1. The Dying Matters GP Pilot Project 2011 Evaluation: Executive Summary

November 2011

Not for circulation until we have launched the findings with our partners
The Dying Matters GP Pilot Project 2011 Evaluation: Executive Summary

The pilot

In 2009 the Dying Matters coalition started a programme of work with a focus on raising awareness of the importance of talking about the end of life and on the role of GPs as key influencers in end of life care and in initiating discussions to help patients to plan and make decisions about their choices. Phase one of this programme included a GP pilot exercise which took place between May and October 2010 and had three objectives. These were to raise the profile of the Dying Matters Coalition, to support GPs in their consultations with patients when the subjects of death, dying and bereavement arose and to appraise communication materials that were purposely designed by GPs, to assist other GPs, in their communication with patients about end of life. The 2010 project\(^1\) showed that with limited intervention it is possible to transform the confidence of GPs in talking about dying with patients, consequently measurably improving end of life care. Phase 2 of the programme has led to a repeat of the GP pilot from April to October 2011 with GPs and practices from three regions across England. GPs were invited to participate in an Enhanced Communication Skills workshop and were given a pack of Dying Matters communication materials to use in their practice and during consultations.

GPs were asked to complete a pre-pilot questionnaire upon attendance to the workshop and a post-pilot questionnaire in September. Using a four point scale, GPs were asked to rate their confidence in starting and having conversations about end of life. In addition, GPs were asked to rate the utility of the Dying Matters communication materials and the usefulness of the Enhanced Communications Skills workshop. GPs were also asked to keep a simple record of end of life conversations they held with patients between May and late August 2011.

GPs consented to questionnaire data being analysed and the anonymity of the participating practices and GPs has been preserved. The data was entered onto a purposely designed database then exported into a spreadsheet for analysis. The results from the 2011 GP pilot project are described in four main sections covering pilot participation, end of life conversations, communication materials and the Dying Matters training approach.

Pilot participation

- 52 GP practices participated in the pilot
- 58 GPs participated in the pilot (60 GPs were recruited, 2 withdrew)
- 53 GPs attended training workshops
- 45 GPs completed and returned pre-pilot questionnaires

\(^1\) The outcomes of the Phase One pilot exercise and evaluation can be found on the Dying Matters website here [http://www.dyingmatters.org/page/gp-pilot-project](http://www.dyingmatters.org/page/gp-pilot-project)
- 46 GPs completed and returned post-pilot questionnaires
- 33 GPs attended the Enhanced Skills Communication workshop and returned both pre- and post-pilot questionnaires
- 6 practices recorded actions following 53 conversations between GP and patient

A proportion of GPs who attended the workshop and completed questionnaires also involved others from their practice in the pilot through using the Dying Matters materials to support conversations. At least another 88 individuals – predominantly GPs - were engaged in this way. A practice-based Gold Standards Framework was the end of life communication mechanism most commonly used by GPs.

**End of life conversations**

**GPs confidence** Pre-pilot, 67% of GPs rated themselves as ‘not confident’ or ‘not very confident’ in initiating conversations about end of life and 58% rated themselves as ‘not confident’ when having a conversation about end of life.

**Increasing confidence** Post-pilot, 91% (42 out of 46) GPs rated themselves as being ‘confident’ or ‘very confident’ when starting conversations about end of life and 98% (all GPs bar one) rated themselves as ‘confident’ or ‘very confident’ when having conversations.

**Changes in GPs confidence** There is a sub-sample of GPs (33 GPs) returning both pre- and post-pilot questionnaires whose confidence ratings can be paired together. Using the paired responses, it is possible to explore the statistical significance in changes in GPs confidence taking place between pre- and post-pilot phases. In GPs taking part in the pilot project, a change in their self-reported confidence in both starting and having conversations about end of life can be observed between the pre and post pilot phase.

- GPs self-reported confidence in initiating conversations shifted firmly from ‘not very confident’ to ‘confident’. The probability that this change in GPs confidence is due purely to chance is extremely small ($P > 0.001$).
- Whilst a larger proportion of GPs described themselves as confident in having conversations in the pre-pilot phase, an increase in confidence was still observed. The probability that this change is due purely to chance is extremely small ($P > 0.001$).

It is not possible to attribute this increase in confidence to a specific element of the intervention (e.g. attendance to the Enhanced Communication Skills workshop) but it can be said with confidence that participating in this pilot increased GPs confidence in both initiating and having conversations about death and dying with patients.

