

# 'Now nobody falls through the net': practitioners' perspectives on the Gold Standards Framework for community palliative care

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The Gold Standards Framework (GSF) seeks to facilitate consistent and high quality community palliative care through a set of guidelines, mechanisms and assessment tools. The present study set out to examine practitioners' perspectives on the GSF during its first national roll-out. Two general practices that had adopted the GSF were recruited in each of four geographical areas, and each matched as closely as possible with a non-GSF practice. Sixty-eight semi-structured telephone interviews were carried out with general practitioners and district nurses in 16 selected practices, along with the GSF facilitator and up to four other 'stakeholders' in each area. Analysis revealed that the majority of GSF participants felt that the framework had strengthened their provision of community palliative care. In particular, communication within primary health care teams and co-ordination of services improved, aspects which were better in the GSF practices than in the matched non-GSF practices. Practitioners felt there was more consistency of care, with a reduced likelihood that individual patients would 'slip through the net'. The most common areas of concern were in relation to the workload associated with the role of the GSF co-ordinator. Implications for the development and effective implementation of the framework and for further research are discussed. *Palliative Medicine* 2005; **19**: 619–627

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## Introduction

There is a growing awareness of the important role of generalist community practitioners in the provision of palliative care. The recent guidance from the UK National Institute for Clinical Excellence,<sup>1</sup> affirms that most palliative care is delivered by the patient's usual generalist healthcare provider. However, there are many potential difficulties facing community practitioners in ensuring the quality of this care and support. Levels of knowledge and experience of palliative care amongst community professionals vary considerably. Crisis admissions to hospital may occur where there is a lack of symptom control, carer breakdown, or poor experiences of services.<sup>2,3</sup> Co-ordinating the various agencies that may be involved with a palliative care patient can be a major challenge, especially with regard to the relationship between in-hours and out-of-hours services.<sup>1,4–6</sup> Support for carers is vital, but identifying

their needs may be hard where they themselves may not be fully aware of them.<sup>7</sup>

Responding to such challenges, the Gold Standards Framework (GSF) is a national initiative that seeks to facilitate consistent and high quality community palliative care. Growing out of earlier work on out-of-hours services,<sup>5,6</sup> the GSF was developed by Dr Keri Thomas with support from the NHS Cancer Services Collaborative and Macmillan Cancer Relief. Following a pilot phase (referred to as 'phase one'), the framework was rolled out to 76 practices across 18 areas of England, Scotland and Northern Ireland ('phase two'). Box 1 presents a summary of the development and contents of the GSF up to the point at which this study was carried out.

The present study was carried out in phase two of the GSF programme, which ran from February 2002 to January 2003. Its focus was on the experiences of key members of the primary health care team (PHCT) in practices implementing the GSF. We were concerned to discover how the framework was integrated into the daily life of a practice, and whether practitioners saw it as succeeding in meeting their aspirations for community palliative care. Specifically, we sought to address the following research questions:

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## Box 1. The development of the GSF

The GSF was initially developed by Dr Keri Thomas in her capacity as Macmillan GP facilitator, working in the area of West Yorkshire, UK, covered by the then Calderdale and Kirklees Health Authority. Following extensive practice visits and other consultations focused on community palliative care, the first version of the framework was produced and piloted for a year in 12 practices in West Yorkshire, commencing in February 2001. On the basis of positive evaluation of phase one, the framework was rolled out nationally for phase two, supported by Macmillan Cancer Relief and the Cancer Services Collaborative of the NHS Modernization Agency. Phase two ran for a year from February 2002.

Drawing on an extensive review of the literature, the GSF presents guidelines, mechanisms and assessment tools for community palliative care. It proposes a three-step model of good practice, in which practitioners must firstly identify their palliative care patients, secondly assess their needs (and those of their carers), and thirdly plan care and support to meet the needs. To help practitioners follow these steps, the framework centres on seven key areas (known as the '7 Cs') that professionals need to address in order to provide good, holistic care. These are as follows:

**C1 Communication**

A supportive care register is compiled and maintained, to record, plan and monitor care. This is used as a focus for discussion of palliative care patients at regular primary health care team (PHCT) meetings.

