Working together to improve end of life care

Consultation on Community Pharmacy Quality Improvement ('Daffodil') Standards for Palliative and End of Life Care

We are consulting on new standards on palliative and end-of-life care for community pharmacy. The consultation will be open for a four-week period from November 1 – December 1 2022

Consultation responses can be completed electronically here or in Word format below. If using Word format, please send consultation responses to daffodilstandards@rpharms.com.

All consultation questions are listed at the end of this document (p8).

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The Royal Pharmaceutical Society has teamed up end-of- life charity, Marie Curie, to launch a partnership to develop professional standards in palliative and end-of-life care for community pharmacy.

The Standards will be available for pharmacy teams across the whole of the UK and will provide a free, evidence-based framework to help community pharmacies self-assess and continuously improve their palliative, end-of-life and bereavement care for patients and carers.

They will enable community pharmacy teams to work together to develop their practice. These standards will align with the established Royal College of General Practitioners (RCGP) and Marie Curie 'Daffodil Standards for advanced serious illness and end of life care' for GP Practices.

Community Pharmacy & Palliative Care

People living with life-limiting conditions and palliative care needs will have some basic expectations and having timely access to medicines and clinical support from a skilled pharmacy team are amongst them.

This support may involve providing information about any new medicines started to help manage symptoms, and an explanation and reassurance about medicines that are stopped (where the benefit:risk balance suggests that it is the best thing to do).

Other key contributions that Community Pharmacy can make in palliative or end-of-life care include:

- advice on administration of medicines should swallowing become a problem e.g. availability of liquid formulations, patches;
- dealing with medicines supply chain issues where they arise;
- helping with monitoring the wellbeing of the patient and their carer(s) through their regular contact and accessibility;
- helping with signposting to the right support to meet the needs of the patient or their carer(s), by working with the local multi-disciplinary team.

Developing the draft standards

The current draft standards are based on evidence and the views and experience of those who are involved in community pharmacy and palliative and end-of-life care.

To complement a robust review of existing UK and international evidence and literature on the subject, the main source of expertise that have informed the standards to date has been a steering group consisting of community pharmacy experts, and other healthcare professionals with expertise in palliative and end-of-life care.

Regular input and advice has also been provided by the RPS Community Pharmacy Expert Advisory Group. Input has also been sought by those who have experienced palliative and end-of-life care from a patient/family perspective, as well as other relevant stakeholders with a community pharmacy and/or palliative or end-of-life care remit.

Putting the standards into practice

The draft standards cover eight core areas (see below). The community pharmacy will deliver the eight standards through a range of activities, as summarised in the table below. The standards are a focus for quality improvement and reflect good practice in palliative and end-of-life care delivery, with a medicines management focus. There is no formal accreditation process but a self-assessment and continuous quality improvement approach.

The standards reflect good practice and can be applied to a whole population affected by palliative and end-of-life care and bereavement, or a pharmacy can choose to focus on a particular standard of interest or a cohort of people.

It is recognised that the standards should not be too onerous for community pharmacy to achieve, and evidence gathered can be used for multiple purposes (E.g continuing professional development or inspections).

The standards should also be inclusive and available for us by everyone working within community pharmacy, including individual locum pharmacists. Therefore, the final published standards will be available for individuals to ‘sign up’ and complete those standards that can be met by an individual locum pharmacists (see column in the table).

Supporting to put standards into practice

The final published standards will be accompanied by a range of supportive materials, similar to the resources supplied as part of the RCGP standards.

The draft standards

Daffodil Standard (as per and consistent with RCGP standards)	Community Pharmacy can:	Applicable to Individual Pharmacist?	Additional Information or Clarifications to Note
1. Professional and competent clinical and non-clinical staff required to provide high quality, safe and compassionate care in Advanced Serious Illness and end of life care.	1.1 Ensure that each staff member understands their role and responsibility for Advanced Serious Illness, Life-limiting illness or end of life care. 1.2 Ensure all staff are able and confident to communicate effectively with people who have palliative care needs (and their carers). 1.3 Identified pharmacy champion for Palliative and end of life care.	√ √	Named champion could be a pharmacist, pharmacy technician or dispenser. Access to appropriate training for <u>all</u> staff will be supported by the project team working collaboratively with education providers across the UK. The final product will also signpost to existing -e-learning materials and resources.
2. There is early identification and recording that a person has an Advanced Serious Illness or EOLC needs	2.1 Develop multidisciplinary team working so that pharmacy is aware at an early stage of a patients' status, potential support needs and their identified multi-disciplinary team members and how to access them. 2.2 Ensure appropriate documentation and sharing information <u>within</u> the pharmacy to help identify and prioritise the needs of a patient e.g. patient medication record.	√	A common challenge facing pharmacies is a lack of communication and "IT system" interoperability for sharing health information. Access to electronic health records and the ability to record pharmaceutical interventions and information gleaned from patients or their carers, remains limited. This results in the pharmacy team having to rely on informal

