Derbyshire End of Life Care Guidance:

A pathway for supporting people in the last year of life
Contents

• Introduction
• Supportive care flow charts - colour coding
• Green supportive care/Prognosis of less than 1 year
• Advance Care Planning, Information Prescriptions
• Amber supportive care/Prognosis of less than 6 months
• Amber supportive care/Prognosis of a few weeks
• Red supportive care/Prognosis of less than one week
• Care After Death, Bereavement Care, Continued Learning
• Additional services, Specialist Palliative Care, Coordination of Care
• Standards, Audit

Appendices

1. GSF Prognostic Indicator (adapted GSF)
2. Breaking Bad News
3. Palliative care read codes

Glossary

References and Web Links

Acknowledgements

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Advance Care Planning project team,
EOL Team,
EOL Programme Board,
EOL Clinical Reference Group,
Patient & Public Involvement group.
Introduction

End of life care is the responsibility of all health and many social care providers that care for:

- People with less than one year to live
- People with long term progressive eventually fatal illness
- People diagnosed with the condition from which they will eventually die. These include long term conditions, organ failure, cancer, cerebral-vascular illness and dementia.

The provision of end of life care involves palliative and supportive care where the goal is achievement of the best quality of life for patients and their families. A range of people from informal carers to others with more specialised skills such as medical, nursing and allied health and social care professionals provides this. The focus of palliative care is teamwork, providing support whatever the setting whether in people’s own homes, hospital and hospice or care homes. In relation to place of death, national research demonstrates a disparity between patients preferred place of death, and the actual place of death. Whilst over 50% would prefer to die at home this is only achieved for approximately 20% of people whatever the cause of death.

Choice has a crucial role in health and social care service provision, and for people nearing the end of life. Achievement of choice provides an indication of the quality of services available to support the individual’s preference. Enabling choice in regard to preferred priorities for care and preferred place of death can have a positive impact in bereavement, promoting health and the well being of all involved. Also by matching need with resources it is hoped that services can be more effectively and efficiently delivered. A minority of patients need admission to specialist services such as hospitals or hospices if good care is achieved in the community. Choice should be irrespective of diagnosis, ensuring equal opportunity for all those wherever possible to plan for end of life care.

Figure 1 - Derbyshire Supportive Care Pathway Flowchart

is founded on the use of evidence based practice, and the principles of advance care planning. This is in accordance with the NHS End of Life Care Programme, with a management plan to optimise quality of life using recognised tools including:

**Gold Standards Framework (GSF)**

[www.goldstandardsframework.nhs.uk](http://www.goldstandardsframework.nhs.uk)

The aim is to improve palliative care provided by the whole primary care team by improving continuity of care, teamwork, out of hours provision as well as symptom management and patient, carer and staff support.

**The Derbyshire Care Pathway for the last years of life (introduced January 2010)/Liverpool Care Pathway for the Dying Patient (LCP)**


These Pathways empower health and social care professionals to deliver high quality proactive care to dying patients and their family regardless of diagnosis.

The flowchart is colour coded using the Green, Amber, Red coding, as an alternative to using timescales when planning and providing care.
Figure 1

Supportive Care Pathway Flowchart (v3.0)

- Patient has end of life care needs (Last 12 months of life)
- Patient added to GP Practice palliative/supportive care register
- General practice nominate lead GP, nurse and practice coordinator
- Holistic assessment visit (see opposite) by community nurse and key worker from community nursing team. Assess need for Rightcare and submit to OOH where completed

- Does patient have specialist palliative care needs?
  - No
  - Refer to specialist palliative care for assessment and management in partnership with PHCT
  - Ongoing monthly GP practice multi disciplinary palliative care meetings
  - Ongoing review (see opposite) support by key workers Refer to appropriate support services (see opposite) according to need.

- Patient deteriorating and assessed as entering the dying phase (see opposite)
  - Assessment visits by GP/RN (see opposite) Agree use of LCP/ Derbysire LCPQ pathway

- What is the preferred place of care?
  - Hospice, care home, other
  - Home

- Liaise with appropriate service to enable preferred place of care (see opposite)
  - Ongoing visits (see opposite) by RN to provide holistic nursing care
  - RN continuation of care following patient death (see opposite)
  - General practice after death analysis

- Does the patient have specialist palliative care needs?
  - No
  - Yes
  - Refer to specialist palliative care for assessment and management in partnership with PHCT
**Supportive Care Pathway Flowchart**