**C2 Co-ordination**

Each PHCT has a designated GSF co-ordinator, responsible for overseeing the implementation and utilization of the framework.

**C3 Control of symptoms**

Through proper assessment, monitoring and an anticipatory approach to care, patients' symptoms are controlled as effectively as possible.

**C4 Continuity**

Clear and consistent transfer of information between agencies is a priority – in particular, between in-hours and out-of-hours services. This is achieved by mechanisms such as out-of-hours handover forms, and the use of lead practitioners nominated for each registered palliative care patient.

**C5 Continued learning**

The PHCT commits itself to continued learning relevant to all aspects of community palliative care.

**C6 Carer support**

Meeting the needs of carers is seen as an integral part of high quality community palliative care. This includes routinely offering bereavement support.

**C7 Care of the dying (terminal phase)**

The holistic needs of the patient in the very last days of life (and of their carers) are met, following recommendations for best practice such as the Liverpool Integrated Care Pathway.<sup>9</sup>

The GSF programme is organized in areas, each with its own facilitator – usually a GP with a strong interest in palliative care, in some cases with an existing role as a Macmillan GP facilitator. Within each participating practice, the lead GP has overall responsibility for guiding the implementation of the scheme within the practice. The co-ordinator is responsible for the day-to-day running of the scheme, including such things as maintenance of the supportive care register, disseminating information about palliative care to colleagues, and returning monitoring information for evaluation purposes.

- What was the perceived impact of the GSF on palliative care services in the community, from the perspectives of primary care practitioners?
- What lessons can we draw from practitioners' experiences for the development of the framework, to facilitate wider uptake and successful implementation of the GSF?

Note that we use the term 'practitioner' to refer to any primary health care professional involved in the provision of palliative care (usually alongside other services). Where we are referring to a specific profession we will name it explicitly (e.g., 'GPs', 'district nurses').

## Methods

The methodology adopted for this study was a form of qualitative case study, incorporating comparisons between GSF and non-GSF practices. Epistemologically, the study is located towards the 'realist' end of the spectrum for qualitative research.<sup>10,11</sup>

### Design and procedure

We recruited practices from four separate geographical areas in Scotland and the North of England. The areas were selected to ensure diversity in terms of overall level of local involvement in GSF, availability of specialist palliative care resources, and socio-economic and geographic characteristics. We aimed to recruit two GSF practices from each area, and two matched non-GSF practices. Data were collected using semi-structured interviews, carried out over the telephone; an approach we found effective in a previous study.<sup>6</sup> Ethical approval was granted by the Local Research Ethics Committees of the four participating areas.

### Recruiting practices

Practices were recruited with the assistance of the GSF facilitators for each area. They were purposively matched as closely as possible in terms of list size, type of population served, and PHCT composition. In one area (Area Four) we were unable to recruit a second non-GSF practice in the time available to us (Table 1).

Within each practice we sought to interview the lead GP, GSF co-ordinator (nurse or administrator), and one other GP and district nurse. We also interviewed the GSF facilitator for each area, and up to four additional local 'key stakeholders'. These were individuals identified by other participants – most often by the GSF facilitators – who were particularly well-positioned to provide us with a deeper understanding of palliative care issues in their area. In total, we carried out 68 interviews. Details of participants interviewed are given in Table 2.

### Interview procedure

The semi-structured interview guide included questions focused on the '7Cs' and the extent to which participants felt that they were achieving these standards. GSF participants were asked how their practice joined the framework, the process of managing it, and their perceptions of its impact. Non-GSF participants were asked whether they were aware of the framework, whether they had considered joining it in the past, and if they were, why they had not done so. All participants were asked what they thought about their practice's potential future use of the framework. All interviews were conducted by telephone, at pre-arranged times. They averaged 35 minutes in length (range 30 minutes to one hour), were tape-recorded with participants' consent, and transcribed in full.

