

Transforming End of Life Care in Acute Hospitals

Anita Hayes Programme Director

NHS

Improving Quality





“We knew she was going to die, she knew she was going to die, but just wanted it to be pain free.

The staff on the whole carried on as if she was going to get better and seemed unable to recognise the inevitable and change their tone and planning accordingly.”

comment posted on the Patient Opinion website
www.patientopinion.org.uk eolc 2nd annual report 2010

What the people we serve want....

My goals/outcomes

National Voices

People shaping health and social care



Communication

Emergencies

**Person centered
coordinated care**

“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes”

Information

Transitions

Care planning

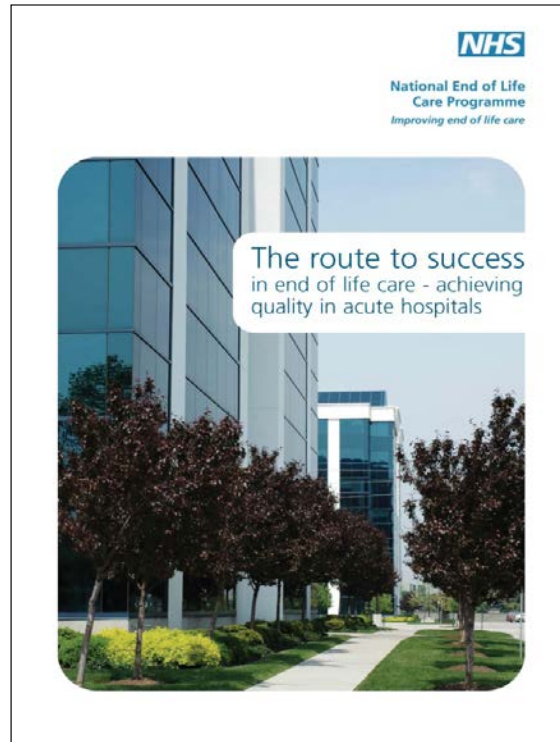
Decision-making

National bereavement survey

- **Overall quality of care** - 23% rate as fair/poor
- **Coordination of care:**
 - Community services - 14% did not work well together
 - Hospital/community – 31% did not work well together
- **Relief of pain and suffering at home** – 51% partially/not at all