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2 Note on statistics: both unpaired t-tests of differences (between 45 and 46 GPs self-ratings) and paired t-tests of differences (between 33 GPs self-ratings) were carried out. T-tests are a simple but robust test. To perform a t-test, GP self-reports were converted from their qualitative state to a number i.e. not confident = 1, not very confident = 2, confident = 3 and very confident = 4. A null hypothesis (i.e. there has been no change) was tested.
Actions following end of life conversations  Six practices recorded actions following 53 conversations between GP and patient. It was considered inappropriate to attempt to draw conclusions from records from only six of 57 practices in total and these are not discussed here.

Working with the patient’s agenda first  Overall, 93% of GPs rated themselves as being either ‘very confident’ or ‘confident’ in being able to work with the patient’s agenda first in a conversation, before integrating their own.

Barriers  GPs were asked if they were able to identify potential barriers to people from their practice being given sufficient or timely information in order to make informed choices about their wishes. Twenty out of 46 GPs could identify potential barriers, 23 could not and 3 did not give a response. Just over a third of GPs chose to give a more detailed description of the potential barriers they could identify. The strongest themes arising from these responses were about time and timing - “This type of conversation cannot be rushed or squeezed into a standard 10 [minute] consultation” and “If patient is unwell timing is important” – as well as the desire not to upset patients or remove hope - “General unwillingness on behalf of professionals to initiate difficult conversations for fear of upsetting patients” and “Attitudes of some staff who thought the subject was important but also felt patients might feel that we are “giving up” on them if we initiate the conversation or that the subject was “too morbid”...”. Other GPs commented on the number and range of professionals involved in end of life care - “Different professionals being at different stages of familiarity and comfort with this area” and “…eol takes a lot of professionals involved so difficult to know who should have the conversation”. There were also a few references to denial - “Many doctors still feel that ‘denial’ is the...most frequently chosen method of coping with EOL”.

Communication Materials

GPs preferences  The Dying Matters leaflet ‘To Do List’ is the most highly rated by GPs and ranks highest of all the materials GPs would recommend to a colleague.

Utility of the materials  Two thirds of GPs returning a post-pilot questionnaire provided additional comments on how and when they used the Dying Matters leaflets and posters. Some GPs did not use the materials at all - “I haven’t had a conversation about dying with any of my patients”. Others used them and found them helpful - “Had 2 conversations, one used leaflets which was very useful”, “I found them a useful adjunct” and “Leaflets useful as supporting materials for patients”.

A few GPs had put effort into displaying the materials or disseminated them in other ways - “I did put out some of the leaflets as a display in our waiting room and the posters” and “I have put all the materials in our staff room and have made a mini-display”.

3 ‘eol’ and ‘EOL’ are an abbreviation of ‘End of Life’
Some GPs had not heard any feedback from people receiving the materials, making it harder to appraise their impact - “Only handed out one leaflet personally & did not get any specific feedback”, “Poster was displayed - not sure of impact. No comments by patients.”.

Selecting materials appropriate to the patient’s needs was very important to GPs - “Copies of the leaflets were given to three individual patients who had elderly family members who were dying or were carers for frail elderly people”, “Leaflets very useful when thinking/discussing these issues with a patient but more useful when trying to involve family in decisions as well” and “*Leaflets given to carers were most popular*”.

**Why GPs didn’t use the materials** Several GPs commented that they hadn’t used the materials with their patients because the materials were not suitable for the patient’s needs and circumstances - “Not always appropriate for the patient” and “Not always relevant to the patient”. Others did not like the content of the leaflets and did not wish to use them as they were uncertain of their impact - “I found some patients were shocked by the materials and although commented that it was thought provoking I found it difficult to gauge how patients would react to the material” and “I still feel a sense of unease using them and it depends on the patient/relative and our existing relationship”.

Several GPs made specific references to the reduced capacity of some patients to take in this kind of communication material, making the leaflets inappropriate - “...most terminally ill patients have been demented in nursing homes so not appropriate” also “...patients...had dementia and lacked capacity to take on board the leaflet’s contents”. For some, practical issues simply got in the way - “...on a home visit and I didn’t have them to hand” and “...don’t always have to hand when conversation arose”.

