NHS
South West
Clinical Networks

How to guide for implementing the Quality Outcome Framework for End of Life

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Overall Aim of the Quality Outcomes Framework

To increase the percentage of each domain by using quality improvement methodology [1]

1:
Early identification and support for people with advanced progressive illness who might die within the next twelve months.

2:
Well-planned and coordinated care that is responsive to the patient’s changing needs with the aim of improving the experience of care.

3:
Identification and support for family / informal care-givers, both as part of the core care team around the patient and as individuals facing impending bereavement.

Step One

As a Practice you need to identify areas for improvement. Use your "Palliative/End of Life Register" to identify key themes with the assistance of an After-Death Analysis Tool.

Each Practice should hold a Palliative/End of Life Register which lists all patients identified as being in the last 6-12 months with an advanced progressive disease or condition including frailty.

Useful links:

https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/palliative-and-end-of-life-care-toolkit.aspx

https://www.goldstandardsframework.org.uk/cd-content/uploads/files/Library%2C%20Tools%20%26%20resources/Prognostic%20Scoring%20Paper.pdf

Each practice should complete a **CASE NOTE AUDIT** using an after death analysis tool **(see appendices)** to form a baseline for the Quality Improvement . An agreed number of randomly selected case notes of patients who had an expected death in the last 6 months are analysed

Useful links:

https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/palliative-and-end-of-life-care-toolkit.aspx

http://www.goldstandardsframework.org.uk/cd-content/uploads/files/Library,%20Tools%20%26%20resources/EOLC%20in%20Primary%20Care%20national%20snapshot%20-%20Key%20Findings.pdf

Step Two

The aim is to identify and prioritise on which areas for improvement for your Practice. You may agree to have similar priorities across your Primary Care Network or different ones and pool the outcomes of your work.

Suggested key areas recognised for improvement
(some points taken from Devon CCG):

Measuring the numbers of deaths which had been identified on the Palliative/End of Life Register (those within the last 6-12 months or known to be actively dying) *i.e. as a Practice, are you identifying all patients that should be on the register?* [2]

Measuring the number of patients identified as dying with Anticipatory Medicines prescribed (Just in Case medicines) available in the place of care *i.e. have all patients on the register got a plan for proactive care in place? Could have more patients had Just in Case medication in place?* [3]

Increasing communication with all care providers through better use of 'Electronic Palliative Care Co-ordination system (EPaCCS)' *i.e. are all patients on the Supportive End of Life Register recorded on your EPaCCS are flagged as* ***RED*** */* ***AMBER****?* [2,4,5]

Measuring how many patients have personised care plans in place (person-centred) *i.e.. as part of your MDT meeting, are plans put in place, could this be improved on?* [5]

Measuring the quality of care plans including Advance Care Plans (that may include the Power of Attorney and Advance Decisions), and emergency treatment preferences including cardiopulmonary resuscitation escalation e.g. on TEP or TEP forms *i.e. are actively recording future preferences of patients identified as dying in the last 6-12 months?* [6]

Measuring the number of identifications of the main carer with an offer of assessment, support and bereavement follow-up *i.e.. can you improve on carer support and proactive crisis management, so the patient remains at home.* [5,7]

Refer to page 7 for further guidance

Once you have identified a priority area to improve, record a baseline so that you can start the first phase of "quality improvement methodology"

Step Three

Develop outcomes that sets out on how to improve on your identified priority area—make them SMART

For more information and create an action plan - Click here

Specific:

The way you express your outcome must target the issue you are concerned with precisely.

Measurable:

What gets measured gets managed. You must therefore express your outcome in a measurable form.

Achievable:

You need to set an outcome that will 'stretch' your Practice. That contributes to getting the best outcome for your patients/carers. But you must not set the outcome so far beyond your Practices capabilities that the outcome demotivates you and may have a 'rebound' adverse effect on performance instead.

Realistic:

You need to set outcomes that are within the Practices reach.

Timebound:

You must make clear by when the objective is to be achieved.[8]

To create an Effective Action Plan

- Choose an appropriate goal and clearly define your objective.
- Use a team to create your **action plan**.
- Choose **action** steps that are concrete, measurable and attainable.
- Identify who is responsible for each **action** step and who will be supporting them.

