Royal College of General Practitioners

Marie Curie
Care and support through terminal illness

The Daffodil Standards

Bitesized Reflections Template

Palliative and End of Life Care across General Practice populations

One person dies every minute in the UK. With an ageing population, deaths - along with a greater need for palliative and end of life care and support - are set to rise by 25% by 2040. Evidence tells us the majority of people want to be cared for and die in their own home or care home, where possible. Most people who die in the community receive palliative and end of life care from their general practice team, without involvement of hospice care. Up to 75% of people who die have a 'predictable' death. Therefore, with simple steps to help us improve our processes, leadership and personalised care planning in general practice to enable better planned end of life care, we have an opportunity to make a bigger impact on people's experiences of care, grief and bereavement. This consistency can be further enhanced by groups of practices working together to enable common goals and streamlining of processes and support.

Primary Care Network, GP Cluster or Federation supporting Care Homes for Older People

When many older people move into a care home (residential and nursing) it is often due to poor or deteriorating health. With the person's consent, it can be a very helpful opportunity to consider 'what matters most to you' conversations between the resident, those important to them, care home staff and the GP team. If relevant, these may include care preferences, treatment escalation planning and DNACPR discussions, in case of a sudden deterioration and a need for emergency care.

An ambition for Primary Care Network, GP Cluster or Federation is to improve the care for their local populations. Older people in care homes can be reviewed as part of an entire practice or Primary Care Network, GP Cluster or Federation population and this is described in the core Daffodil Standards. However, there have been many requests from general practice for some simple tools to focus solely on the quality of care delivered by general practice to older people in care homes. This pack offers some guidance to Primary Care Network, GP Cluster or Federation to reflect on and build ideas together of how to improve care delivered by general practice teams to older people in care homes.

What are the Daffodil standards?

The Daffodil Standards are the UK General Practice Standards for Advanced Serious Illness and End of Life Care.

They are a blend of quality statements, evidence-based tools, reflective learning exercises and quality improvement steps. The Standards have been designed by GPs and experts to offer a structure for practices, whatever the starting level, to have a clear strategy to consistently deliver the best care to all people affected by terminal illness.

There are eight core Daffodil Standards designed to help practices, to focus aspects of their EOLC quality improvement on older people in care homes and wider population.

The Daffodil Standards cover eight core areas below:

1. Professional and competent staff
2. Early identification
3. Carer Support
4. Seamless, planned, coordinated care
5. Assessment of unique needs of the patient
6. Quality care during the last days of life
7. Care after death
8. General Practice as hubs within compassionate communities

What are the Daffodil Standards applied to care homes?

Practices have asked for tools that can help them simply assess aspects of their current care and reflect on deaths and urgent care. We've distilled the 8 standards into two levels – core essential and enhanced. We examples of bite-sized assessments and improvements – not everything needs to be done all at once and the tools aim to fit into your usual practice. Small steps can make big improvements in care. This aims to be practical and deliverable by practices and primary care networks.

LEVEL 1 – Core Essential – Internal Practice Systems to enable consistency of care

Level one looks at leadership and systems within the practice including how you involve your multidisciplinary team some of whom maybe external to the practice. Most practices either on their own or along with members or their primary care network, cluster or locality should be able to aim for level 1.

LEVEL 2 – Enhanced: Improving Communication, Shared Planning & Compassionate Care.

Level 2 builds on embedding ongoing continuous quality improvement, sharing learning and ideas within your team and the wider MDT. It encourages innovation, generation and testing of ideas and learning from deaths, urgent care, each other and the wider team.

Appendix 1
Primary Care Network, GP Cluster or Federation – Collated practice results and reflection questions on achieving agreed goals

Primary Care Network, GP Cluster or Federation discussion template

The Primary Care Network, GP Cluster or Federation commits to collate information on practices undertaking	Self-Assessment	PCN %/ number of practices	Local area/ region %/ number of practices	Responsible Team Member collecting information	Completion plan date	Notes
1. Level 1	**% of practice using RCGP/Marie Curie DS MDT template for care home residents** **This may also include breakdown such as %:** • Increase alignment of care, with 'what matters most to the resident conversations', including 111/999/a+e attendance and admissions • reduction in deaths without preferred place of death recorded, • increase in relevant electronic plans, documenting 'what matters most' to the resident, including treatment escalation/ anticipatory planning.					
2. Level 2	**% of practices presented MDT template learning and planned improvement cycles to PCN to share learning**					

LEVEL 3 – Advanced – due 2021

For consideration to support End of Life Care quality improvement:

- Psychological and bereavement support for staff
- Cultural and Leadership support for practices and across the networks of practices
- Evolution of Primary Care Networks, Clusters and (GP) Federations clinical specialist role to facilitate Quality Improvement for EOLC across the networks of practices - for both care homes and population, enabling career progression

Education and Training needs for all staff

- Connectivity with Community Development and potential options for residents and families for increased awareness, knowledge to enable wellbeing + self-care (where wanted and appropriate).
- Consider how the General Practice connects, signposts and works with the technology and the community (e.g. faith groups, schools, businesses, animal support groups, local/national charities and peer support groups etc) to improve the social health and engagement levels to improve mental health, wellbeing and reduce social isolation and loneliness