**Patient has end of life care needs (Last 12 months of life)**
- Patient could be identified through:
  - Modified GSF Prognostic indicator guidance (PGS)
  - Acute admission data from previous year – accessed via parr tool
  - In house searches of disease registers
  - Karnofsky Performance status score
  - WHO performance status

**Holistic assessment visit by community nurse and key worker from community nursing team**
- Holistic assessment includes;
  - Physical, social, psychological and spiritual needs
  - Advance care planning discussions and preferred place of care
  - Care pathway documentation
  - OOH management plan

**Ongoing review – support by key workers**
- Community nursing ongoing review to include;
  - Monthly review contact/visit, increasing to weekly according to patient needs
  - Review needs for specialist palliative care and/or supportive care services
  - Arrangements for Just in case bantanticipatory medication in patient’s home

**Refer to appropriate support services according to need**
- Supportive care could include;
  - Social care
  - Respite, day service, support groups

**Patient deteriorating and assessed as entering the dying phase**
- Signs of the dying phase could include;
  - Profound weakness
  - Diminished intake of food and fluids
  - Difficulty swallowing or taking oral medicines
  - Drowsy or reduced cognition
  - Red bound
  - Needs assistance with all care
  - Maybe disoriented in time or place

**Assessment visits by GP/RN**
- Assessment visit should include;
  - Commencement of care pathway for dying phase
  - Review advance care plan and DNAR status
  - Updated patient summary to OOH provider and OOH community nursing

**Liaise with appropriate service to enable preferred place of care**
- Additional supportive care could include;
  - 24/7 supportive care at home, supportive care service, night sitting
  - Existing package of social care

**Ongoing daily visits by RN (or team member) to provide holistic nursing care**
- RN/Community nursing ongoing visits and holistic nursing care to include;
  - Daily review contact
  - Holistic nursing care according to pathway
  - Referral for appropriate supportive care

**RN continuation of care following patient death**
- RN Community nursing continuation of care to include;
  - Provision of information on what to do following death
  - Bereavement contact/visit within 1 week

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A pathway for supporting people in the last year of life
Identifying the point when people may have a life expectancy of one year is complex, especially for those with a non-cancer diagnosis. For many people with a cancer diagnosis there is often a clear point at which the person moves from curative to palliative care. For those with a non-cancer diagnosis it is not unusual for there to be periods of deterioration which respond well to specific interventions. Prognostic indicators have been suggested as a support to those clinicians making this decision (Appendix 1 Derbyshire adapted version).

This is a trigger for the primary healthcare team to consider use of the “Gold Standards Framework for Community Palliative Care” in managing the person’s care.

The focus is on the seven principles of:

- Communication
- Co-ordination of the person’s care
- Control of symptoms
- Continuity of care
- Continued learning
- Carer support
- Care of the dying.

At this stage in the pathway a holistic patient assessment and physical examination is completed to identify any unmet needs. In addition at this time there should be a rigorous assessment of carer needs. The outcome of these assessments will determine appropriate action including referral to other services such as specialist palliative care or long-term conditions management teams. “Carer fatigue” is a major contributory factor in crisis hospital admissions. One of the factors is the lack of appropriate and timely support and equipment provision. Assessment should consider the full range of respite care - at home or in a bedded facility - and provision of assistive equipment.

Communicating assessment and care planning information to all those involved in the person’s care is essential. In addition to existing systems for sharing paper and electronic patient care records, the use of a patient-held file e.g. “My Future Care” document should be considered at this time (*This document will be available via the End of Life pages of the NHS Derbyshire County website).

This document was piloted across 4 sites in the county during the ACP project phase (summer 2009).

Communicating information to the person about the prognosis of their condition should be considered at this time. “Breaking Bad News Guidelines” have been produced by Mid-Trent Cancer Network (Appendix 2, http://information4u.org.uk/?q=node/94) and by North Trent Cancer Network (http://www.northtrentcancernetwork.nhs.uk/profession als/key-documents/breaking-bad-news) to support this.

The person having these discussions should have received appropriate communications skills training. In acknowledging the sensitive nature of this discussion the role and concept of a named key worker should be introduced. The key worker has been defined as “A named professional who is ‘best placed’ to ensure the person receives co-ordinated, holistic and timely end of life care”. In primary care this is likely to be a member of the community nursing and community matrons.

Methods for effective communication between primary and secondary care must be established as a priority. In accordance with the General Medical Services contract Quality Outcomes Framework section “Palliative care/Supportive care”, details concerning these people will be added to the practice register and their care reviewed regularly. The Quality Outcomes Framework measures are a minimum, and additional end of life quality standards and outcome measures are being developed to support further service improvement and monitoring. New standards will be introduced from April 2010.

