Royal College of General Practitioners

Marie Curie
Care and support through terminal illness

The Daffodil Standards

Bitesized Reflections Guidance Notes

RCGP & Marie Curie Daffodil Standards - General Practice EOLC Good Practice Reflections.

Some simple steps to reflect on to help improve the quality of end of life care across your general practice population.
This is not meant to be done all at once and simply aims to offer some evidence-based examples of bite-size reflections on quality assurance both on elements of planned care achieved and also planning future care.
As we continue delivering care through COVID-19, below is an end of life care update for general practice. These align with the RCGP & Marie Curie Daffodil Standards core eight domains.

Suggestions for use: Use alongside your EOLC MDT template.
Prioritise a few key questions relevant to your practice, to reflect on with the team.

Daffodil Standard:	Learning from EOLC in wave 1 – check-in	For consideration:
Standard 1 Professional and Competent Staff	Support needs of staff to enable delivery of personalised end of life care	Connect with local, regional and national training offers Share with EOLC commissioning leads Flag any unmet learning needs with your EOLC clinical or practice lead.
	Named end of life care & MDT practice leads	
	Does the practice know how to access local specialist advice 24/7 advice line?	
	Have you undertaken reflective practice to identify areas for improvement in EOLC? Do you know how to access support and training to address gaps in EOLC knowledge/skills? Have the practice assessed staff unmet training needs? Do you know how to access the EOLC training pack for your area?	
Standard 2 Identification of patients	How are you identifying patients who may a) Be within the last year of life b) Benefit from advance care planning e.g. people who have a diagnosis that affects capacity c) Have complex symptom control needs d) Benefit from additional psychosocial care and support	Tools: MDT discussion SPICT Prognostic Indicators Frailty Index GSF Prognostic indicator Identification tool i.e. reaching all patient groups, not just people with cancer or in the last weeks of life. Plus, reaching people who may not have or be able to navigate digital access to gain access to general practice.
	If a tool is used to identify 'at risk' patients, who clinically reviews patients for appropriateness?	
	Once identified, how does your practice ensure quick, easy access to patients (and their care-givers) to talk with and see (F2F/remotely) that does not rely on digital access?	
	Are you regularly reviewing your entire caseload of these identified patients?	
	Should any of these patients be put on the shielding register?	
Standard 3 Carer Support	How are you identifying care-givers, (incl next of kin, Lasting Power of Attorney and legal guardian)?	www.CSNAT.org MDT discussion Social Prescribers Hospice – Compassionate Neighbours Wider carer support weblinks
	How are you assessing the needs (or signposting for assessment) of care-givers?	
	How are you offering (or signposting to) support for care-givers?	
Standard 4 Seamless, well planned, coordinated care	What processes have you got in place to support consistent planned care for patients + carers affected by end of life? Consider consistent communication with entire practice team and MDT	Flags – Identification, Care Plan/ CMC, Preferred place of care/death, DNACPR status MDT template Coding review of key data to be monitored Are all team members clear where to look to help them help a patient/ carer quickly in their role e.g. if needed, receptionist to enable urgent access, clinical staff understand 'what matters most' including treatment escalation plan in case of an emergency
	Expected and Unexpected deaths – how is learning embedded into practice including from 111/ 999/ A+E attendance or admission?	MDT reflection process • Was there anything the MDT could have done to support the patient/ family? • using MDT template had patient/ carer been identified, did 'what matter most' conversations occur with the patient/family? Was a care plan in place (CMC), were care preferences achieved? (i.e. did the plan make any difference?