**GPs comments on other materials that would be helpful** GPs commented that it would be helpful to change the existing content or format of materials to make them more appropriate for particular audiences - “Leaflets don’t take into account language barriers or cultural beliefs. EOL planning and discussions are very difficult in certain ethnic groups. Tailor made literature similar to these leaflets would be very useful” and “A video of a real-life end of life discussion in a dementia home”. Others wanted feedback on the patient experience - “Could one try to capture how patients felt these conversations went i.e. what did they think about how the GP handled such encounters”,

GPs commented that materials which help with starting the end of life conversation are most useful - “How to START 'death and dying' conversation - MAIN problem identified by myself and colleagues. The principles of the actual conversation which includes open ended questions, empathy, acknowledgement, etc are practised in everyday consultations by most GPs. A DVD showing different scenarios and different ways of APPROACHING the conversation would be very useful ”. One GP suggested material for GPs themselves - “Leaflets that point out the benefits to GPs of initiating conversations i.e. increased patient satisfaction, fewer complaints, improved ongoing care of
carers/family after death, improved communication across the primary care team, recognition of high standard for CQC etc”.

**Dying Matters training approach**

**GPs recommendation of the pilot approach** 38 out of 46 GPs (83%) returning a post-pilot questionnaire would recommend the Dying Matters pilot approach, consisting of a workshop supported by Dying Matters materials, to a colleague. There were a few comments from GPs on targeting the training at those most in need or exploring incentives to encourage GPs to attend - “Not sure of recommending this pilot approach. Many GPs who need communication skills training will not ‘sign up’ unless it is recognised e.g. at appraisal, 360° feedback”, also “I think they [the communication skills training & materials] would be more helpful to less experienced and younger GPs”.

**GPs rating of the enhanced communications skills workshop** Three quarters of GPs rated the enhanced communication skills workshop as either ‘very helpful’ or ‘helpful’ - “Would particularly recommend the workshop”.

**A training DVD** 82% of GPs thought that a training DVD would be ‘helpful’ or ‘very helpful’.

**Some limitations of the Pilot Project to bear in mind**

There are a number of limitations to bear in mind when considering the findings of the two pilots and in contemplating their wider application:

- The GPs and practices who have participated in the pilots are self-selected and are likely to be the greatest enthusiasts and the ‘early adopters’ of improvements in end of life care and of the Dying Matters approach and principles.
- The comparison of GPs self-rated confidence, before and after the pilot, shows a demonstrable shift away from ‘not very confident’ to ‘confident’. There are a small number of cases in which a GP’s confidence had changed but the GP had not participated in all the elements of the pilot and it is not possible to attribute this change to a specific element of the pilot. In a study such as this, it is not unusual to observe that change has taken place despite minimal intervention (sometimes commonly called the Hawthorne effect).
- The pilot did not explore any other factors (or causes) such as the GPs practice activities or other end of life initiatives, which may have contributed to the observed changes – however, the pilot did not set out to do this and the methods and findings are entirely appropriate to the objectives and scope of the work.

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4 The **Hawthorne effect** is a form of reactivity or change whereby people modify an aspect of their behaviour (e.g. their behaviour at work) that is being experimentally measured, simply in response to the fact that they are being studied, not in response to any particular experimental manipulation.
Headlines from the evaluation
The evaluation of the GP Pilot Project 2011 shows that:

- In GPs taking part in the pilot project, a change in their self-reported confidence in both initiating and having conversations about end of life can be observed between the pre- and post-pilot phase. The probability that this change in GPs confidence is due purely to chance is extremely small ($P > 0.001$). Although it is not possible to attribute this increase in confidence to a specific element of the intervention (e.g. attendance to the Enhanced Communication Skills workshop) but it can be said with confidence that participating in this pilot increased GPs confidence in initiating and having conversations about end of life.

- 93% of GPs rated themselves as being either ‘very confident’ or ‘confident’ in being able to work with the patients agenda first in a conversation, before integrating their own.

- Twenty out of 46 GPs could identify potential barriers to patients receiving sufficient and timely information in order to make informed choices about their end of life wishes. GPs described these barriers as time and timing; the number and range of professionals involved in end of life care and the denial of end of life exhibited by patients, family members and other professionals.

- The Dying Matters leaflet ‘To Do List’ is the most highly rated by GPs and ranks highest of all the materials GPs would recommend to a colleague.

- When GPs were using the Dying Matters materials, the main things they were considering were; whether or not the content and style of the materials were appropriate to the needs of the patient; the time, place and opportunity to use them and whether or not the patient would react positively.

- If GPs were not using the Dying Matters leaflet it was because they considered the material an inappropriate match for the patients needs – in particular patients with reduced capacity e.g. those with dementia, were unsure of how the patient might react or the practical issue of not having the leaflets to hand.

