Palliative Care CCG contract 2015/16

Aim

1. Aim of this contract is to encourage GP’s to identify those patients who may be in the last year of life and to offer them an opportunity to create an Advance Care Plan (ACP) and to record the details of this on CMC if they agree to do so.
2. Evidence from Coordinate My Care suggests that those patients who have an ACP are more likely to die in their preferred place of death and to avoid unnecessary hospital admissions.

Interdependencies with other GP contracts

Patients may be included in this contract and the Frail Home Visiting GP contract (if patients are housebound and deemed to be in the last year of life). There will also be patients that are eligible for one of these contracts but not the other.

Service specification

1. Each practice should have a Lead GP for End of Life care. This GP should attend a training session on End of Life care once every 3 years and this training should include refresher training on the use of CMC (this could be online training, attending an educational meeting, or meeting with the local CMC coordinator), to cascade information to other practice staff and to be the practice lead contact for St Joseph’s Hospice
2. Practices should actively identify those patients who may be in the last year of life (using the SPIC'T tool or other means)
3. Practices should code patients as to create a last years of life register (to access the template in EMIS LV either enter Palliative Care or read code ZV57C), codes are:
   - 8BJ1 Palliative Treatment
   - 8BA2 Terminal Care
   - ZV57C Palliative Care
   - 8BAe Anticipatory Palliative Care
4. Practices should offer patients information about their disease trajectory, and offer the opportunity to create an ACP (should be recorded when patients have been offered an ACP, and whether they accepted or declined), which should be recorded on CMC (once the patient has consented, the details can be entered onto the CMC by a non-clinician and then approved by a clinician once entered i.e. the GP does not have to enter all the information), and include at least the following:
   - Preferred place of care
- Preferred place of death
- A discussion about resuscitation and the circumstances in which the patient and/or the health care professional feel it would not be appropriate. This could result in a DNACPR form on CMC
- Any other patient wishes
- This information can be recorded on the City and Hackney Care Plan if the patient does not wish to create a CMC record
- If patients require more support to create an ACP they should be referred to PCPCS or Palliative care CNS or another service if appropriate e.g. dementia Advisor
- Patients should be supported to create an ADRT if they wish to do so
- The CMC record does not have to be created or updated by the GP but would usually need to be approved by the GP
- The ACP and CMC record should be reviewed at least once a year

5. Patients should be supported to die at home if they wish to do so. This would involve being willing to visit the patient at least every 2 weeks so that the death certificate can be issued when needed (patients can be included on Frail Home Visiting GP contract if they are housebound as these home visits should be funded via this contract). It would also involve liaising with nursing teams, social services and other clinicians as appropriate and being willing to discuss the ACP with family members and carers if the patient gives consent.

6. Patients on the palliative care register should be discussed at the monthly practice MDT (which should ideally be attended by palliative care CNS).

Outcomes

The service is expected to support the following improvements:

- Reduction in Emergency admissions at end of life
- Reduction in LOS at end of life
- Increased proportion of patients dying in preferred place of death.

To assess outcomes of the service, the following KPIs/quality standards will be used:
- Creation and number of patients on last year’s life register (source: CEG)
- Number of patients with ACP recorded (source: CEG)
- Number of patients with CMC record (source: CMC)
- Number of patients with DNACPR and/or ADRT (source: CEG)
- Proportion patients achieving preferred place of death (Public Health Mortality Files and CMC)

Template

A template will be created for practices to record the following:
1. Patient may be in last year of life (which of the above 4 codes do we want to specify? They all state palliative – do we need a different one for last year of life?)
2. ACP offered or declined (code for ACP: 8CME, code for ACP declined needed)
3. CMC record offered or declined (codes needed)
4. DNACPR offered or declined (codes needed; there are 1R0 for yes to resus and 1R1 for no to resus)
5. ADRT offered or declined (codes needed)
6. Evidence of patient discussion at monthly practice MDT (minutes – random audit of patients to be carried out)

The CCG will also monitor what proportion of patients on the palliative care register die each year.

**Payment**

The GP Confederation will be paid £110 per patient on the practice palliative care registers with complete templates (with the above inclusions), as long as there is, for each practice:
- A last years of life GP lead
- A minimum of 2 patients per 1000 of the whole practice list has completed palliative care templates (0.2%)
- A maximum of 5 patients per 1000 of whole practice list has completed palliative care templates (0.5%)

And therefore a minimum of 588 and a maximum of 1470 patient templates are completed across City and Hackney.

NB: This payment is only covering the criteria in the service specification above, not home visiting (covered by core contract for patients as end of life and the Frail Home Visiting contract). As above, if patient identified as end of life and eligible for this contract becomes housebound then they also become eligible for Frail Home Visiting Contract and so can attract payment via that contract.