**Table 1** Details of participating practices and GSF to non-GSF matching

Area	Matched practices	List size	No. of GPs	Location
1	GSF 1/1	9500	3 ft+2 pt	Semi-rural village
	Non-GSF 1/4	10000	4	Semi-rural small town
	GSF 1/2	4000	1 ft, 1 pt, 1 registrar	Semi-rural small town
	Non-GSF 1/3	6000	3 ft+1 pt	Semi-rural village
2	GSF 2/1	8900	4	Suburban
	Non-GSF 2/5	10600	4	Urban
	GSF 2/2	6200	5	Urban
	Non-GSF 2/4	3776	2	Urban
3	GSF 3/1	8000	5	Urban
	Non-GSF 3/4	11250	4 ft+1 pt	Suburban
	GSF 3/2	6700	3	Urban
	Non-GSF 3/3	4100	2	Urban
4	GSF 4/2	9000	3 ft+2 pt	Urban – high deprivation
	Non-GSF 4/3	9000	3	Urban – high deprivation
	GSF 4/1	4500	2 ft+2 pt	Urban – high deprivation

**Table 2** Participating practitioners from each area

Area	Practitioners recruited								
	General practitioners		District nurses		Practice administrative staff		Totals		
	GSF	Non-GSF	GSF	Non-GSF	GSF	Non-GSF	GSF	Non-GSF	GSF facilitators and additional
1	4	2	4	4	0	0	8	6	5
2	3	4	3	4	2	0	8	8	4
3	4	3	3	2	0	0	7	5	5
4	4	1	4	2	0	0	8	3	1
Totals	15	10	14	12	2	0	31	22	15

### Analysis

We employed a variant of the 'matrix' style of thematic qualitative analysis.<sup>12–14</sup> In this, main themes identified as relevant to the research question(s) are used as headings for columns in a large table, with cases as rows. Relevant material from interview transcripts is summarized in the appropriate cell on the table. In our study, we specified initial themes related to the '7Cs', but modified, refined and added to these in light of preliminary coding of the data.

Our analysis involved the construction of three levels of matrices. First, we produced a matrix for each practice, with the individual participant as the 'case'. We then condensed the matrices at an area level, with data summarized for each practice as a whole. Finally, we produced a comparative matrix for each area, enabling us to look at differences between GSF and non-GSF practices. At each stage of the analytical process we employed quality checks, involving comparisons of coding between team members and – at key stages – with independent experts (see King *et al.*<sup>14</sup>).

### Findings

We present below the outcomes of the thematic analysis across GSF practices, followed by a comparison of thematic data between GSF and non-GSF practices.

#### Thematic analysis of interviews from GSF practices

The summary of the main findings is organized around seven main thematic areas used in the analytical matrices: joining the framework, communication, co-ordination, care of the patient (including terminal care), continuity, continued learning, carer support. (Note that all names are pseudonyms. Areas and practices have been anonymized by the use of code numbers; for instance 'A1/P2' refers to Area 1, Practice 2.) In Box 2 we present illustrative quotes from the transcripts relating to each main theme.

#### Joining the GSF programme

The decision to use the framework was usually taken by one GP – who then proceeded to be the lead GP for the framework in the practice. The extent to which the wider team was consulted about the decision appeared to vary considerably. A range of reasons for joining was given, with the desire to improve communication within the team and to be more consistent in standards of care especially stressed. The training provided on joining the framework was generally viewed as helpful, but some co-ordinators felt that the amount of reading material at the start was excessive.

#### Communication

Most participants felt that the GSF had led to improved communication within the team. Multi-disciplinary meetings were seen as very important in achieving this. In many cases, participants also thought that the GSF had facilitated improved communication with patients and carers, in terms of establishing their needs, and ensuring that they understood which services they could access. Finally, good readily-accessible communication with local specialist palliative care services was seen as very valuable, as was the involvement of specialists in educational activities for practice staff.

