

## Palliative Care, COPD and Falls QoF QiP Pathways GG&C – ver 6 17.10.11

### 1. Context

1.1 QoF QP for Unscheduled care required the development of three admissions pathways that were agreed between the Board and LMC. The primary purpose of developing and agreeing these pathways was to ensure that best practice is happening across the primary secondary interface, resulting in a minimisation of avoidable admissions. In that sense these are more anticipatory care pathways than 'point of admission' pathways.

The Board has decided to focus on the highest risk patients (of future admissions) based on the SPARRA tool. This will allow a focus on the highest risk patients, avoid the need to case find and allow an incremental step to a future pathway that might aspire to case find from a wider patient population.

### 2. Supporting information

2.1 Please note that the following information is provided simply as background and consists largely of a copy of the Palliative Care Enhanced Service, and a collation of information on QoF QP, gathered from various sources. These are provided simply as a reminder of the principles underlying each.

2.2 Palliative Care in Quality and Outcomes Framework (*italics provided to emphasise key elements*)

i) The practice has a *complete register* available of all patients in need of palliative care/support irrespective of age (PC 3)

ii) The practice has *regular* (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (PC 2)

iii) There is a system to *alert the out-of-hours service or duty doctor* to patients dying at home (Records 13)

2.3 Palliative Care Enhanced Service – key elements (**Appendix A**)

Practices should;

1. Ensure that they *include patients* identified with palliative and end of life care needs *irrespective of diagnosis* on their QoF palliative care register.

2. Ensure that patients on the QoF palliative care register have been *assessed and a care plan compiled* within 2 weeks of inclusion on the register.

3. Ensure that, for each patient on the QoF palliative care register, an up to date *palliative care summary is made available to professionals involved in their care in the out of hours period* within 2 weeks of inclusion in the register.

4. Ensure that practices assess when patients on the palliative care register reach the last days of their life and *use a recognised integrated care pathway* (e.g. Liverpool Care Pathway).

2.4 QoF QP Unscheduled admissions pathways – guidance and template questions/actions

## i) Guidance

The practice participates in an external peer review to compare its data on emergency admissions in relation to other practices in their agreed review group. The focus of the review is for practices to consider significant variances and where it may be appropriate to amend current arrangements for the management of emergency admissions. Practices should agree action plans to demonstrate engagement / delivery against three specified clinical care pathways aimed at avoiding unnecessary emergency admissions.

## ii) Template Questions/Actions

Question 1; Comment on how your overall practice / individual GP admission patterns for this pathway compare with other practices in the agreed review group. If they are significantly higher or lower than the review group average why, in the view of the practice, would this be the case?

Question 2; Reflecting on your internal practice analysis and discussions with colleagues at the external peer review session, describe a minimum of 3 specific actions the practice will undertake to reduce the level of potentially avoidable admissions in the future.

Question 3: Undertake a Significant Event Review (SER) of a sample of patients admitted via this pathway between 01/01/11-31/12/11 (1 per 1000 patients on your list up to a maximum of 5) [see recommended SER template, Annex A]. Consider if these admissions were potentially avoidable or whether alternative management of the patients could have been taken to avoid the admission e.g. by more effective use of current resources or provision of improved services. Briefly detail the key outcomes of this review

Question 4: Whole system issues: describe particular issues that have been identified out with the practice's control that could contribute to improving this pathway for the care of patients.

## 2.5 Scottish Government guidance on this part of QOF QP

QP8. Using improved clinical pathways (11 OOF points) - practice engages with the development of and follows 3 agreed care pathways (agreed with the LMC) ...and produces a report of the action taken by 15th March 2012. In Scotland to demonstrate application of the pathway the practice is required to carry out a process of reflective practice to analyse patient journey along each of the three pathways chosen (1 per 1000 registered patients up to a maximum of 5 for each pathway).

NHS Boards working with Local Medical Committees will agree these pathways ensuring engagement from all relevant parts of the system including secondary care.

The Scottish Government and the Scottish General Practitioners Committee have provided support material to help Boards and LMCs with those choices...In nearly every case this material consists primarily of a distillation of existing best practice material and research. It is intended as a resource to support the development and agreement of local pathways which will make the biggest difference in terms of the quality and productivity of NHS care.

