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

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Introduction

The Pharmaceutical Services Negotiating Committee (PSNC) promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health and Social Care as the body that represents NHS pharmacy contractors. We work closely with Local Pharmaceutical Committees (LPCs) to support their role as the local NHS representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

We welcome the opportunity to be able to provide our response to the Consultation on Community Pharmacy Quality Improvement ('Daffodil') Standards for Palliative and End of Life Care (PEoLC).

Response

Community pharmacies aim to provide the best possible care for all patients and service users in the communities that they serve. In doing so, they will always seek to provide excellent care to people living with life-limiting conditions and palliative care needs, and their carers.

The proposed standards appear to sit outside the context of a commissioned pharmacy service. While they are proposed as being available for pharmacy teams across the whole of the UK, they make no reference to locally commissioned PEoLC services and the requirements that may already be in place within NHS contractual frameworks.

The setting of a standard brings with it an expectation, internally within the profession and externally, that pharmacies will be aligned to it. We would question whether it would be more appropriate for the document to be described as guidance to community pharmacy, as we believe the setting of standards is a role solely for the General Pharmaceutical Council.

The standards highlight the expectation that people living with life-limiting conditions and palliative care needs should have timely access to medicines and clinical support from a skilled pharmacy team. We agree with that statement and believe this is core to what community pharmacy seeks to achieve, regardless of the type of medicines being dispensed.

However, there appears to be no consideration as to how the workload associated with adherence to the proposed standards will be supported or remunerated. Most of the proposals within the document will remain aspirational unless they are supported by appropriate funding. We recognise that the Royal Pharmaceutical Society (RPS) has been vocal on the need for there to be fair funding for community pharmacies to provide the current services that patients and the NHS need. It follows that appropriate funding would also be required to support adherence to any new standards expected of community pharmacies.

While many local NHS organisations do commission PEoLC services, which may support adherence to some of the proposed standards, such services involve stockholding of a locally agreed formulary of PEoLC medicines, and they are deliberately not commissioned from all pharmacies. The number of pharmacies commissioned to provide such local PEoLC services is not monitored nationally by the NHS, so it is not possible to identify the impact this local commissioning could positively have on supporting adherence with the proposed standards.

Externally, the implication of setting a standard is that stakeholders, such as general practice and patient support groups, will expect that all pharmacies will adhere to the standards. This could result in unintended reputational damage to the sector when pharmacies are perceived not to be adherent with the standards.

In conclusion, while we support the principle of driving improved care for people living with life-limiting conditions and palliative care needs, and their carers, we question the appropriateness of introducing any standards where the necessary funding to implement the standards within community pharmacies cannot be guaranteed.

Additionally, where standards or guidance are issued by the RPS and there will be a need for resources to support their implementation, be those resources financial or practical tools for use by pharmacy contractors, there should be a clear acknowledgement of this in the document, so all readers are clear about the potential barriers to adoption, including those which are outside of the control of pharmacy contractors.

We provide specific comments on the individual draft standards below.

Standard 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.

There is a reference to appropriate training for all staff being made available by the project team working with education providers across the UK. Committing to undertaking, currently unspecified, training presents an unquantifiable workload and financial burden for pharmacy contractors which is simply not realistic with the current levels of NHS funding for community pharmacy.

The suggestion of there being a pharmacy champion for PEoLC also adds an additional burden to community pharmacies, as there will be expectations on the initial and ongoing development of those individuals. Given the current workforce pressures in the sector, this is an unrealistic expectation and an additional unfunded training burden. Appointing a 'champion' also has the potential to mean that work is inappropriately viewed as being 'owned' by one individual, rather than responsibilities being shared across all team members.

Standard 2 - There is early identification and recording that a person has an Advanced Serious Illness or EOLC needs

The aim of this standard is entirely laudable, but such a standard should not apply until NHS IT systems, such as the NHS Summary Care Record and local Shared Care Records, include an appropriate Advanced Serious Illness or end of life care needs flag which is accessible to community pharmacy teams and which can be automatically imported into community pharmacy clinical records systems.

This would require the development or adoption of appropriate data standards within all relevant IT systems, with appropriate support and funding being provided by the NHS to allow IT system suppliers to implement the functionality within their systems.