- 38 out of 46 GPs (83%) would recommend the Dying Matters pilot approach, consisting of a workshop supported by Dying Matters materials, to a colleague.

- Three quarters of GPs attending the Enhanced Communication Skills workshop rated it as either ‘very helpful’ or ‘helpful’.

The programme of work with GPs

In 2009 the Dying Matters coalition started a programme of work with a focus on raising awareness of the importance of talking about the end of life and on the role of GPs as key influencers in end of life care, in initiating discussions to help patients to plan and make decisions about their choices.

Phase one of this programme included a GP pilot exercise which took place between May and October 2010 and had three objectives. These were to raise the profile of the Dying Matters Coalition, to support GPs in their consultations with patients when the subjects of death, dying and bereavement arose and to appraise communication materials that were purposely designed by GPs to assist other GPs in their communication with patients about end of life. GPs were invited to participate in an Enhanced Communication Skills workshop and were given a pack of Dying Matters communication materials to use in their practice and during consultations. GPs were asked to complete a pre-pilot questionnaire upon attendance to the workshop and a post-pilot questionnaire in September. GPs were asked to rate their confidence in starting and having conversations about end of life, using a four point scale. In addition, GPs were asked to rate the utility of the Dying Matters communication materials and the usefulness of the enhanced communications skills workshop. GPs were also asked to keep a simple record of end of life conversations they held with patients between May and late August.

GPs consented to questionnaire data being analysed and the anonymity of the participating practices and GPs has been preserved. The data was entered onto a purposely designed database then exported into a spreadsheet for analysis.

The 2010 project\(^5\) showed that with limited intervention it is possible to transform the confidence of GPs in talking about dying with patients, consequently measurably improving end of life care. Phase 2 of the programme led to a repeat of the GP pilot from April to October 2011 with GPs and practices from three regions across England\(^6\).

In each pilot, three evaluation measures were collected in an identical format. These were:

- GPs self-rating of confidence in starting and having conversations about death and dying, using a four point scale (all 113 GPs participating in the pilots and 64 pairs of GPs pre- and post-pilot ratings)

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\(^5\) The outcomes of the Phase One pilot exercise and evaluation can be found on the Dying Matters website here [http://www.dyingmatters.org/page/gp-pilot-project](http://www.dyingmatters.org/page/gp-pilot-project)

\(^6\) The outcomes of the Phase Two pilot exercise and evaluation will be made available shortly. Please see the Dying Matters website for details [www.dyingmatters.org](http://www.dyingmatters.org)
• GPs records of actions following a conversation, using a conversation record sheet (208 conversations)
• GPs rating of the utility of the three Dying Matters leaflets and the poster, using a four point scale (utility ratings of 99 GPs)

To obtain the maximum benefit from the data collected, these measures have been collated where it is possible and appropriate to do so, to highlight key findings and the overall impact of this programme. It is these measures which are summarised in this document.

Participation in the 2010 and 2011 GP pilots

• 76 GP practices participated in the pilots
• 113 GPs participated in the pilots
• 78 GPs attended enhanced communication skills training workshops
• 88 GPs completed and returned pre-pilot questionnaires
• 99 GPs completed and returned post-pilot questionnaires
• 64 GPs attended the workshop and returned both pre- and post-pilot questionnaires
• 27 practices recorded actions following 208 conversations between GP and patient

End of life conversations: GPs confidence

**GPs confidence** When looking at the self-rated confidence of all GPs returning questionnaires, in the pre-pilot phase two thirds (68%) of GPs rated themselves as ‘not very confident’ or ‘not confident’ in starting conversations about end of life with their patients. At the end of the pilot phase, 88 out of 99 GPs (89%) rated themselves as either ‘confident’ or very ‘confident’.

In the pre-pilot phase, just over half of all GPs rated themselves as ‘confident’ in having conversations with their patients about death, dying and bereavement and just under half – 45% - rated themselves as ‘not very confident’ or ‘not confident’. At the end of the pilot phase, 93 out of 99 GPs (94%) of GPs rated themselves as either ‘confident’ or very ‘confident’ in having these conversations.

**Increasing confidence: changes in GPs confidence** There is a sub-sample of 64 GPs returning both pre- and post-pilot questionnaires whose confidence ratings can be paired together. Using the 64 pairs of data, it is possible to explore the statistical significance in changes in confidence taking place between pre- and post-pilot phases.

In GPs taking part in the Dying Matters pilots, a change in their self-reported confidence in both initiating and having conversations about end of life can be observed between the pre and post pilot phase.

