

End of Life Care Strategy

Promoting high quality care for all adults at the end of life.



Quality Markers Consultation

November 2008

DH INFORMATION READER BOX

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Circulation List	
Description	The End of Life Care Strategy published in July 2008 includes a commitment to consult on national quality standards (now called Quality Markers). A response to this consultation will be published on the Consultations website at: http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm
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Timing	Consultation closes 6 February 2009
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For Recipient's Use	

Quality Markers and Measures for End of Life Care

Draft for Consultation

Introduction

1. Care for people at the end of life has in the past not been a high priority for all health and social care services. As a result the quality of this care varies across the country. While there are examples of excellent practice they are not consistent throughout the services. We need to ensure that the entire system learns from the best.
2. This issue is now being addressed, first through the NHS Next Stage Review, published in June, which focuses on end of life care as one of eight principal care pathways, and specifically through the End of Life Care Strategy, published in July 2008, which explores the topic in more detail.
3. As part of the development work on the SHA visions for end of life care, which formed part of the NHS Next Stage Review, the SHA End of Life Care Pathway Chairs identified that commissioners and providers needed support in delivering improvements in care. They unanimously requested that a unified national approach should be taken to develop quality standards for care provided to people at the end of life.
4. In response to this the Department of Health, with input from the SHA Pathway Chairs, has developed the attached draft, and we are now consulting on this in line with the commitment in the End of Life Care Strategy. This is attached at Annex A.
5. The Strategy refers to these as “national standards”. However the Department of Health has agreed that, following *High quality care for All*, only NICE should issue quality standards. This draft has been developed at the request of the service, with input from the service, and the final version needs to be owned and implemented by the service. We therefore need to use terms which will convey that message and which are consistent with the Next Stage Review vision.
6. To answer this point this document refers to “quality markers” (the term adopted by the recent National Stroke Strategy) rather than “national standards”.

Definition of end of life care

7. End of life care has been defined by the National Council for Palliative Care as: ‘care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes

management of pain and other symptoms and provision of psychological, social, spiritual and practical support'.

Structure of the proposed quality markers

8. The draft markers are consistent with the holistic approach to care described above, and are based around the whole systems framework and care pathway set out in the End of Life Care Strategy (see Annex B). They have been designed as a supportive guide, setting out what will be needed for high quality end of life care to be delivered from the perspective of both commissioners and providers (NHS, voluntary and independent sector).
9. The markers are based on the structures and processes of care which are most likely to yield good outcomes for people who are approaching the end of life, and their families and carers.
10. They are accompanied by suggested measures for assessment of compliance, which commissioners and providers should find helpful in their audit and evaluation of services. One such measure is the locality-wide register for patients approaching the end of life. It is hoped that this can be implemented in the future, and there are plans for piloting work to begin in January 2009.
11. Use of the markers will not be mandatory. They are being made available as a tool which people may find useful in the commissioning, provision and assessment of end of life care services. We expect that people will select those markers which are most relevant to their own circumstances, service patterns and service developments.
12. The markers as drafted reflect the system as it currently operates. Over time some may cease to be relevant. For example, as PCTs develop as World Class Commissioners, commissioning for outcomes, they are unlikely to be engaged in detailed workforce planning as set out in Marker 1.8.

Intended audience

13. The quality markers have been designed to be especially helpful to commissioners of services as they begin to put into place services that address the direction of travel set out by World Class Commissioning, the local visions and by the End of Life Care Strategy. PCTs have the lead role in commissioning end of life care services, but will need to work closely on this with local authorities. PCTs may also need to work closely with each other when services are shared between specialist palliative care in-patient facilities (e.g. hospices).
14. As performance managers, SHAs may also wish to consider how best to measure progress towards the markers.. They may, for example, wish

to ask individual PCTs to complete a self-assessment, and PCTs may in turn wish to ask providers to do the same. Alternatively SHAs (and/or PCTs) may wish to institute some form of peer review appraisal process.

15. The quality markers will also be of use to service providers as a guide to assess their progress in delivering improvements in end of life care.
16. The regulators may also wish to make use of the quality markers when undertaking assessments of end of life care provision.

