

Consultation feedback form: draft quality indicators for palliative and end of life care

Consultation is a key element of developing our quality indicators. Your views and comments are valuable to us. All the comments and suggestions we receive will remain confidential (and be processed in line with the Data Protection Act 1998) and will only be used to help develop **quality indicators for palliative and end of life care**. All comments received will be treated anonymously. We would be grateful if you could provide feedback on:

- Appropriateness.
- Key points or areas that are not covered.
- Feasibility of data collection.
- Usefulness in prompting and supporting improvement in palliative care.

The consultation closes on Friday **21 December 2012**.

Please return your completed form by email to hcis.peolc@nhs.net or alternatively you can return the completed form to Jim Smith, Project Officer, Healthcare Improvement Scotland, Delta House, 50 West Nile Street, Glasgow G1 2NP.

At the end of the consultation period, we will collate all comments and the project group will respond to each comment received on the draft quality indicators. We will publish all comments (which will be anonymised), together with the project group's response on the Healthcare Improvement Scotland website (www.healthcareimprovementscotland.org)

Indicator 1: Identifying people with palliative and end of life care needs

Appropriateness	This is an appropriate and relevant measure.
Key points or areas that are not covered	Practices with large number of elderly people and complex multimorbid people should be able to identify more people for whom this would be applicable than, for instance, those in student areas. This should be taken into account when interpreting this indicator.
Feasibility of data collection	This data is routinely sent from primary care for QOF payments.
Usefulness in prompting and supporting improvement in palliative care	Likely to be useful -- partly through primary care staff becoming more skilled at recognising need and also through creating a register that should prompt further management and discussion.
Other comment	<p>There is a level of knowledge and education required for staff to become aware that a patient is suitable for this register (e.g. recognising the palliative nature of illnesses other than cancer) – and this is itself should be good for patient care.</p> <p>In Scotland the great majority of practices are completing the new LES which is giving health boards data about the number of malignant and non-malignant patients that are being identified. Thus, this indicator could comprise two parts: the number of patients with cancer listed with a general practice and who are on the palliative care register, and the number of non-malignant patients etc.</p>

Indicator 2: Assessment and care planning to meet patients' palliative and end of life care needs.

Appropriateness	Fairly appropriate.
Key points or areas that are not covered	<p>If widely and well used, the ePCS could become a respected and useful tool. It is mainly created in primary care and used in acute care. Specialist palliative care has recently gained access to reading but not altering the ePCS data. The College understands its use is variable throughout Scotland so cannot be sure that the ePCS is used well and widely enough for it to be an indicator.</p> <p>Some local Scottish studies in practices show that a number of older people such as those in care homes may have advance care plans done with no ePCS generated. It is possible to have an incomplete ePCS without full information recorded, meaning indicator figures could appear good with the amount of useful information still being limited.</p>
Feasibility of data collection	Feasible.
Usefulness in prompting and supporting improvement in palliative care	Potentially useful and could also help monitor the feasibility of the ePCS itself.
Other comment	The indicator is more a proxy of whether palliative care needs are being assessed and planned for rather than being met.

Indicator 3: Accessing the anticipatory care plan (ACP) in all unscheduled care settings.

Appropriateness	Fairly appropriate. This indicator would be useful for measuring implementation of the ePCS but the College is unsure if it is a direct measure of quality at present.
Key points or areas that are not covered	N/A
Feasibility of data collection	Should be feasible.
Usefulness in prompting and supporting improvement in palliative care	Access to the data cannot ensure implementation of any of the suggestions or wishes recorded on the ePCS. Even if the ePCS has been accessed, there can be no assumption that it has favourably influenced care.
Other comment	<p>Users of the ePCS still need to have a high degree of understanding of palliative care and well developed skills in sensitive communication. For example, preferences regarding hospital admission recorded in the ePCS may have changed in the light of new symptoms.</p> <p>Considerable work will be required to encourage out of hours clinicians to access the ePCS and for primary care to generate more ePCS.</p>

Indicator 4: Place of care at end of life.

<p>Appropriateness</p>	<p>Highly appropriate measure, because there is some certainty that excessive time spent in hospital is not desired by patients in their last months.</p>
<p>Key points or areas that are not covered</p>	<p>The rationale talks about place of death whereas the indicator measures place of care.</p> <p>The College feels that the indicator (proportion of last months spent in hospital) is more relevant than place of death and that the rationale paragraph could be clearer.</p>
<p>Feasibility of data collection</p>	<p>Very feasible.</p>
<p>Usefulness in prompting and supporting improvement in palliative care</p>	<p>Usefulness in supporting improvement is potentially quite high. These figures may pick up extreme failures in community palliative care (i.e. those where care is so lacking that patients are forced to remain in hospital) but there may not be a direct correlation between place of care and quality of care for many patients.</p>
<p>Other comment</p>	<p>Clarification would be welcome on whether a hospice is counted as a community setting or a hospital.</p>

Any further comments

These indicators do not measure or indicate quality of patient care: this should be taken into account if they are to be introduced as Quality Indicators.

The College feels that an important opportunity to engage secondary care in improved palliative care has perhaps been missed when developing these measures - secondary care physicians need to be involved in anticipatory care planning. In addition the importance of communication from secondary to primary care has not been fully acknowledged.

Thank you.

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