			systems and often being unable to provide the most effective contribution.
3. Carer Support – before and after death	3.1 Identify any carer(s) in a timely fashion 3.2 Structured approach to identification of carers' needs.	√	The carer is often required to manage a complex medicines regimen and pharmacy support with advice and information can improve quality and safety of medicines administration. The project team will develop tools to support a structured approach.
4. Seamless, well-planned, co-ordinated care	4.1 Provide information to patient/carer re: use of medicines (new and existing). 4.2 Engage with multi-disciplinary team meetings and/or local communication systems where in place (and share information across the multidisciplinary team). 4.3 Collect (and share) data on medicines-related issues for individual patients.	√	A template is planned for <u>local</u> team details to be shared. Patient/carer understanding of medication, any changes and how to optimise outcome. Recognition of care contributions across **all** settings. Consistent messaging for individual with palliative and end-of-life care and EOLC needs and their family/carers.
5. Care is based on the assessed unique needs of the patient, carer and family	5.1 Requests sharing of advance/future care plan (where available/relevant). 5.2 Implement individual medication review and medicines optimisation-personalised, holistic and reflective approach.	√	A clear and structured medication review is desirable to address the individual needs.

			Holistic support including home situation, non-medicinal needs e.g. oral hygiene.
6. Quality care during the last days of life	6.1 Proactively manage medicines supply chain. Stock holding/access/signpost as locally agreed. 6.2 Identify and advise/address (within own level of competence or refer) any issues with medicines use and administration e.g. swallowing, formulations. 6.3 Reflect on lessons from individual care to improve future care provision (and share within pharmacy and MDT).	√	Robust and timely medication supply is a key concern from carers. Local/national challenges re: supply availability and robust local information sharing.
7. Care after death and bereavement support	7.1 Have understanding and be able to provide individuals with information or signpost to grief and bereavement. support, using appropriate local resources 7.2 Stop repeat medication supply, as appropriate. 7.3 Handle returned medicines compassionately.	√ √ √	Acknowledge death with carer(s). Signpost as needed.
8. General Practice as a hub within Compassionate Communities	8.1 Support the development of compassionate communities.		"Compassionate communities" is a specific initiative currently under development. It is built on a combined ethos of a Public Health Approach to Palliative and End of Life Care and Community Development. The community pharmacy will also consider the wellbeing needs of staff members and the

			impact of dealing with bereaved carers.

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1. Will the standards help improve the quality of palliative and end-of-life care delivered through pharmacies?

   YES/NO

   Whilst the Company Chemists' Associations' supports the RPS' ambitions to improve standards for those receiving palliative or end of life care, we do not believe that these standards will sufficiently support those ambitions. We think the standards suggested will lead to duplicative and confusing 'checklists' for pharmacy professionals to consider when providing care.

   A number of existing standards, set by the General Pharmaceutical Council, support pharmacists to provide safe, effective and person-centred care to people receiving end-of-life care and their carers. For example, GPhC standards 1 (providing person-centred care), 2 (work in partnership with others), 3 (communicate effectively), 5 (use professional judgement) cover the majority of the intended outcomes of the Daffodil standards.

   We're also concerned about the potential unintended consequences or liabilities resulting from the imposition of these standards. These standards have potential to introduce additional reference points against which pharmacy professionals may be challenged externally (e.g in a coroners hearing) in the event of incidents beyond a pharmacists control, such as delay in the supply of medication.

   We think a better way to promote higher standards of care in community pharmacy for patients receiving palliative and end-of-life care would be for funded CPD training, and additional learning programmes through the Centre for Postgraduate Pharmacy Education. We would also support, in principle, the RPS development of best practice examples, case studies, or guidance to support pharmacy teams in delivering effective and compassionate care to those at the end of their life.

2. Are the standards

   - pitched at the right level *YES/NO*
   - clear about what should be achieved *YES/NO*
   - flexible enough *YES/NO*
   - achievable *YES/NO*
   - sufficiently aspirational? *YES/NO*

   If you answer 'no', please provide further comments:

   As mentioned above, we support the ambition and outcomes behind the majority of the standards listed above. We think the better way to change

outcomes and drive improvements in care would be to link these to GPhC standards, with best practice guidance on how pharmacy professionals could better meet those standards (set by the GPhC) tailored for EoLC and palliative care patients produced by the RPS.