Related work programmes

17. In parallel with the development of these quality markers and measures of the structure and process of healthcare delivery, the Department of Health is working to develop a suite of outcome measures for end of life care. These are likely to include:
 - Place of death (available from ONS)
 - Audits of care given to recently deceased patients (such as the National Care of the Dying Audit from Hospitals, which is based on the Liverpool Care Pathway).
 - Surveys of bereaved relatives based on the successful VOICES surveys which have been used extensively in end of life care research studies.
18. The Department has also been consulting on the registration requirements for all those providers which will fall into the remit of the new Care Quality Commission. We are currently analysing the responses to that consultation and will ensure that we make the appropriate cross-references to the outcomes from this one.

Consultation questions

19. We are keen to hear the views of a range of people and organisations on the proposed quality markers, including: commissioning and provider organisations, regulators, service managers, clinicians and others with an interest in end of life care services.

20. The central areas on which we would greatly welcome views are:

- **Will these quality markers be useful to commissioners, performance managers and service providers?**
- **Do the suggested quality markers cover the right aspects of end of life care provision? Should some of them be removed or others added?**
- **Are the identified measures fit for purpose? Should any others be included?**

21. The consultation will run until 06 February 2009. All responses should be submitted to the End of Life Care Team at the Department of Health via the contact details below:

End of Life Care Team
Department of Health
Room 402, Wellington House
133-155 Waterloo Road
London
SE1 8UG

eolc@dh.gsi.gov.uk

Criteria for consultation

22. This consultation follows the 'Government Code of Practice'. In particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

23. The full text of the code of practice is on the Better Regulation website at:

[Link to consultation Code of Practice](#)

Comments on the consultation process itself

24. If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact Consultations Coordinator
 Department of Health
 3E48, Quarry House
 Leeds
 LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

25. We manage the information you provide in response to this consultation in accordance with the Department of Health's [Information Charter](#).

26. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

27. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.
28. The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

29. A summary of the response to this consultation will be made available before or alongside any further action, such as publishing the final version of these Quality Markers, and will be placed on the Consultations website at <http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

Impact Assessments

30. The Department carried out full Impact and Equality Impact Assessments on the End of Life Care Strategy as a whole. These Quality Markers were a commitment in the Strategy as one component of implementation, and are therefore covered in the existing Impact Assessments.

Annex A

QUALITY MARKERS – DRAFT FOR CONSULTATION

The quality markers and measures are set out in nine parts:

- Part 1: Quality markers for PCTs.
Some of these markers will be the sole responsibility of PCTs. For others, PCTs will be responsible for ensuring that local service providers match quality markers. For the latter the recommended measures are given in Parts 2 to 9.
- Part 2: Quality markers for primary care.
- Part 3: Quality markers for acute hospitals.
- Part 4: Quality markers for community hospitals
- Part 5: Quality markers for care homes.
- Part 6: Quality markers for specialist palliative care in-patient facilities e.g. hospices
- Part 7: Quality markers for specialist end of life care services in the community.
- Part 8: Quality markers for ambulance services.
- Part 9: Quality markers for out of hours (OOH) services.

Part 1: Quality markers for PCTs

1.1. Public awareness

PCTs to demonstrate that:

- 1.1.1 They are aware of the views of their population with regard to the delivery of care at the end of life.

Measure: Reports of surveys or focus groups related to the views of the local population regarding end of life issues.

- 1.1.2 They have a strategy for promoting public awareness with regard to issues around death, dying and end of life care.

Measure: The strategic plan for end of life care (see 1.2.2) includes actions to be taken to promote awareness of end of life issues.

1.2 Strategic Planning

PCTs to demonstrate that:

- 1.2.1 The needs of the local population for end of life care have been appropriately assessed.

Measure: Availability of a needs assessment report.

- 1.2.2 They have developed a strategic plan for end of life care, which encompasses patients with all diagnoses and care provided in any setting and covers each step in the End of Life Care Pathway.

Measure: Availability of a comprehensive strategic plan for the locality.

- 1.2.3 The plan has been developed jointly with social care and the voluntary sector and takes account of the views of service providers and service users.

