

Dear Colleague

**THE PRIMARY MEDICAL SERVICES
DIRECTED ENHANCED SERVICES (SCOTLAND) 2019
PALLIATIVE CARE SCHEME**

Summary

1. This document summarises the plan for the arrangements to be entered into for the new Palliative Care Directed Enhanced Service Scheme in Scotland which will come into effect from 1 April 2019. The Scheme is established by the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2018, issued under cover of circular PCA (M)(2018) 04 and which came into force on 1 April 2018.
2. This plan replaces the previous Palliative Care Scheme plan which was issued in April 2012. This Directed Enhanced Service Scheme (“DES”) will start on 1 April 2019 and will run on a year on year basis until further notice.
3. The Scottish Government published a 'Strategic Framework for Action on Palliative and End of Life Care' in December 2015.
4. In keeping with this Strategic Framework for Action, this DES supports practices in taking a systematic approach to palliative and end of life care, to ensure that they identify appropriate patients for the Palliative Care register and that these patients have an anticipatory care planning approach to their care, with a Key Information Summary (KIS) completed and available in the Out of Hours (“OOH”) period.

04 April 2019

Addresses

For Action

Chief Executives NHS Boards
Director of Practitioner Services
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PC Leads

For Information

GP Practices

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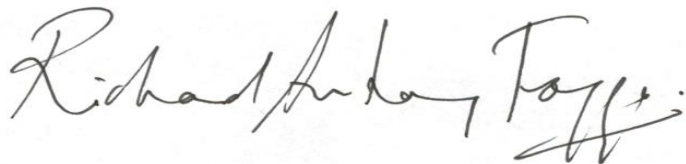
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5. This work is expected to be carried out within the context of the wider multidisciplinary team both within and outwith the practice, as it may be used in quality improvement work in GP clusters.
6. This circular also—
 - gives Directions to Health Boards on behalf of Scottish Ministers detailing the payment arrangements which must be made under the DES at **Annex A**
 - provides the rationale of the Palliative Care Directed Enhanced Services
 - provides guidance on developing a [palliative care register](#) & [anticipatory care planning](#)
 - provides a Sample Report Form: Significant Event Analysis
 - provides a Palliative Care: Reporting Template 2019-20 for level 2 Activity

Action

7. NHS Boards are requested to action these Directions and ensure that their primary medical services contractors are aware of them.

Yours sincerely

A handwritten signature in black ink, reading "Richard Foggo". The signature is written in a cursive style with a prominent initial 'R' and a long, sweeping tail.

RICHARD FOGGO
Deputy Director and Head of Primary Care Division

Palliative Care Directed Enhanced Service:

Outline of the DES

1. This plan is intended to support practices in meeting the requirements of this DES. Sections in the specification are highlighted in the boxed sections below followed by guidance notes.

Eligibility

2. Participating practices must have one or more palliative care patients on their registered list who have consented to the use of KIS in order to be eligible to participate in the DES.

Definitions

3. (a) In this DES —

“anticipatory care plan” means the plan required to be compiled and summarised in the patient’s key information summary (KIS) for Level 1 Activity under the DES and must include, as a minimum, the patient’s relevant diagnosis, consent to participate in KIS and the plan’s review date,

“Health Board” means unless the context otherwise requires, the Health Board which is a party to the contract, arrangement or agreement with the practice, and

“OOH” means out of hours, which is a service that runs during the following times—

(a) the period beginning at 1830 hours on any day from Monday to Thursday and ending at 0800 hours the following day,

(b) the period between 1830 hours on Friday and 0800 hours on the following Monday,

(c) Christmas Day, New Year’s Day and,

(d) any other public or local holiday which is agreed in writing between a Health Board and a provider,

(b) References to “practices” are to be read as a reference to the primary medical services contractor who has a particular type of contract or agreement with their Health Board, whether a GMS contract, a 17C agreement or a 2C arrangement.

Requirements

Level 1 Activity

4. Participating practices are required to:
 - Ensure that they include patients identified with Palliative and end of life care needs irrespective of diagnosis on their palliative care register.
 - Ensure that patients on the palliative care register have been assessed and a care plan, otherwise referred to as an anticipatory care plan, is compiled and summarised in a KIS (with appropriate consent from that patient). The KIS

should be completed and made available to professionals involved in the patient's care in the OOH period within 4 weeks of inclusion on the register.

