

# End of life care in primary care

Supporting practices to develop further



An example of results from a single practice  
taking part in the national ADA snapshot



THE  
Evidence  
Centre

# Key points

*“How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services.”* (End of Life Care Strategy 2008)

Every year, about 1% of your practice population dies. This is set to rise exponentially over the next few years. In 2009 more than 800 practices were invited to take part in the first ever national snapshot of end of life care in primary care. **This report illustrates the findings from one anonymised practice.**

In 2009, the Department of Health launched the Quality Markers for end of life care. These are not mandatory requirements, but the table below shows how the example practice compares to others that took part in the national snapshot in terms of the Quality Markers for primary care.

*Comparing your practice with averages from the national snapshot for end of life care in primary care*

Quality marker – primary care	Snapshot average	Practice
<b>Quality marker 2.1: developing strategy and plans</b>		
100% of practices develop action plan and evaluate	Not measured	Not measured
<b>Quality marker 2.2: mechanism to assess and document</b>		
100% of practices adopt GSF or similar approach	92% using	Not measured
% whose preferred place of care is recorded	56% of those on register	35%
% who die in their preferred place of care	42% of those on register	29%
<b>Quality marker 2.3: mechanism to assess and document carer needs</b>		
% whose carer is recorded	Not measured	Not measured
% carer’s assessment / carers needs recorded	50% of those on register	18%
<b>Quality marker 2.4: use of multidisciplinary team meetings quarterly</b>		
% discussed at multidisciplinary team meeting in final year	78% of those on register	35%
<b>Quality marker 2.5: communication with out of hours</b>		
Protocols for sharing information with out of hours	Not measured	Not measured
% on register with info given to out of hours	46% of those on register	0%
<b>Quality marker 2.6: nominating a key worker</b>		
% with a key worker identified	74% of those on register	35%
<b>Quality marker 2.7-9: awareness and action regarding training needs</b>		
Awareness of training needs	Not measured	Not measured
<b>Quality marker 2.10: adopting care management pathway when dying</b>		
% of those dying at home where the Liverpool Care Pathway or equivalent was used	60% of those on register who died at home	20%
<b>Quality marker 2.11: collate information on quality of care for audit purposes</b>		
% who die at home	31% of those on register	29%
% who die in their preferred place of care	42% of those on register	29%
% of carers who receive bereavement support	32% all deaths; 52% register	6% on register
Audit of complaints and compliments	Not measured	Not measured

This report was prepared by Omega, the National Association for End of Life Care and The Evidence Centre, an independent research organisation, using information one practice submitted for the 2009 snapshot of end of life care.

# Background

*“The next few years are crucial for primary care if we are to ensure that we can deliver a gold standard of end of life care for all who need – as the number of deaths increases, there is a looming avalanche of need awaiting us.”* (Professor Keri Thomas, National Clinical Lead for the GSF Centre)

Every year, about half a million people die in England, equating to 1% of the population. Death and dying affects us all and improving end of life care is now a national priority. The NHS Next Stage Review, the End of Life Care Strategy and your local PCT all emphasise that supporting people nearing the end of life is just as important as promoting good health throughout life.

The Department of Health’s End of Life Care Strategy and Quality Markers have provided strategic direction for improving end of life care. Other resources such as the Gold Standards Framework include evidence-based suggestions to help practices give the best care to people who are dying and their families. In all of these documents, there is an increasing focus on the role of primary care in supporting people nearing the end of life, so in 2009 the first ever snapshot in primary care was undertaken. The snapshot was run by Omega, the National Association for End of Life Care, working with experts from the Gold Standards Framework Centre and The Evidence Centre. It was funded by the National End of Life Care Programme and individual PCTs.

## Top tip

All practice teams work hard to care for people at the end of life. All of us could do better. You can use this report to build on your good practice, improve care further, create an action plan, think about further training and as part of your appraisal and revalidation process. We’ve provided a template at the end so you can jot down your notes and actions as you read through each section.

502 of the 874 invited practices took part, using the online After Death Analysis tool (ADA) to provide feedback about all of the deaths in the practice population during February and March 2009. Practices provided the final information retrospectively up until August 2009.

**Information is available for an amazing 4487 people, spread throughout 15 PCT areas and 9 SHA areas.**

**The ‘Example anonymous practice’ contributed 64 records. The practice that submitted the greatest number of records was selected for use in this anonymised example.**

The small number of records provided by each practice means that the percentages and comparisons throughout this report are not necessarily robust, but we’re providing this information to show how you compare in general terms with other practices that took part and to provide top tips to help you think about how you’re caring for those nearing the end of life. This also gives you a flavour of what can be achieved using a structured tool such as ADA.

