The WHO describes palliative care as ‘the active, holistic care of patients with advanced, progressive illness’.1 GPs are in an ideal position to provide and coordinate this care for a number of reasons:

- they have long-established relationships with their patients which are so important at this critical time in a patient’s life
- they are used to dealing with comorbidity and uncertainty
- they are trained to treat patients holistically which is central to the palliative care approach.

GPs have to be able to provide high quality, equitable care, and to work together effectively with specialist teams if they are to provide the best primary palliative care for all who require it.

There is an increasing imperative to be able to recognise the needs of all patients nearing the end of their lives, not just those with cancer, and to be able to extend some of the developments in care provided for cancer patients to those with other illnesses, which constitute 75% of all deaths.

Proactive end of life care

In order to provide optimal care for any patient nearing the end of their life, i.e. not just in the terminal or dying phase, but in their last year, we need to be able to do three things:

- identify where a patient is on their illness trajectory – do they have years, months, weeks or days to live? This then allows proactive management, calmer planning and less ‘fire-fighting’ crisis management
- assess their needs, and those of their family/carers, in the light of their advance care plan
- plan (using a management plan) and then provide their care according to the patient’s preferences and varying needs, at different times.

There needs to be a better way to identify when patients are in their last year of life.

Up until now GPs have mainly considered cancer patients eligible for DS1500 attendance allowance as the criterion for inclusion on a palliative care register, but the new prognostic indicator guidance paper2 is being...
A key point is for all hospital and hospice clinicians who recognise that a patient may be in their last year of life to notify the patient’s GP and recommend that the patient is added to the palliative care register.

**QOF points**

The recognition of the importance of palliative care is demonstrated by the addition of clinical indicators for palliative care in the revised QOF. This positive step will encourage good proactive palliative care in primary care. Although there are only six points for palliative care in the revised contract (which includes care for all patients estimated to be in the last year of life), when combined with cancer, dementia and other areas,
practices can claim up to 52 points if they are using the Gold Standards Framework (Table 1, p. 31).

For the first time good palliative care in primary care will be recognised and rewarded, but providing this best care for everyone at the end of their life is not always easy. However, considerable experience has been gained over the past few years, using tools such as the Gold Standards Framework (GSF), and we hope that by sharing this expertise we will enable all primary healthcare teams to undertake this rewarding task.

Palliative care is important to GPs and is an intrinsic and special part of the job. So, despite its demands, many practitioners prioritise care of the dying and have made comments such as “it reminds us of why we came into medicine in the first place”, and “it brings us back to what matters, real patient care”.

The 1% rule

About 1% of your patients will die each year or, put another way, 1% of them are in their last year of life. We need to find ways of identifying these patients so that we can then assess their needs and preferences in order to plan for them and to provide the right services at the appropriate time, e.g. send the handover form to the out of hours provider, ensure the DS1500 form has been completed and that arrangements have been made for respite for the carer and intensive support at home for terminal care. As healthcare providers we need to help give them the best care possible at each stage in that final year of life.

On average, each GP has 20 deaths per year: about one-quarter will die from cancer – these are the patients that have generally been thought of when initially discussing palliative care; about one-third will die from organ failure, e.g. heart failure and COPD; about one-third will die from...
Table 3: The seven Cs of the Gold Standards Framework (GSF)

<table>
<thead>
<tr>
<th>C1 – Communication:</th>
<th>set up the register and meet regularly as a team</th>
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<tbody>
<tr>
<td></td>
<td>ensure that the patients have the information they need e.g. in home packs</td>
</tr>
<tr>
<td>C2 – Co-ordination:</td>
<td>appoint a co-ordinator</td>
</tr>
<tr>
<td>C3 – Control of symptoms:</td>
<td>pool knowledge and expertise to address physical, psychological, social and spiritual needs</td>
</tr>
<tr>
<td></td>
<td>use symptom assessment tools</td>
</tr>
<tr>
<td>C4 – Continuity of care:</td>
<td>inform the out of hours service about the patients</td>
</tr>
<tr>
<td></td>
<td>work together with the secondary care teams</td>
</tr>
<tr>
<td>C5 – Continued learning:</td>
<td>use audit (e.g. place of death) and significant event or after death analysis</td>
</tr>
<tr>
<td></td>
<td>identify and address knowledge gaps</td>
</tr>
<tr>
<td>C6 – Carer support:</td>
<td>identify and address their emotional, practical and financial needs</td>
</tr>
<tr>
<td></td>
<td>extend care into the bereavement phase</td>
</tr>
<tr>
<td>C7 – Care in the dying phase:</td>
<td>use a protocol for the last 48 hours of life, such as the Liverpool Care Pathway, for more information (<a href="http://www.endoflifecare.nhs.uk">www.endoflifecare.nhs.uk</a>)</td>
</tr>
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</table>