Top Tip: Keep It Simple and Straightforward

Step Four

Implement the action plan, monitor and develop this using "Quality Improvement Methodology"

Complete a Quality Improvement monitoring template (example) [9]

Identified priority	Expected Outcome using SMART	Components to achieve	Time Scales	Actions	Person who is responsible	Issues for direction

Use a PDSA Cycle to measure your improvements and challenges (example below) [10]

Phases	Actions	Objectives
Plan	Before taking action, plan what change, or improvement is needed and how it will be achieved.	Identify area of opportunity Form team and define process Select Project Collect and analyse data. Identify data problem.
Do	Implement planned change or improvement on a small scale	Implement change or improvement
Study	Measure results and compare to plan goals. Results of tested change or improvement are evaluated for further action.	Measure effect Plan successful? Determine next action
Act	Take corrective action based on results of study.	Standardise change. Document project.

Further reading can be accessed - here [11]

Step Five

Participate in Primary Care Network peer review meetings (minimum of 2)

This will depend on individual Primary care Networks on how these will be managed.

You will be expected to bring back your results to these meeting. For example, the first participation you may share your priority area, baseline and initial quality improvement results and your PDSA cycle.

Some key points to think about:

Decide what ‘success’ will look like – how will you know you have succeeded?

Explore further learning on Quality Improvement Methodology:
https://www.england.nhs.uk/publication/quality-improvement-module-documentation-end-of-life-care/

Toolkits available:

RCGP/Marie Curie Daffodil core Standards for advanced serious illness and end of life care in general practice https://www.rcgp.org.uk/daffodilstandards

Macmillan General Practice Toolkit
https://www.macmillan.org.uk/_images/cancer-care-in-primary%20care-a-quality-toolkit-for-general-practice-module-four_tcm9-351803.pdf

Supporting Quality Improvement activity in EoLC (Gold Standards Framework)
https://www.macmillan.org.uk/_images/quality-improvement-for-primary-and-community-care_tcm9-351804.pdf

Further Guidance:

NICE QS for End of Life Care in Adults (QS13)
https://www.nice.org.uk/guidance/QS13

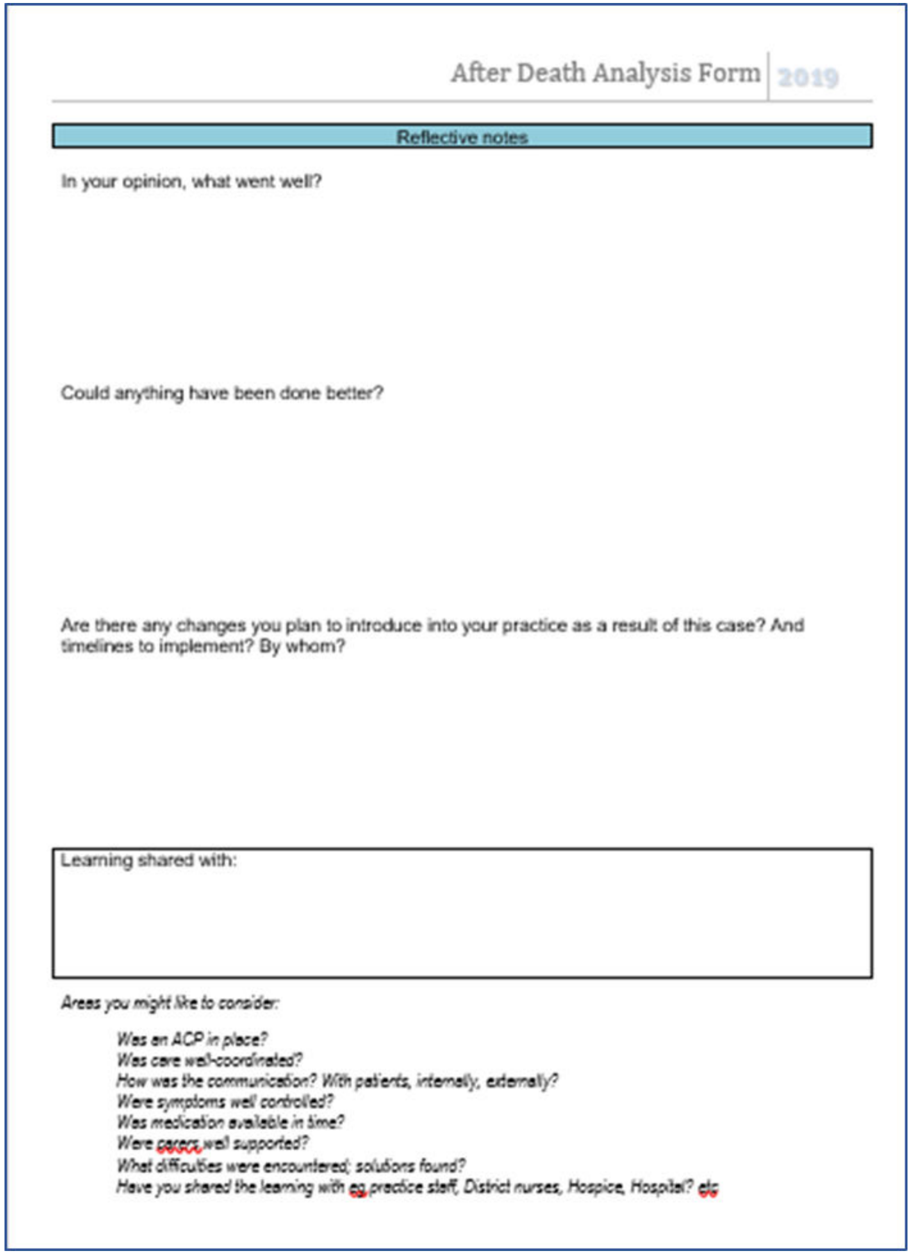
Care of dying adults in the last days of life (QS144)
https://www.nice.org.uk/guidance/ng31

