

Palliative Care and the GMS Contract Quality and Outcomes Framework (QOF)

Guidance Paper – 1st March 06 Version 1.10

As from April 2006, with the new GMS contract, there are additional QOF points for palliative care:-

- 3 points are awarded for holding a **palliative care register**, i.e a register of those patients thought to be in need of palliative/supportive care or in the last year or so of life;
- 3 points for reviewing those patients on the register at a **multidisciplinary team meeting** (MDT) at least three monthly.
- Other points related to care for patients with advanced disease such as dementia etc

All the templates and tools needed to begin this work, and to claim the new palliative care points are available on the GSF website: http://www.goldstandardsframework.nhs.uk/gp_contract.php

This is also the basis for the first level of the **Gold Standards Framework Programme**, a programme for community palliative care that has been running since 2001 and is now being used by one third of practices in England. The programme has been shown to lead to real improvements in care for this group of vulnerable patients, as well as to better organised care and improved team working. It also leads to more people dying in their place of choice (56% of people would choose to die at home, yet only about 24% do so). Therefore, by setting up your register and the MDT meetings, you will not only be earning the QOF points, but will also begin to see the benefits for your team and for your patients.

Summary for Primary Care Teams

1. Why do it?

- a. Almost 1% of your patients die each year, some with an unrecognised palliative care phase-how can we ensure best care for these patients? Use of this framework for community palliative care, GSF, has been recommended as an example of best practice by NICE, RCGP, NHS End of Life Care Programme and recommended in the recent White Paper.
- b. You and your team will enjoy improved team-working, communication and job satisfaction by providing high quality, well organised care, and enabling patients and their families to receive best care at this most crucial stage. More patients are enabled to die at home, if they wish, with fewer hospitalisations.
- c. Practices who are using GSF well, find that more of their patients are enabled to die at home if they wish, with fewer hospital admissions.
- d. You can claim at least 6 QOF points, and other points for doing all of GSF, and some areas have a palliative care Locally Enhanced Service (LES).

2. What to do

- a. **Identify** your patients in need of palliative care life including non-cancer patients. Use the triggers in the Prognostic Indicator Guidance (PIG) paper, to approach your prevalence figures
- b. Set up a palliative care **register** of these patients – eg using GSF templates.
- c. **Meet** to discuss, review and plan care for these patients, using for example the suggested meeting plan (this can be part of your usual MDT meeting). This is the first level of GSF.

3. What next?

- a. Join the GSF Programme to build on this the first level of GSF detailed in the QOF - contact us or your End of life Care Lead for Facilitator details - info@goldstandardsframework.co.uk or info@eolc.nhs.uk
- b. The benefits are that you will be part of the national and local momentum, develop key areas further (C2-7 of the GSF programme), receive resources, and access further developments
- c. Consider regular review of all your patient deaths eg After Death Analysis/ SEA.

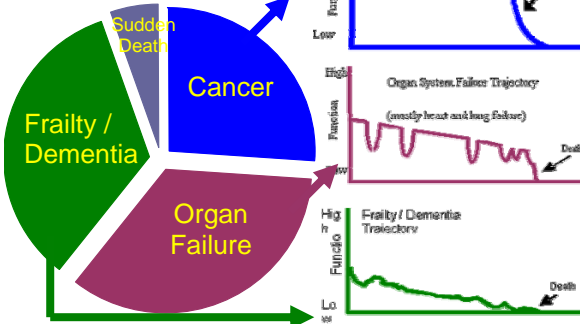
4. What about practices already using GSF?

- a. Continue using GSF, review regularly, and mainstream as a practice protocol.
- b. Include more non-cancer patients on the register, to approach the predicted prevalence figures. Audit regularly.
- c. Extend to further levels of GSF eg Advance Care Planning, GSF in Care Homes etc.