It is now being used by approximately one-third of all primary healthcare teams in England, and is being used right across the UK. Teams report better quality of care for their patients, better organised care, fewer crises and unplanned admissions, and better team working.

The Department of Health publication Building on the best: Choice, responsiveness and equity in the NHS, published in 2003, demonstrated that patients and carers want more choice over care at the end of their lives.

The NHS End of Life Care programme (www.endoflifecare.nhs.uk) was set up in 2004 to address these issues and the GSF is supported by the programme. It is also supported by the NICE guidance on supportive and palliative care, available at www.nice.org.uk.

Its use is recommended by the RCGP, the Heart Improvement Programme (www.eguidelines.co.uk) was set up in 2004 to address these issues and the GSF is supported by the programme. It is also supported by the NICE guidance on supportive and palliative care, and by the National Service Framework for Renal Services.

Therefore the GSF has gained support from specialists and generalists alike.

Table 2, p. 31, covers the Read codes that can be used.

There are three main steps in the GSF:

- identify the patients so that you can begin to provide some proactive rather than simply reactive care
- assess their needs and those of their carers
- plan their care:
  - plans must be made together with the patient and carer so that their wishes are taken into account
  - plans must be communicated to all involved, so that if for example a patient wishes to die at home, everyone including the reception staff know that that is the plan, and unnecessary ambulances and hospital admissions are avoided.

Therefore, achieving all the palliative care points in the nGMS contract is
the first step towards the Gold Standards Framework.

Achieving all the palliative care points in the nGMS contract ...

It must be remembered that the palliative care register should include all those patients with advanced disease, not just cancer patients. Suggestions are available in the GSF prognostic indicators guidance paper on how best to identify these people, available on the GSF website, although prognostication will never be entirely accurate.

Clinical prediction of survival is not an exact science with errors (defined as more than double or less than half of actual survival) noted 30% of the time. Two-thirds of errors are based on over-optimism and one-third on over-pessimism. However, there are considerable benefits in identifying these patients so that we can begin to address their needs earlier in their illness.

Triggers for supportive and/or palliative care

We suggest using the following methods:

- the surprise question – would you be surprised if your patient were to die in the next 6-12 months? This is an intuitive question integrating co-morbidity, social and other factors
- choice/need – the patient with advanced disease may choose comfort care only rather than ‘curative’ treatment; they may also be in special need of supportive/palliative care
- clinical indicators of advanced disease – see prognostic indicators guidance paper.

The prognostic indicators guidance paper attempts to provide teams with the guidance necessary to identify those patients nearing the end of life, from any cause. It will be updated regularly and should be seen as an educational tool to be distributed widely among the team.

Indispensable information for medicines management

For more information please go to www.pammtrak.co.uk, email info@pammtrak.co.uk or call Ramesh Patel on 020 8566 2127
However, teams new to the GSF may find it easier to begin with their cancer patients, and as they develop in confidence, they can extend their register to include their non-cancer patients.

Initially you could ask your specialist community palliative care nurse which patients they have on their list, but it is important to build on this and include more non-cancer patients, e.g. those with COPD and heart failure.

Appointing a member of the PHCT to act as a coordinator is recommended to coordinate the process and the patient’s care. They can then ensure the register is kept up to date and can manage the multidisciplinary team meetings that will ensue.

The palliative care register

There are templates for the register on the GSF website.