# Who took part?

*Number of practices and records included in the national snapshot*

SHA area	PCT	Invited practices	Participating practices	Proportion participating	Records submitted
East Midlands	Lincoln	102	71	70%	868
East of England	Suffolk	68	36	53%	370
London	Sutton and Merton	54	31	57%	168
	Wandsworth	54	35	65%	163
North West	Salford	54	28	52%	200
South Central	Milton Keynes Health	26	13	50%	117
South East Coast	Surrey	36	26	72%	204
	West Sussex	94	37	39%	403
South West	Bath and NE Somerset	26	21	81%	214
	Bournemouth and Poole	44	29	66%	346
	Devon	108	55	51%	543
West Midlands	Heart of Birmingham	74	13	18%	48
	Solihull	31	30	97%	237
	Walsall	63	44	70%	233
Yorkshire & Humber	Wakefield	40	33	83%	373
<b>Total</b>		<b>874</b>	<b>502</b>	<b>57%</b>	<b>4487</b>

Note: the 'proportion participating' column shows the proportion of all invited practices that submitted one or more records.

In total, 57% of practices that were invited chose to take part. Information about the total number of deaths in participating areas is not available but based on information provided by PCTs and national averages it is estimated that about half of all deaths in participating areas were included in the snapshot.

52% of the 4487 records received were for women who died between February and March 2009, 81% were White and the age at death ranged from 0 to 106 years (average 79 years). This is likely to broadly represent the demographics of people dying in February and March 2009 throughout England, though the snapshot did not aim to be representative.

The snapshot included all deaths, whether they were sudden or expected. 51% died in hospital, 20% died at home, 18% died in care homes and 6% in hospices.

The most commonly recorded causes of death were cancer, infection and unknown causes. Even so, only one quarter were recorded as dying from cancer related complications. This is important because it demonstrates that the national snapshot includes a wide range of both cancer and non cancer related deaths. The table below shows people’s primary diagnosis.

*Primary diagnosis of people included*

Diagnoses	%
Lung cancer	6
Upper GI cancer	4
Colorectal cancer	3
Breast cancer	2
Haematological cancer	2
Prostate cancer	2
Gynaecological cancer	1
All other cancer	6
<b>Total cancer diagnoses</b>	<b>26</b>
Heart failure	10
COPD or benign respiratory cause	7
Frailty or ‘old age’	7
Stroke	6
Dementia	5
End stage renal failure	2
Multiple morbidities	2
Parkinson’s disease	1
Other neurological disorders	1
Other diagnosis not listed	15
None (no diagnosis or illness)	3
Not known	15
<b>Total non cancer diagnoses</b>	<b>74</b>

All the feedback collected during the snapshot as well as research evidence suggests that practices are doing a great job of supporting people nearing the end of life – and want to do even better.

Research evidence and the national End of Life Care Strategy suggests there are several **key areas** where primary care teams can most enhance end of life care:



We’ve used these key features to organise the information you provided for the national snapshot overleaf. We have not summarised the ‘delivery of high quality services’ aspect (which focuses on use of other community services and hospital admissions) because the numbers per practice are too small to be meaningful.

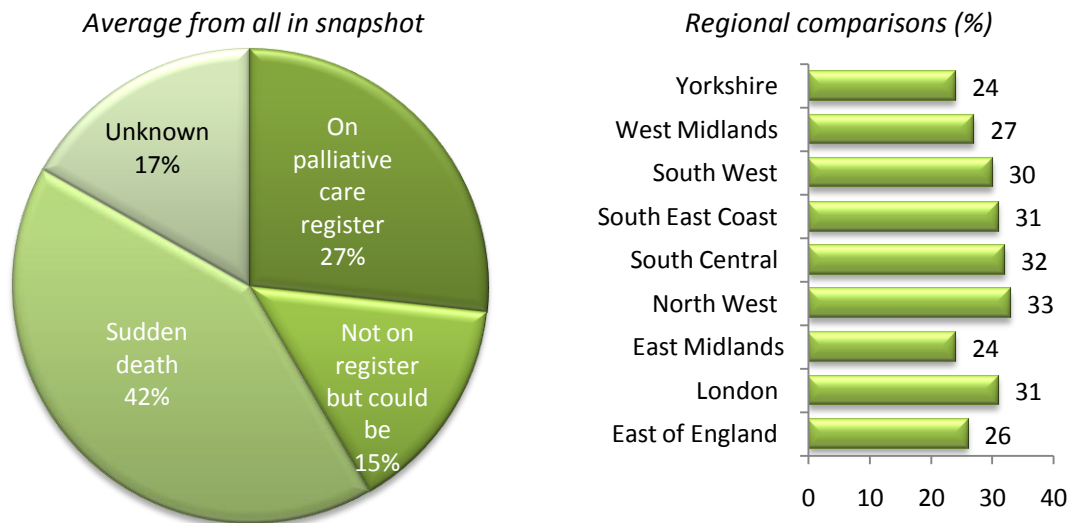
# Identify: who's on your register?

## Did you know?

The first step in providing high quality end of life care is to identify people who may be in the last 6-12 months of life. The Quality and Outcomes Framework (QOF) and the Gold Standards Framework both encourage practices to create a palliative care register and 99.8% of practices now claim QOF points for having a register. This is great news because people on a register often receive more proactive care planning and support, and have better outcomes. But it can be difficult to identify everyone nearing the end of life at the best time to optimise their care. It's important to think about whether we're putting people on the register appropriately.