Measure: Written documentation of people / organisations involved in the development of the strategic plan.

- 1.2.4 The strategic plans for end of life care encompass the volume and quality of services provided - for example, for care homes, (e.g. how many deaths are occurring in different care homes each year and whether relevant care homes have processes in place to ensure high quality care).

Measure: Comprehensive information on current service delivery by care homes is included in the strategic plan.

1.2.5 There are transparent funding mechanisms for end of life care services.

Measure: The strategic plan provides information on the funding arrangements for specific end of life care services that take account, where appropriate, of the relevant principles and undertakings in the Compact Funding and Procurement Code of Good Practice.

1.3 Identification, communication, and care planning

PCTs to demonstrate that all providers have processes in place to:

- 1.3.1 Identify those who are approaching the end of life.
- 1.3.2 Ensure that discussions with individuals regarding end of life issues are undertaken by appropriately trained staff.
- 1.3.3 Ensure that individuals' needs for care are appropriately assessed.
- 1.3.4 Ensure that patients are offered a care plan. This is an advance wishes document which not only encompasses a patient's needs and preferences, but also funeral arrangements, finance etc
- 1.3.5 Ensure entry onto a locality-wide end of life care register, if available.¹
- 1.3.6 Ensure that patients' preferences and choices are documented.
- 1.3.7 Ensure that the needs of carers are appropriately assessed and recorded and that support is offered pre and post bereavement.

[Measures for these markers are shown in Parts 2-9.]

1.4 Coordination of care across organisational boundaries

PCTs to demonstrate that:

- 1.4.1 Mechanisms are in place to ensure that care for individuals is coordinated across organisational boundaries 24/7.

Measure: Documentation of processes for transferring information about individuals who are approaching the end of life between primary care, ambulance services, OOH providers, hospitals, care homes etc.

Measure: Audits of effectiveness of transfer of information (e.g. availability of care plans and DNAR status to OOH or emergency services).

¹ Pilots for locality-wide end of life care registers will commence in Jan 09

1.4.2 A locality-wide register of patients approaching the end of life is maintained.

Measure: Existence of a locality-wide register.

Measure: Proportion of deceased patients who were entered onto the locality-wide register.

1.4.3 The register is available for all relevant health and social care professionals providing care for an individual patient.

Measure: Documentation of governance arrangements related to access to the end of life care register.

1.4.4 The register holds information regarding advance care plans and DNAR status of the individual, subject to their consent.

Measure: Contents of register (e.g. names of patients; full care plans; organ donor status; DNAR status).

1.5 Availability of services

PCTs to demonstrate that:

1.5.1 Essential services are available in the community 24/7 to enable people to live and die in the place of their choice. These include:

- nursing services,(including rapid response services)
- medical services
- personal care services
- Access to pharmacy services.

Measure: Documentation regarding community services and the proportion of the local population covered by these services

1.5.2 Those approaching end of life have access to equipment required in their homes within 24-48 hours.

Measure: Documentation of processes to access equipment

Measure: Audits of equipment provision (e.g. time from request to delivery).

1.5.3 Patients at the end of life can be transferred within locally agreed time scales, by the effective commissioning of ambulance and other transport services.

Measure: Local commissioning contracts with ambulances and other transport services to include the locally-defined transfer time requirement for patients approaching the end of life.

1.5.4 There is appropriate provision of specialist palliative care services to meet the needs of the population. These will include:

- Community palliative care services

Measure: Existence of a multiprofessional specialist palliative care team or teams covering the whole community and days / hours of working e.g. provision of out of hours services.

- Hospital palliative care services

Measure: Existence of a multiprofessional specialist palliative care team in each acute hospital and day / hours of working e.g. provision of out of hours services.

- In-patient services (e.g. specialist palliative care services)

Measure: Numbers of specialist palliative care beds available per 100,000 population.

1.5.5 Patients have access to advice from specialists in palliative care, irrespective of diagnosis or location. The NICE guidance on specialist palliative care recommends that specialist palliative care services should be available on a 24-hour, seven day a week basis.

