Unplanned Admissions and End of Life Care

Like many British GPs I find professional life busy at present. We know why that is. We have been remarkably successful as a profession, contributing to the fact that the number of people aged over 80 will double between 2010 and 2030. We do an amazing job considering that, for the over 80s, consultation rate is reported to be 14/year. I hope these figures encourage you to support the RCGP Put Patients First Campaign (http://www.rcgp.org.uk/campaign-home/~/media/Files/Policy/PPF/Put-Patients-First-campaign-brief.ashx. Please also engage and support those involved in commissioning to put in place services to help support you as trusted GPs to care for your patients better. RCGP advice on commissioning priorities may help you with guidance on urgent priorities to help patients and GP's, including ideas about partnership working to allow sustainable workload planning in this time of demographic change. (http://www.mariecurie.org.uk/Global/commissioners-and-referrers/Commissioning-EOLC-to-improve-patient-outcomes.pdf)

With my special responsibility for leading on End of Life issues I find attending a one day RCGP accredited 'hot topics' update program such as that run by Dr Simon Curtis FRCGP very helpful to keep my generalist knowledge up to date.

A major section on this year's course was about the introduction in England of the new Unplanned Admissions Enhanced Service (http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/general-practice-contract/unplanned-admissions-2014). This follows the retirement of many unpopular QOF targets and includes the need for personalised plans. This may well allow us to exemption report more often patients with multimorbidity. A recent BJGP paper (BJGP2013:63:315) argues that exception reporting should be seen as a quality marker of patient centred evidence based care.

The good news about this service is that it contains components that many GP's already do as routine high quality primary care, and this will now get recognised. Applying the GSF principles of Identify, Assess and Plan and then coding the patients' needs should make the processes required for the DES manageable. (http://www.goldstandardsframework.org.uk)

One challenge maybe the potential complexity of now finding the 2% of patients at risk of admission after many have been working hard to find the 1% (http://www.dyingmatters.org/gp) likely to be in the last year of their lives. Clearly this 1% is an important subgroup of the 2% we are required to identify. However, with the increasing multimorbidity we work with as GPs, it is more realistic to identify people in their last years of life than predicting accurately those that are in their last year. Having 2 systems in place would be complex when we need to do everything we can as GP's to keep things simple. I will work hard to try to ensure reporting systems recognise the link between good end of life care co-ordination using tools such as EPaCCs/KIS (see relevant article in this same issue) as part of case management to reduce inappropriate or unnecessary admissions. Although some reports suggest case management has little impact, a risk identification and case management programme in NHS Highland has significantly reduced unplanned admissions and hospital bed days (BJGP2012;62;84)

Other available help comes from tools such as the 'QAdmissions' Tool for predicting emergency admissions (http://bmjopen.bmj.com/content/3/8/e003482.full)

Highlighted in the 'hot topics' course literature is an excellent article entitled 'Best care for the dying patient'(http://www.bmj.com/content/347/bmj.f4428), co-authored by co-author Mayur Lakhani well known to GPs as a highly respected past Chair of the RCGP, now Chairman of the National Council of Palliative Care.

In this article 10 Key elements are highlighted.

Ten key elements of care for the dying patient

- Recognition that the patient is dying
- Communication with the patient (where possible) and always with family and loved ones
- Spiritual care
- Anticipatory prescribing for symptoms of pain, respiratory tract secretions, agitation, nausea and vomiting, dyspnoea
- Review of clinical interventions should be in the patient's best interests
- Hydration review, including the need for commencement or cessation
- Nutritional review, including commencement or cessation
- Full discussion of the care plan with the patient and relative or carer
- Regular reassessment of the patient
- Dignified and respectful care after death

By applying these Key elements we will reduce unnecessary hospital admissions and deaths.

Dr Peter Nightingale