5. The palliative care register should include all patients with a life limiting condition, identified as benefitting from a palliative approach to their care, not just those with cancer. Healthcare Improvement Scotland has published a [Palliative care identification tools comparator](#) which may also assist. The tool at **Annex C** is one example of these and may assist in the identification of patients who should be on the Palliative Care register.
6. Anticipatory care planning is at the core of good Palliative Care (Anticipatory Care Planning: [anticipatory care planning toolkit](#)). Pro-active care planning and management and the early management of symptoms can enhance the quality of life for patients and their carers and help to prevent crises and unscheduled hospital admissions. This should include the use of anticipatory prescribing, particularly for conditions such as advanced heart failure and COPD where sudden exacerbations are likely, and for end of life medication. Steps should be taken to ensure that frail patients, living with support at home or in care homes, also have access to the benefits of this approach.
7. The information required for the patient's anticipatory care needs must be recorded in a standardised format in the KIS.
8. It is essential for high quality, coordinated care that health professionals working in the OOH period have information pertinent to the care of patients with palliative and end of life care needs, with the patient's consent.
9. To recognise that the development of an anticipatory care plan may involve sensitive discussions over a period of time, this DES will be payable following the practice adding the patient to the Palliative Care register and within four weeks of entry on the register, entering the following basic data on to KIS
 - Relevant diagnosis
 - Indication that patient has consented to share information
 - Review date
10. It is recognised that further discussions, including patient and carer understanding of diagnosis and prognosis, preferred place of care, DNACPR status etc are critical aspects of the anticipatory care plan. However, these may be discussed quite appropriately later than four weeks after initially adding the patient to the Palliative Care register. The KIS or equivalent notes should be updated regularly to share this, or any other new or changed information, with OOH colleagues.

Level 2 Activity

11. Participating practices are required to:
 - Engage in a programme of reflective practice involving the wider multidisciplinary team as described below to ensure that they are assessing when a patient on the

palliative care register reaches the last days of their life and that those patients receive appropriate high quality care.

12. Key areas recognised as delivering high quality palliative care and that should be considered in reflective practice include:

- **Identification of patients with long term conditions (LTC) other than cancer, including the frail elderly**

Do you find this difficult? Did the available [tools](#), or the guidance in Annex C help?

- **Expected or unexpected death**

If any of your patients who died with a LTC, including the frail elderly in the past year were not on your palliative care register then

- consider the reasons for this
- could it have been predicted by using the available [tools](#) or guidance in Annex C?

- **Use of Anticipatory Care Planning and KIS**

If any of your patients who died with a LTC (including the frail elderly) in the past year did not have an KIS then

- consider the reasons for this
- would it have been helpful?

- The number of patients fulfilling the criteria in Table 1 below should be entered in the Level 2 Activity report at Annex E.

Table 1 - Level 2 Activity

Practice population at 1 Apr 2019	Number who died from cancer 1.4.2019-31.3.2020	Number who died with LTC other than cancer 1.4.2019-31.3.2020	Number of SEAs completed, shared and submitted

With reference to table 2, from their total patient deaths during the year, practices should carry out a minimum of 3 reflective practice (Significant Event Analysis (SEA)) with a maximum of 3 for practices with less than 6,000 patients on their practice list, rising to 1 per 1,000 patients on their patient list for larger practices to an upper limit of 15. If the total number of eligible deaths is less than 1 per 1000 patients, then practices should carry out a reflective practice on all such deaths.

SEA case choice will be at practice discretion, in line with our professionalism agenda, but should reflect, where possible, a case mix of both cancer and noncancer diagnoses and a case mix where care went according to plan (a so- called good death) and where care did not go according to plan.

Table 2 - Minimum and Maximum no. of SEAS

Practice population at 1 Apr 2019	Minimum Number of SEAs	Maximum Number of SEAS
<6,000	3	3
6,000-6,999	3	6
7,000-7,999	3	7
8,000-8,999	3	8
9,000-9,999	3	9
10,000-10,999	3	10
11,000-11,999	3	11
12,000-12,999	3	12
13,000-13,999	3	13
14,000-14,999	3	14
15,000-15,999	3	15

13. The SEA can be completed in the current format within the Scottish appraisal toolkit, or using the template in **Annex D**.

14. Practices must submit the Level 2 Activity report of overall reflective activity to be completed using reporting template at **Annex E**.

15. **Reporting arrangements** Information will be extracted or must be provided to the Health Board at the end of each financial year as described below:

LEVEL 1: A patient will be added to the palliative care register when the appropriate box is ticked on KIS. Once the clinician is ready to send the care plan to the OOH service, the consent button must be ticked and this must be within 4 weeks of the patient being entered on the KIS system. An automatic data extraction for level 1 payments will be generated for each patient entered in the palliative care register in KIS.

LEVEL 2 activity: The practice must complete a report on the criteria at paragraphs 11 and 12 using the template form at Annex E.

The practice must submit that report to the Health Board at the end of the financial year.

16. Practices are required to collect information on patients they enter on their Palliative Care register on or after 19th March 2019 and up to and including 18th March 2020.

17. Practices must supply their Health Board with such information as that Health Board may reasonably request for the purposes of monitoring the practice's performance of its obligations under the plan.

