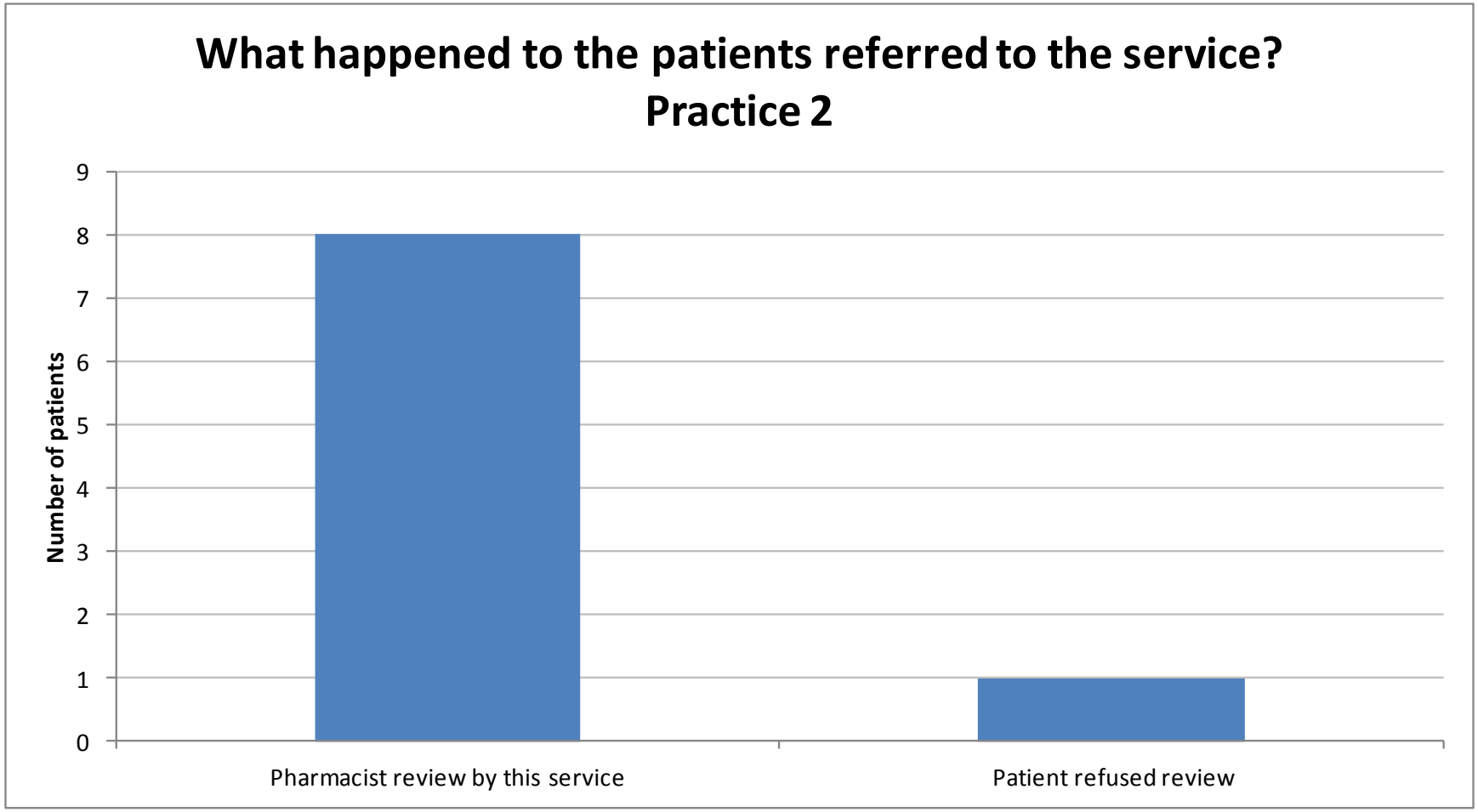
There were no physiotherapists , occupational therapists or student nurses in the practice.