#### Co-ordination: roles in the GSF

In all practices, the lead GPs and co-ordinators knew their area GSF facilitator, and they were unanimously positive about the support they received from them. Other staff varied in whether they were clear who their area facilitator was, and whether they understood the role. In all practices except the two from Area Two, the role of GSF co-ordinator was filled by a district nurse. Often they had effectively been 'volunteered' for the role, as a result of their interest or experience in palliative care. Co-ordinators found their role interesting and fulfilling, but often complained about the workload associated with it. This appeared to be mainly due to competing pressures from clinical workload, as well as in some practices excessive reliance on the co-ordinator alone to

## Box 2. Examples of typical quotes relating to each main theme

All names are pseudonyms. Practices are referred to by code numbers; '1/1' thus refers to area one, practice one.

**Joining the framework**

... it would improve our palliative care and sort of standardise it to make sure that everybody got the same level of care and the same standards of care. (Hannah, DN, 1/1)

I think the hand book that we have got is very large and very daunting, if anybody has got to read that, it's huge, have you seen it? (Nancy, DN, 1/1)

**Communication**

Because we're a two-site practice it means that we're getting together with the colleagues that we don't usually work with like the other nurses who work on the other site. We can give them information about ideas that we have, and vice versa. We can also help them with things that we've tried in symptom management with patients and again they can tell us things. (Barbara, DN, 4/2)

It gives patients confidence as well that there is a team of people looking after them and that they're not so much out on a limb and, you know, also we can give them information which we just didn't have available before. (Bernadette, GP, 4/2)

**Co-ordination: roles in the GSF**

He's [the GSF Facilitator] been at every meeting as far I've been able to attend and he's made himself available should we have any queries, you know he's very approachable, so that's been excellent. (Cathy, DN, 3/1)

I mean we are busy at the moment and we just don't have time to em keep the paperwork necessary up to date when the case load is heavy, that really has impacted on it when it's busy, the case load. (Nancy, DN and Co-ordinator, 1/1)

**Co-ordination: supportive care register**

They're [i.e., palliative care patients] certainly not getting missed ... we tend to be better informed about what's happening with a particular patient than we would have been otherwise. (Ken, GP, 1/1)

**Co-ordination: the use of 'tools'**

It puts some structure to the discussion and as I say you get clarity of information on the same patients. ... You're getting the same, you're asking the same questions on each individual patient and you're using the same criteria to measure the information that you're looking at, so yes it is helpful. (Lyndsey, Practice Manager, 2/1)

Yes it [7Cs] does sort of remind you of the systematic approach to care but I think a lot of times you do these things without realising that you're following a pattern anyway. (Cathy, DN, 3/1)

**Care of the patient**

We've avoided problems with symptom control by sorting out medication before things like constipation and nausea have got to the stage that he's needed either more intensive treatment or even admission to hospital. (Robin, GP, 3/1)

**Continuity**

I think we make sure that they've all got a, like a [handover] form, you know, a palliative care handover form, things like that ... we lapsed a bit before, we're on the ball with it now. (Belinda, DN, 1/2)

**Continued learning**

The education sessions that we've done at the practice, they've made us more aware of different things . . . you know, like say breaking bad news . . . and the pain . . . we did one on pain management and that helped us a lot. (Sabrina, DN, 3/2)

**Carer support**

They [Carers] do get more support [since GSF] actually because their needs may be more sort of better addressed . . . we'd sort of discuss various problems as a group and then a member of that group says well, he can sort something out for that. (Ken, GP, 1/1)

We try to meet people in the immediate aftermath. I tend to loosely keep tabs on people and kind of encourage them to come back, but I'm sure it's not structured enough. People slip through the net. (Paul, GP, 4/1)

'carry' the framework. The requirement to compile data for audit of the framework contributed significantly to the perceived burden of 'paperwork'. Interestingly, in the two practices where a member of the administrative staff took on the co-ordinator role, excessive workload was not cited as a problem.