Payment Arrangements – Directions to Health Boards

Annex A

The Scottish Ministers give the following Directions to Health Boards in exercise of the powers conferred by section 17E(3A), 17M and 105(7) of the National Health Service (Scotland) Act 1978 and all other powers enabling them to do so. Primary medical services contractors who have entered into an arrangement with a Health Board in accordance with its Palliative Care Scheme under the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2018 (“DES Directions 2018”) will be paid for completion of the numbered criteria as follows:

Level 1 activity - £68 per completion of KIS with no cap applied

Level 2 activity - £250 per practice for administration and infrastructure costs of carrying out an overall programme of reflective practice and thereafter £58 per incident of reflective practice (as described in paragraph 11 and 12 above) carried out up to a maximum total of 15 at a maximum rate of 1 per 1,000 registered patients

A **Level 1** payment will follow automatic data extraction. Practices must submit a printed version of the reflective practice template/ learning report for **level 2** payment **Annex E**. No patient identifiable information should be included.

Duration

1. This DES will be funded in the first instance for one year from 1 April 2019. Payments will be made on an arrears quarterly basis.

Payment Verification

2. Prior to issuing payments in accordance with the above paragraph, Health Boards must require primary medical service contractors who have entered into an arrangement with a Health Board in terms of the Palliative Care Scheme in the DES Directions 2018 to sign a declaration to confirm that they are meeting the requirements of the DES Directions 2018.
3. The Health Board must, where necessary, vary the primary medical services contractor’s contract so that the plan (i.e. the arrangements summarised in this document) comprises part of the primary medical services contractor’s contract and the requirements of the plan (i.e. these arrangements) are conditions of the contract.

Reporting

4. Health Boards should submit an annual report to Primary Care Division, Scottish Government outlining participation and levels of payment in their areas.

1. The World Health Organisation (WHO) defined Palliative care in 2004 as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Planning for care at the end of life should be responsive to patient choice regarding their preferred place of care and place of death.
2. Palliative and end of life care are integral aspects of the care delivered by any health or social care professional to those living with and dying from any advanced, progressive or incurable condition. Palliative care is not just about care in the last months, days and hours of a person's life, but about ensuring quality of life for both patients and families at every stage of the disease process from diagnosis onwards. A palliative care approach should be used as appropriate alongside active disease management from an early stage in the disease process. Palliative care focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.
3. People in their last year of life have significantly higher numbers of unplanned admissions to hospital. There is evidence that by enabling patients to think ahead and anticipate some of the changes that might occur, that healthcare services can respond to meet changing needs in a safer, more effective and person centred way.
4. The Scottish Government published a 'Strategic Framework for Action on Palliative and End of Life Care' in December 2015. This contains a vision that 'By 2021, everyone in Scotland who needs palliative care will have access to it', and is underpinned by 10 commitments. The first of these commitments focuses on better identification and care co-ordination of those who can benefit from palliative and end of life care.
5. In keeping with this Strategic Framework for Action, and the developments that have come from its implementation, this DES supports practices to:
 - ensure that they identify appropriate patients for the Palliative Care register;
 - adopt an anticipatory care planning approach through multidisciplinary working with patients, those close to them, and health and social care professionals. With appropriate consent, a summary of the ACP should be shared with providers of unscheduled care through the KIS.
 - determine a patient's preferences as they approach the end of life, including preferred place of care, and to adopt a co-ordinated and systematic approach to this care.
6. The main causes of death in the UK (i.e. cancer organ failure, dementia and/or frailty) are fairly evenly distributed and all can benefit from effective palliative and

end of life care. However, the pattern of progression of advanced respiratory, cardiac or other organ failure will differ from that of cancer. End-stage cancer is likely to be characterised by a gradual and steady deterioration while end-stage respiratory disease may be characterised by acute exacerbations and remissions. End-stage cardiac disease may be similar but the risk of sudden death is greater. Frailty, which is the commonist trajectory, has a longer trajectory, marked by slow decline or unpredictable length. Understanding the differences between these trajectories can help in planning care more appropriately to meet patients' and carers' needs.