## Your results

The proportion of deaths the example practice submitted to the snapshot that were on a register is 27%. Overall, 27% of all deaths submitted by practices taking part in the snapshot were on a register.



## Top tip

Don't be afraid to add more names to your register. You can prioritise people according to need (final days, final weeks, final months, final year) to make sure this doesn't make the group size unmanageable and then focus on those with the most immediate needs (see [www.goldstandardsframework.nhs.uk](http://www.goldstandardsframework.nhs.uk) for examples). The Gold Standards Framework's Prognostic Indicator Guidance was developed to support the introduction of QOF palliative care points. This tool helps you identify which people might be in the final 6-12 months of life and should be included on the register.

# Identify: people without cancer

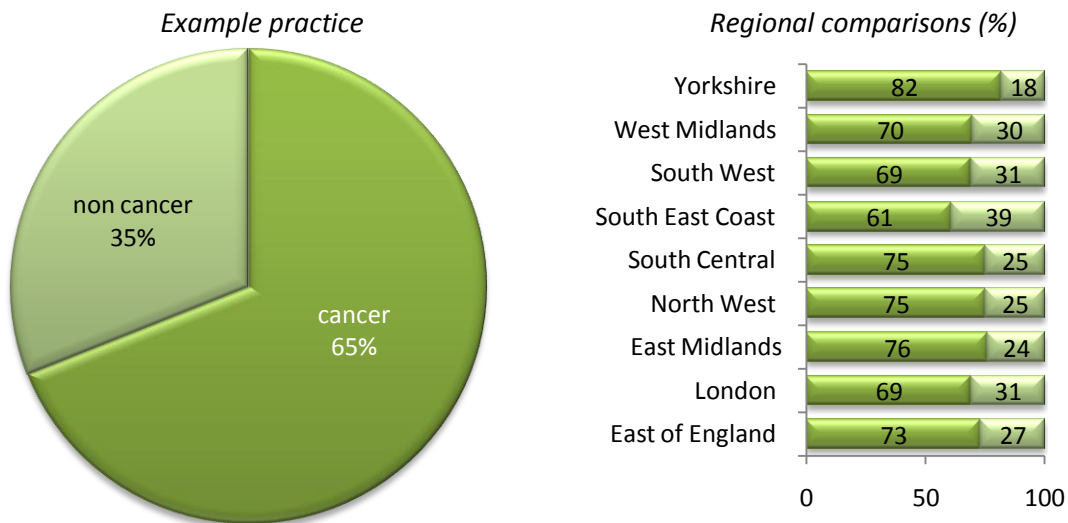
## Did you know?

High quality end of life care is recommended for everyone, regardless of diagnosis. From 2008-9 this has been reflected in QOF, whereby people in the final year of life of all ages and with all end stage conditions are to be listed on the palliative care register.

Traditionally, people with cancer have been over-represented on palliative care registers, even though more and more people are dying of frailty and co-morbidity. People with non-cancer illnesses have needs that are equal to, if not greater than, those with cancer. We know from research evidence that people included on palliative care registers generally receive more coordinated and better quality end of life care. If people without cancer are not routinely included, this means some of those most in need may be receiving suboptimal levels of care.

## Your results

The proportion of deaths from the example practice's register with a primary diagnosis other than cancer was 35%. The overall average of all practices participating in the snapshot was 29%.



## Top tip

It might be harder to identify when people without cancer are nearing the final 6-12 months of life. Using the 'surprise question' can help identify more people. As a team, ask yourselves, 'would we be surprised if this person were to die in the next months or weeks or days?' or 'would we be surprised if this person was still alive in 12 months?' This can help identify more people to add to the register.

# Identify: more people in their last year

## Did you know?

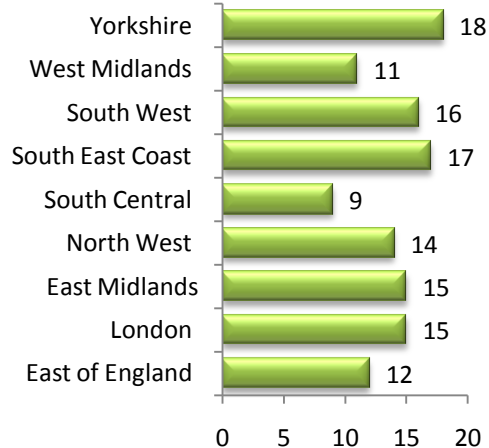
There is most potential for improving care when a person could have been recognised as being in the last year of life but wasn't. Practices thought that about four out of ten deaths in the national snapshot were sudden or unpredictable, but research from the National Audit Office suggests only around 10% of deaths are totally sudden or unpredictable. This suggests that many more people could be on the palliative care register than currently and practices might need more information and support to identify these people. The ADA tool helps you reflect on whether we might have been able to predict the deaths of people who were not on a register weeks or months in advance. For participating practices, on average around 15% of people who died in February and March 2009 were estimated to have been predictable deaths but not on a register. The 'sudden deaths' category might also include some people whose deaths could have been predicted and who missed out on the most supportive end of life care.