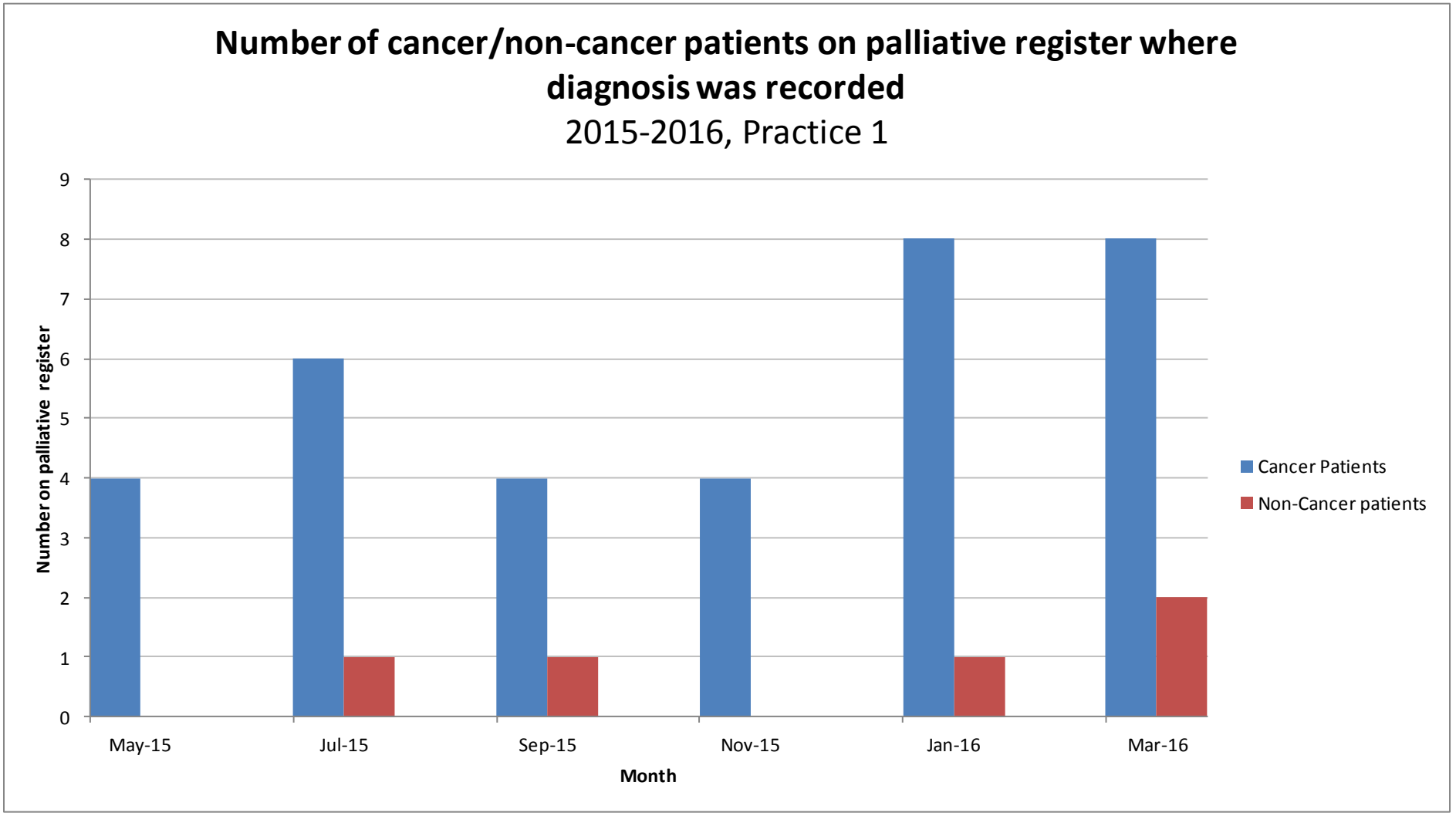
What will be your Outcome Measures?