The principle of community pharmacists and their teams working collaboratively with other local health and care providers, as part of multidisciplinary teams, is to be encouraged. However, the NHS in England has spent several years and made very significant financial investments in supporting multidisciplinary working across Primary Care Networks (PCN), but none of that funding has been directed towards developing and supporting teamworking between community pharmacies and the general practices making up PCNs. The development of effective teams requires the investment of time by all involved, ideally in the pursuit of shared endeavours, such as improving the provision of PEoLC services across a local network of providers. The investment of time inevitably also requires a financial investment to be made by health and care providers, and that must be funded by the NHS.

Standard 3 - Carer Support – before and after death

While pharmacy teams may be able to identify some carers, through their interactions with individuals, this is an inevitably piecemeal approach which could not easily meet the proposed requirement to identify any carers in a timely manner. General practices currently have a more formal expectation to record the details of carers in patient records and as with Standard 2, we believe the NHS should take action to allow this information to be shared across

NHS IT systems and providers, rather than placing a burden on all pharmacy and other healthcare teams to maintain a multitude of local records relating to carers.

The concept of working through a structured process to identify a carer's needs may have merit, but the burden this would have on pharmacy teams is currently unclear and any such additional workload would need to be appropriately funded by the NHS.

Standard 4 - Seamless, well-planned, co-ordinated care

Engagement with multi-disciplinary teams and the completion / collection of data to be shared with local teams is currently an unfunded activity and in addition to the need for this to be funded before such a standard would be appropriate to be introduced, there would also be a need for community pharmacy IT systems to be developed, with this being directly funded by the NHS.

Standard 5 - Care is based on the assessed unique needs of the patient, carer and family

Community pharmacists could provide a medication review for people living with life-limiting conditions and palliative care needs, however such a service would need to be commissioned by the NHS. Structured Medication Reviews (SMR) in general practices are funded via the PCN Directed Enhanced Service and community pharmacy has no access to this funding stream. Additionally, the outcomes from SMRs are not routinely shared with community pharmacists.

Standard 6 - Quality care during the last days of life

The PEoLC Action Plan criterion in the 2022/23 and 2023/24 Pharmacy Quality Schemes (PQS) aims to ensure there are sufficient arrangements in place so patients and their relatives/carers and healthcare professionals can obtain PEoLC medicines in a timely manner. The PQS criterion will allow the identification of pharmacies, via NHS Service Finder, that stock 16 recommended medications used in PEoLC. The list of 16 medicines, plus parenteral haloperidol, was developed for NHS England by clinical experts in the PEoLC field, including specialist pharmacist input into this process.

The PQS criterion will support the proposed Standard 6.1, however it does largely rely on either the goodwill of pharmacy contractors holding the stock of those medicines or this being supported through locally commissioned PEoLC services. At present, there can be significant local variation in the formularies adopted by these local services and we suggest there should be a national recommendation to align the local formularies with the nationally recommended 16 + 1 medicines. Over time, this would provide a more robust and easily identifiable network of community pharmacies stocking these essential medicines across England. It could also support the national provision of associated guidance, related to any issues with medicines use, availability and administration, e.g. swallowing and alternative formulations, to be issued.

The implementation of voluntary standards related to the stocking of PEoLC medicines could potentially result in confusion where local PEoLC services are in place, with varying compliance with the standards at contractor level. It might be more appropriate for local commissioners to consider the inclusion of some of the proposed standards as requirements in local services, thus providing a route via which some of the burden associated with the chosen standards could be funded by the NHS.

Standard 7 - Care after death and bereavement support

Responding compassionately following a death, stopping repeat medication supply and taking back returned medicines would all reflect standard practice within community pharmacy, so they do not seem necessary to include

in the standards for quality improvement. The RPS could helpfully collate information on signposting options that community pharmacy teams could use with carers and relatives requiring more support.

Standard 8 - General Practice as a hub within Compassionate Communities

As “Compassionate communities” is currently an initiative under development, it is unclear how or whether it would appropriately fit within the community pharmacy standards. As such, it seems premature to include such a, currently undefined, requirement in the standards.