## Your results

*Example practice*

On palliative care register	27%
Could have been predicted within days of death	2%
Could have been predicted within weeks of death	2%
Could have been predicted within months of death	2%
Could have been predicted within a year of death	0%
Sudden death	0%

*% 'could have been predicted'*



Note: we have not listed the % of records left blank or where the practice stated 'don't know.'

## Top tip

Think about how well your team is doing at identifying people at the end of life. You could reflect following the death of people not on the register to consider whether their death could have been predicted. This may help you put more patients on the register in future. The Gold Standards Framework Prognostic Indicators Guidance or similar can help practices identify people at an appropriate stage in their illness. Following the death of anyone on the register, you could also think about whether they were identified at the earliest opportunity.

# Assess: advance care planning

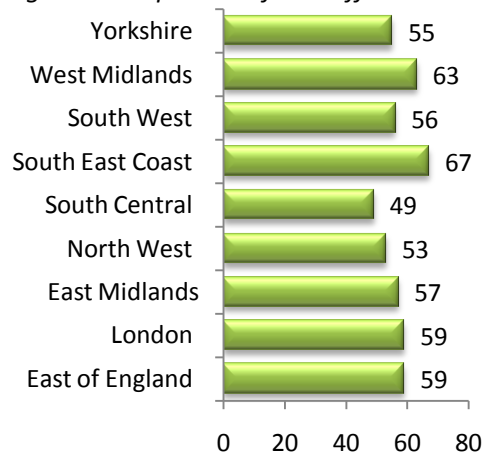
## Did you know?

Offering people an opportunity to discuss their wishes near the end of life is important. As all clinicians know, some people do not wish to discuss these things and this must be respected. At other times, practice teams fear a negative reaction, but research suggests that for many people, open and honest discussions help them come to terms with things and enable them to live out their final stage of life better prepared and less frightened. These talks are known as 'advance care planning' discussions and enable people and their families to consider their future care and complete a statement of needs and preferences. Advance care planning increases patient choice and control and helps people talk with carers and relatives so they are better prepared too. Everyone on your palliative care register should be offered an advance care planning discussion. An advance care plan does not have formal legal power and is not the same as an advanced directive or care plan. It just helps when considering a person's best interests and wishes.

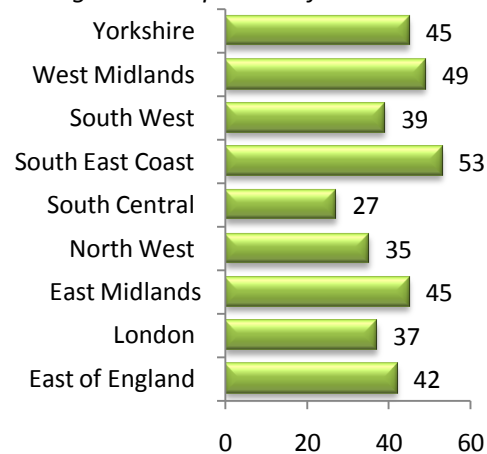
## Your results

The proportion of people on the example practice's register who were offered an advance care planning discussion was 35% and the proportion with a documented advance care plan was 29%. The overall averages for all practices taking part in the snapshot were 58% and 43% respectively.

*Regional comparisons for % offered discussion*



*Regional comparisons for % with care plan*



## Top tip

Every person should be offered an advance care planning discussion within weeks of being placed on the register. Having a simple checklist of questions to ask can help, such as what would you like to happen or not happen and what is your preferred place of care at the end? There are templates such as the GSF Thinking Ahead document, Preferred Priorities of Care or templates developed in local areas. The actual tool matters less than having a sensitive and open discussion.

# Plan and co-ordinate: meetings

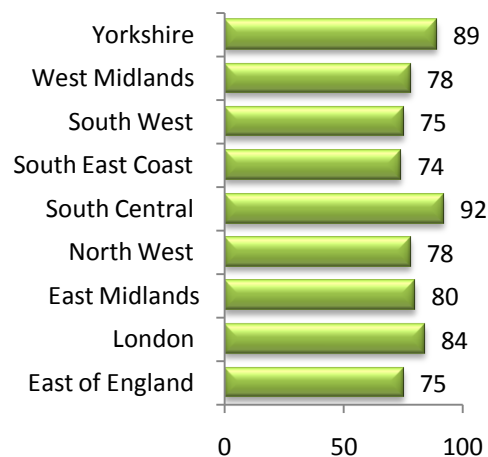
## Did you know?

Planning and co-ordinating care is key to supporting people at the end of life. Although the steps, structures and systems are straightforward, getting it right every time is complex. Most practices have a regular multidisciplinary team meeting to discuss people nearing the end of life. The aim is to discuss people's needs and ensure that all aspects of care are considered. Many practices find that three-monthly meetings are not frequent enough as patients' needs can change rapidly. For this reason monthly meetings are recommended. At a minimum, multidisciplinary meetings should involve GPs, district nurses, palliative care community nurse specialists if available, and a member of the reception or administration staff. It is important to keep minutes with designated actions, code and record discussions in the patients' notes and provide information as needed to other team members. Teamwork is at the core of excellent end of life care.