The lead GP's role appeared more flexible and open to interpretation than the co-ordinator's role. While they were generally seen as a source of expert medical advice on palliative care for the PHCT, chaired meetings, and encouraged the participation of their fellow GPs, lead GPs varied considerably in what else they did. Their active championing of the framework seemed an influential factor in the enthusiasm with which the practice as a whole embraced the GSF.

**Co-ordination: supportive care register**

Six of the eight practices had set up some form of supportive care register since the start of the GSF. While creating, and to a lesser extent maintaining, the register involved a substantial amount of work, the vast majority of participants felt it had been worthwhile. Above all, they saw the register as helping them to be more consistent in the care they gave, decreasing the likelihood that some patients would 'slip through the net'.

**Co-ordination: the use of 'tools'**

The GSF provides practices with a number of assessment tools in the form of checklists, which may be used in reviewing patients, assessing their needs, and for educational purposes. We focused particularly on the two general checklists that are highlighted in the introductory material to the framework; the '7Cs' (discussed above; see Figure 1) and the PEPSI-COLA checklist<sup>1</sup>.

<sup>1</sup> The acronym relates to the areas covered by the checklist: Physical, Emotional, Personal, Social support, Information and communication, Control, Out of hours and emergency, Late (end of life), Afterwards (bereavement). Under each area is a more detailed and specific set of reminders and suggestions.

The latter is described by Thomas (2003) as 'a broad-brush holistic approach to trigger consideration of all areas, not a tick box [exercise]' (p. 209).<sup>8</sup> We also talked about other tools when these were raised by interviewees.

We found considerable variation in awareness and use of these tools between – and sometimes within – practices. The PEPSI-COLA checklist was used quite often to help structure a review of patients from the register at team meetings, though somewhat less often in patient assessments. District nurses felt that although such tools were useful reminders about holistic care, they already embraced such an approach in their standard practice. It also appeared that some participants found the checklists too time-consuming, probably because they were using them too rigidly.

**Care of the patient**

The GSF's anticipatory approach to care was commonly seen as having positive effects on symptom control and pain management. Better planning meant that medication and syringe drivers were available when needed – especially out-of-hours – and crises could be averted. Other benefits referred to by some practitioners included the use of pain diaries, and symptom control and pain management sheets.

Issues specific to terminal care were mentioned less often than general symptom control and pain management. Several participants referred to the fact that the GSF had increased their awareness of the need to establish a preference for place of death, and their confidence in discussing this with patients.

**Continuity**

Many practices were already using mechanisms, such as handover forms, to communicate with out-of-hours service providers before the implementation of GSF. Nevertheless, quite a few participants commented that the GSF had helped reinforce this good practice; for instance, by being more consistent in the use of forms.

Continuity was further enhanced in some practices by the introduction of the use of ‘named practitioners’ for all palliative care patients.

**Continued learning**

In all four areas, educational events related to the GSF were held. However, in most of our practices, these were only attended by the lead GP and co-ordinator. Two of the eight practices held regular in-house educational activities, which were valued by participants. Finding time to attend educational activities, and prioritizing between palliative care and other subjects, were common problems.

**Carer support**

The GSF was widely seen as helping to ensure more consistent and co-ordinated carer support, though this remained an area where many of our participants saw room for further improvements; for instance, two practices were planning to set up a Carers’ Register in the near future. Bereavement support was frequently singled out as requiring a more planned and consistent approach.

**Comparison of GSF and non-GSF practices**

We systematically compared accounts of how palliative care was organized in seven of the eight GSF practices with purposively matched non-GSF practices. (In Area Four we were unable to recruit a second non-GSF practice.) We took a conservative approach here, only highlighting those aspects where we felt that there were strong grounds to conclude that there was a real difference between practices. Table 3 shows the extent

to which there appeared to be strong and consistent differences between GSF and non-GSF practices.