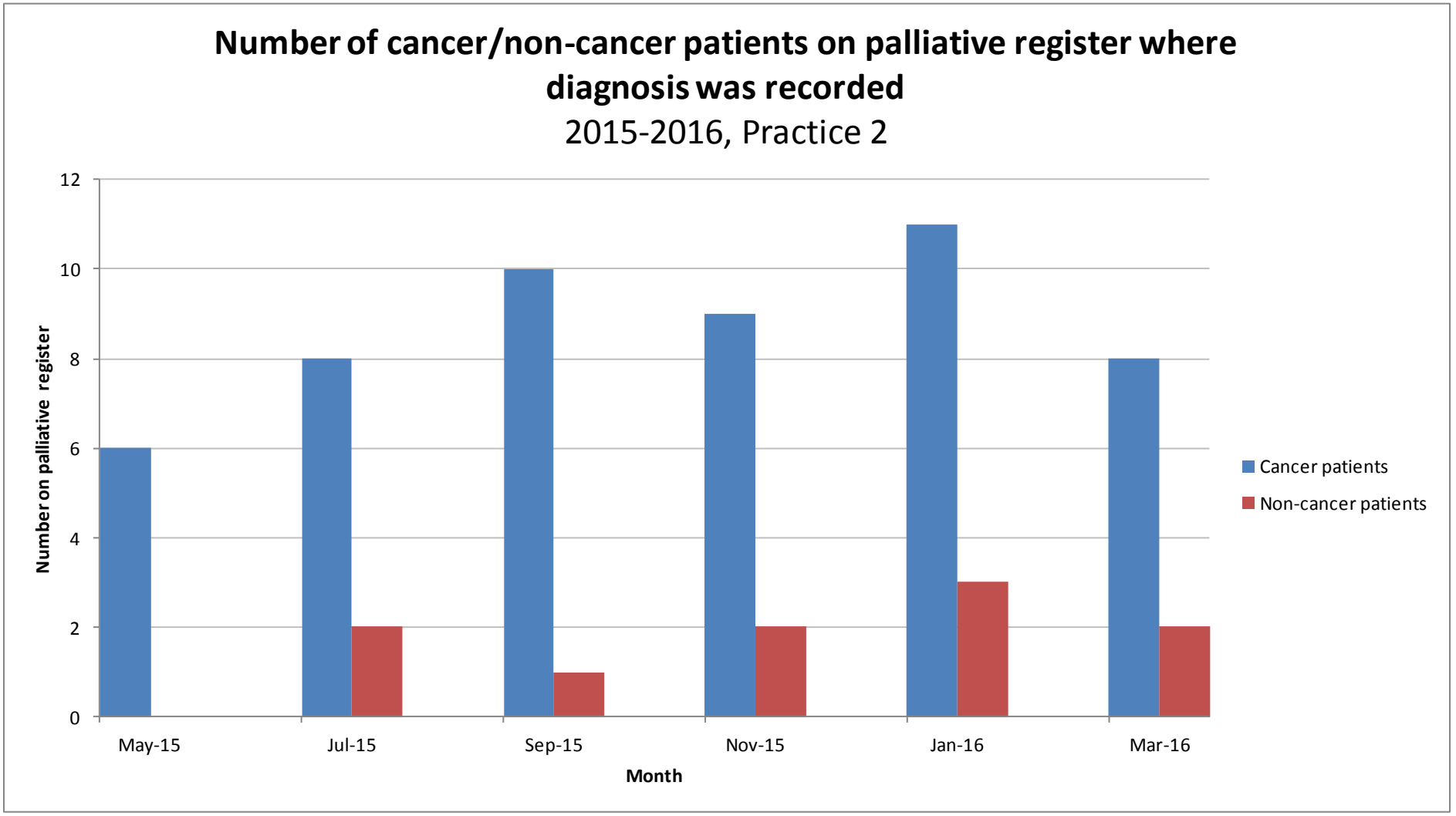
- ✓ Numbers on Palliative register vs practice total patient numbers
- ✓ Numbers on Palliative register with diagnosis recorded
- Number of palliative patients prioritised for MDT by pharmacist – *as pharmacist not in GP surgery daily to review patients being discharged form hospital had to rely on GPs for referrals*
- ✓ Number of medicines interventions made for palliative patients, with details: medicine rationalisation, symptom control advice & referral to appropriate service in line with GSF standards
- ✓ Questionnaire to evaluate patient/carer & GP perception of pharmacist involvement in care
- Qualitative feedback from practice staff on pharmacist input and educational needs assessment – *No reply to educational questionnaire*


Number of patients on palliative register in 2015-2016
70
60
50
40
30
20
10
0
Numbers on Palliative Register
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
Date
Practice 1
Practice 2
1% of 6,000 population


What happened to the patients referred to the service?
Practice 1
Number of patients
5
4
3
2
1
0
Pharmacist review by this service
Already seen by specialists
Died before review


What happened to the patients referred to the service?
Practice 2
Number of patients
9
8
7
6
5
4
3
2
1
0
Pharmacist review by this service
Patient refused review


Number of cancer/non-cancer patients on palliative register where diagnosis was recorded
2015-2016, Practice 1
Number on palliative register
0
1
2
3
4
5
6
7
8
9
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
Month
Cancer Patients
Non-Cancer patients