## Your results

In the example practice, 35% of those on the register who died were discussed at a multidisciplinary team meeting at least once in their final three months of life. For all participating practices, the average was 78% of those on a register.

*Regional comparisons for those on a register (%)*



## Top tip

Remember that effective multidisciplinary team meetings also provide an opportunity to find out about local services from all the different partners attending. More people can then be offered a range of services to suit their situation. If you identify gaps in the services available locally, feed these back to your PCT end of life care lead. This will help the PCT recognise gaps and commission the most appropriate new developments for your area.

# Plan and co-ordinate: records

## Did you know?

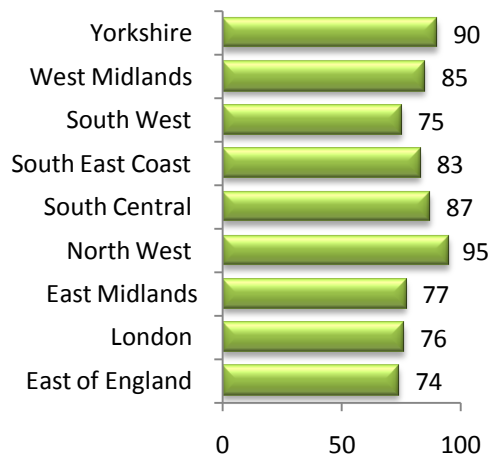
The Department of Health's End of Life Care Strategy recommends that practices take a systematic approach to end of life care, such as implementing the Gold Standards Framework or similar. This includes putting a system in place to ensure that all aspects of care are considered for each person on the register.

There should be a clear record of whether the patient has had an opportunity to discuss end of life issues, any preferences they've expressed, whether they have been advised to claim benefits and whether out of hours services have information about their condition, for example.

## Your results

35% of deaths from the example practice's register had a record to ensure all aspects of care were considered. The average for all in the snapshot was 80% of people on the palliative care register.

*Regional comparisons for those on a register (%)*



## Top tip

Using a checklist at multidisciplinary team meetings is one way to check and record that all aspects of care are considered during the patient's illness. When completing the national snapshot, some practices found that their record keeping could be improved. Improving your records isn't just for audit purposes though, it's essential for providing better care. For example, it's important that other team members can find information easily about people's care if their usual GP or nurse is away.

# Plan and co-ordinate: key workers

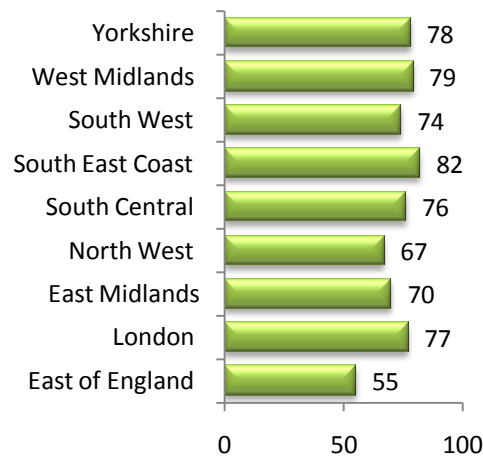
## Did you know?

The Department of Health's Quality Markers for End of Life Care suggest that each person on the palliative care register should have a primary care key worker. This person is responsible for co-ordinating care, keeping patients and their families engaged and informed and sharing information throughout the team. The patient should be aware of their key worker's name and contact details. Ideally, people should be involved in deciding who their key worker is.

## Your results

35% of deaths from the example practice's register had a key worker assigned to help co-ordinate care. For the entire snapshot, on average practices said 74% of people on registers had a key worker assigned.

*Regional comparisons for those on a register (%)*



## Top tip

The concept of key workers is still being developed. The most important thing is that people and their carers have the contact details of a named person within the practice to get in touch with for ongoing information and support.

# Plan and co-ordinate: out of hours

## Did you know?

Sharing information is important to ensure a smooth transition between services. Out of hours services are sometimes overlooked but there are three reasons for giving information to out of hours services:

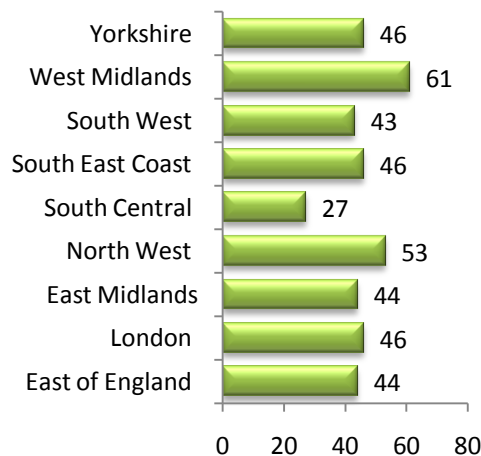
- People are often concerned about using out of hours services as the doctors or nurses may not have any information about their condition.
- Out of hours services could prioritise these people if they had information about them.
- Doctors working for out of hours services find it difficult to support patients without good information and may refer people to hospital inappropriately due to lack of information.

