Using Care Profiles to Augment the End of Life Care Pathway

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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 care in early 2010

Design, Structure and Content:
The Generic Template Contains Information on:
- Health Needs Group (e.g. Neoplasms); 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>Assessment: Home setting</td>
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<td></td>
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<tr>
<td>100%</td>
<td>Undertake Assessment</td>
<td>1 x Band 6 DN &lt;br&gt; 1 x Band 5 DN</td>
<td>Once</td>
<td>Range 1 – 2hrs &lt;br&gt; Mean 1 hr 20min</td>
<td>Home</td>
<td>Goals assessed &amp; Care plan identified &lt;br&gt; Initial care delivered &amp; Symptoms managed &lt;br&gt; Variances recorded with outcomes information provided &lt;br&gt; Equipment/sundries identified &amp; received</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>Once</td>
<td>30min</td>
<td></td>
<td></td>
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</tbody>
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**GP face-to-face visit required at some point, as GP normally certifies death, which requires GP seeing patient within 2 weeks prior to death.

Ongoing Assessment and Treatment: Home Setting

| 100% | Morning | 1 x Band 6 DN plus 1 Band 3 | Once daily | Range 1hr 30min–2hr <br> Mean 1 hr 45min | Home | LCP completed at each visit <br> Goals reassessed <br> Care plan delivered <br> Symptoms managed <br> Variances recorded with outcomes <br> Care/ families reassured / information supplied <br> Patient supported <br> Care provided in place of choice |
|       | Afternoon | 1 x Band 5 DN plus 1 Band 3 | Once daily | Range 30-45 min <br> Mean 35 min |       |       |
|       | Evening | 1 x Band 5 DN plus 1 Band 3 | Once daily | Range 30-45 min <br> Mean 35 min |       |       |
| 35% day: 55% night: & 10% 24/7 | Support worker depending upon need | Support worker 1 x Band 3 | As required | Range 1-2 hrs |       |       |
| 40% | CPSN(Specialist or Matron): Accompany DN when DN on (above) scheduled visit | 1 x Band 7 DN | Once over pathway | Range 30-45 min <br> Mean 35 min |       |       |

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 enable Commissioners to break down Care Pathways into constituent parts.
- Commissioners can match expected service with required resources.
- Care Profiles:
  - Are simple and flexible, and Complement and augment integrated Care Pathways.
  - Record outcomes throughout the patient journey.
  - Support audit and quality systems.
  - Enable the commissioning of End of Life and other services.
  - Enable consensus across sectors and interests through transparency.
  - Will evolve over time.
- End of Life services will vary between PCTs, benchmarking is important.
- Care profiles can support GP commissioning by providing clinically relevant and detailed information to specify and cost services.

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