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7 Note on statistics: paired t-test of differences, pre- and post-pilot, in the self-rated confidence of 64 GPs was performed. A null hypothesis (i.e. there has been no change) was tested.
These observations were:

- GPs self-reported confidence in initiating conversations shifted from ‘not very confident’ to ‘confident’. The probability that this change in GPs confidence is due purely to chance is extremely small ($P > 0.001$)
- Whilst a larger proportion of GPs described themselves as confident in having conversations in the pre-pilot phase, an increase in confidence was still observed. The probability that this change is due purely to chance is extremely small ($P > 0.001$)

It is not possible to attribute this increase in confidence to a specific element of the intervention (e.g. attendance to the enhanced communication skills workshop) but it can be said with confidence that participating in the Dying Matters pilot projects increased GPs confidence in both initiating and having conversations about death and dying with patients.

**End of life conversations: actions following a conversation**

**Age and gender of patients** GPs recorded a total of 208 conversations with 81 males and 121 females (in 6 conversations gender was not recorded). The median age of patients with whom GPs discussed end of life was 76 years old (sample range 74 years, interquartile range 24 years, the ages of 20 patients was not recorded).

**Type of consultation where conversations take place** Half of all initial conversations about death and dying recorded by GPs took place between the GP and their patient and just over a quarter of end of life conversations followed on from an earlier one. Included within the 208 consultations when the GP discussed end of life, there are 16 ‘pairs’ of conversations when the GP planned and then carried out a subsequent conversation with the patient. In 3 of the 11 pairs, at first the patient had rejected the conversation about end of life.

**Type of Illness** Almost half of all patients with whom GPs discussed end of life had cancer and one fifth of conversations were with, or about, patients who had dementia or who were elderly or frail. Nine conversations took place between GPs and a patient or a family member following bereavement.

**Stage of illness** GPs were taking to patients about end of life throughout all stages of illness and life (from 25 to 99 years of age) and 60% of conversations took place with patients who were in an advanced, metastatic or end stage of illness.

**Conversation triggers** Deterioration in a patient’s condition was the trigger for a quarter (26%) of GPs end of life conversations. A further quarter of conversations were triggered by a question from the patient or a family member or carer. Around 1 in 7 conversations were triggered by a patient being in pain or showing signs of distress or anxiety.
Continuing the conversation  From the combined pilot data, the response of patients to a conversation to started by a GP is that 178 chose to continue the conversation and 21 rejected the conversation

Nine times out of ten, if a GP initiates a conversation about end of life, a patient will continue it; “My experience has been that the majority of the patients with whom I have had these conversations have been relieved and appreciative. Only very occasionally (perhaps 1 in 10 times) did patient not wish to discuss the prospect of deteriorating health and increasing care needs and implications of this” [GP comment, 2011 pilot]

Actions taken by GPs following a conversation  The most frequent outcome of conversation about death and dying is for a GP to have a further conversation with the patient’s family. Actions such as planning to have another conversation with the patient, placing the patient on the End of Life care register and recording the patients preferred place of care follow a third of conversations. One in three conversations developed into a discussion about the patient’s wishes regarding resuscitation and one in four conversations led to DNAR being recorded in the patient’s notes. The thing least likely to happen is that no action is taken. A number of ‘other’ actions are taken by GPs following an end of life discussion, including; discussing the patient’s pain and discomfort and reviewing pain management; undertaking a treatment and medication review to control symptoms; requesting involvement of District Nurse(s) and others e.g. MacMillan Nurse and Night Sitters and a referral or offer of support to family members and carers.

GPs use and recommendations of the Dying Matters materials  GPs rate the Dying Matters leaflet ‘To Do List’ as the most useful material overall, for both initiating and helping to support conversations about end of life. It is also the leaflet they are most likely to recommend to a colleague – 80% of GPs would recommend the leaflet ‘To Do List’ to a colleague. ‘To Do List’ is also the leaflets GPs are most likely to give to a patient following a conversation about end of life; giving these leaflets to patients and carers in one quarter of end of life conversations.

GPs also find the Dying Matters leaflets ‘Remember When We’ and ‘5 Things To Do’ useful for starting conversations and ‘Remember When We’ slightly more useful when having conversations.

The Dying Matters poster is the least useful material for GPs in initiating or having conversations. GPs found it most difficult to gauge the impact of the poster as this was often displayed in the waiting room/area and they received little or no feedback about it from patients.