Appendices

After-death analysis tool examples

After Death Analysis: Case Note Review [Based on 'Ambitions of Care ']					
	1	2	3	4	5
Date of death					
Place of death					
ON EoL register					
Priority 1: Recognition - Clear documentation that:					
It has been recognised by a named senior clinician that the patient is in the last few days of life/dying					
Clear documentation justifying the diagnosis of dying is recorded					
Within the week that the patient is dying, the patient's needs and wishes are reviewed at least once					
Priority 2: Communication - Clear documentation that discussions have been held by a named senior clinician regarding prognosis with:					
The patient who is in the last days of life (enter N/A if patient too unwell)					
Family/carer that the patient is now in the last days of life					
Goals of care recorded					
Preferred place of care recorded					
Priority 3: Involve (Clear documentation that the dying person had):					
Identified the person(s) they want involved in discussions around their care					
An Advance Care plan					
An ADRT					
an existing Lasting Power of Attorney in place for health and welfare decisions (enter N/A if not appropriate)					
A TEP/DNAR :					
Discussed with patient and/or carers					
Not appropriate to discuss with patient and/or carers					
EPaCCS data recorded					
Clear documentation that there were discussions with the patient's identified person(s) regarding the patient's treatment and care					
Priority 4: Needs					
Clear documentation that the needs of the families and others identified as important to the dying person were assessed					
Priority 5: Individual plan of care: Clear documentation that the patient's individual plan of care included:					
symptom control					
psychological/emotional support					
social support					
spiritual/cultural/religious support					
"support" to eat and drink as long as they wished to do so					
Bereavement care – note of care given to family/carers					

***Reference**: Dr Susanna Hill Macmillan GP/SW EoL Clinical Lead/Devon CCG*



After Death Analysis Form 2019

Reflective notes

In your opinion, what went well?