*http://www.derbyshirecounty.nhs.uk
Advance Care Planning

The single assessment process should provide relevant documentation for the initiation of advance care planning. The involvement of the patient and significant others in decisions about their care is recognised at this early stage of the guidance.

Advance Care Plans should be considered at this time using relevant tools i.e. Advance Decisions to Refuse Treatment (sometimes referred to as Living Wills) www.adrtnhs.co.uk http://www.derbyshirecountypect.nhs.uk/training.asp

One of the areas for discussion will be the preference of the person regarding delivery of care along with place of care / death. Clearly this is a sensitive subject, again requiring communication skills training. However, by addressing the issue it is possible to increase the likelihood of achieving the preferences people have for their future care, whether this be treatment modalities or place of care. By recording such details it is also possible to audit the outcome of care and analyse the reasons for deviation from original decisions.

Advance care planning is an entirely voluntary process. Patients need access to the support of a variety of professionals with appropriate communications skills to fully explore their own choices. Provision of this range of support could include referral for psychological support. However the patient’s Advance Care Plan would be drawn up by the patient together with their nominated health or social care professional.

NHS Derbyshire County has recently piloted the ‘My Future Care’ document to be introduced as part of the ACP process from April 2010 and will be available at: http://www.derbyshirecounty.nhs.uk

This document enables preferences to be recorded and regularly reviewed.

Information Prescriptions

At every stage of the pathway, the information requirements of the patients and carer(s) must be considered. Examples of End of Life and Carer’s Information Pathways are on the Mid-Trent Cancer Network’s information website http://information4u.org.uk/. The precise content of an Information Prescription depends on individual circumstances, but will include health and wellbeing, practical and financial advice – including entitlements to welfare and benefits - at appropriate stages.

Amber supportive care/
Prognosis of less than six months

At this stage the person (regardless of diagnosis) may apply for attendance allowance or disability allowance under special rules using a DS1500 form, downloadable from www.direct.gov.uk. See also website: www.macmillan.org.uk. This will ensure applications are processed on a fast-track method. There should also be further assessment regarding the continuing care needs of the person and consideration of application for support according to eligibility criteria. These initiatives along with other potential benefits provide support for the person and those involved in their care.

Communicating information to the provider of Out of Hours care - Derbyshire Healthcare United (DHU) / and the ambulance service should be considered at this time using the relevant templates (Rightcare form, Special Patient Notes, EMAS End of Life Decision Registration Form) or existing “flagging” systems. The out of hours services then ensure priority access when receiving referrals for that patient. This may include communicating DNAR status, in accordance with local DNAR policy.

Carer support may be further enhanced at this stage by the judicious use of respite support. This may be provided in a number of ways and involve day or residential care in hospice, hospital or care home setting. Some providers offer respite through a sitting service provided in the patient’s home. The most appropriate type of respite support should be discussed and agreed with the patient, carer and health

Amber supportive care/
Prognosis of “a few weeks”

This stage is characterised by deterioration suggesting the patient is entering the terminal phase of their condition. This is a trigger for reviewing advance care plans and documenting any desired changes to My Future Care / PPC and/or ADRT.

Further needs assessment should take place regarding the continuing care needs of the person and consideration of application for support according to
eligibility criteria. The framework for NHS Continuing Care funding includes a fast track process which can be used by a senior clinician for people with a rapidly deteriorating condition. This is appropriate for patients on the end of life care pathway who have reached the “weeks prognosis” stage.

Prescription of a ‘Just in case/anticipatory drugbox should be considered at this stage after discussion with the patient and carer. This ensures that there is an emergency supply of PRN (as required) subcutaneous medication in the patient’s home in advance of any deterioration in the patient’s ability to take medication orally. When required these will help control any distressing symptoms of pain, restlessness and agitation, nausea and vomiting, and respiratory tract secretions which may occur.

The carer’s needs should be reviewed to ensure that the appropriate type and level of support is in place to enable them to cope, especially if the patient has chosen to die at home. Information should be provided on how to access advice and support if a crisis arises.

**Communicating information to DHU the provider of Out of Hours Care and the ambulance service is essential at this time using relevant templates (Rightcare form, Special Patient Note, EMAS Registration of End of Life Decision form) or existing practice referral systems.**

**Red supportive care/Prognosis of less than a week**

When a patient is thought to be entering the last week of life, the MDT should commence daily reviews in order to ensure that the Derbyshire care pathway for the last days of life / Liverpool Care Pathway for the dying patient is introduced as a mechanism for managing the person’s care during the last days of the person’s life. This period of care is consistent with “care of the dying” as defined in the GSF; the focus is on the proactive management of the person’s care and all those involved at this stage.

