Background of Care Profiles

- Care Profiles first developed in 1990s in selected Community Trusts across country
- Targeted care delivered in community settings
- Make explicit the expected service offered to a patient group to meet their needs
- Describe patterns of care or treatment at each stage of Care Pathway
- Clarify relationship between clinical practice and resource use
- Incorporate quality standards and outcomes
- Common framework facilitates comparisons

Care Profiles complement Care Pathways

Liverpool PCT piloted Care Profiles approach to commissioning of End of Life (EoL) care in early 2010

Design, Structure and Content:

The Generic Template Contains Information on:

- Health Needs Group (e.g. Neoplasm); Care Aim; Expected Outcome; Plan/ Protocol: Skill Mix/ Frequency/ Duration/ Location/ Outcome; Consumables; Costing; Limiting Factors; and Quality Standards

It enables Commissioners to specify: what service(s) a patient should expect to receive; at what stage in the disease process; with what resources; and with what expected outcomes.

It enables description of what service “an average patient” would be expected to receive at a particular stage of a given disease process.

Example Extract from Section 4: Plan/ Protocol of End of Life – Stage D: Final Days Pathway (plus post-death bereavement support up to time of funeral)

<table>
<thead>
<tr>
<th>% in group</th>
<th>Plan/Protocol</th>
<th>Skill Mix</th>
<th>Frequency</th>
<th>Duration</th>
<th>Location</th>
<th>Outcomes/ Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Undertake Assessment</td>
<td>1 x Band 6 DN, 1 x Band 5 DN</td>
<td>Once</td>
<td>Range 1 – 2hrs Mean 1 hr 20min</td>
<td>Home</td>
<td>Goals assessed &amp; Care plan identified Related medicines received Initial care delivered &amp; Symptoms managed Variances recorded with outcomes Information provided Equipment/sundry identified &amp; received</td>
</tr>
<tr>
<td>35%night; 55% day; &amp; 10% 24/7</td>
<td>Support worker depending upon need</td>
<td>Support worker 1x Band 3</td>
<td>As required</td>
<td>Range 1-24hr</td>
<td>LCP completed at each visit Goals reassessed Care plan delivered Symptoms managed Variances recorded with outcomes Care/ families reassured / information supplied Patient supported Care provided in place of choice</td>
<td></td>
</tr>
<tr>
<td>40%</td>
<td>CSPN (Specialist or Matron): Accompany DN when DN on (above) scheduled visit</td>
<td>1 x Band 7 DN</td>
<td>Once over pathway</td>
<td>Range 30–45min Mean 35 min</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GP face-to-face visit required at some point, as GP normally certifies death, which requires GP seeing patient within the 2 weeks prior to death.**

Results:

- Care Profiles developed for:
  - Stage A: Supportive Care (6-12 months ahead of projected death),
  - Stage B: Palliative Care (1-6 months ahead of projected death),
  - Stage C: Anticipatory Palliative Care (Final Days – one month ahead of projected death)
  - Stage D: Final Days (plus post-death bereavement support up to time of funeral)
  - “Uncertainty” Profile: What happens when a patient/carer is uncertain of what to do, when they are on their own and a problem or crisis arises?
  - Comprehensive requirements identified for people living at home or in a care home.
  - Skill mix, delivery, quality and outcomes set for each stage of End of Life pathway
  - Consistent with local End of Life Supportive Care Register and Read codes
  - Basic End of Life service requirements are same irrespective of the related disease.
  - Integration into Liverpool PCT’s End of Life Care commissioning process

Conclusions:

- Care Profiles are a Commissioning Tool which enable Commissioners to break down Care Pathways into constituent parts.
- Commissioners can match expected service with required resources, and therefore EoL Care Profiles enable and support the recommendations of the Palliative Care Funding Review in relation to EoL services outside hospitals
- Care Profiles:
  - Are simple and flexible, and Complement and augment integrated Care Pathways
  - Record outcomes throughout patient journey, and support audit & quality systems
  - Support Advance Care Planning, by ensuring the range, quality and consistency of information given to patients & carers, with any potential choices highlighted
  - Enable the commissioning of End of Life and other services
  - Enable consensus across sectors and interests through transparency
  - Will evolve over time
  - EoL services will vary between PCTs; Benchmarking is important.
- Care profiles can support GP commissioning of EoL services by providing clinically relevant and detailed information to specify and cost services.