Measure: Documentation that specialist palliative care advice is available in all locations (e.g. including care homes, prisons etc.).

Measure: Audits of specialist palliative care provision to care homes.

1.5.6 Processes are in place to facilitate urgent and safe discharge to the community of those who wish to die at home.

Measure: Documentation of processes to facilitate urgent discharge to the community (e.g. Hospital2Home schemes; Discharge nurses for end of life care etc.).

Measure: Audits of numbers of patients discharged home to die and the outcome of these discharges (e.g. readmission rates).

1.5.7 People approaching the end of life living in care homes have appropriate access to 24/7 medical services.

Measure: Documentation of processes to access medical care both within normal working hours and out of hours.

1.5.8 People approaching the end of life living in care homes have access to primary care services, including equipment and pharmacy.

Measure: Documentation of processes for accessing equipment and drugs for patients near the end of their lives.

Measure: Audits of access to equipment and drugs.

- 1.5.9 People approaching the end of life living in care homes have the same level of access to specialist palliative care services as for those living at home.

Measure: Documentation of processes for accessing specialist palliative care services.

Measure: Audits of number / proportion of deceased patients who received specialist palliative care services.

1.6 Care in the last days of life.

PCTs to demonstrate that:

- 1.6.1 All care providers adopt a common approach to care for people in the last days of life.

Measure: Number / proportion of providers adopting a standardised approach (e.g. Liverpool Care Pathway or equivalent).

Measure: Number / proportion of patients dying with the Liverpool Care Pathway (or equivalent) in place.

1.7 Care in the days after death.

PCTs to demonstrate that:

- 1.7.1 All providers have appropriate processes in place for verification and certification of death, and care after death, including viewing of the body and return of personal property.

- 1.7.2 All providers have assessed their current environments from the perspective of people at the end of life and their carers and have incorporated plans for change into their formal estates strategies.

Measure: Number / proportion of providers using the “after death” module of the Liverpool Care Pathway (or equivalent).

Measure: Number / proportion of patients for whom the after death module of LCP (or equivalent) was used (including patients who died suddenly).

Measure: Audit of estates strategies

- 1.7.3. That providers have assessed the needs, and provision for bereavement services including support for children.

Measure: Audit of questionnaires assessing the experience of those using bereavement services and appropriate action taken.

1.8 Workforce planning

PCTs to demonstrate that:

- 1.8.1 Workforce requirements for specialist palliative care services have been appropriately assessed and agreed with those responsible for workforce at SHA level.

Measure: Written evidence that specialist palliative care workforce requirements have been agreed with the SHA.

- 1.8.2 The needs for education and training in communication and end of life care of other staff (GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc) have been assessed and prioritised and appropriate programmes initiated.

Measure: The local strategic plan encompasses education and training requirements and priorities for staff who are not specialists in palliative care.

Measure: The local strategic plan encompasses training in communications skills related to end of life care.

- 1.8.3 All providers have processes to identify staff (in all professions and grades) who require training in end of life care.

- 1.8.4 All providers enable relevant staff to attend appropriate training courses.

- 1.8.5 All providers document which staff have received training in end of life care.

Measure: Documentary evidence of staff who require training, have received training and who have attended training courses, including refresher courses.

1.9 Monitoring

PCTs to demonstrate that:

- 1.9.1 A coherent approach to data collection on end of life care is in place across the whole locality.

Measure: The strategic plan should include arrangements for data collection on end of life care issues by all providers. This should be proportionate to the nature and level of service provided.

Measure: The information that providers are expected to collect on end of life care should be specified in local contracts or service level agreements.

1.9.2 Individual organisations monitor the quality and outputs of end of life care and submit relevant information for local and national audits.

Measure: The number / proportion of general practices which provide data in line with local agreements.

Measure: The number / proportion of care homes which provide data in line with local agreements.

Measure: The number / proportion of hospitals which provide data in line with local agreements.

Measure: The number / proportion of specialist palliative care in-patient facilities e.g. hospices which provide data in line with local agreements.