If GPs decide that the Dying Matters materials are an appropriate part of the patients/carer conversation or consultation, they will use them if they are to hand.
Some limitations of the Pilot Project to bear in mind

Some limitations to bear in mind

There are a number of limitations to bear in mind when considering the findings of the two pilots and in contemplating their wider application:

- The GPs and practices who have participated in the pilots are self-selected and are likely to be the greatest enthusiasts and the ‘early adopters’ of improvements in end of life care and of the Dying Matters approach and principles
- The 2011 GP pilot has considered and built on the findings and learning from the first pilot in 2010 and, whilst this is a natural and even desirable occurrence, it cannot be assumed that the pilots are identical or that the results are automatically comparable
- The comparison of GPs self-rated confidence, before and after the pilot, shows a demonstrable shift away from ‘not very confident’ to ‘confident’. There are a small number of cases in which a GP’s confidence had changed but the GP had not participated in all the elements of the pilot and it is not possible to attribute this change to a specific element of the pilot. In a study such as this, it is not unusual to observe that change has taken place despite minimal intervention (sometimes commonly called the Hawthorne effect⁸)
- Neither pilot explored any other factors (or causes) such as the GPs practice activities or other end of life initiatives, which may have contributed to the observed changes – however, neither pilot set out to do this and the methods and findings are entirely appropriate and proportionate to the objectives and scope of the work

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⁸ The Hawthorne effect is a form of reactivity or change whereby people modify an aspect of their behaviour (e.g. their behaviour at work) that is being experimentally measured, simply in response to the fact that they are being studied, not in response to any particular experimental manipulation.
Headlines from the evaluation of both pilots

The evaluation of both the GP Pilot Projects shows that:

- 76 GP practices and 113 GPs in total have engaged in the Dying Matters GP Pilot Projects 2010-2011, participating through; GPs attendance to an Enhanced Communication Skills workshop, using Dying Matters materials, completing and submitting pre- and post-pilot evaluation questionnaires (an overall compliance rate of 79%), recording actions of conversations held with patients, family members and carers and undertaking a practice death audit.

- At the beginning of the pilots, just over half of all GPs rated themselves as ‘confident’ in having conversations with their patients about death, dying and bereavement and just under half – 45% - rated themselves as ‘not very confident’ or ‘not confident’. At the end of the pilot phase, 93 out of 99 GPs (94%) rated themselves as either ‘confident’ or very ‘confident’ in having these conversations.

- GPs self-rated confidence in initiating conversations shifted from ‘not very confident’ in the pre-pilot phase to ‘confident’ in the post-pilot phase. Similarly, an increase in GPs self-rated confidence in having conversations was observed. The probability that these changes in GPs confidence are due purely to chance is extremely small ($P > 0.001$). Both the Dying Matters GP Pilot Projects show that with limited intervention it is possible to significantly increase the confidence of GPs in talking about dying with patients.

- GPs rate the leaflet ‘To Do List’ as the most useful material overall, for both initiating and helping to support conversations about end of life. It is also the leaflet they are most likely to recommend to a colleague. GPs also find the leaflets ‘Remember When We’ and ‘5 Things To Do’ useful for starting conversations and ‘Remember When We’ slightly more useful when having conversations. The poster is the least useful material for GPs in initiating or having conversations.

- If a GP decides, using their professional judgement, that the Dying Matters materials are an appropriate part of the patients/carers treatment or consultation, they will use them if they are to hand.

- Deterioration in a patient’s condition was the trigger for slightly more than a quarter of GPs end of life conversations. A further quarter of conversations were triggered by a question from the patient or a family member or carer. Around 1 in 7 conversations are triggered by a patient being in pain or showing signs of distress or anxiety.

- End of life is not just about old age - GPs were discussing death, dying and bereavement issues with people from a broad age range, from 25 to 99 years of age.
• Nine times out of ten, if a GP starts a conversation about death, dying and bereavement, a patient will continue it.

• GPs self-reported confidence does not appear to influence in any way a patient’s rejection or continuation of a conversation about end of life.

• Half of all GPs conversations with patients about end of life result in the GP having a conversation with the patient’s family member(s). One in three conversations lead to planning to have another conversation with the patient, placing the patient on the End of Life care register and recording the patients preferred place of care followed a third of conversations.

• One in three end of life conversations developed into a discussion with the patient about their wishes regarding resuscitation and one in four conversations led to ‘DNAR’ being recorded in the patient’s notes.

• The thing least likely to happen, following an end of life discussion between a GP and a patient, is that the GP takes no action.