

How do Gold Standard Framework meetings support Palliative Care delivery as part of primary care services? An observational study



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Background

The Gold Standard Framework (GSF) is now well established and recognised tool to support GP practices to organise high quality Palliative and End of Life Care at home (in the last 6-12 months of life). Whilst uptake of the GSF is widespread there is a lack of evidence to demonstrate how it supports GPs and district nurses to deliver palliative care in primary care. This small study provides insight into the use of GSF meetings within 3 GP practices within NHS Forth Valley.

Methods

GP practices that were considered 'good examples' (see box below), in relation to use of GSF, were invited to take part in the study. Following on from ethical opinion from local research ethical committee, eight GSF meetings were observed and tape recorded. Thematic analysis was used to analyse data, providing order to the data set and allowing for key themes to emerge and be identified.

Good examples

GP practices that were known to have implemented GSF through formal processes such as: having special palliative care register and regular multi-professional meetings with input from clinical nurse specialist at the local hospice.

Recruitment

Letters were sent to twenty five GP practices identified, as above, offering them to take part in the study. Nine practices offered to take part in the study and three of them were chosen allowing for rural area and GP practices within two different towns to be included in the study.

Findings

GP practice	Length of meetings	Number of Patients on the palliative care register*	Who attended GSF meetings	Size of GP practice
A	31.5-38.5 min.	5	All GPs within the practice, DNs, CNS from local hospice sometime	approx 6.300 patients
B	29.2-38.4 min.	12-19	1 designated GP DNs, CNS from local hospice always	approx 10.600 patients
C	62-65 min.	54-56 (mostly cancer patients)	All GPs, practice manager, DNs, CNS from local hospice sometimes	approx 2.400 patients

*All patients on the register were discussed at each GSF meeting.

Key themes emerged

1. Criteria for the Palliative Care Register who and when

It was noticeable that it varied considerable how many patients practices had on their palliative care register list (see table). There was no evidence of practice B or C using the 'surprise question' to identify patients and within practice A it was evident that there was uncertainty as to how to interpret the question. It was also evident that the practice that had the highest number of patients on the palliative care register had patients on the list that were relatively stable.

GP practice C

GP1: the last time I saw her [patient 3] I thought she was looking really good and doing very well.

GP2: She's fine [patient 4], she said she would get in touch with us if necessary and it was very much you know "I don't need to hear from you".

GP 1: Patient 5, Nothing.

GP practice A

GP 5: I'm just wondering the criteria for putting someone on the palliative care that's why I'm bringing it up just now. These people, I don't know Mrs C [who has end stage COPD], Mr R I wouldn't see it, he's got a terminal respiratory illness I don't see him as end stage... So Mr R [patient] I would be surprised if he wasn't here in a year's time but I wouldn'tI don't know..... A year's quite a long time anyone over 90 I'd be surprised if they were still here ...we took a 102 year old off the palliative care register cause he'd had it for so long and still going strong

2. GSF meetings were constructed through informal dialogue

GSF meetings were mostly constructed through informal dialogue with no evidence of formal assessment tools or use of GSF documents. Discussion was mostly based on memory and information was shared by the team member/s that had last seen the patients.

GP 1: Mr C [the patient] who Dr X [GP at the practice] been seeing em... I think maybe you've seen her at one point as well Dr Y [Gp] she's now on Oramorph for anxiety and breathlessness....Did you [looks at district nurse] say you know her

DN: I met her when she came out of hospital right it was just to... got her a mattress and different bits of equipment for her and left her a contact number

3. Dialogue structured around symptoms and coping at home

It was evident that discussion around each patient had the purpose of highlighting their current situation with the focus on their symptoms and how they were coping at home. This was done through informal dialogue between the nurses and the doctor/s. It appeared that the discussion served the purpose of information sharing and 'checking' the overall situation.

GP1: Mrs C [patient] so any update on her?

DN1: At the moment we're not actually got any input, we've seen her a couple of times when she first came home from hospital but family are coping really really well the last time we were there

GP1: Okay

DN1: But if she does need our input that's not a problem either

GP1: Okay so there's no active district nurse input em... : I'm not sure when.. emmm ...can you maybe pop her up on your screen just to see I know Dr Y has been visiting it was just to see if there's anything we should be aware of

4. Coordinating Care

GSF meetings were used for update on the patient's condition and situation. It was evident that this served the purpose of coordinating the care between the GPs, district nurses and CNS from the local hospice.

DN1: Em... Mrs L [patient] who we were just updating A [CNS Hospice] about cause A didn't realise that L was admitted to the hospital last week with query spinal cord compression em...and we haven't heard anything since so but em...

CNS: Well I'm off next week so if she gets home I can pick it up when I get back but if there any cause for concern just phone along speak to one of the CNS at the hospice

GP 1: Okay Mrs C.... she also had she has a DS1500 completed, she has an advance care plan and an electronic palliative care summary and we've also discussed em...DNACPR

GP1: Oh well....I think everything's up to date and in hand she'd preferred to be at home for end of life care em...

5. Advance Care Planning

Practice A was the only practice that used the GSF meetings systematically to check if documents related to Advance Care Planning had been filled out and was in place in patients' notes.

Conclusion

The professionals attending the GSF meetings appeared to have a good knowledge of the patients on their palliative care register without the need to refer to medical notes.

The 'tools' and 'checklists' developed for use with the GSF did not appear to be used in the practices observed.

There appeared to be a challenge around identifying who and when patients should be placed on the Palliative Care register. There is ongoing uncertainty around how to interpret 'the surprise question'.

It is unclear whether being on the Palliative Care register improves clinical outcome in relation to Palliative and End of Life Care within the primary care setting and further research is needed to explore this.

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