The well tried and tested SCR1, or summary sheet of all palliative care patients, will act as a checklist to record, plan and monitor patient care. It reminds us to make sure that the DS1500 has been completed; that the out of hours service has been informed of the patient’s needs; and to consider the patient’s choice with regard to place of care and/or place of death.

Once the register is set up the regular multidisciplinary team meetings can be held to discuss those patients on the register.

Palliative care 2 (PC2)

Although the QOF points are awarded for 3-monthly meetings we recommend holding them monthly, as patients can deteriorate rapidly at the end of life. The register, or SCR1, can be used as a tool to facilitate discussion and care planning for these patients at the monthly multidisciplinary team meetings. This is a way to pool expertise and knowledge, ensuring that available resources are used in the most effective way possible.

Initially you could ask your specialist palliative care nurse which patients they have on their list, but it is important to build on this and include more non-cancer patients.

The aims of the case review meetings are to improve the flow of information (particularly out of hours and between different teams) and to:

- ensure that each patient has a management plan as defined by the practice team, and that decisions are acted upon by the most appropriate member of the team
- ensure that the management plan includes preferences for place of care
- ensure that the support needs of carers are discussed and addressed wherever possible.

The essential personnel to invite to the multidisciplinary team meetings include GPs, district nurses, practice managers and preferably specialist palliative care nurses, social workers and a member of the administration team.

As the meetings become established teams may want to invite the respiratory nurse or the heart failure nurse, particularly once they start to identify more of their non-cancer patients.

The information held on the register is also easily accessed to facilitate audit and significant event analysis. At each meeting reviewing deaths from the past month should become routine as the team will learn from this reflective practice.

Continuing the GSF

It is hoped that once teams see the benefit of working in this way they will want to extend this work, and to take on more of the principles of the GSF. There are seven key tasks in the programme, also known as the seven Cs, to work towards (see Table 3, p. 34).

The QOF2 palliative care points cover C1 and C2.

Support and advice is available through local End of Life project leads, accessed via the Strategic Health Authorities; or from the GSF website.

GSF developments

We encourage the inclusion of more non-cancer patients, and of patients in other settings, in the GSF. There is a separate and very enthusiastic GSF in Care Homes Programme, involving more than 300 care homes, looking at how we can improve the care of our patients in this setting.

We also have GSF pilots in community hospitals, children and GSF ‘in-reach’ to hospitals.

Advanced care planning is an integral part of this process, enabling patients to express their wishes for future care, and we are developing tools to facilitate this.

Audit is an important part of the GSF from which we can all learn. We are developing tools such as the ‘after
Prescribing Information
Refer to full Summary of Product Characteristics before prescribing

AVANDAMET Rosiglitazone/metformin HCl

Prescribing Information for Avandamet Use in Dual Therapy Only. Refer to full Summary of Product Characteristics before prescribing. AVANDAMET Rosiglitazone/metformin HCl: Presentation: AVANDAMET Basic: 2mg/500mg film-coated tablets containing 2mg rosiglitazone with 500mg metformin HCl. AVANDAMET 2mg/1000mg & 4mg/1000mg film-coated tablets containing 2mg or 4mg rosiglitazone respectively with 1000mg metformin HCl. Indications: Treatment of type 2 diabetes mellitus patients, particularly overweight patients who are unable to achieve sufficient glycaemic control at their maximally tolerated dose of metformin alone. Posology & administration: 4mg rosiglitazone/1000mg metformin with food. Can be increased to 8mg rosiglitazone/2000mg metformin if greater glycaemic control is required. Elderly: Renal function should be monitored regularly. Children & adolescents: Not recommended. Contraindications: Hypersensitivity: history of cardiac failure (NYHA stages 1 to IV), disease which may cause tissue hypoxia; hepatic impairment, acute alcohol intoxication/alcoholism, diabetic ketoacidosis/precoma; renal impairment; acute conditions that may alter renal function; lactation; concurrent insulin. Special warnings & precautions: Lactic acidosis can occur as a result of metformin accumulation, primarily in patients with significant renal failure. Renal function serum creatinine concentrations should be determined regularly (see SPC). Fluid retention & cardiac failure: Rosiglitazone can cause dose-related fluid retention that may rarely be associated with rapid & excessive weight gain & may exacerbate or precipitate heart failure. Heart failure occurred uncommonly in double-blind studies with metformin (0.2%). Monitor signs & symptoms of fluid retention. Discontinue if deterioration in cardiac status. Heart failure reported more frequently when history of heart failure, elderly, or mild or moderate renal failure, or when used in combination with insulin. Concomitant administration with NSAIDs may increase risk of oedema. Monitoring of diuretic effect & reports of hepatocellular dysfunction; the incidence of all adverse events relating to liver and biliary systems was <1.5% in any treatment group and similar to placebo. Therapy should not be initiated in patients with unstable angina, recent MI, heart failure & pulmonary oedema; very rare cases of angioedema & urticaria. Pregnancy: Avoid use during pregnancy. Contains lactose. Lactation; concomitant insulin. Failure to observe warning & caution statements relating to liver and biliary systems was <1.5% in any treatment group and similar to placebo. Therapy should not be initiated in patients with unstable angina, recent MI, heart failure & pulmonary oedema; very rare cases of angioedema & urticaria. Pregnancy & lactation: Rosiglitazone not cleared by haemodialysis. Special warnings & precautions: Lactic acidosis: very rare.

