A GOOD PRACTICE GUIDE

To highlight the needs of carers and carers' health

The Princess Royal Trust for Carers

www.carers.org/professionals

www.rcgp.org.uk

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The Aim of this Toolkit

There is a strong and widely held view that involving patients and carers in decisions about healthcare at both personal and strategic levels is fundamentally important to the improvement of health and social care services, as well as being a basic right.

Government policy acknowledges the need for unpaid carers to be at the centre of health and social care. There are six million carers in this country, many of whom find that their health, well-being and income are affected as their caring responsibilities increase. Supporting carers can save both money and time with shorter appointment times, a reduced number of inappropriate queries, and potential reductions in GP prescription costs (eg antidepressants).

The performance of Primary Care Organisations (PCOs) in England & Wales is measured by the Healthcare Commission. PCOs need to demonstrate that they have achieved the core standards and made improvements against the developmental standards outlined in S*tandards for Better Health*. The RCGP Quality Team Development (QTD) programme is an established team based developmental tool which enables PCOs to provide evidence demonstrating achievement of the desired outcomes within S*tandards for Better Health*.

This toolkit has been based on the QTD programme and the criteria are drawn from a number of existing resources, including QTD, but have been specifically drafted to focus on PCOs involvement and inclusion of carers in service planning and delivery. References for each criteria are noted in column 1.

Self Assessment Guide

The principal purpose of this toolkit is to enable the primary care team to assess themselves against agreed criteria for the services they provide for patients and their carers focusing on teamwork and practice organisation. It is designed so that it can be shared by team members and different views can be obtained and discussed. The aim is to identify things that the team is doing well, and also to lead to an agreed development plan for the team. Each criterion should therefore be rated either as fully achieved, as in need of improvement or not achieved at all.
The self assessment toolkit can easily be completed in a team meeting and will allow reflection and consideration the quality and services provides for carers.
This can form the basis of a development plan for the practice.

The Criteria

Services for Carers **Practices recognise that carers are key partners in the provision of care**	**Not met at all**	**Needs Improvement**	**Fully achieved**	**References**
1 ACCESSIBILITY				
a) Carers are able to obtain the service of the team at appropriate time and without undue delay.	❑	❑	❑	
Evidenced by:				
b) Practices take account of the needs and responsibilities of carers, as well as patients, when making decisions about home visits and appointments.	❑	❑	❑	QPA QTD PrAcc1.3G SBH C17 SBH D11
Evidenced by:				
c) In a medical emergency involving a carer, practice systems must ensure the needs of both the carer and cared for are addressed.	❑	❑	❑	QTD PrAcc1.11E SBHC19

Evidenced by:				
d) Practices ensure discharge from hospital procedures recognise carers as key partners in discharge planning and continuity of care.	❑	❑	❑	QPA QTD
Evidenced by:				

2 AVAILABILITY OF INFORMATION

a) The team communicates openly with carers and activity encourages their involvement in decisions affecting the patient and carer.	❑	❑	❑	QTD SBH C17 SBHD9
Evidenced by:				
b) The practice supports carers as key partners by providing leaflets which outline carers' rights, responsibilities and the services provided for carers by the practice.	❑	❑	❑	QPA QTD SBH C16
Evidenced by:				

c) The practice has up to date information for carers about national and local support services across a range of specialist areas.	❑	❑	❑	QTD SBHC16
Evidenced by:				

3 MANAGEMENT OF CHRONIC ILLNESS

a) The team supports carers of patients with long term conditions to effectively manage their care at home and reduce the need for hospital admissions.	❑	❑	❑	QPA QTD PrAcc6.1E PrAcc6.2G PrAcc6.3Q SBH D10 SBH D11
Evidenced by:				
b) The team supports carers to manage their own health needs and offer an annual health check.	❑	❑	❑	QPA QTD
Evidenced by:				
c) The team ensures that carers are involved in planning the care for people with multiple problems including high risk patients.	❑	❑	❑	QPA QTD PrAcc6.1E PrAcc6.2G PrAcc6.3Q
Evidenced by:				

4 MEDICINES MANAGEMENT

a) The team involves carers in the appropriate use of medicines by ensuring they are informed about administering them as well as the benefits and significant side effects.	❑	❑	❑	QPA QTD PrAcc3.2G SBH C4d
Evidenced by:				
b) Medication reviews take into account the carers understanding of the use of medication, significant side effects, appropriate monitoring and review of the need for continued treatment	❑	❑	❑	QPA QTD PrAcc3.2G SBH D1
Evidenced by:				