3. Do the standards cover the important aspects of palliative and end-of-life care for community pharmacies?

   YES/NO

   Further comments:

4. Will the standards encourage collaborative working between Community Pharmacy and other key providers of palliative and end-of-life care support e.g. General Practice?

   YES/NO

   Further comments:

5. Do you have any specific comments on the any of the individual standards? If so please note them below.

   Standard 1 Comments:

   We think a better approach would be for each pharmacy to have an appropriately number of trained staff. We therefore assume that once a pharmacy has an identified pharmacy champion for palliative and end-of-life care (standard 1,3), then standards 1.1 and 1.2 are not required.

   Standard 2 Comments:

   Standard 2 sets unrealistic expectations for how closely pharmacists can work with other healthcare professionals as part of a multidisciplinary team. Unless all MDT meetings take place virtually, then it is extremely unlikely that an RP would be able to attend during the hours when their pharmacy is operating.

   Community pharmacists are typically not involved in a patient's palliative care until the pharmacy receives the prescription, and there is little value in a community pharmacist being involved prior to this point.

   GPhC standard 2 already sets out how pharmacists are expected to work in partnership with others, including by:

- identifying and working with the individuals and teams who are involved in the person's care
- contacting, involving and working with the relevant local and national organisations
- demonstrate effective team working
- adapt their communication to bring about effective partnership working
- work with others to make sure there is continuity of care for the person concerned

However, we agree with the RPS comments that access to electronic health records and care plans and the lack of interoperability between different IT systems across the health service makes it more difficult for pharmacists to provide the most effective information. We would support further consideration on this matter from pharmacy commissioners and the Government.

Standard 3 Comments:

Whilst we recognise the importance of carers being involved the management of medicines at the end of a person's life, we think the needs identified are appropriately addressed by the GPhC. For example, standard 3 of the standards for pharmacy professionals state that pharmacists should:

- identify and work with the individuals and teams who are involved in the person's care

- communicate effectively with others involved in the care of the person.

We would welcome RPS guidance or tools which would help pharmacists and others to structure conversations with carers appropriately.

Standard 4 Comments:

We do not believe 4.1 should be a separate standard, it is already covered under existing GPhC standards. We would express concern should pharmacists not be providing this information.

Under GPhC standard 1, pharmacy professionals must provide person-centred care, including by:

- involving, supporting and enabling every person to make decisions about their health, care and wellbeing
- giving the person all relevant information in a way they can understand, so they can make informed decisions and choices

For standards 4.2 and 4.3, please see standard 2 comments.

We are unclear about the intent of the proposed template for sharing local team details. We would need further information on who will compile the list and own the data. If each pharmacy must do this there will be considerable duplication of effort and scope for error

Standard 5 Comments:

We believe these standards are already captured under GPhC Standard 1: Pharmacy professionals must provide person-centred care, including:

- involve, support and enable every person when making decisions about their health, care and wellbeing
- listen to the person and understand their needs and what matters to them
- give the person all relevant information in a way they can understand, so they can make informed decisions and choices

Standard 6 Comments:

Whilst recognising the importance of ensuring patients have timely access to medicines, there are circumstances outside of a pharmacist's control which may mean this is not always possible, and we would be concerned about any unintended consequences of listing this management of the medicine supply chain as a standard.

If medicines are not available due to circumstances beyond the pharmacy team's control, the alternative is to encourage pro-active engagement with the prescriber.

This is covered by GPhC standard 5, which states that pharmacy professionals must use their professional judgement. Under this standard, pharmacy professionals should:

- use their judgement to make clinical and professional decisions with the person or others
- have the information they need to provide appropriate care

Standard 7 Comments:

We believe this is best covered by GPhC standard 3 which states that pharmacy professionals must communicate effectively, including by:

- adapting their communication to meet the needs of the person they are communicating with

Standard 8 Comments:

We would need further detail on how this standard could be achieved. Our understanding from the RCGP standards and the information in this document is that this standard would focus on support from employers to staff. As a general principle, we think this is best decided by the employers themselves and does not require professional standards.

We would also wish to seek clarity on the definition of community pharmacy in this context, in particular, does the 'community pharmacy' mean the building, the staff, the professionals, the RP/SP or the business owner?

Please ensure to provide the following information with your response:

Are you responding as an individual or on behalf of an organisation?

If organisation:

Name of organisation: Company Chemists' Association

If individual response:

Your name & role:

Thank you for responding to the consultation. Please send your consultation response to Daffodilstandards@rpharms.com.