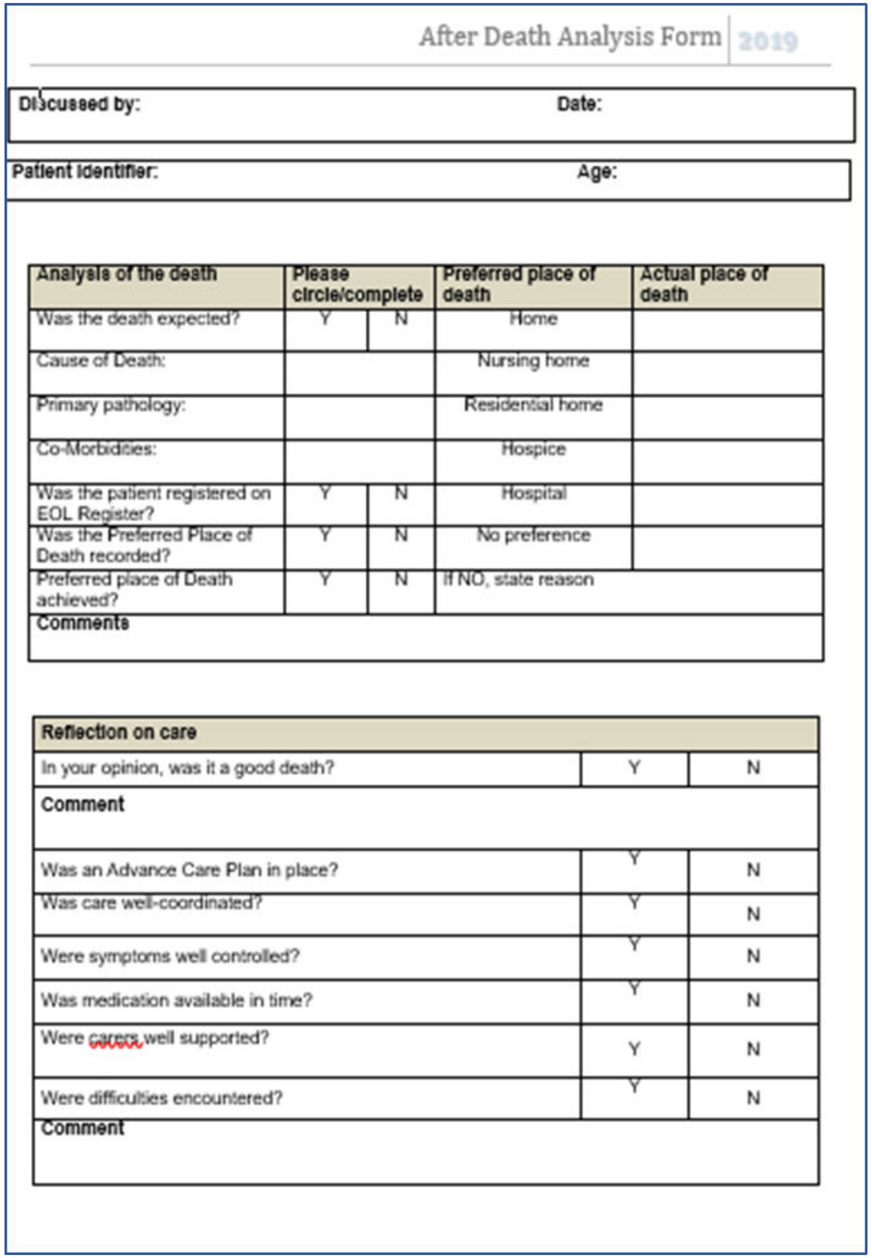
Could anything have been done better?

Are there any changes you plan to introduce into your practice as a result of this case? And timelines to implement? By whom?

Learning shared with:

Areas you might like to consider:

- *Was an ACP in place?*
- *Was care well-coordinated?*
- *How was the communication? With patients, internally, externally?*
- *Were symptoms well controlled?*
- *Was medication available in time?*
- *Were carers well supported?*
- *What difficulties were encountered; solutions found?*
- *Have you shared the learning with eg practice staff, District nurses, Hospice, Hospital? etc*



After Death Analysis Form 2019

Discussed by: **Date:**

Patient Identifier: **Age:**

Analysis of the death	**Please circle/complete**		**Preferred place of death**	**Actual place of death**
Was the death expected?	Y	N	Home	
Cause of Death:			Nursing home	
Primary pathology:			Residential home	
Co-Morbidities:			Hospice	
Was the patient registered on EOL Register?	Y	N	Hospital	
Was the Preferred Place of Death recorded?	Y	N	No preference	
Preferred place of Death achieved?	Y	N	If NO, state reason	
Comments				