Getting Going

a) Identification of patients – Identify your patients in need of palliative care, including non-cancer patients, using the 3 triggers below (and the PIG paper). The palliative care register should include all patients in the last 6-12 months of life, and this will be reflected in the prevalence figures. Each GP may have approximately 20 patients dying each year; about 5 with cancer, 6-7 with organ failure (heart failure, COPD, renal failure etc), 6-7 with general frailty and decline, and only 1-2 sudden deaths. For those for whom we have some time to prepare, we need to be able to put things in place to best support them and to deliver the kind of care they would wish for... the kind of care you would wish for yourself or your family.

GP's Workload – Average 20 deaths/GP/yr (approximate proportions)



About 1% of your population will die each year ie 1% are in their last year of life- can we try to identify these patients, assess their needs and preferences and plan to help give them best care in their final year of life?

About a quarter will die from cancer - these are the traditional patients you might think of when considering palliative care
About a third will die from organ failure eg heart failure, COPD
About a third will die from multiple organ failure, frailty/ dementia
About a twelfth will die suddenly with little or no warning

Suggestions are available in the GSF Prognostic Indicator Guidance Paper on how best to identify these people – see www.goldstandardsframework.nhs.uk/gp_contract.php. Teams who haven't been using GSF or are only beginning to develop a Palliative Care Register may find it easier to begin with their cancer patients and then add in other non-cancer patients later. It may be harder to recognise the other non-cancer dying patients unless you actively seek them out or apply the 'Surprise question' to more seriously ill patients, and yet they outnumber cancer patients three to one. We are not suggesting that all elderly frail patients should be included on the register unless they fulfil the criteria of need or predicted decline. Certainly more Heart Failure/ COPD patients should be included. Eventually the register should be for all patients estimated to be in their last year of life or in need of palliative/supportive care.

Three triggers for Supportive/ Palliative Care - to identify these patients we can use any of the following methods:

- 1. The surprise question**, "Would you be surprised if this patient were to die in the next 6-12 months" - an intuitive question integrating co-morbidity, social and other factors.
- 2. Choice/ Need** - The patient with advanced disease makes a **choice** for comfort care only, not 'curative' treatment, or is in special **need** of supportive / palliative care.
- 3. Clinical indicators** - Specific indicators of advanced disease for each of the three main end of life patient groups - cancer, organ failure, elderly frail/ dementia (see Prognostic Indicator Guidance paper on website)

b) The Palliative Care Register – Two register templates are suggested in the GSF Programme. The well used Summary sheet of all palliative care patients, the SCR1, can act as a checklist to record, plan, and monitor patient care. It reminds us, for example, to make sure that the DS1500 has been completed, and that the out of hours service has been informed about these patients, to consider patient choice with regards to place of care etc. This encourages us to have those sometimes difficult and complex discussions around end of life issues, including where they would like to be cared for. The SCR2 sheet includes factual information about each patient, and can be used as a Handover Form for the out of hours service, referral form etc. These are electronic or paper.

c) MDT/PHCT Meetings - Once the register is set up, the regular MDT meetings to discuss those patients can be arranged. Although the QOF points are awarded for 3 monthly meetings, we would recommend holding them monthly, as patients can deteriorate rapidly at the end of life, and they may be part of a pre-existing practice meeting. It is helpful to appoint a coordinator to arrange these meetings and to keep the register up to date, usually a district nurse, practice nurse or a practice manager. At the meetings, the register (SCR1) can be used as a tool to facilitate discussion of these patients. In this way we are pooling knowledge and expertise, and ensuring that the available resources are used in the most effective way possible. The information held on the register is also easily accessed for audit and significant event analysis, facilitating reflective practice in your team.

d) Next steps - *Over 3,000 practices in the UK have found that using this simple system improves their communication, improves proactive planning and leads to better patient care.* We hope that when teams new to this system see the benefits of working in this way, that they will want to take it that bit further, by adding further steps of GSF at their own pace e.g. by sending OOH handover forms, better support for carers, better links with specialists etc. Most areas will have a local Facilitator who can help with implementation at practice level- do contact GSF central team for any queries, or contact your SHA End of Life Project Lead. The GSF Central Team will try to support all practices, whether they use GSF or not, in their care for people nearing the end of their lives.

GSF is part of the End of Life Care Programme