Anticipate resistance: proposed implementation of the GSF will prompt different responses from team members and some may show resistance behaviours, such as passive resistance or active opposition. These are common reactions to change (Pearce, 2007) and can be addressed by inviting people to discuss and identify their objections and suggest realistic solutions.

Evaluate current practice
The team may need to have an explanation of why it is necessary to implement the GSF. Evidence supporting the need for change and against which their service can be benchmarked is helpful, and can be compiled by various methods, for example, by using:

- Documents published by the DH (2009; 2008a);
- Local palliative care/cancer networks in conjunction with published research.

Care can be evaluated locally using the methods in Box 1, generating data which would enable team members to determine for themselves that change is necessary and increasing the likelihood that they will accept, support and facilitate implementation (Gopee and Galloway, 2009; Hodges, 2008). These methods can also be used to evaluate care after implementing each level to determine how or whether improvements have been made and where gaps exist.

Identify a coordinator
The team should identify a GSF coordinator, defining what the role entails before deciding who would be best to undertake it. Once the coordinator is identified it is important to work out how the role can be incorporated into their current workload, identifying capacity and workload issues and areas for appropriate delegation.

Produce a register of patients
A palliative care register (also known as supportive care register) should be produced (Thomas, 2003), listing all patients receiving palliative care and likely to be in the last 12 months of life.

This register forms the basis of multidisciplinary team (MDT) meetings and ensures all relevant patients are known to the team. The aim is to keep their condition manageable in the community through proactive management and crisis avoidance. The register also ensures patients have rapid access to services to meet their needs, such as new or repeat prescriptions and prompt review visits by relevant practitioners.

The register must be updated to keep pace with changing situations; this requires good communication between the team who identify eligible patients and the coordinator who adds them to the register. GP practices that have a “complete register available of all patients in need of palliative care/support” (British Medical Association and NHS Employers, 2009) can claim three Quality and Outcomes Framework (QOF) points per year, worth around £600.

Identify eligible patients: the team must identify their educational needs in terms of making prognoses and determine how these needs can be met, to ensure they are able to recognise patients who they consider may be in the last 12 months of life and report these to the practice. The sooner patients are identified the sooner advance care planning can begin. Financial constraints mean education resources will inevitably be affected, so innovative and cost effective methods of addressing knowledge gaps will be needed.

Organise primary healthcare team meetings
After the initial meeting, dates for future MDT meetings should be organised, in which patients on the register are discussed. Effective communication between caregivers is vital, as best care depends on recognising patients who they consider may be in the last 12 months of life and report these to the practice. The sooner patients are identified the sooner advance care planning can begin. Financial constraints mean education resources will inevitably be affected, so innovative and cost effective methods of addressing knowledge gaps will be needed.

FIG 1. THE SEVEN KEY TASKS IN RELATION TO LEVELS OF IMPLEMENTATION

| Level 1 | Communication | Coordination |
| Level 2 | Control of symptoms | Continuity including out of hours | Continued learning |
| Level 3 | Carer support | Care in the dying phase |


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