Information should be provided to family / carers when the Derbyshire care pathway for the last days of life / the Liverpool Care Pathway is commenced, about what to expect and what to do when the patient dies. As a minimum they should be provided with a leaflet such as “Coping with Dying” (LCP) or “End of Life – the Facts” (Marie Curie)

**Assessment of current medication, the discontinuation of non-essential drugs and the prescribing of PRN sub-cutaneous medication.**

It is essential that DHU the provider of Out of Hours Care and the ambulance service are notified of the patient’s status at this time using the relevant notification forms (Rightcare form) or referral systems.

In the event of the patient dying (whatever the setting) certification of death should be carried out as soon as possible. It is acknowledged that in some settings i.e. care homes and community hospitals nursing staff are trained to undertake what is referred to as **verification of death**. This expedites transfer of the body of the person, and the process of events after death.

**Care After Death**

Completion of Section 3 of the Derbyshire Pathway for the last days of life LCP (Care After Death) is appropriate for all deaths, including unexpected deaths where Derbyshire/LCP has not already been initiated.

Leaflet D49 “What to do after a death in England and Wales” (DWP) or local information should be provided to the next of kin.

All relevant services should be informed, including notification to the DHU provider of Out of Hours Care / and the ambulance service to cancel the Rightcare form, Special Patient Note / EMAS End of Life Decision Registration.

**Bereavement Care**

This guidance recognises the provision of support for the psycho-social wellbeing of all those who are bereaved following the person’s death. The advantage of early involvement of the key worker supports the development of rapport and through continuity provides support for risk assessment of complicated grief. Whilst spiritual support is integral throughout this guidance it may have particular emphasis at this stage. Equally referral to the appropriate specialist services may be considered necessary at this time.

**Continued Learning**

GSF emphasise the need for continued MDT learning throughout the process. Circumstances that should prompt this include unexpected deaths of patients on the Supportive/Palliative register; deaths of patients that do not occur in the preferred place and feedback from the audit process. Use of the GSF After Death Analysis tool is recommended.
Additional services to meet individual needs

Some services may be needed at any stage of the pathway according to the individual patient or carer’s requirements and circumstances. These include clinical nurse specialist (CNS), specialist psychological support, respite care, self-help and support groups, equipment loan services, spiritual care and specialist palliative care (SPC). Many people will access psychological, emotional and spiritual help through their own informal support networks, but the need for access to specific services should be considered as part of the regular multi disciplinary team meetings.

Specialist Palliative Care

Referral for specialist palliative care involvement should be considered at any stage of the pathway where there are complex physical and / or psychosocial needs. Patients may be referred to, and/or advice sought from, specialist palliative care teams, for:

- Complex pain and symptom management
- Psychological support for patients and families who are experiencing difficulty in accepting and coming to terms with the disease process
- Discharge planning (for those in hospitals) where specialist support is considered a requirement to help promote the quality of life for the patient and family
- Terminal care where specialist advice is required to enhance the comfort of the patient and family

Coordination of care

The national EoL care strategy recognises the importance of coordinated care within the pathway. For individual patients and carers, this follows on from assessment and care planning, with regular review of needs. The coordination of services must exist within teams and across organisational boundaries.

Because a person’s needs may change rapidly, the ability of services to respond rapidly and in a coordinated manner is essential; when the patient’s prognosis is measured in weeks, days matter, and when it is measured in days, hours matter.

Single assessment, patient-held records, GSF, named key workers, 24-hour help lines and patient alert systems for hospital admissions, out of hours and transport services all contribute to the effective coordination of care at the end of life.

Standards

The indicators of success for implementation of this approach reinforce a number of principles relating to the provision of quality palliative/supportive care:

- The equitable delivery of care regardless of diagnosis or setting
- The opportunity to make an advance plan for end of life care that reflects individual choice and preferences
- The assurance of best practice through the use of evidence based tools in all settings
- The assurances of consistency, continuity and coordination throughout this approach pathway by a named key worker.

