**LEVEL 1 – Core Essentials – Internal General Practice Systems to enable consistency of care**

Practice

Shared Vision

Systematisation of Processes

Leadership

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| **LEVEL 1 – Core Essentials – Internal General** **Practice Systems to enable consistency of care** |
| **The General Practice commits to meet the Standard by**  | **Self-Assessment**  | **Responsible Team Member** | **Completion** | **Notes** |
| 1. **Leadership** for Daffodil Standards
 | * 1. Confirm practice clinical lead (this does not necessarily need to be a GP)
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| * 1. Confirm practice non-clinical lead
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| * 1. Confirm route for seeking specialist palliative care advice
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| * 1. If not already, invite key EOLC stakeholders to MDT
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| * 1. Consider developing dedicated PCN/cluster/GP federations clinical specialist EOLC role (this does not necessarily need to be a GP)
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| 1. Share practice vision
 | * 1. Practice meeting/event
* communicate and engage all practice staff to ensure all understand goals and can be involved, at an appropriate level
* Reinforce a culture of continuous learning and improvement in the practice
* Clarify any learning needs of staff
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| 2.2 Share with MDT members |  |  |  |
| 2.3 Share with patient groups + PCN/GP cluster / federation |  |  |  |
| 1. Review of your practice system PROCESSES to ensure consistency to allow easy monitoring
 | **For example:** |  |  |  |
| 3.1 GeneralConsistent, clear coding e.g. identified with palliative / supportive care needs, personalised/ anticipatory care plan in place, NOK/family contact details: consider using IT template to aid this |
| 3.2 Following identification on palliative / supportive care registerFace to face or remote alternative where this is not safe or possible - note [GMC guidance for remote consultation decision making](https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations)), medication review and care planning discussions involving NOK/ key contacts and MDT staff within agreed set timeframeOffer personalised/ anticipatory care and support planning with ‘what matters most’ conversations, including preferences for care and support +/- CPR status, as appropriate for the person and family.NB: [RCGP joint statement on advance care planning](https://www.rcgp.org.uk/about-us/news/2020/april/joint-statement-on-advance-care-planning.aspx)Ensure no blanket DNACPR policies and avoid DNACPR decisions in isolation, ensuring part of wider ‘what matters most’ discussions and care planning journey. |
| 3.3 Ongoing Care and SupportFace to face or remote alternative where this is not safe or possible - note [GMC guidance for remote consultation decision making](https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations)), and MDT review within agreed timeline if stableInvolve patient and NOK/LPA/ Family/ Advocate in Care Plan decision-making & updatesClear process for escalating concerns of nurses/ care staff/ family to promptly assess need for reviewEncouraging feedback on significant changes in health and wellbeing such as sustained reduced intake, weight loss, high or low BMs, reduced mood/ interaction or mobility |
| 3.4 DyingEarly recognition of reversible/ preventable deterioration.Early recognition of deterioration and dying. |
| 3.5 Family Support + BereavementCollect key family/ NOK/ LPA/ advocate or allocated SW contact details, as appropriateTo involve those important to the patient in personalised /anticipatory care planning discussions, with their consent where appropriateContact family/ care-givers on death to offer condolences and offer/sign-post to bereavement support |
| 1. RCGP MDT template
 | * 1. Use [RCGP MDT template](https://www.rcgp.org.uk/-/media/Files/CIRC/Daffodil%20Standards/September%202021%20refresh/mdt-template-all-palliative-patients.ashx?la=en) for all patients to enable consistent care and support and/ or use [RCGP retrospective death audit](https://www.rcgp.org.uk/-/media/Files/CIRC/Daffodil%20Standards/September%202021%20refresh/eolc-retrospective-death-audit.ashx?la=en) to help focus diagnosing practice areas for improvement
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