Reflection on care		
In your opinion, was it a good death?	Y	N
Comment		
Was an Advance Care Plan in place?	Y	N
Was care well-coordinated?	Y	N
Were symptoms well controlled?	Y	N
Was medication available in time?	Y	N
Were carers well supported?	Y	N
Were difficulties encountered?	Y	N
Comment		

Activity Plan Example (Collect basic practice data from Computer record)

Practice Name		
Total List Size		
List size by gender	Male	Female
Age ranges	Male	Female
0-18		
18-65		
65-80		
80-90		
90+		
Deaths in last 12 months 1.6.18 – 31.05.19		
Number		
Percent of total practice List		
Patients identified as dying in last 12 months of life– on End of Life/GSF register		
Number		
Percent of total number of deaths		
Patients with JIC medication in last 12 months of life		
Number		
Percent of total number of deaths		
Patients with Advance Care plan		
Number		
Percent of total number of deaths		
Patients with TEP/DNAR form in last 12 months of life		
Number		
Percent of total number of deaths		
Patients with EPaCcS record		
Number		
Percent of Total Number of Deaths		

***Reference**: Dr Susanna Hill Macmillan GP/SW EoL Clinical Lead/Devon CCG*

Further examples:

https://www.smartsheet.com/develop-plan-action-free-templates

End of life care – QOF indicator 2019-20

Indicator	Points	Achievement thresholds
QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance	27	NA
QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.	10	NA

Rationale

In 2015 the National Palliative and End of Life Care Partnership published *Ambitions for palliative and end of life care: a national framework for local action 2015-2020*. This quality improvement activity is designed to support practices to respond to those ambitions and to build the foundations needed to provide excellent, holistic and individualised care for all. Identifying patients in need of end of life care, assessing their needs and preferences, and proactively planning their care with them are key steps in the provision of high quality care at the end of life in general practice. There is evidence to suggest that there is the potential for the quality of this care to be improved139. Increased use of healthcare services during this time also occurs often with limited clinical effectiveness and poor experiences for people. Better identification of people in the last year of their life followed by appropriate care planning and support for them are recognised as key elements of good medical practice as set out by the General Medical Council (*Treatment and care towards the end of life: good practice in decision making*, 2010).

Involving, supporting and caring for all those important to the dying person is also recognised as a key foundation of good end of life care. As well as being individuals facing impending loss and grief, they often provide a key caring role for the dying person.
139 National Audit Office. End of Life Care: Report by the Comptroller and Auditor General. 2008; available from
https://www.nao.org.uk/wp-content/uploads/2008/11/07081043.pdf

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in relation to the following aspects of care:

1. **Early identification and support for people** with advanced progressive illness who might die within the next twelve months.

2. **Well-planned and coordinated care** that is responsive to the patient’s changing needs with the aim of improving the experience of care.

3. **Identification and support for family / informal care-givers**, both as part of the core care team around the patient and as individuals facing impending bereavement.

Practices will need to:

1. Evaluate the current quality of their end of life care and identify areas for improvement – this would usually include a retrospective death audit (QI003)

2. Identify quality improvement activities and set improvement goals to improve performance (QI003)

3. Implement the improvement plan (QI003)

4. Participate in a minimum of 2 GP network peer review meetings (QI004) Complete the QI monitoring template in relation to this module (QI003 + QI004)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide for patients and their families at the end of life. This would usually include the completion of a retrospective baseline audit analysis of deaths unless this has been completed in the previous 3 months. Box 4 provides further information about how to do this. The purpose of this is to understand firstly, the numbers of people who had been identified on the palliative care register and therefore deaths which had been anticipated and secondly, how many patients had care plans in place. If the practice already has well-established end of life care process then this baseline audit analysis could focus upon other aspects of care such as:

- Priority care goals achieved e.g. is preferred place of death recorded and achieved?

- Quality of care plans including treatment escalation and advance care plans e.g. legal status of Power of Attorney and advance Directives, and emergency
- treatment preferences such as recording of decision on cardiopulmonary
- resuscitation (note evidence suggests that this should be part of the care
- planning process and not done in isolation).