5 REFERRALS

a) Carers are referred to team members or other statutory and voluntary agencies where appropriate e.g. respite care, local carers centre, OT, social services.	❑	❑	❑	QPA QTD
Evidenced by:				
b) Where appropriate carers are copied into correspondence in relation to referrals.	❑	❑	❑	QPA QTD
Evidenced by:				

6 PREVENTATIVE CARE AND HEALTH PROMOTION

a)The needs of carers are addressed in all areas of preventative care and health promotion.	❑	❑	❑	QPA QTD SBH C6 SBH D2
Evidenced by:				
b) Carers are offered influenza vaccinations annually as part of the high priority groups.	❑	❑	❑	
Evidenced by:				

7 CHILDREN'S HEALTH

a) The Practice has a protocol for identifying and supporting children who may need carers and a system for making referrals to appropriate statutory and voluntary services for support.	❑	❑	❑	QPA QTD SBH C2 QOFCHS1
Evidenced by:				

8 MENTAL HEALTH SERVICES

a) The number of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate is at least 50%	❑	❑	❑	QTD QOF MH6 QMAS
Evidenced by:				
b) In developing care pathways for patients with mental health problems or severe mental illness the team must address the needs and involvement of carers in plans for shared care.	❑	❑	❑	QPA QTD SBH C17 SBHD11
Evidenced by:				
c) The team has a policy for the assessment, management and referral of patients who abuse drugs or alcohol, which includes the needs of carers.	❑	❑	❑	QTD
Evidenced by:				

9 CONTINUED CARE IN THE HOME

a) Patients requiring care in their home are assessed by members of the team and care is planned with them and their carers to meet their needs and wishes.	❑	❑	❑	QTD PrAcc11.1G SBH D10
Evidenced by:				

b) Patients and their carers are offered information and choice about the care they receive.	❑	❑	❑	QTD PrAcc11.3G SBH C18
Evidenced by:				
c) Team members regularly review together the care they are providing, assessing the impact on the team, the carer and the patient.	❑	❑	❑	QTD PrAcc11.7Q
Evidenced by:				
d) The team has a protocol for the identification of carers and a mechanism for the referral of carers who want a social services assessment.	❑	❑	❑	QPA PrAcc11.2G QOF MAN9
Evidenced by:				
e) The team works together and with other agencies to provide end of life and palliative care which meets the needs of patients and recognises the carer as a key partner in decision making.	❑	❑	❑	QTD PrAcc11.4G
Evidenced by:				

f) The team ensures that bereaved carers and relatives receive the support they require.	❑	❑	❑	QTD PrAcc11.8Q GSF
Evidenced by:				

10 PALLIATIVE CARE

a) The practice has a complete register available of all patients in need of palliative care/ support and their carers.	❑	❑	❑	QPA QOF PC1 QMAS
Evidenced by:				
b) The practice has regular (at least 3 monthly) multidisciplinary case review meetings, that include the health and support needs of carers.	❑	❑	❑	QPA QOF PC2 QMAS
Evidenced by:				

Abbreviations

GSF = Gold Standards Framework (Palliative Care) a practice based system to improve the organisation and quality of care for patients in their last stages of life in the community. a

PrAcc =RCGP Northern Ireland Practice Accreditation Programme developed from the RCGP Scotland Practice Accreditation Scheme, a professionally led multidisciplinary programme supporting clinical governance and enhanced patient care through a team based approach

QMAS = Quality Management Analysis System. A national IT system which gives GP practices and PCOs objective evidence and feedback on quality of care delivered to patients.

QOF = Quality and Outcomes Framework. The Quality and Outcomes Framework (QOF) measures achievement in primary care against evidence based indicators. The indicators cover four 'domains' – clinical; organisational; patient experience; and additional services.

The QOF became part of the new voluntary part of the General Medical Services (GMS) and of Personal Medical Services (PMS) contracts on 1 April 2004. The QOF is a UK wide initiative and although participation in the scheme is voluntary, take up is extremely high for GMS and PMS practices (over 95%) and achievement of QOF thresholds results in bonus payments.

QPA = RCGP Quality Practice Award. QPA is a quality assurance process undertaken by practices, which recognises a high standard of quality patient care delivered by every member of the practice team. Each practice is required to submit a portfolio of written evidence set against 23 sets of criteria.

QTD =RCGP Quality Team Development programme is a team appraisal with a comprehensive evaluation of clinical governance processes in a practice. It is designed to support general practices in improving the quality of their services.

RCGP = Royal College of General Practitioners.

SBH = Standards for Better Health. This document was published formally as an integral part of National Standards, Local Action (July 2004) which set out the framework for all NHS organisations and social service authorities to use in planning over the next three financial years.

SBH C = A core criterion in the SBH standards framework.

SBH D = A developmental criterion in the SBH standards framework.