Part 2: Quality markers for primary care

All GP practices to demonstrate that they:

2.1 Have mechanisms in place to identify, assess and document the needs and preferences of those approaching the end of life [e.g. use of Gold Standards Framework] and their carers.

Measure: Number / proportion of general practices that have adopted an approach to end of life care management (e.g. GSF / KITE etc.).

2.2 Discuss and record the needs of those approaching the end of life at multi-disciplinary team meetings.

Measure: Audits of the proportion of deceased patients who were discussed at a practice level multidisciplinary meeting in the last year of their lives.

2.3 Provide information on individuals approaching the end of life proactively to out of hours services (e.g. through the locality-wide register and/or through the extension of GSF).

Measure: Documentation of processes for informing out of hours care providers regarding individuals at the end of life.

Measure: Proportion of patients entered onto a practice-based EOLC register for whom information was communicated to OOH providers.

- 2.4 Nominate a key worker for each person approaching the end of life.

Measure: Processes for nominating and recording who is the key worker.

Measure: Audits of the proportion of people approaching the end of life with a documented key worker.

- 2.5 Adopt a care pathway management approach when people are in the dying phase (e.g. through use of the Liverpool Care Pathway or equivalent).

Measure: Use of LCP (or equivalent) for patients dying in their homes.

Measure: Proportion of patients dying in their own homes with LCP (or equivalent) being used.

- 2.6 Collate information on the quality of care provided to individuals after their death for audit purposes (e.g. using a tool such as the After Death Analysis [ADA] from the Gold Standards Framework).

Measure: Number of patients for whom audit data on end of life care is available from primary care.

Part 3: Quality markers for acute hospitals

All acute hospital providers to demonstrate that:

- 3.1 They have developed a vision (strategic plan) for end of life care, which is congruent with the strategic plan developed by the PCT for the locality.

Measure: Availability of a strategic plan for the hospital.

- 3.2 They have a multi-disciplinary specialist palliative care team.

Measure: Documentation of members of the hospital specialist palliative care team and hours of services.

Measure: documentation of out of hours services, including out of hours arrangements.

- 3.3 They have effective mechanisms for identifying those who are approaching the end of life.

Measure: Availability of training for frontline hospital clinicians in identification of patients approaching the end of life.

Measure: Numbers / proportions of frontline clinicians who have undergone formal training.

- 3.4 They have effective mechanisms for assessing and recording the needs and preferences of those who are approaching the end of life.

Measure: Documentation of processes for assessing and recording needs and preferences for end of life care.

Measure: Audits of numbers of patients with a written record of their needs and preferences for end of life care.

Measure: Reference 1.4.1 in terms of access to patient information on presentation at A&E

- 3.5 They have effective mechanisms for identifying the patient's preferred place of care, and where hospital is not the preferred place of death they have procedures in place to discharge the patient in a safe and timely manner.

Measure: Audit number of patients who achieve their preferred place of care. Feedback reasons for non achievement to develop practice both with in the acute trust and PCT.

- 3.6 They offer care plans to all individuals who are approaching the end of life.

Measure: Proportion of all deceased patients who had an end of life care plan (or documentation that a care plan had been offered but declined).

- 3.7 They ensure that relevant information on individuals approaching the end of life is entered into a locality-wide register (where available).

Measure: Number / proportion of deceased patients who were recorded on the locality-wide register.

- 3.8 They ensure that staff involved in discussing end of life issues are appropriately trained.

Measure: Availability of training programmes for staff involved in discussing end of life issues with patients.

Measure: Documentation of staff who have undergone formal training.

- 3.9 They use a care pathway (such as the Liverpool Care Pathway or equivalent) for those who are dying and for care of the body after death.

Measure: Protocols for use of a recognised pathway (e.g. LCP or equivalent) for dying patients and for use after death in patients who die suddenly.

- 3.10 They assess the needs of carers and relatives and provide them with appropriate support during the patient's time in hospital and in the period around death, if the patient dies in hospital.

Measure: Documentation of processes to ensure the needs of carers are assessed.

Measure: Availability of staff with dedicated time for supporting carers reflected in their job plans.

- 3.11 They have designated quiet spaces in wards for relatives, which are specifically used for this purpose.