- Main carer is identified with offer of assessment and support

- Anticipatory medicines are available in the place of care

We encourage practices, particularly those with well-established end of life care processes to seek the views of family members / informal carers which for example could be done through a ***survey of carers*** or a ***structured interview with one carer or patient every six months*** to evaluate how well the practice meets their needs and what improvements could be made.

Box 4: How to do a retrospective death baseline analysis (audit)

Practices should review a sample of X deaths over the previous 12 months to establish baseline performance on the areas of care listed above and to calculate their expected palliative care register size. A suggested template to support data collection for the audit can be downloaded from:
https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/

The number of deaths each year will vary between individual practices due to differences in the demographics of the practice population. Practices could use the number of deaths reported in their practice populations in the previous year to assess how well they are identifying patients who would benefit from end of life care. An audit standard against which to assess current practice would be that the practice was successfully anticipating approximately 60% of deaths.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT analysis. Guidance as to how to do this can be found in the accompanying RCGP guide How to get started in QI140. Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

140 RCGP. https://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/quality-improvement-guide-for-general-practice.aspx

2. Identifying quality improvement activities and setting improvement goals

The identification of quality improvement activities should be informed by the results of the retrospective death baseline audit and analysis. Practices should focus their QI activities on delivering improvement across the following four **measures**:

1. An increase in the proportion of people who die from advanced serious illness who had been **identified** in a timely manner on a practice ‘supportive care register’, in order to enable improved end of life care, reliably and early enough for all those who may benefit from support.

2. An increase in the proportion of people who died from advanced serious illness who were sensitively **offered timely and relevant personalised care and support plan discussions**; **documented and shared electronically** (with appropriate data sharing agreements in place) to support the delivery of coordinated, responsive care in and out of hours with key cross-sector stakeholders.

3. An increase in the proportion of people who died from advanced serious illness where a family member / informal care-giver/ next-of-kin had been **identified**; with an increase in those who were **offered holistic support before and after death,** reliably and early enough for all those who may benefit from support.

4. A reliable system in place to monitor and enable improvement based on timely feedback of the **experience of care** from staff, patients and carer perspectives.

These measures will be used at a national level to assess the impact of the module.
Identification and care planning should be addressed in parallel. Improvement activity should focus on impact. and may include a dedicated focus on specific areas or patient groups e.g. the practice may perform well in relation to supporting patients with cancer at the end of life, but could improve in relation to other patient groups e.g. those with respiratory disease, children with life limiting illnesses or people with learning disabilities.

Practices may also wish to review the RCGP and Marie-Curie Daffodil standards: core Standards for advanced serious illness and end of life care in general practice141 and the NICE QS for End of Life Care in Adults (QS13) and Care of dying adults in the last days of life (QS144) for further suggestions of appropriate quality improvement activities.

For each of the measures, practices should identify and agree their own objectives which are *SMART* See Box 5 for examples of SMART outcomes. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

141 https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/daffodil- standards.aspx

Box 5: Examples of SMART outcomes for each measure

Measure 1:

Baseline analysis from retrospective audit – 20% of people affected by serious illness and end of life care who died, had already been identified on a practice ‘supportive care register’.

SMART outcome: Increase from 20% to X% of people **affected by serious illness and end of life care who died, to be identified** on a practice ‘supportive care register’, over the next 6 months.

Measure 2:

Baseline analysis from retrospective audit – 10% of people **affected by serious illness and end of life care who died**, had been sensitively offered timely and relevant personalised care and support plan discussions and these were **documented and shared electronically.**

SMART outcome: Increase from 10% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people **affected by serious illness and end of life care who died, to be** sensitively offered timely and relevant personalised care and support plan discussions and have these **documented and shared electronically.**

Measure 3:
Baseline analysis from retrospective audit – 10% **of family members / informal care-givers/ next-of-kin** identified on a practice ‘supportive care register’ were contacted and offered information on dealing with grief and bereavement within 1 month of the person on the register dying.