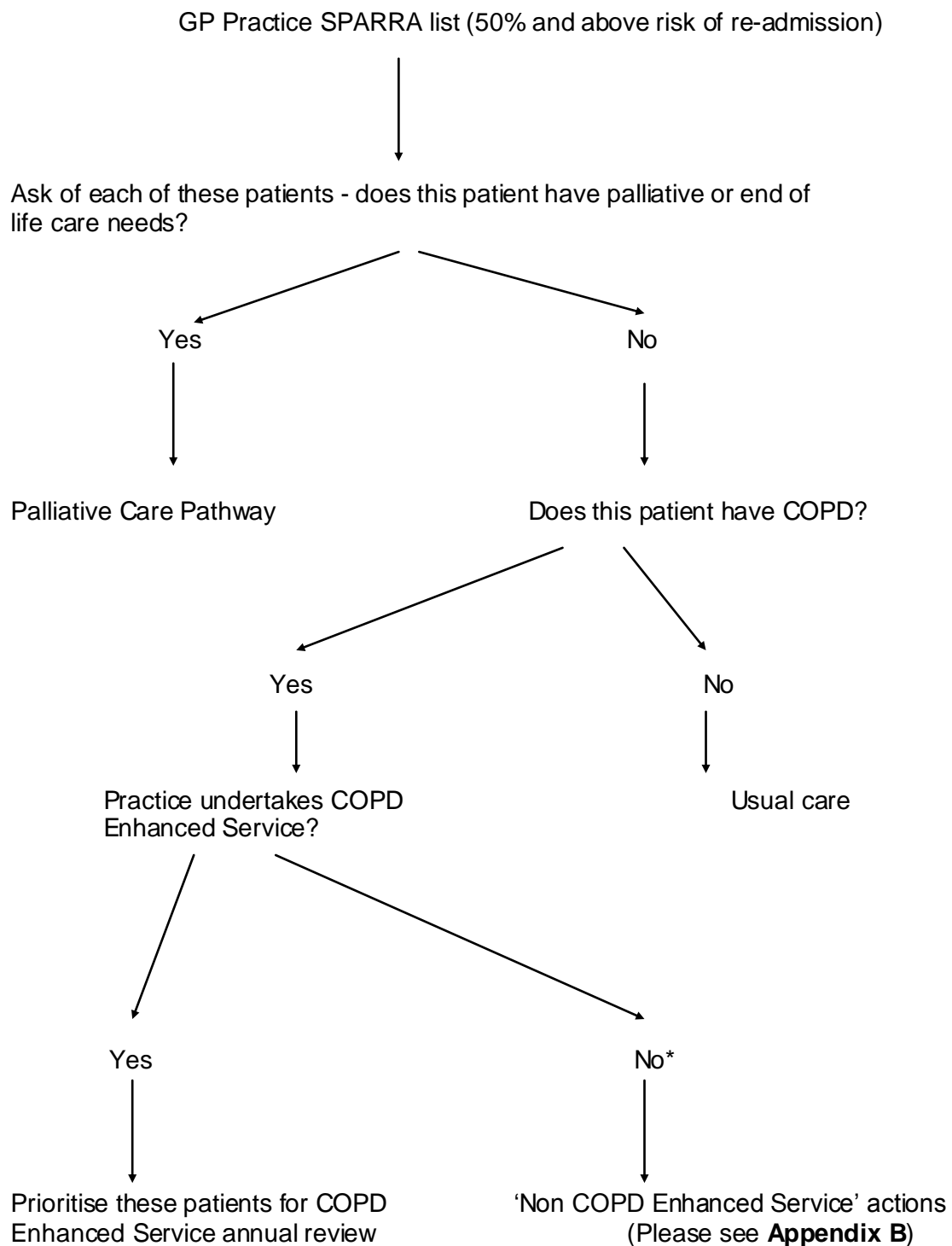
### **3. Principles agreed by GG&C Pathways Steering Group (Joint Board and LMC group)**

3.1 Pathways should;

- be aspirational (improve care)
- not expect practices to do work over and above that included in either good medical practice, or relevant Enhanced Services/QOF
- be as simple and straightforward as possible



## 5. COPD Pathway



\*Practices have the opportunity to opt in to the COPD Enhanced Service at this point. They should contact Tom Clackson in the first instance if they wish to do so.