Number of cancer/non-cancer patients on palliative register where diagnosis was recorded
2015-2016, Practice 2
12
10
8
6
4
2
0
Number on palliative register
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
Month
Cancer patients
Non-cancer patients

Questionnaire feedback

- 4 feedback forms from patients/carers returned
- Completed by relatives
- 3 positive, 1 could not remember review occurring!
- GPs - positive

Supportive Care Medication Review

Balancing measures

- Number of GP consultations for palliative patients - IT support obtained some data but yet to be analysed due to time constraints
- Number of OOH calls from patient – Difficult to collate data, IT support needed and access to OOH data – being sought currently
- Number of palliative admissions – this may need to be reviewed as project progresses – data not easily available, indication for admission not quickly identifiable from data search
- Number of district nurse visits to patient – *is this possible to identify?* –No, records not kept in GP surgeries
- What impact has the pharmacist had on patient/carer learning – can we ascertain this from questionnaires ? Not audited as part of project to date

The Learning

The role would be more successful if carried out by a pharmacist with a more permanent attachment to the GP surgery. This would aid:

- Better identification of appropriate patients
- More opportunity to identify recently discharged patients from hospital that would benefit from palliative review
- Continuity of care – the patient should be able to contact the pharmacist if needed
- Regular access to GP systems and improved understanding of systems and procedures – remote access not available / lack of time to spend learning a complex system. Improved recording of palliative patients is needed, their issues, what actions have been completed, in an easy accessible manner eg: on palliative register, OOH communication, JICB initiated, DS1500 completed – coding needs to be used correctly
- Better relationship building opportunities with MDT if more contact
- Regular GP / nurse access to pharmacist to resolve palliative issues / drug queries / procurement problems - beneficial

Current challenges to roll out in other areas:

- Time!
- IT equipment and system navigation
- GP reluctance to refer
- GP reluctance to increase size of Palliative Care register
- Too many codes on GP system to allow clear identification of what has been actioned for patient from a palliative care perspective – there are *more than 8 different palliative codes at least!* I cannot find consistency in what is used
- GP referring too late
- Early support from IT and project management if to continue as project
- Need referral pathways to OT / Physio / Counselling

Ministerial Priorities

1. Achieving service sustainability √

• Better use of resources & skills for palliative patients in primary care setting

2. Improving access √

• Greater awareness & identification of patients in palliative stages

• Improved responsiveness to palliative needs in community, for both cancer and non-cancer patients

• Professionals have greater access to specialist expertise for palliative stages

3. Moving services from hospitals to community √

• Moving care for palliative stages of long term conditions and cancer into the community

• Greater numbers of patients dying in preferred place of death

Next Steps

- Lack of time to commit further to the project due to new role

- Feedback from the Patients/carers & GPs was very positive, benefits were felt by the patients & carers

- Continued work would provide more patients with the service and more robust data and hopefully a change of culture within GP practices to move towards achieving more of the GSF for palliative care in Primary Care

Discussion – 21st Sept 2016

- Specialist palliative care pharmacist doing reviews in primary care and referring for MDT discussions
- Mainly cancer patients – more predictable decline than organ failure patients
- Hard getting the service off the ground
- Not had sufficient time or support to do as much as liked; no IT support
- GPs reluctant to refer to service as concerns about increasing size of their palliative care register (due to QOF targets)
- Project not proved effective in terms of numbers seen - BUT patients and carers v positive about service and identified some valuable learning in this area; example of innovation that fails as necessary incentives for professionals are not aligned
- Indicates problems with how palliative care register is populated and used
- The need for a review reflects problems with how patients are treated when identified as palliative - why aren't these things happening automatically? Due to range of professionals involved in treatment of cancer – difficult to standardise the pathway
- Palliative care patients need someone who can develop a rapport with patients, so difficult for someone in secondary care with little contact with these patients to do
- Need better referral pathways – to OT, physio, MH counselling
- Referrals to pall pharmacist are made to late for effective interventions and supportive network
- Improvements would promote dying in preferred place of death
- Reference made to the 'just-in-case' box – occasionally used, problems with supply, GPs find cumbersome and restricting to use. All Wales review underway to make more user-friendly; extending use to WAST.
- Potential for this role to be undertaken by non-specialist – need time and structured questions for palliative care; could be done by other pharmacists with support from specialist.
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