**Implementation tool for**

**the NCEPOD report**

**‘Planning for the End’**

Driver diagrams

<https://www.ncepod.org.uk/2024eolc.html>

Driver diagrams are used to visually display a team’s theory of what can lead to or “drives,” the achievement of a project aim. The diagram is a useful tool for communicating to a range of stakeholders where, and how an aim can be achieved and how, and by who, change can be delivered.

* The **AIMS** can be based on an issues identified in the study
* The **PRIMARY DRIVERS** can illustrate ways of achieving the initial aims
* The **SECONDARY DRIVERS** are components of the primary drivers that the team believe can help achieve the aim
* The **SPECIFIC CHANGE OF IDEAS** can relate to findings in the report or ideas that can test the secondary drivers

This should be done as a multidisciplinary/team exercise to get different perspectives and as many potential drivers, aims and ways to arrive at the initial aim as possible. We have provided an example of a key issue that was identified during the study as an example. The diagrams we have provided are a starting point and should be adapted and expanded to fit your need. The second driver diagram is blank and can be copied or printed out blank for any additional issues you have identified.

Example: End of Life Care – Parallel planning

**Aim**

**Ideas to change concept**

**Secondary drivers**

**Primary drivers**

|  |
| --- |
| Patients with advanced chronic disease are not referred to, and reviewed by palliative care teams |

|  |
| --- |
| Building this approach into normal hospital processes, such as a box on an admission proforma may help identify patients in need of palliative care and would embed it into clinical practice. |

|  |
| --- |
| Earlier non-specialist palliative care will support people to make sure their life before death is comfortable and their wider needs are being met, while their underlying illness is still being treated. |

|  |
| --- |
| Early and comprehensive plan that involves the patient and avoids multiple readmissions to hospital, if that is their wish |

|  |
| --- |
| Raising awareness amongst specialist teams caring for patients with advanced chronic disease to have conversations with patients and their families about end of life care wishes |

|  |
| --- |
| Ensure that patients with advanced chronic disease have access to palliative care alongside disease modifying treatment (parallel planning) to improve symptom control and quality of life. |

|  |
| --- |
| Educate all relevant healthcare professionals about the normalising conversations about death and dying. |

|  |
| --- |
| Embed palliative care and end of life care training as a core competency for all healthcare professionals. |

|  |
| --- |
| Network with community providers of healthcare to ensure advance care plans are shared widely |
| Allow sufficient access to holistic care required e.g. nutrition, hydration, psychological support and pain management towards the end of life |

|  |
| --- |
| Engage with commissioners and the executive board to ensure that there is sufficient funding to cover the required posts to deliver holistic support for the of patients towards the end of life |

Template: End of Life Care – **Prioritise parallel planning**

|  |  |  |  |
| --- | --- | --- | --- |
| **Aim** | **Primary Drivers** | **Secondary Drivers** | **Ideas to change concept** |
| **Ensure that patients with advanced chronic disease have access to palliative care alongside disease modifying treatment (parallel planning) to improve symptom control and quality of life.** | Patients with advanced chronic disease are not referred to, and reviewed by palliative care teams | Earlier non-specialist palliative care will support people to make sure their life before death is comfortable and their wider needs are being met, while their underlying illness is still being treated. | Building this approach into normal hospital processes, such as a box on an admission proforma may help identify patients in need of palliative care and would embed it into clinical practice. |
| Early and comprehensive plan that involves the patient and avoids recurrent admissions hospital, if that is their wish | Network with community providers of healthcare to ensure advance care plans are shared widely | Engage with commissioners and the executive board to ensure that there is sufficient funding to cover the required posts to deliver holistic support for the of patients towards the end of life |
| Allow sufficient access to holistic care required e.g. nutrition, hydration, psychological support and pain management towards the end of life |
| Raising awareness amongst specialist teams caring for patients with advanced chronic disease to have conversations with patients and their families about end of life care wishes | Educate all relevant healthcare professionals about the normalising conversations about death and dying. | Embed palliative care and end of life care training as a core competency for all healthcare professionals. |

Template: End of Life Care – **xxxxx**

**Ideas to change concept**

**Secondary drivers**

**Primary drivers**

**Aim**

|  |
| --- |
|  |

|  |
| --- |
|  |
|  |

|  |
| --- |
|  |
|  |

|  |
| --- |
|  |

|  |
| --- |
|  |

|  |
| --- |
|  |
|  |

|  |
| --- |
|  |
|  |

|  |
| --- |
|  |
|  |

|  |
| --- |
|  |

|  |
| --- |
|  |
|  |

Template: End of Life Care – **xxxx**

|  |  |  |  |
| --- | --- | --- | --- |
| **Aim** | **Primary Drivers** | **Secondary Drivers** | **Ideas to change concept** |
|  |  |  |  |
|  |  |  |
|  |
|  |  |  |