## 6. Falls Pathway

Using this pathway ensures that patients receive a multifunctional assessment and may prevent subsequent falls and admission to hospital.

Patient Presentation	GP component	Home Falls Prevention Service	Secondary Care	Shared Care
Patient presents with; - a fall - an injury caused by a fall - GP notified of a fall by third party	GP; - manages acute illness or injury - refers patient over 65 to Home Falls Prevention Service for multifactorial Falls Risk Assessment	Home Falls Assessment triage then triggers review; - Medical risk factors - Multidisciplinary review - Signposts to all required specialist assessment	- Considers specialist outpatient service e.g. Falls Clinic - If patient admitted then plan discharge and rehabilitation	Home Falls Prevention Service feeds back to GP re outcome of referral

### Community Falls Prevention Programme

#### Definition of a fall:

A sudden unintentional change in position, causing one to land on a lower level, or on an object, the floor, or the ground. Tinetti (1987)

#### Criteria for referral

Person is 65 years or over  
 Lives at home (not a care home)  
 One or more fall(s) in past 12 months  
 Person should have an address within the NHSGG&C Health Board Postcodes

#### How to Refer:

Refer the patient to the Community Falls Prevention Programme (CFPP) in the first instance. All patients will be screened to exclude urgent medical conditions as part of the initial screening process i.e. blackout, cardiac symptoms etc.

Any patient who triggers with an urgent medical condition as part of the triage process will be fast tracked to a Consultant Geriatrician for an urgent medical review.

- Please advise the patient that you have made the referral. They should expect to receive a telephone call from CFPP to arrange a screening visit which will be carried out in their home.
- For patients who do not have the ability to answer detailed questions over the phone can you please give contact details for someone that would be able to assist with this information?

#### Who not to refer

Patients under 65 years – suggest refer to Local Community Rehabilitation Teams which will be established by April 2011.

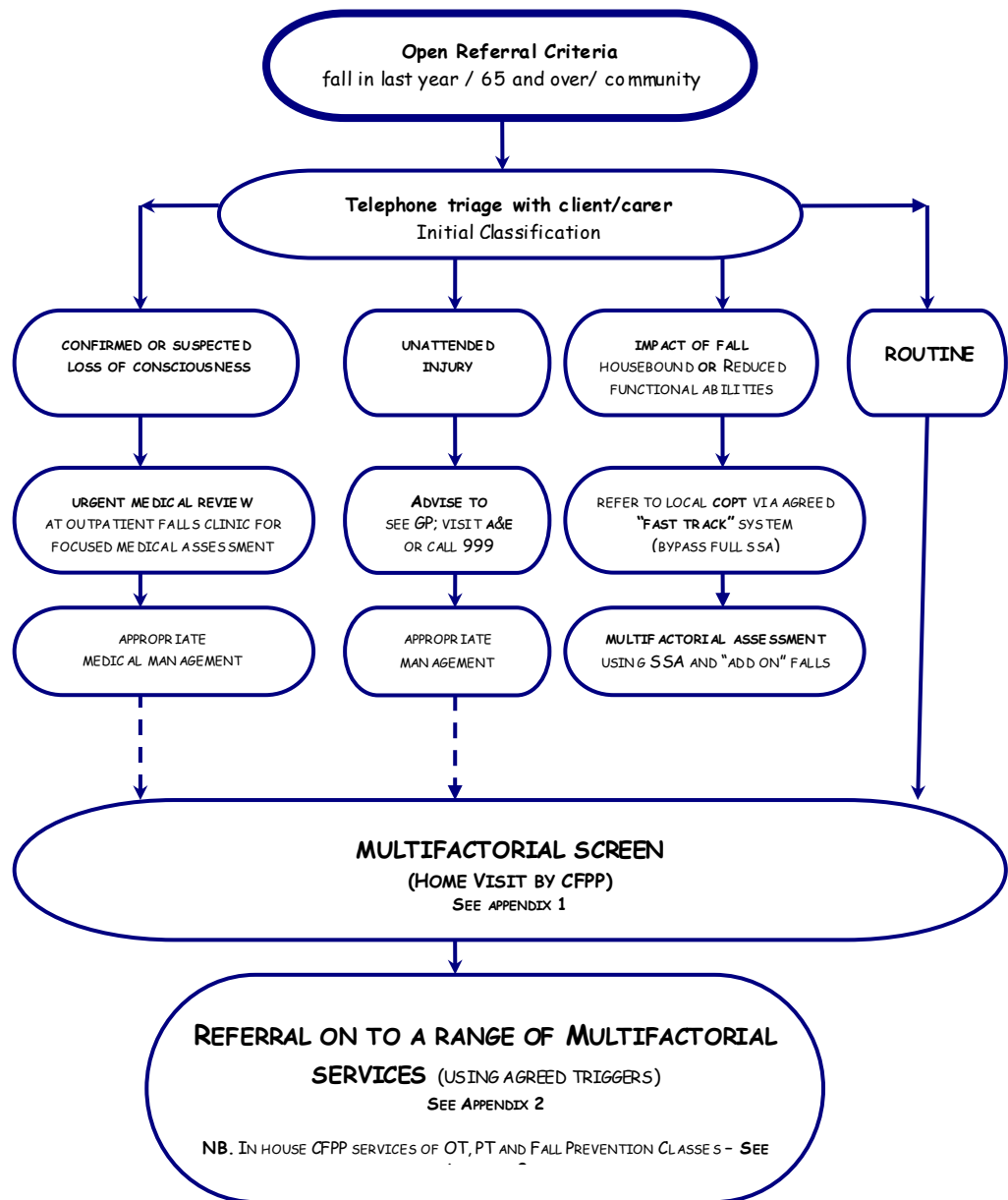
#### What does this service offer?