A simple paper or electronic handover sheet can resolve all these issues and is already part of QOF.

## Your results

0% of deaths from the example practice's register had an out of hours handover sent. For all those taking part in the snapshot, on average practices said 46% of people on registers had an out of hours handover sent.

*Regional comparisons for those on a register (%)*



## Top tip

Having triggers to share information can work well. For example, information could be sent to out of hours whenever someone is first put on the palliative care register and when they start declining week by week rather than month by month. Prescribing 'just in case' drugs or starting a syringe driver could also prompt you to update the out of hours information. This way, the majority of people's information will have been shared by the last weeks of life, when unforeseen problems are most likely to occur.

# Plan and co-ordinate: reflection

## Did you know?

Reflecting on your challenges and successes as a practice is an important part of improving care. It's also one of the recommendations from the Department of Health's Quality Markers. Using the ADA tool is one way to demonstrate innovation and reflection.

Other types of ongoing reflection are possible too. Significant event audit (SEA) can be used for any death, both to consider the good things that happened and any areas for improvement.

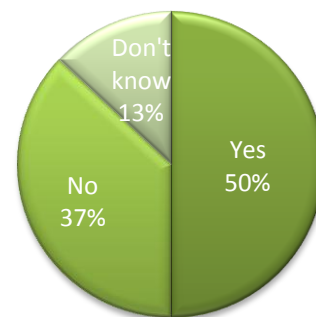
## Your results

For all deaths the example practice submitted, whether on the register or not, in 0% of cases the team discussed the patient's care following the death at a reflective practice session or significant event analysis. For all participating practices the average was 29%. The example practice formally reflected on 0% of those on a register, compared to 50% on average in other practices.

*% of those on register reflected on by example practice*



*Average for entire snapshot (on register)*



## Top tip

After each death in your practice, you might want to consider some of the following questions: What can we do to make every death the best that we can? What did we do well that we can replicate? What did not go as well as it could have? What can we learn from this death that might improve care of other people at the end of their life? Discussing real people in this way can have a big impact on learning.

# Manage: final days

## Did you know?

Planning care for the last few days of life is key. Patients and relatives often appreciate being told, sensitively, if the end is near. Diagnosis of the dying phase is therefore important. The Liverpool Care Pathway or a local integrated care pathway for the final days of life can provide a useful structure. If people improve they can come off the pathway.

Prescribing medications in advance to help with common symptoms at the end of life can maximise symptom control and avoid crises, including relatives having to leave to visit a pharmacy at a crucial time. Do not attempt resuscitation or 'allow a natural death' discussions and paperwork are part of planning care at this time.

## Your results

- The national snapshot found that 57% of people on the palliative care register who died at home or in a care home had their care co-ordinated using a care pathway for the last days of life. For the example practice, the equivalent proportion was 25%.
- The national snapshot found that anticipatory prescribing occurred for 65% of people on the palliative care register dying at home or in a care home. For the example practice the proportion was 17%.
- The national snapshot found that 20% of people on the palliative care register had a 'do not attempt resuscitation' (DNAR) document in the community. For the example practice the proportion was 6%.
- A recurring theme was that many practices were uncertain of what care and processes were provided for specific individuals. For example practices did not know whether there was a DNAR order for about one third of all deaths in the national snapshot. This might mean there is an opportunity to develop better record keeping, as recommended by the End of Life Care Strategy and Quality Markers.

## Top tip

Think about whether your practice uses a protocol for those who want to die at home. You could hold a team discussion to brainstorm ideas about how to really implement this protocol to the fullest extent rather than 'going through the motions' or seeing it as a tick box exercise. Your practice team is a wealth of information and good ideas – so you should draw on the whole team as much as possible.

# Manage: preferred place of care

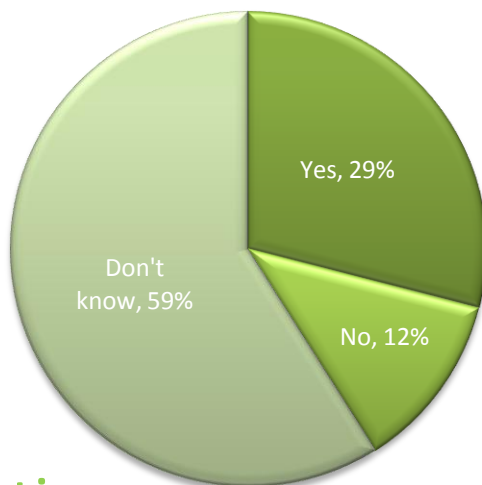
## Did you know?