In order to measure success in the provision of high quality end of life care, a number of quality standards have been agreed locally:

- Actual versus expected numbers of patients on EOL Supportive/Palliative registers
- Percentage of patients on EOL registers with a documented Advance Care Plan
- Percentage of patients with a nominated key worker
- Number of completed Derbyshire Care Pathways/ Liverpool Care Pathways
- Increased number of patients supported to receive care in preferred place of choice
- Reduced numbers of inappropriate admissions into acute hospitals (and subsequent deaths in hospital)
- Percentage of patients dying in preferred place (last recorded preference).
Audit

It is strongly recommended that practices make full use of read codes relating to End of Life Care – templates can be developed for practice use to record evidence of care provided according to GSF principles and End of life pathway goals. These can be used to monitor progress against the above quality standards, and to provide evidence of:

• Adherence to the principles of the GSF approach
• Referral to all appropriate members of the multidisciplinary team, including palliative care specialists when necessary, supported by a care package tailored to the individual’s and carer’s needs.

Audit of completed documentation provides evidence of the levels of achievement of the 15 goals within the Derbyshire Pathway.

The Quality Outcomes Framework for General Medical Services gives a high level indication of numbers of patients on a supportive and palliative care GP register, whose care needs are discussed by a primary care multidisciplinary team at a minimum of three-monthly intervals, but this should be regarded as a minimum standard. Mortality rates indicate that, on average, this relates to up to 1% of the practice population.

Further measurement of the quality of care provided to dying patients and their carers will come from a national survey programme of people who have been bereaved, the analysis of complaints to the NHS relating to end of life care, and organisational self-assessment of structures and processes against quality standards which are being developed to support the NHS End of Life Care Programme.

Issue date: June 2010
Next review due: May 2012
Appendix 1
Derbyshire Prognostic Indicator
With acknowledgment to GP Dr Stephen Miller

PROGNOSTIC INDICATOR GUIDE
(Triggers for supportive/palliative care – modified from GSF)

1. ‘Surprise’ question: “Would you be surprised if patient died in next 6-12 months?”
2. Patient with advanced disease chooses comfort care only
3. Clinical indicators.

(a) **Cancer patients** – metastatic or inoperable not responding to adjuvant/hormonal therapy

(b) **Organ failure**
- **CHF** (at least two of below)
  - NYHA III/IV
  - Repeated hospital admissions
  - Optimal therapy, poor symptom control
- **COPD** (with )
  - FEV1 < 30% (severe disease)
  - > 3 admissions in 12 months
  - LTOT
  - MRC grade 4/5
  - Right heart failure
- **Renal**
  - CKD Stage 5 (eGFR < 15)
  - Symptoms of renal failure, not seeking dialysis or transplant
- **Neurological**
  - MND / Parkinson’s Disease with
  - Poor symptom control and QOL

(c) **Frailty/ Dementia**
- **Frailty** (with )
  - Multiple co-morbidities
  - Deteriorating Karnofsky score
  - Increasing weakness
  - Weight loss
- **Dementia** (with )
  - Poor mobility
  - Incontinence
  - Lack of meaningful communication
  - Physical deterioration

OTHER POSSIBLE SOURCES
Patients in Residential Nursing Homes
PARR TOOL
High input of social service support
Charleston Code.
Appendix 1 continued...

NYHA Classification of Heart Failure

Class I
No limitation. Ordinary physical activity does not cause fatigue, breathlessness or palpitation.

Class II
Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, breathlessness or angina pectoris.

Class III
Marked limitation of physical activity. Although patients are comfortable at rest, less than ordinary activity will lead to symptoms.

Class IV
Inability to carry out any physical activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any physical activity increased discomfort is experienced.

Medical Research Council dyspnoea scale

Grade Degree of breathlessness related to activities
1. Not troubled by breathlessness except on strenuous exercise
2. Short of breath when hurrying or walking up a slight hill
3. Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace.
4. Stops for breath after walking about 100m or after a few minutes on level ground.
5. Too breathless to leave the house, or breathless when dressing or undressing

Karnofsky Performance Status

<table>
<thead>
<tr>
<th>Percentage of normal performance status</th>
<th>KPS (Karnofsky definitions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Normal, no complaints, no evidence of disease</td>
</tr>
<tr>
<td>90</td>
<td>Able to carry on normal activity, minor signs or symptoms of disease</td>
</tr>
<tr>
<td>80</td>
<td>Normal activity with effort, some signs or symptoms of disease</td>
</tr>
<tr>
<td>70</td>
<td>Cares for self, unable to carry on normal activity or do active work</td>
</tr>
<tr>
<td>60</td>
<td>Requires occasional assistance, but is able to care for most of his needs</td>
</tr>
<tr>
<td>50</td>
<td>Requires considerable assistance and frequent medical care</td>
</tr>
<tr>
<td>40</td>
<td>Disabled, requires special care and assistance</td>
</tr>
<tr>
<td>30</td>
<td>Severely disabled, hospitalisation is indicated, although death not imminent</td>
</tr>
<tr>
<td>20</td>
<td>Very sick, hospitalisation necessary, active supportive treatment necessary</td>
</tr>
<tr>
<td>10</td>
<td>Moribund, fatal process progressing rapidly</td>
</tr>
<tr>
<td>0</td>
<td>Dead</td>
</tr>
</tbody>
</table>