Measure: Documentation of processes to ensure needs of relatives are accommodated

- 3.12 They communicate effectively with patients' GPs around end of life decisions and inform the general practice within 24 hours when a patient dies.

Measure: Relevant members of staff having documented responsibility for ensuring communication with GPs when end of life decisions are made and at the time of death.

Measure: Processes for recording that communications have been made with GPs.

Measure: Audits of communication.

- 3.13 They have mechanisms for auditing and reviewing quality of end of life care provided by the hospital.

Measure: Participation in national audits related to care of the dying in hospital.

Measure: Evidence of local reviews of quality of end of life care and resulting action plans.

- 3.14 They have educational programmes for relevant staff groups related to end of life care.

Measure: Availability of educational programmes related to the introduction of LCP or an equivalent pathway.

Measure: Proportion of all hospital wards where patients may be expected to die in which LCP (or equivalent) has been introduced.

Measure: Availability of "foundation" programmes in end of life care for non-registered staff who may have to deal with patients approaching the end of life or just after death or their relatives.

Measure: Numbers of staff attending such programmes

Measure: Availability of educational programmes related to end of life care for registered staff.

Measure: Numbers of staff attending such programmes.

Part 4: Quality markers for Community Hospitals

Community hospitals which provide relevant services to demonstrate that:

- 4.1 They have developed a plan for end of life care, which is congruent with the strategic plan developed by the PCT for the locality.

Measure: Availability of a plan for end of life care for the community hospital.

- 4.2 Preferences for end of life care are discussed and documented with residents

Measure: Audits of patients' records.

- 4.3 Patients' needs for end of life care are assessed on an ongoing basis.

Measure: Documentation of processes to review patients' needs.

- 4.4 Patients who are dying are entered onto a care pathway.

Measure: Number / proportion of deceased patients for whom LCP (or equivalent) was used.

- 4.5 Relatives are involved in end of life care decisions to the extent that they and the resident/patient wish.

Measure: Documented processes for involving relatives in end of life care decisions.

Measure: Audits of the care records of deceased patients assessing involvement of relatives in end of life care decisions.

- 4.6 Other residents are supported following a death in a community hospital.

Measure: Documented processes to support other Patients following a death.

- 4.7 The quality of end of life care provided by the community hospital is audited and reviewed.

Measure: Documented processes to audit and review end of life care.

Measure: Reports of audits / reviews.

- 4.8 Staff involved in discussing end of life issues are appropriately trained and supported.

Measure: Number / proportion of different staff groups who have received communications skills training.

- 4.9 Training programmes on end of life care which are relevant to staff working in community hospitals are available and accessible.

Measure: Availability of training programmes relevant to all types / levels of staff.

Measure: Numbers / proportions of different types / levels of staff who have received training.

- 4.10 Processes are in place to monitor appropriate transfers and admissions of residents between community hospitals and other places of care in the last month of life.

Measure: Documentation by community hospitals of patients who are appropriately transferred and admitted to another place of care with date of transfer, date of return to care home and date of death.

- 4.11 A locally agreed Palliative Care formulary stock of drugs should be readily accessible to all out of hours medical practitioners with robust clinical governance standards in place to protect both patients and staff.

Measure: Evidence of a palliative care formulary

Part 5: Quality markers for care homes

All care home providers which provide services to people approaching the end of life to demonstrate that:

- 5.1 They have developed a plan for end of life care, which is congruent with the strategic plan developed by the PCT for the locality.

Measure: Availability of a plan for end of life care for the care home.

- 5.2 Preferences for end of life care are discussed and documented with residents

Measure: Audits of residents' records.

- 5.3 Residents' needs for end of life care are assessed on an ongoing basis.

Measure: Documentation of processes to review residents' needs.

- 5.4 Residents who are dying are entered onto a care pathway.

Measure: Number / proportion of deceased residents for whom LCP (or equivalent) was used.

- 5.5 Relatives are involved in end of life care decisions to the extent that they and the resident/patient wish.

Measure: Documented processes for involving relatives in end of life care decisions.

Measure: Audits of the care records of deceased residents assessing involvement of relatives in end of life care decisions.