Research suggests that many people would choose to die at home but the majority actually die in hospital. Practice teams have an essential role in helping people live their final days in their preferred place of care. Evidence shows that if people are asked in advance about their preferred place of care at the very end of life, and this is documented, then we're more likely to be able to fulfil people's wishes. Such documentation prompts care such as anticipatory prescribing and informing out of hours services,

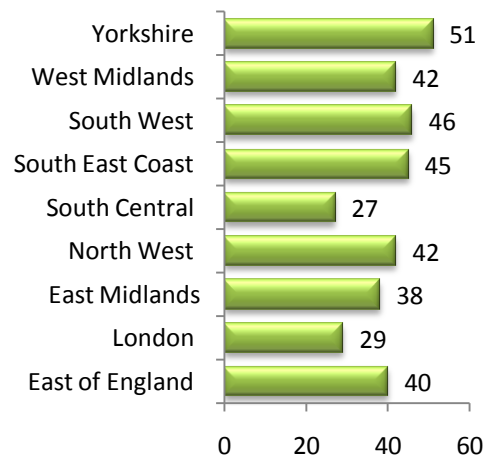
## Your results

For all participating practices, 56% of those on a register had their preferred place documented and 42% died there. 35% of people on the example practice's register had their preferred place recorded.

*% of all dying in preferred place in example practice*



*% dying in preferred place*



## Top tip

End of life discussions can be challenging for many of us so it's vital that you consider what training and support the practice team needs in order to have these discussions. A range of training resources are available. For example, the 'Going for Gold' training programme helps practices consider the needs of different members of the practice team (see [www.goldstandardsframework.org.nhs](http://www.goldstandardsframework.org.nhs)).

# Support: information

## Did you know?

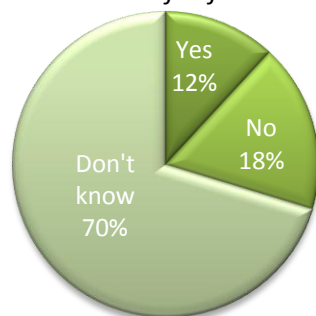
a) *Information about benefits:* The end of life can be a very expensive time for people and their families. People who are stressed financially tend to suffer more symptoms. They may also restrict their lifestyle and be more isolated. There are financial benefits available but many benefits lay unclaimed. The Benefits Agency offers advice for both patients and carers. Benefits are often paid from the date contact was first made, rather than retrospectively, so it's important your practice signposts people.

b) *Written information about the illness:* Patient held information can help cross boundary working, such as out of hours, when social or healthcare staff visit or when going to appointments. This 'passport information' can be given in different ways. 'Information prescriptions' and 'locality registers' are being piloted around the country and may a good way to share information in future.

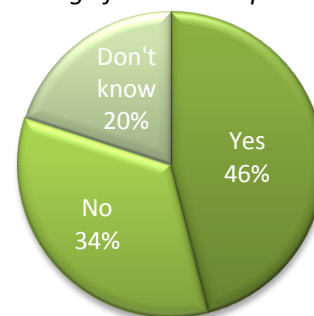
## Your results

a) 12% of deaths from the example practice's register were recorded as being on benefits or had been advised about benefits. For all those taking part in the snapshot, on average practices said 46% of people on registers were on benefits or had been advised about claiming them.

*% on or advised about benefits from example practice*



*Average for all in snapshot*



b) 41% of deaths from the example practice's register had a nurse care plan, patient held record or home pack compared to 61% of all those taking part in the snapshot.

## Top tip

A simple comment advising people to look into what benefits they are entitled to claim can make a huge difference. Some practices give a leaflet including telephone numbers for benefits advice. Simple leaflets can also be used to give people basic information about their condition and care. Some practices leave a printed copy of the out of hours handover information with patients, for example.

# Support: carers

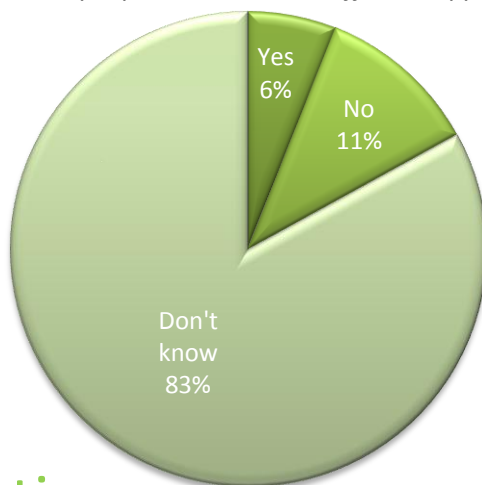
## Did you know?

Carers and relatives provide valuable care for dying people and play a key role in enabling them to remain at home. Carers are entitled to have their own needs assessed and should be referred for a formal assessment if appropriate. Knowing how to seek support, both during normal working hours and out of hours, can help carers avoid crises. Some practices have told us that they don't know how best to support carers. Help is at hand from the RCGP, with a guide entitled *'Supporting carers: an action guide for general practitioners and their teams'* (available online). For carers themselves, there are many services available in the community, such as the Caring With Confidence programme delivered by Omega, and a great deal of other support provided by hospices and other voluntary sector groups. It is also important to have a system in place to ensure that bereavement support and information is offered following all deaths. This may be in the form of a letter or card enclosing information about local support or a telephone call.