Derbyshire End of Life Care Guidance
Appendix 2

Breaking Bad News Flowchart

Step 1 Preparation
Check the patient's notes and talk to the team
Check who should be present
Set time aside
Set the scene and ensure privacy

Step 2 What does the patient know?
‘It would help me to know what you understand about your illness-how did it all start?’

Step 3 Is more information wanted?
‘Would you like me give you more detail about your illness?’

Step 4 Give a warning shot!
‘I’m afraid it looks more serious than we had hoped’

Step 5 Allow patient to refuse information at this time
‘It must be very hard to accept this’

Step 6 Explain (if requested)
A narrative of events can be a useful
Elicit and listen to concerns
‘What are the main things that you are worried about?’

Encourage ventilation of feelings
‘How does that news leave you feeling?’

Summarise and plan
‘Your main concerns at the moment seem to be…’

Offer availability and support
Follow-up appointment
‘We will work on this together.’

Communicate with the Team
Document in notes and letters, inform patients GP

September 2008
### Appendix 3

#### Standard Read Codes

**QOF** = Codes used within QOF

<table>
<thead>
<tr>
<th>5 Byte Version 2 Read Codes (EMIS, Vision, iSoft systems)</th>
<th>CTv3 Codes (TPP SystmOne system)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8BA2. Supportive care</strong></td>
<td><strong>XaHv4 Agreement of care plan</strong></td>
</tr>
<tr>
<td><strong>8BA3. Terminal care</strong></td>
<td><strong>XaHy3 Review of care plan</strong></td>
</tr>
<tr>
<td><strong>8CS.. Agreement of care plan</strong></td>
<td><strong>XaLdI Palliative care plan review</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaOsQ Review of care programme approach care plan</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaQ90 Agreement of care programme approach care plan</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaGdF Final days pathway</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaNhN Seen in out of hours centre</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaLdP Preferred place of death</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaLdN Preferred place of death: hospice</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaLdT Preferred place of death: community hospital</strong></td>
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<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaLdJ Preferred place of death: hospice</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaLdP Preferred place of death: hospice</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaNhP Preferred place of death discussed with patient</strong></td>
</tr>
<tr>
<td><strong>8BA2. Terminal care</strong></td>
<td><strong>XaNhP Preferred place of death discussed with significant other</strong></td>
</tr>
<tr>
<td><strong>Xa6Kb Place of death</strong></td>
<td><strong>XaHv4 Agreement of care plan</strong></td>
</tr>
<tr>
<td><strong>XaGdF Final days pathway</strong></td>
<td><strong>XaHy3 Review of care plan</strong></td>
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<td><strong>XaLdH Final days pathway</strong></td>
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<td><strong>Xa6Kb Place of death</strong></td>
<td><strong>XaLdH Final days pathway</strong></td>
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#### Z57/C – palliative care – QOF

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- 9z2 = GP OOH handover form completed
- 9x0 = GP OOH service notified of cancer care plan
- 9r1 = not for resuscitation
- 9c7 = care support
- 8RMN = issue of palliative care anticipatory medication box
- 8GAD = cross intervention

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Glossary
ACP Advance Care Plan/Planning
ADRT Advance Decision to Refuse Treatment
DH Department of Health
DHU Derbyshire Health United
DNAR Do Not Attempt Resuscitation
DS1500 Report entitling person at end of life to access benefits
EMAS East Midlands Ambulance Service
Eol End of Life
GP General Practitioner
GSF Gold Standards Framework
KPI Key Performance Indicator
IAPT Improving Access to Psychological Therapies
LCP Liverpool Care Pathway
MDT Multi-Disciplinary Team
NICE National Institute for Health and Clinical Excellence
NHSD NHS Direct
OOH Out of Hours
PCT Primary Care Trust
PPC Preferred Priorities for Care
PRN Pro Re Nata (as necessary)
SPC Specialist Palliative Care

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