- 5.6 Other residents are supported following a death in a care home.

Measure: Documented processes to support other residents following a death.

Measure: Results of surveys (or other assessments) of residents' views regarding the deaths of others.

- 5.7 The quality of end of life care provided by the care home is audited and reviewed.

Measure: Documented processes to audit and review end of life care.

Measure: Reports of audits / reviews.

- 5.8 Staff involved in discussing end of life issues are appropriately trained and supported.

Measure: Number / proportion of different staff groups who have received communications skills training.

- 5.9 Training programmes on end of life care which are relevant to staff working in care homes are available and accessible.

Measure: Availability of training programmes relevant to all types / levels of staff.

Measure: Numbers / proportions of different types / levels of staff who have received training.

- 5.10 Processes are in place to monitor appropriate transfers and admissions of residents between care homes and hospitals in the last month of life.

Measure: Documentation by care homes of patients who are appropriately transferred and admitted to hospital with date of transfer, date of return to care home and date of death.

- 5.11 A locally agreed Palliative Care formulary stock of drugs should be readily accessible to all out of hours medical practitioners with robust clinical governance standards in place to protect both patients and staff.

Measure: Evidence of a palliative care formulary

Part 6: Quality markers for specialist palliative care in patient facilities e.g. hospices

All specialist palliative care in-patient facilities to demonstrate that:

- 6.1 They have developed a vision (strategic plan) for end of life care, which is congruent with the strategic plan developed by the PCT for the locality.

Measure: Availability of a plan for end of life care for the specialist palliative care in-patient facility.

- 6.2 Preferences for end of life care are discussed and documented with patients.

Measure: Audits of patients' records.

- 6.3 Patients' needs for end of life care are assessed on an ongoing basis.

Measure: Documentation of processes to review patients' needs.

- 6.4 Patients who are dying are entered onto a care pathway.

Measure: Number / proportion of deceased patients for whom LCP (or equivalent) was used.

- 6.5 Relatives are involved in end of life care decisions to the extent that they and the resident/patient wish.

Measure: Documented processes for involving relatives in end of life care decisions.

Measure: Audits of the care records of deceased residents assessing involvement of relatives in end of life care decisions.

- 6.6 Other patients are supported following a death in a specialist palliative care in-patient facility.

Measure: Documented processes to support other patients following a death.

- 6.7 The quality of end of life care provided by specialist palliative care in-patient facilities is audited and reviewed.

Measure: Documented processes to audit and review end of life care.

Measure: Reports of audits / reviews.

- 6.8 Staff involved in discussing end of life issues are appropriately trained.

Measure: Number / proportion of different staff groups who have received communications skills training.

- 6.9 Training programmes on end of life care which are relevant to staff working in specialist end of life care in-patient facilities are available and accessible.

Measure: Availability of training programmes relevant to all types / levels of staff.

Measure: Numbers / proportions of different types / levels of staff who have received training.

Part 7: Quality markers for specialist end of life care services in the community

Providers of specialist community palliative care services to demonstrate that:

- 7.1 Multi professional specialist palliative care teams cover the whole community including care homes and other residential care facilities.

Measure: Measure: Existence of a multiprofessional specialist palliative care team or teams covering the whole community and days /hours of working e.g. provision of out of hours services.

- 7.2 Specialist palliative care community services are available to all patients with life limiting illness, irrespective of diagnosis

Measure: demonstration of case mix in annual minimum data set submission to the National Council for Palliative Care.

- 7.3 Specialist palliative care community services are available to visit and assess patients 09.00 to 17.00, seven days per week.

Measure: documentation of on call rotas

- 7.4 Specialist palliative care advice is available 24 hours per day, 7 days per week.

Measure: documentation demonstrating phone numbers of specialist palliative care advice line

- 7.5 Measures and processes are in place, as part of the Specialist Services, to ensure, where possible, that patients wishing to die at home are able to do so. This will include, for example, suitably trained carers or nurses, to be available at short notice and arrangements, easy access to medicines, and mechanisms to exist for rapid 'discharge to die' from hospital or hospice. This will require collaboration with other providers such as ambulance services, Primary Care and Social Services.