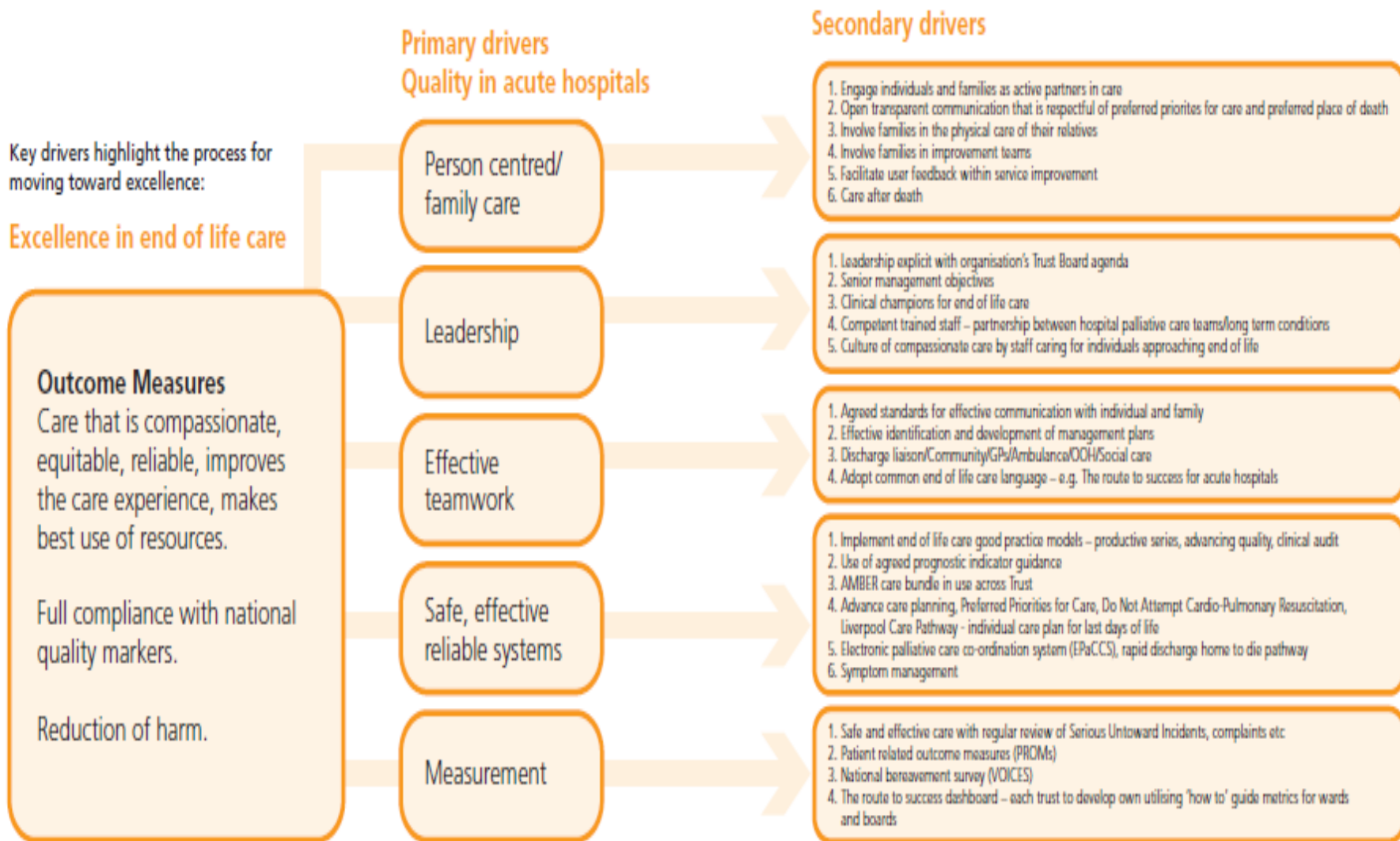
Delivery of high quality services

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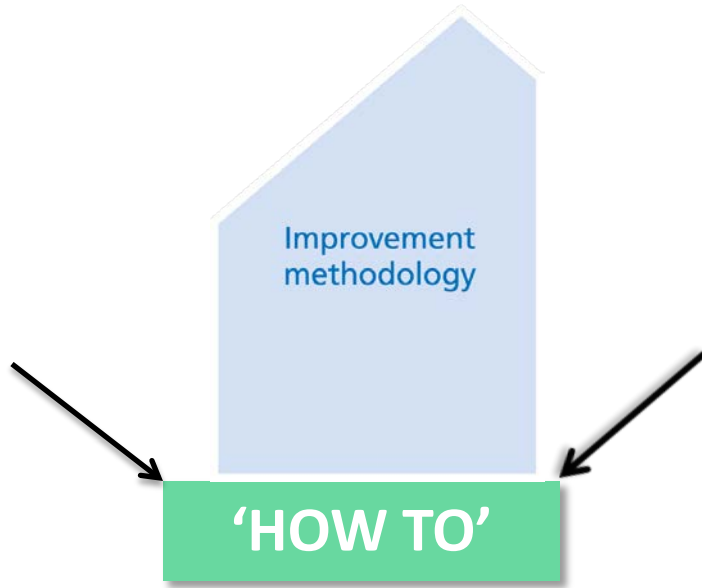