Environmental Hazard Assessment, Screening of patients functional abilities, Medication review by specialist pharmacist, Occupational Therapy, referral on to relevant health services following screening process, including Physiotherapy and /or 12 week exercise programme if appropriate.

#### Contact details

Community Falls Prevention Programme (CFPP)  
3<sup>rd</sup> Floor Clutha House  
Cornwall Street (South)  
Glasgow, G41 1AF  
Phone: 0141 427 8311  
Fax: 0141 427 8308  
E-mail: [gg.fallsadmin@nhs.net](mailto:gg.fallsadmin@nhs.net)

## Community Fall Prevention Programme (CFPP) Pathway



NB. Please do not refer to Community Falls Prevention Programme where client/patient is already being seen by COPT/IRIS/DART Community Rehabilitation Teams as these services also deliver multi-factorial falls assessment and interventions.

Lorna Kelly  
David Leese  
John Nugent  
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Ver 6 17.10.11



## **Appendix A**

**Practices have the opportunity to opt in to the Palliative Care Enhanced Service at this point and are asked to contact Tom Clackson in the first instance if they wish to do so.**

In order to meet the requirements of the Palliative Care Enhanced Service, practices should;

1. Ensure that they include patients identified with palliative and end of life care needs irrespective of diagnosis on their QOF palliative care register.
2. Ensure that patients on the QOF palliative care register have been assessed and a care plan compiled within 2 weeks of inclusion on the register.
3. Ensure that, for each patient on the QOF palliative care register, an up to date palliative care summary is made available to professionals involved in their care in the out of hours period within 2 weeks of inclusion in the register.
4. Ensure that practices assess when patients on the palliative care register reach the last days of their life and use a recognised integrated care pathway (e.g. Liverpool Care Pathway).

## Appendix B

**Practices have the opportunity to opt in to the COPD Enhanced Service at this point and are asked to contact Tom Clackson in the first instance if they wish to do so.**

'Non COPD Enhanced Service' actions

Principles

- i) evidence of impact on admission avoidance
- ii) can be seen as core clinical care, rather than an 'enhanced' service
- iii) actions do not mandate additional investigations (eg spirometry) with capacity constraints
- iv) the following can be done opportunistically whenever these patients are seen in the surgery or at home

Practices should make three attempts before the end of the current contract year to offer, opportunistically, if possible;

- An assessment of smoking status and referral of patients who express a readiness to quit to smokefree services.
- All COPD patients the annual seasonal influenza vaccination
- A review for symptoms of breathlessness and exercise limitation, using the MRC Grading System, referring patients who express agreement to Live Active (MRC grades 1 and 2) or Pulmonary Rehabilitation (MRC grades 3, 4 and 5)
- A review of all patients with continuing breathlessness and exercise limitation to ensure that their inhaled therapies are optimised (Enhanced Services guidance can be provided for this element of the review if that would be helpful)