**Example case study - Led by Dr Sophie Brandon, GP**

Starting the Daffodil Standards

**Our practice context**

* Inner city, training practice (3 sites) in one of the most deprived and diverse boroughs in the UK
* List size almost 16K, grown 1200 in last 1 year
* Nursing home residents

**Why our practice started the Daffodil Standards**

* Gave us a step-by-step guide towards delivering excellent EOL care
* Already putting a lot of work into quality of EOL care, particularly at the nursing home, but wanted assurance all people received the same level of care
* Varying confidence and experience among our GPs
* Local commissioner offered support

**Our QI journey**

We took the plunge and signed up online to the Daffodil Standards - we got our practice welcome pack quickly in the post!

Level 1

* We appointed a GP lead across each of 3 sites.
* Met with all staff to introduce the Daffodil standards and agreed to work towards them
* Agreed with all staff on the planned audit which would inform us about which areas we needed to prioritise
* Got excited and decided to audit all deaths (77) rather than 20 deaths to collect our baseline data (Time taken 2 sessions)

Level 2

Method: EMIS Web search of relevant codes followed by manual search for missing data by Practice Manager

**Results:**

* Total number of deaths reviewed = 77
* Average age = 78.3 years
* 50/50 Male /Female ratio
* 65/77 had their ethnic status recorded. Of these 65, 12 (18%) were white British coded
* Main diagnoses: 31% (24/77) Non-BCC cancer, 45% (35/77) dementia or likely dementia.  Cause of death often not recorded.
* 58% Nursing Home residents
* 3 sudden deaths - the rest we thought there were opportunities to plan EOLC but only 35% were on the practice palliative care register.
* Only 47% had a carer recorded (Daffodil Standard 3 - evidence 60-90% of people in the last year of life will have an informal carer)
* None had a carer’s support needs assessment (offered/sign-posted/completed)
* None were documented to have been sent condolences or offered bereavement support

Interestingly, in the nursing home 88% of residents had an electronic, shared EOLC plan and only 18% of people living independently had been recorded to have a plan. In both settings, of the people who had no recorded EOLC plan, significantly more people died in hospital

**Sharing and using baseline data**

We ran series of meetings across all staff groups where we

* Reminded about Daffodil Standards
* Shared baseline data – the variance in early identification and EOL planning – and lack of carer support
* Set targets to meet the evidence-based standards
* Agreed interventions to meet the targets
* Same info circulated to all staff by email

We prioritised where we needed to make improvements across the Daffodil Standards. From the baseline data we decided to focus on:

Standard 1: Professional and Competent Staff

  Plan: Whole practice training programme

  Measure: Training attendance, survey to staff on learning needs

Standard 2: Early Identification

  Plan: Whole practice awareness, GP lists

  Measure: Palliative care register & Electronic EOLC plans - numbers

Standard 3: Carer support – before and after

  Plan: CSNAT tool, Primary care navigator

  Measure: Use of CSNAT tool & Bereavement letter

**What did we achieve with the Daffodil Standards in 3 months?**

* Shared practice vision of improved EOLC, what that could look like and how to get there.
* 35% to 64% of people who died had been identified on the palliative care register for anticipatory supportive care planning
* 0% to 64% of people with a recorded NOK had condolences and bereavement info sent.
* For people living in their own residence we increased the number of people with an electronic EOLC plan from 18% to 50%