Posology & administration

Rosiglitazone+metformin

2mg/1000mg – 56 film-coated tablets £27.71 (EU/1/03/258/009); 4mg/1000mg – 56 film-coated tablets £52.45 (EU/1/03/258/012).

Adverse effects

Common: hyperglycaemia, hirsutism, dizziness, nasopharyngitis, skin infections.

Uncommon: constipation, hyperlipidaemia, diabetes mellitus aggravated, urticaria, pruritus.

Rare: skin rashes, hyperkalaemia, bone pain.

Very rare: anaphylactic reactions, transient oedema.

is very rare.

Overdose: No data for AVANDAMET. Doses of up to 30mg rosiglitazone well tolerated. A large overdose of metformin may lead to lactic acidosis. Supportive treatment should be initiated, dictated by patient's clinical status. Rosiglitazone not cleared by haemodialysis. Basic NHS costs: AVANDAMET 2mg/500mg – 112 film-coated tablets £32.45 (EU/1/03/258/006), 2mg/1000mg – 56 film-coated tablets £27.71 (EU/1/03/258/009, 4mg/1000mg – 56 film-coated tablets £32.45 (EU/1/03/258/012). Marketing Authorisation Holder: SmithKline Beecham plc, 860 Great West Road, Brentford, Middlesex TW8 9GS.

Legal category: POM. Date of preparation: April 2006. Further information is available from: Customer Contact Centre, GlassmedKline, Stockley Park West, Uxbridge, Middlesex UB11 1BS; customercontact@skg.com; Freephone 0800 221 441. AVANDAMET is a registered trademark of the GlassmedKline Group of Companies © Reference: 1. Bailey CJ et al. Clin Ther 2001; 23(7): 1348-61.

June 2006 AM/PAV/07/12/1

In order to continually monitor and evaluate the safety of AVANDAMET, we encourage healthcare professionals to report adverse events, pregnancy, overdose and unanticipated benefits to GlassmedKline at 0800 221 441. Please consult the Summary of Product Characteristics for full details on the safety profile of AVANDAMET. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

GP CONTRACT: QOF2

Although the task may seem daunting, we would urge primary healthcare teams to get started and give the GSF a go.

The new QOF2 palliative care points can be a real stepping stone to making significant practice developments in this vitally important area of end of life care.

There are huge benefits, not just to our patients, but to healthcare professionals as well, in terms of job satisfaction and better team working. By organising palliative care better we can make even be seeing a time saving for the team, with a reduced number of crises occurring.

The new QOF2 palliative care points can be a real stepping stone to making significant practice developments in this vitally important area of end of life care.

Reference:


www.goldstandardsframework.nhs.uk


(5) NICE guidance on cancer services – Improving supportive and palliative care for adults with cancer research evidence www.nice.org.uk


Acknowledgement

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