**Discussion**

**Overall perceived impact**

Despite differences between – and sometimes within – practices, there are some strong common themes readily discernable. On the positive side, the GSF was widely seen as making care more standardized and consistent, with less danger of patients ‘slipping through the net’. Practitioners tended to feel more aware of patients’ and carers’ needs because of the GSF, and some have clearly been empowered to respond to them by the framework. The combination of regular meetings to discuss palliative care patients and the use of a supportive care register seems to us to have played a key role in making the GSF successful. It is worth noting that seven of the eight GSF practices expressed intent to continue with the framework after the phase 2 period, while in the remaining case opinions were divided (with district nurses more enthusiastic than GPs).

On the negative side, there was generally perceived to be an excessive amount of ‘paperwork’ associated with the framework, most of which fell on the co-ordinator. As we noted earlier, some of this was due to evaluation requirements, which have been reduced in subsequent phases of GSF implementation. However, excessive reliance on one person to keep the GSF on track in a practice – especially a district nurse managing this work alongside their normal caseload – leaves the framework vulnerable if that person should become unable or unwilling to fulfil the role. The direct benefits of the

**Table 3** Comparison of GSF and non-GSF practices

Theme	GSF/non-GSF comparison
Communication	GSF practices somewhat more likely to hold regular PHCT meetings (six GSF practices compared to three non-GSF) and to allocate time specifically to palliative care issues (six GSF practices compared to one non-GSF) Only one non-GSF practice used equivalent to GSF homepacks, which were used in all GSF practices
Co-ordination	GSF practices much more likely than non-GSF practices to: use some kind of supportive care or cancer register (all GSF compared to three non-GSF) have members of staff with formal responsibility for overseeing palliative care issues (all GSF compared to two non-GSF) use systematic tools such as the PEPSI-COLA checklist (six GSF compared to none of the non-GSF)
Care of the patient	Some indication of more emphasis on consistency of care in GSF practices (five GSF draw attention to specific efforts to improve consistency, compared to two non-GSF), and on importance of discussing preferred place of death with patients and carers (strongly emphasized in two GSF practices but none of the non-GSF)
Continuity	No substantial differences between GSF and non-GSF practices in the measures they took to try to ensure continuity out-of-hours GSF practices more likely than non-GSF practices to have ‘named practitioners’ for palliative care patients
Continued learning	In three of the seven paired comparisons, GSF practices had greater involvement than non-GSF in palliative care education. In others there was no notable difference
Carer support	No clear evidence of substantial differences between GSF and non-GSF practices

framework to patients may not be very apparent in the short term, given that at any one time a practice may have relatively few palliative care patients on its list. Some practitioners may therefore initially feel that the benefits of the framework are not great enough to outweigh the costs in terms of time and effort in setting it up and maintaining it. However, our experience, as noted above, was that the majority felt continued participation to be worthwhile.

The GSF is a flexible framework, in that those adopting it are not compelled to take on all aspects from the start, and are allowed to find their own means of achieving many of the desired ends. This has important strengths, in that practices can develop ownership by adopting it in a way that fits their particular circumstances, and at their own speed. However, there are also potential weaknesses. Flexibility makes it easier to 'drift' into disengagement from the framework. It may make it harder to attribute benefits to the framework *per se*. Practices may feel they are already meeting the standards of the GSF through their own procedures. This may well be the case, but there is also a danger that carrying on with practice 'as normal' may mean that weaknesses are overlooked. Finally, practices may avoid parts of the framework that are actually of central importance if it is to have a positive impact.

All 16 practices felt that the palliative care they provided was generally of good quality. However, quite often non-GSF participants said that while individual patients generally received good care, the quality could be sporadic. At the same time, GSF participants often saw consistency of standards as a key gain from the framework. This supports the notion that through formalizing consistent good practice, the GSF can act as a safety net, ensuring that as many patients as possible receive high quality care. Such a safety net is especially valuable where an organization is under multiple external pressures, as general practices commonly are, with many competing priorities.