SMART outcome: Increase from 10% to X% (practice to decide) of **family members / informal care-givers/ next-of-kin** identified on the practice ‘supportive care register’ to be contacted and offered information on dealing with grief and bereavement within X weeks /months (practice to decide) of the person on the register dying – within a 12-month period.

Measure 4:
SMART Outcomes:
To support and reflect on retrospective death audit and practice-relevant QI planning within the 12-month period, achieving a minimum of:

a) 2-5 family/care-giver or patient interviews (See Appendix 1) e.g. semi-structured discussion, using an agreed template or annual carer survey relevant to EOLC needs.
Optional and additional SMART OUTCOMES could include:

- Staff feedback to support the QI planning (See Appendix 1) e.g. survey
- MDT feedback to support the QI planning (See Appendix 1) e.g. survey, discussion at MDT

3. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community and related services (such as district nurses, hospice services, and community pharmacy) where practicable. Where possible, patients and their family members and informal care givers should be involved in continuous quality improvement around people affected by advanced serious illness and end of life care. This is especially the case in relation to measures 3 and 4.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set for themselves in relation to the measures they are focusing on. Example case studies can be viewed at https://www.england.nhs.uk/wp- content/uploads/2019/03/1920-qof-quality-improvement-case-studies.pdf

4. GP Network peer review meetings

A key objective of the network peer review meetings is to enable shared learning across the network. The aim of this is to improve learning from deaths and the provision of best practice end of life care. It is also intended to provide a forum for practices to identify wider system issues impacting upon care quality which may require a collective response.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 6.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but it is recommended that the first meeting takes place early in the QI activity and the second towards the end.

Box 6: Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI activity and focus on:

- Sharing the outputs of the diagnostic work to understand the issues for each practice about end of life care.

- Validation of practice improvement targets.

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity in end of life care is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances then they will need to demonstrate other active engagement in network peer learning and review.

The reporting template is available from https://www.england.nhs.uk/publication/quality-improvement-module-documentation- end-of-life-care/ .

Patient identifiable information should not be included in this template or appended to it.

Taken from NHS England (2019) A five-year framework for GP contract reform to implement *The NHS Long Term Plan*
https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

References and further resources

1. NHS England (2019) Investment and evolution: A five-year framework for GP contract reform to implement *The NHS Long Term Plan.* London. NHSE https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

2. Social Research Institute (2011) *End of Life Registers Evaluation Interim Report*. London. Ipsos MORI.

3. Leadership Alliance for the Care of Dying People (LACDP) (2014) *One Chance to get it Right.* London. LACDP.

4. Henry C and Seymour J (2007) *Advance Care Planning for Health and Social Care staff.* London. The Stationary Office.

5. Planning ahead for the end of life: https://www.nhs.uk/conditions/end-of-life-care/#planning-ahead-for-the-end-of-life

6. Advance care planning in general practice – does policy match reality? https://compassionindying.org.uk/library/advance-care-planning-in-general-practice-does-policy-match-reality/

7. Talking about dying: How to begin honest conversations about what lies ahead: https://www.rcplondon.ac.uk/projects/outputs/talking-about-dying-how-begin-honest-conversations-about-what-lies-ahead?utm_source=resuscounciluk_medium=NL_date=Dec2018

8. National Audit Office (2019) SMART outcomes. (*Accessed 11 September 2019*) https://www.nao.org.uk/successful-commissioning/designing-services/smart-outcomes/

9. Quality Improvement templates (2019) (*Accessed 11 September 2019*) https://images.app.goo.gl/qZj1j8Apb96oaofX7

10. Institute for Healthcare Improvement (2019) Plan-Do-Study-Act (PDSA) Worksheet (*Accessed 11 September 2019*) http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

11. Siriwardena N A (2009) Using quality improvement methods for evaluating health care(*Accessed 11 September 2019*) http://primarycare.imedpub.com/using-quality-improvement-methods-for-evaluating-health-care.pdf

Further resources

Institute for Healthcare improvement (2019) http://www.ihi.org/

National Palliative and End of Life Care Partnership (NEoLCP) (2015) Ambitions for Palliative and End of Life Care: A national Framework for Local action 2015-2020 NEoLCP http://endoflifecareambitions.org.uk/