

# Assessing your own Palliative Care Meetings

This is a tool for GPs designed to help them improve their GSF Palliative care meetings.

## What is End of Life Care?

End of life care is support for people who are in the last months or years of their life.

End of life care should help you to live as well as possible until you die, and to die with dignity. The people providing your care should ask you about your wishes and preferences, and take these into account as they work with you to plan your care. They should also support your family, carers or other people who are important to you.

## What is Palliative Care?

The definition of palliative care does vary. The definition below is from Scotland and close to that from the WHO. <http://www.palliativecareguidelines.scot.nhs.uk>

Palliative care is an approach to treatment which aims to:

- Improve the quality of life of patients and their families facing the problem of life-threatening illness

- Prevent and relieve suffering

- Identify, assess and treat pain and other problems, physical, psychosocial and spiritual

- Affirm life and regard dying as a normal process

- Offer a support system to help patients live as actively as possible until death

It is appropriate early in the course of illness, in combination with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes

those investigations needed to better understand and manage distressing clinical complications.

## **Are you identifying the right numbers?**

The GSF talks about end of life care patients being in the last year of their life. 1% of your patients die each year. 90% of these are possible to predict in theory. In reality you are doing well to predict 75%. A more accurate figure can be calculated by the number of deaths in the last year which should equal the number of your GSF (Gold Standard Framework). Your register may well exceed 1% if you are identifying patients in need of supportive care who have recovered, for example someone with a condition where the prognosis is difficult e.g. heart failure, acute leukaemia etc.

[http://www.dyingmatters.org/gp\\_page/identifying-end-life-patients](http://www.dyingmatters.org/gp_page/identifying-end-life-patients)

*What is your patient list size?*

*What should be the size of your palliative care register (1% of patient list size)*

*What is the actual size of your palliative care (GSF) register?*

Please reflect on the discrepancies in numbers. Perhaps work out what percentage you are identifying as palliative. A supported palliative care patient and family will not only have a better experience but also will access primary care services less frequently and more appropriately.

You may find that the numbers are not too bad. Now we need to look if they are the right cases.

## Are you identifying the right types of patient?

The answer is very likely to be a resounding “no” In Lincolnshire many patients die without being identified as palliative. Those that are identified are usually in the last few weeks of life.

Most practices have more patients identified with cancer than would be expected. As a general rule over two thirds of your patients should have a non cancer diagnosis. The GSF suggests the following figures: cancer (25%); organ failure (25-30%); frailty, multiple co-morbidity, dementia (40%)

*Are these figures representational of your own palliative care list?*

If not, it is suggested that you do not try to correct this in one go! One solution is to do this in stages.

Agree to use an indication tool so that new patients are picked up. When this is embedded in your practice you will be identifying early palliative care patients and the situation has stopped getting worse.

The next step might be to do some case finding on a specific disease group using your recognised indication tool . e.g Identify a small group of COPD patients with severe disease and who are prescribed oxygen or perhaps have had two emergency admissions recently and present a list of possible candidates for consideration at your next meeting.

Then slowly work through another disease group.

### Further reading:

The 6 page GSF prognostic indicator guidance explains things well and discusses disease trajectories well <http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>

The SPICt (Supportive and Palliative Care Indicator tool) is all on one page, internationally recognised and easier to refer to in practice. <http://www.spict.org.uk/the-spict/>

The RCGP has a toolkit with helpful resources. <http://www.rcgp.org.uk/clinical-and-research/toolkits/palliative-and-end-of-life-care-toolkit.aspx>

## Organisation & Continuity of care

All Lincolnshire health providers have agreed to use the EPaCCS palliative care template to ensure we are all collecting the same clinical codes and to avoid duplication of effort. It also avoids subjecting patients and carers to being asked the same difficult questions by multiple health professionals.

GPs that use the EPaCCS template have a tool available that will automatically create a list of their palliative care patients organised in the GSF colours and with a list of things they have done and things that still need to be done. It is available here:

<http://www.eolc.co.uk/go/?id=157>

There are two types of continuity of care:

management continuity - continuity and consistency of clinical management, including providing and sharing information and care planning, and any necessary co-ordination of care required by the patient. Good clinical records, the EPaCCS template and My Right Care are tools designed to deliver this.

relationship continuity - a continuous therapeutic relationship with a clinician. Generally, relationship continuity is highly valued by patients and clinicians, and the balance of evidence suggests that it leads to more satisfied patients and staff, reduced costs and better health outcomes. However this is becoming more and more difficult to put into practice.

[http://www.kingsfund.org.uk/sites/files/kf/field/field\\_document/continuity-care-patient-experience-gp-inquiry-research-paper-mar11.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_document/continuity-care-patient-experience-gp-inquiry-research-paper-mar11.pdf)

### management continuity

Use of the GSF colours is a way of systematically planning care. It relies on prognostication which can be inaccurate especially in some long term conditions, dementia and frailty. It is not perfect but it helps a busy clinician to focus on the priorities of care. It is of value to non clinical staff in prioritising their work and requests.

Blue (stable, up to 12 months); Green (unstable, months); Yellow (deteriorating, weeks); Red(dying, days)

<http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>

*Do you use the GSF colours?*

The EPaCCS template uses a nationally agreed code set and is used by all the major community provider organisations in Lincolnshire. This will reduce duplication of effort as long as the consent shares are set up correctly with these teams.

*Are your interventions recorded using the EPaCCS template?*

The template has been published Lincolnshire wide and can be downloaded on to your clinical tree. Search in your clinical system for EPaCCS. Further more detailed instructions are included in the extraction tool download (see below) The template viewer allows you to see what codes have been entered by other services already if the consent shares are set up correctly.

*Are you confident that you routinely ensure that palliative care patients have been asked to allow consent to share records at the point of care delivery?*

*Are you using the EPaCCS extraction tool to run your meetings?*

The tool extracts data recorded on the EPaCCS template on your GP clinical system (EMIS or SystmOne). From this it creates a spreadsheet of all your palliative care patients, what you have done for them and what still remains to be done. This gives the practice a systematic approach to palliative care. Admin staff present at the meeting can then update the notes at or soon after the meeting. The tool can be downloaded here: <http://lincolnshire.epaccs.com>

*Do you regularly create a My Right Care plan for your palliative patients?*

## **relationship continuity**

*Do you have a named GP responsible for each patient, agreed by the patient?*

Best practice is to have a named second doctor as well in case of holidays, illness etc. Many practices cannot manage this but good systems of management continuity can reduce the need for this. Some practices identify this GP as the “usual” GP as opposed to the registered GP.

## Conclusion

This tool will help you think how your palliative care meetings might be improved. Early identification of patients needing palliative support is the first step and should be your priority. Initially identifying the right person then allows the right care, in the right place and at the right time to follow.

A wide range of educational resources for health, social care and the general public can be found at: [www.eolc.co.uk](http://www.eolc.co.uk) and in the brochure “A proactive approach to palliative and end of life care for all diagnoses” This website also includes a list of material specific to Lincolnshire. Feedback to this tool and the website is really welcome.

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