District nurse participants were more consistently enthusiastic about the framework than GPs. In part, this may reflect GPs' greater exposure to competing demands from other initiatives in primary care, as well as the fact that district nurses tend to be more directly involved in providing palliative care than GPs.<sup>6</sup> Finally, one of the main benefits of the framework noted in its first few months was improved communication within the team. This is likely to be especially valued by district nurses, given the commonly-reported difficulties they can have in establishing good communication with GPs.<sup>15</sup>

### Limitations of the study

A qualitative evaluation such as this does not seek, in the way a quantitative study would, to claim generalizability. However, it does aspire to 'transferability' in the sense

that a sufficiently thorough analysis of the data is presented to enable readers to learn lessons they can apply to cases in which they are involved.<sup>16</sup> We would argue that by presenting data from eight quite different practices in four geographically distinct areas, we have provided sufficient breadth and depth to offer useful opportunities for transferability. We would note, though, that there may be some practice contexts that differ greatly from our cases; for example, none of our practices was in a remote rural setting.

Studies such as this always tend to disproportionately attract the participation of enthusiasts, and this must be borne in mind in interpreting the findings.<sup>16</sup> In our case, all the GSF practices might be considered enthusiasts. However, the matching non-GSF practices are also likely to have had an interest in palliative care, given their willingness to participate. We therefore feel that consistent differences between the two groups of practices are not likely to merely reflect differences in enthusiasm for and commitment to community palliative care.

### Lessons for implementation

On the basis of our study, we would highlight a number of lessons for enhancing the likelihood of successful implementation. In keeping with our qualitative research, we would stress that this should not be seen as rigid rules, but as guidelines to be considered in the context of a particular practice's situation.

Firstly, it is important that the GSF is 'owned' by the practice team as a whole, rather than being seen as the special interest of one or two members. Making sure that staff are involved in the decision to implement the framework, rather than having it imposed upon them, should help. We also feel that our cases suggest that the use of regular team meetings contribute strongly to a 'deep' rather than 'shallow' adoption of the framework.

Secondly, co-ordinators need to be well-supported. This might mean giving them a measure of relief from other duties, sharing some of the administrative work amongst colleagues, and encouraging their involvement in related professional development activities. Our findings suggest that with a team approach, the co-ordinator can be a non-clinician. In any case, close co-operation with the practice administrators is to be recommended.

Thirdly, practices can take advantage of the flexible nature of the framework to think strategically about how they are going to implement it. They can do so one step at a time, rather than trying to introduce it all at once. They should also be encouraged to creatively develop the framework in ways that respond to their particular local circumstances.

Finally, practices should seek to strengthen their links with local specialist palliative care services. Knowing that specialist advice is available can be important in bolstering the confidence of generalist practitioners. Links with



specialists may also be valuable in terms of educational opportunities that can be built from them.

## Conclusion

Our overall conclusion is positive for the use of the GSF. Almost all the practitioners felt their practice had gained from the framework, and the clear majority wanted to continue with the changes it had brought. The value of the GSF in enhancing communication and co-ordination is especially apparent. Lessons from the research described here have already been drawn upon in the further dissemination of the GSF, for example, in reducing the administrative burden for co-ordinators. Following a two-year support programme from Macmillan, the GSF has now been introduced in almost a fifth of general practices in England, Scotland and Northern Ireland. Use of the GSF has been recommended in the NICE Guidance on supportive and palliative care,<sup>1</sup> as part of the NHS End of Life Care programme, and in the House of Commons Select Committee Report on Palliative Care.<sup>17</sup>

In light of our study, we would suggest the following priorities for future research on the GSF. Firstly, the impact of the framework on patients' and carers' needs to be examined directly. Secondly, more work is required on the roles of the community nurse in palliative care, under the GSF. Finally, the issue of the sustainability of the framework must be addressed.

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