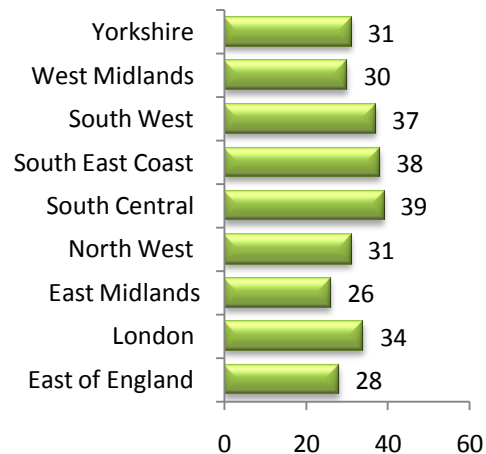
## Your results

For people on the example practice's register, 18% had tailored information provided to carers compared to 69% of all in the snapshot. 18% from the example practice's register had carer's needs assessed compared to 50% overall.

% of all example practice's deaths offered support



% all deaths offered bereavement support



## Top tip

Consider creating a leaflet for carers giving advice about local support, local carers centres, courses, benefits and how to seek advice. You could also give carers specific written information to support them at home so they know what to be concerned about, what to do in a crisis and who to contact, especially out of hours. Creating a bereavement information folder and a practice protocol for bereavement is also a good idea.

# Next steps

We hope this feedback from the first ever national snapshot of end of life care might give you a few new things to think about. All participating practices are receiving a copy of the national findings, but this report is designed to show how your information contributed to the national picture and how you can continue to provide high quality care for your patients and their families.

We hope that using the online ADA tool has helped to stimulate thought, act as an improvement strategy and be a catalyst for your own action planning. The best ideas and solutions to meet your situation will come from your own team, and that's why it's so important for you to reflect and consider actions and next steps.

We suggest the following:

- Consider this report at a **team meeting** to highlight areas that you feel are going well and identify any challenges.
- Use something like the **action planning sheet** overleaf to jot down ideas about what you will focus on next. This is just an example of a structure that might be useful, and you'll have your own ideas about what will work well for you. The Omega team would love to see a copy of your plan, in confidence, to get an idea of any changes you're thinking about.
- Make use of the wide range of resources on the internet. For example, you could visit the Gold Standards Framework website to download the Primary Care Briefing Paper and many new resources and tools to help you move forward: [goldstandardsframework.nhs.uk](http://goldstandardsframework.nhs.uk)
- The National GSF Centre has also developed a **training** programme for practice teams on dvd. 'Going for Gold' has been developed especially for practice teams, with helpful guidance and suggestions for improvement. It includes a 'Focus on Nurses' section to help district nurses, practice nurses and others as recommended by the Royal College of Nursing and the Transforming Community Services programme. There is a free introductory session on dvd to help your team to consider their strengths and weaknesses and identify learning needs together. This might already be available from your PCT or get in touch with the GSF team to request a copy: [info@goldstandardsframework.co.uk](mailto:info@goldstandardsframework.co.uk) or telephone 01922 604666.
- If you are interested in continuing to use **ADA online** to monitor your progress in future, ask your PCT or get in touch with Omega: [ada@omega.uk.net](mailto:ada@omega.uk.net), telephone 0845 2593163.

# Action planning

**Practice name:**

Actions to help achieve quality markers	Action	By when	Lead: role
<b>Quality marker 2.1: developing strategy and plans</b>			
Develop practice action plan and evaluate its implementation			
<b>Quality marker 2.2: mechanism to assess and document</b>			
<b>Identify:</b> Adopt GSF or similar approach, including expanding those on a register			
<b>Assess:</b> Record preferred place of care			
<b>Manage:</b> Increase % who die in their preferred place of care			
<b>Quality marker 2.3: mechanism to assess and document carer needs</b>			
<b>Support:</b> Record the carer			
<b>Support:</b> Carer's needs recorded			
<b>Quality marker 2.4: use of multidisciplinary team meetings quarterly</b>			
<b>Plan:</b> Discuss all on register at multidisciplinary team meeting			
<b>Quality marker 2.5: communication with out of hours</b>			
<b>Plan:</b> Have protocols for sharing information with out of hours			
<b>Plan:</b> Give info about those on register to out of hours			
<b>Quality marker 2.6: nominating a key worker</b>			
<b>Plan:</b> Identify a key worker			
<b>Quality marker 2.7-9: awareness and action regarding training needs</b>			
<b>Plan:</b> Awareness of training needs			
<b>Quality marker 2.10: adopting care management pathway when dying</b>			
<b>Manage:</b> Increase % of those dying at home where Care Pathway is used			
<b>Quality marker 2.11: collate information on quality of care for audit purposes</b>			
<b>Deliver:</b> Increase % who die at home			
<b>Support:</b> Increase % of carers who receive bereavement support			
Audit of complaints and compliments			

The Omega team is eager to see whether the snapshot has made a difference to you. Please send a copy of your plan, in confidence, to Omega, London House, Town Walls, Shrewsbury SY1 1TX or [ADA@omega.uk.net](mailto:ADA@omega.uk.net)