Measure: Operational Policies in the community for 'Discharges to die'; detail of place and place of choice of death as part of annual activity reports

- 7.6 Presence of member of specialist palliative care team at multi disciplinary meetings (Gold Standard Framework or equivalent) to discuss the management of patients on end of life register

Measure: signed list of meeting attendees demonstrating presence of member of specialist palliative care team

- 7.7 Community based specialist palliative care teams act as an educational resource for the training of generalist palliative care in the community, including GP practices, district nursing services, care homes and community hospitals (See marker 1.8.2, PCT requirement for education for workforce planning for non palliative care specialists).

Measure: Availability of strategic plan for the education of community based providers of end of life care.

Measure – see standard 1.8.2

Part 8: Quality markers for ambulance services

Ambulance service providers to demonstrate that:

- 8.1 They are able to respond to urgent calls to transfer patients at the end of life within locally-defined timescales.

Measure: Whether trusts have a local policy on timeframes for response to end of life call.

Measure: Audits of compliance with timeframes set out in this policy..

- 8.2 They have mechanisms for identifying patients who are known to be approaching the end of life and who have expressed a wish to remain in their own homes or in a care home if that is their normal place of residence.

Measure: Audit of whether data provided by PCTs or other services on people approaching the end of life has been uploaded onto ambulance systems..

Measure: Audit of whether, for calls where information was uploaded and available, the crew took action in line with that information.

Measure: Whether trusts have a local policy on how crews should handle calls to patients who are at the end of life.

- 8.3 They have processes to identify patients for whom a Do Not Attempt Resuscitation (DNAR) order has been signed.

Measure: Audit of whether data provided by PCTs or other services on patients with a DNAR order has been uploaded into ambulance systems

Measure: Audit of whether, for calls where information was uploaded and available, the crew took appropriate action.

Measure: Whether trusts have a local policy on how crews should handle calls to patients with a DNAR order, taking into account national clinical guidelines.

Part 9: Quality markers for out of hours medical services

Providers of medical OOH services to demonstrate that:

- 9.1 The Gold Standards Framework, Preferred Priorities of Care and Liverpool Care Pathway for the Dying or equivalent approaches have been adopted by all primary care providers including out of hours services.

Measure: All those approaching the end of life are on a register.

- 9.2 Medical practitioners providing out of hours service are competent in providing general palliative care including symptom control, the use of syringe drivers, assessing need, communication skills and providing support to both the patient and carers in relation to DNAR and advance directives.

Measurement: Documentary evidence of staff who require training, have received training and who have attended training courses, including refresher courses.

- 9.2 Medical practitioners have information on rapid access to other out of hours services such as specialist palliative care advice, symptom control drugs, rapid response nursing support

Measure: Availability and audit of the above services

- 9.3 Systems are established to ensure that up-to-date information is shared between day time services and out of hour providers, including knowledge of the person's preferred place of care, current drugs and emergency medication available at home and the patients

- 9.4 A locally agreed Palliative Care formulary stock of drugs should be readily accessible to all out of hours medical practitioners with robust clinical governance standards in place to protect both patients and staff.

Measure: Audit of the preferred place of care.

Measure: Audit of the outcome of OOH consultation

Measure: Evidence of a palliative care formulary.

Annex B

The End of Life Care Framework

31. The markers map onto the different elements of the End of Life Care Framework, which have been set out in the national strategy. These include:

- Raising public awareness about death, dying and end of life care issues.
- Local strategic planning.
- The end of life care pathway:
 - Identifying people who are approaching the end of life and starting the conversation.
 - Assessing the needs of individual patients and carers and planning their care.
 - Coordination of care both within and between organisations.
 - Availability of services 24/7 with integrated service delivery of high quality care.
 - Review of individual patients' needs.
 - Care in the last days of life.
 - Care in the days after death.
 - Information and support for carers and families.
- Environments for care.
- Workforce development.
 - Communication skills.
 - Education and training in end of life care.
- Measurement of progress.
 - Markers for structure and processes of care.
 - Outcome measures



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