	Coordination - Do you know your local services and pathways to support patients at the end of life?	Crisis response services Community palliative care + Hospice services Co-ordination Centres/hubs Social prescribing teams Sign-posting websites to community support groups.
	Do you have access to 24/7 specialist EOLC?	
	How does your practice ensure easy access to flagged EOLC patients/ families who are unable to use digital platforms?	
Standard 5 Personalised care and support plans / CMC	Are all Advance Care Planning conversations uploaded onto shared electronic palliative care record platform? Do the plans include 'What Matters Most to you and your family' information, to support care and Treatment Escalation Planning.	Do you/ staff need training /support to be confident on shared electronic palliative care record platform? Are there other staff who can support? e.g. New roles in PCN, GP Cluster and Federation social prescribers, care home support **Online training** https://www.coordinatemycare.co.uk/for-healthcare-professionals/training-viewing-creating-cmc-care-plans/
	Once identified, who will undertake compassionate conversations and develop Advance Care Plans?	
	Have you reviewed your caseload of patients with a shared electronic palliative care record to ensure appropriate? Do any patients with a shared electronic palliative care record need to be reviewed? i.e. a new diagnosis, a change in status or function, family concern	
	When other staff are creating or updating plans do these need to be reviewed and published?	
DNACPRs	Do you know which patients have a DNACPR? Has the decision-making and involvement of the patient/family/ advocate been reviewed recently?	NOTE: • Ensure each DNACPR decision is individualised to the person i.e. no blanket DNACPRs for any patient group • Ensure DNACPR decisions are not made in isolation and patients also have an electronic palliative care record plan to support What Matters Most to them, including care preferences. https://www.bmj.com/content/356/bmj.j813 • Sensitively involve and communicate with the patient and with consent or best interest – the family/ advocate
	People with Learning Disabilities	GP practices have been asked via the Quality and Outcomes Framework to review all DNACPRs for people with a learning disability registered with their practice and confirm that they were determined appropriately and continue to be clinically appropriate. This is included in the primary care/ GP contract for 2020-21. https://www.england.nhs.uk/wp-content/uploads/2020/07/Action-from-learning-report-2020.pdf
Standard 6 Quality of Care in the last days of life	Understand and document the Five Priorities of Care for the Dying Person: 'One Chance To Get It Right' https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf	1. The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly. 2. Sensitive communication takes place between staff and the person who is dying and those important to them. Conversations are appropriately documented. 3. The dying person, and those identified as important to them, are involved in decisions about treatment and care. 4. The people important to the dying person are listened to and their needs are respected. 5. Care is tailored to the individual and delivered with compassion – with an individual care plan in place
	Anticipatory medication and prescribing: • Do you know the COVID drug pathways and non COVID access? • In hours and Out of Hours access? • Do you know how to access syringe drivers?	Be able to prescribe and have readily available medications to control symptoms for anticipatory prescribing in the last days of life Consider local guidance. Links to RCGP and external EOLC prescribing guidance https://elearning.rcgp.org.uk/mod/page/view.php?id=10537#RCGP
	Care of the dying: Have you seen the patient (Face to Face or remotely) to enable good care and certification of death?	GMC guidance – remote or face to face consultations? https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations

Standard 7 Care after death	Are all teams clear on the local process for Verification and Certification of death in the community? After a death, what is the practice process to contact the bereaved and offer condolences / support? What support can you / your practice signpost bereaved families to?	Check local guidance Clarify bereavement services and hospice local offers Do you have bereavement information readily available – referral routes? Do you have bereavement leaflets/links? Examples: Marie Curie UK - Information and Support Service - 7 days a week https://www.mariecurie.org.uk/support Telephone Support line for public and staff: 0800 090 2309 National example of GP Surgery Bereavement leaflet - https://www.england.nhs.uk/london/wpcontent/uploads/sites/8/2020/03/NHS-Bereavement-Leaflet.pdf COVID CRUSE - Grief and Trauma - https://www.cruse.org.uk/coronavirus/trauma A collaborative guide to COVID-19 care - https://covid-at-home.info/
Standard 8 General Practice as hubs within Compassionate Communities	**Staff wellbeing** Do you have a support system in your practice to identify and support staff whose well-being is affected by or who have **personally** suffered a serious diagnosis or bereavement? Do you / your PCN, GP Cluster and Federation have an informal/ formal system to support members of the team who may be affected by emotional / physical strain of caring for people dying and the bereaved during this year. How do you understand if you are meeting the support and wellbeing needs of your staff to help both themselves, each other and your practice population? **Patient/ Carer feedback** How are you collecting feedback (positive and negative) to improve your service to meet the diverse needs of your population with end of life care needs?	Resources for looking after ourselves and each other. UK: Support with mental wellbeing, finance, housing and unemployment https://www.mentalhealth.org.uk/coronavirus England: NHS Practitioner Health provides https://www.practitionerhealth.nhs.uk/covid-19-workforcewellbeing Northern Ireland: www.nidirect.gov.uk Scotland: section on Mental Wellbeing: https://www.nhsinform.scot/illnesses-and-conditions/infectionsand-poisoning/coronavirus-covid-19 Wales For doctors in training: Professional Support Unit HEIW. ProfessionalSupport@wales.nhs.uk For all doctors: Health for Health Professionals www.hhpwales.co.uk RCN – COVID and your mental wellbeing https://www.rcn.org.uk/get-help/member-support-services/counselling-service/covid-19-and-your-mentalwellbeing Marie Curie UK - Information and Support Service - 7 days a week https://www.mariecurie.org.uk/support Telephone Support line for public and staff: 0800 090 2309 Create a system for “touching base” with staff – including those working remotely.