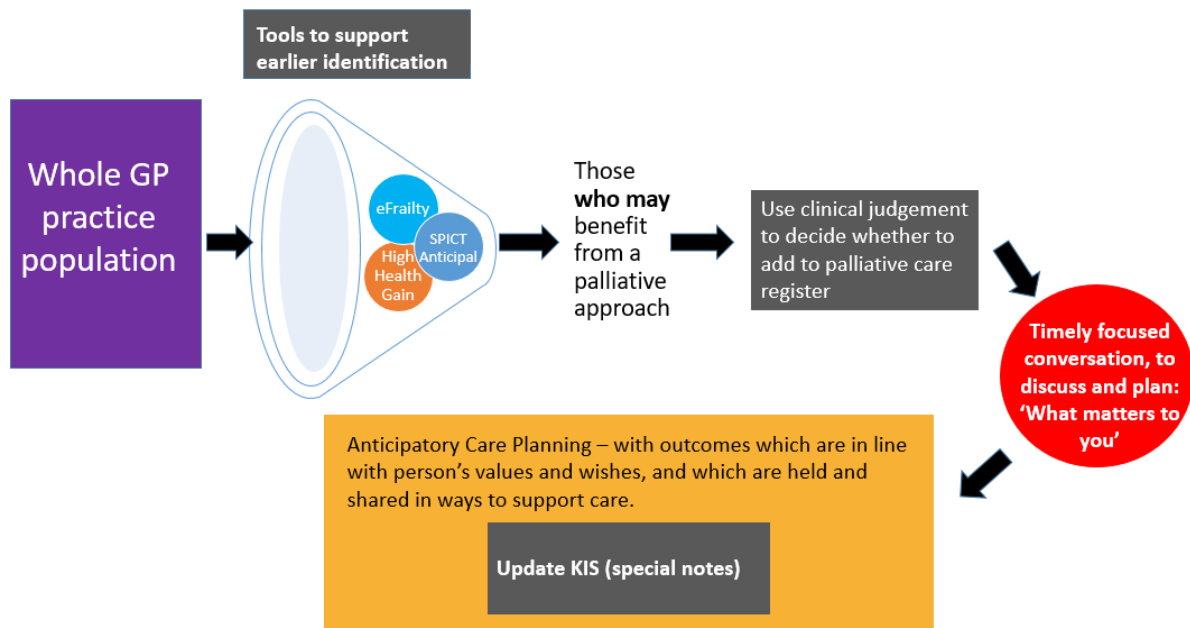
7. A Palliative care approach and the subsequent stepping up and stepping down to appropriate types and levels of care should be considered at the initial diagnosis of a life-limiting condition, as well as at times of critical events and changes in disease progression. This will include:
 - holistic assessment, with the patient and carer, of their physical, social, emotional, cultural, religious and spiritual care needs and other relevant life circumstances;
 - planning, coordination and delivery of appropriate care based on the needs identified;
 - appropriate sharing and communication across all care settings of the needs, and plans identified and actions taken; and
 - Regular review and repetition of the assessment and planning cycle.

References

Illness trajectories and palliative care. Murray, S; Kendall, M; Boyd, K; Sheikh, A. BMJ 2005; 330; 1007-1011. doi:10.1136/bmj.330.7498.1007-1011

Gold Standards Framework: <http://www.goldstandardsframework.org.uk>

Tools and guidance are available [here](#).



Sample Report Form: Significant Event Analysis

Date of significant event meeting:

Date report compiled:

1.1 What happened?

In particular for Palliative Care DES purposes consider the following information:

- How early in the diagnosis was a palliative approach considered?
- What evidence is there of an anticipatory care planning approach?
- What was the quality of information contained in the KIS?
- What did the care look like in the last days of life?

1.2 Why did it happen?

1.2.1 (Describe the main and underlying reasons – positive and negative – contributing to why the event happened. Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event).

1.3 What have you learned?

1.3.1 (Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education & training; the need to follow systems or procedures; the vital importance of team working or effective communication).

1.4 What have you changed?

1.4.1 (Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a letter of apology to a patient or a new protocol).

Palliative Care: Reporting Template 2019-20 for level 2 activity

PALLIATIVE CARE DES LEVEL 2 ACTIVITY – PRACTICE REPORT

Practice Name and Code:

Date of reflective practice meeting:

Attendees:

Please enter the appropriate numbers of patients in the boxes below

Practice population at 1 Apr 2019	Number who died from cancer 1.4.2019-31.3.2020		Number who died from long term condition (LTC) other than cancer 1.4.2019-31.3.2020	
Number of SEAs completed	Percentage of above who were on palliative care register	Percentage of above with KIS	Percentage of above on palliative care register	Percentage of above with KIS

1. Examining the care of the patients who died, are there emerging themes of note under any of the following headings?

- **Identification of patients with long term conditions (LTC) other than cancer who have palliative care needs**

Do you find this difficult? Did the available tools or guidance in Annex C help?

- **Expected or unexpected death**

If any of your patients who died from a LTC in the past year were not on your palliative care register then

- consider the reasons for this

- could it have been predicted by using the available tools or guidance in Annex C?

- **Anticipatory Care Planning and the KIS**
If any of your patients who died from a LTC in the past year did not have an ACP or a KIS then
 - consider the reasons for this
 - would it have been helpful?

2. List 3 (or more) Learning Points for the Practice as a whole or individuals

3. What does the Practice intend to do to implement these learning points?

4. What needs to happen within your local Health and Social Care Partnership, NHS Health Board or at national level to support and improve the care of patients with palliative care needs?