Key drivers for excellence

Figure 1: Key drivers for excellence in end of life care



Putting the purpose into practice



These modules create *The Productive Ward*



3 Modules

- Getting Started
- End of life care Pathway Steps
- 1 - 6
- How to sustain

Enablers

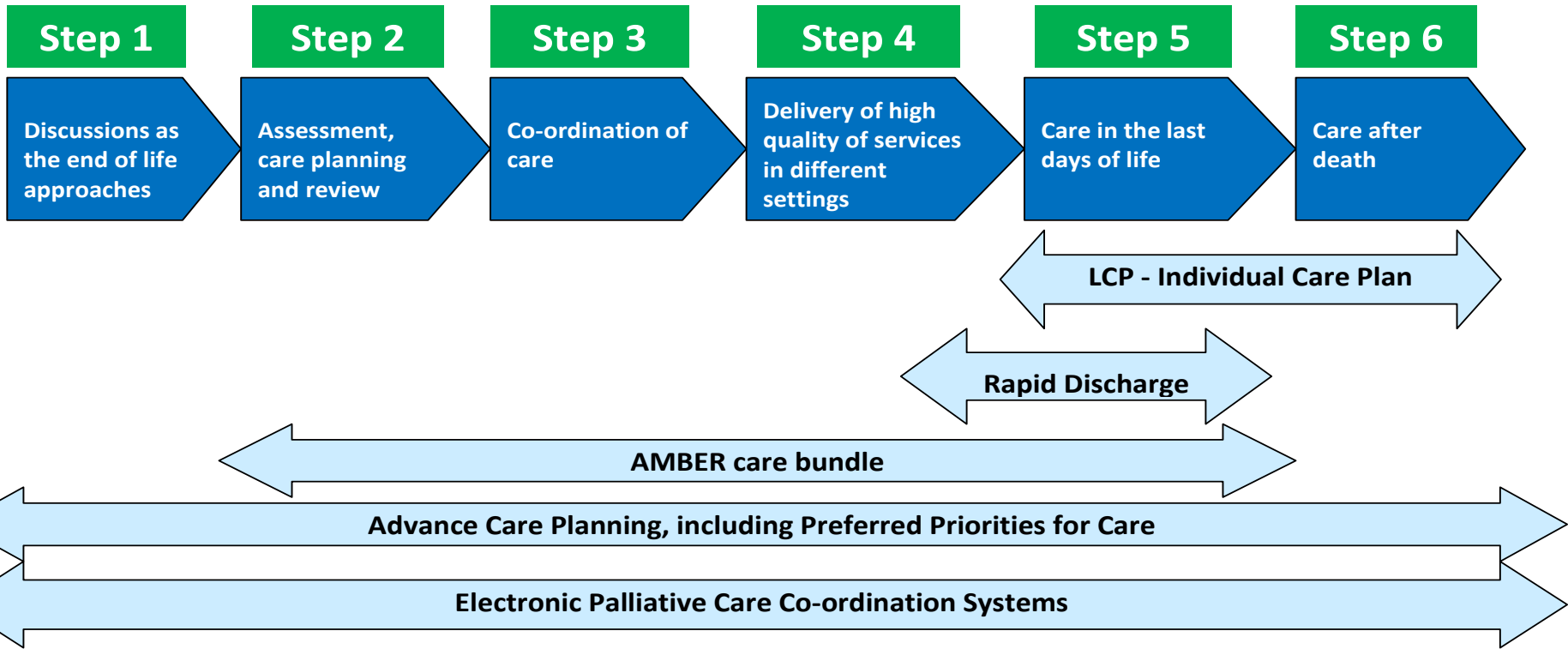
- Advance Care Planning
- AMBER care bundle for managing patients whose recovery is uncertain
- Electronic palliative care coordination systems (EPaCCS)
- Rapid Discharge Home
- LCP- care of the dying patient- end of life care plans

Metrics

- Organisational
- Ward
- Spread at Sept 2013 x 68 Trusts across England



Key Enablers and Outcomes along the 6 step end of life care pathway



Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5	Outcome 6
Users, families & carers are given the opportunity for open & honest discussions with staff that form the basis for advance care planning & meets individual choices wherever possible	Individuals have a holistic assessment resulting in an agreed care plan with regular review of their needs & preferences. Plus the needs of carers are assessed, acted on & reviewed regularly	Systems developed across local primary, community, secondary & social care as well as ambulance will ensure co-ordinated care that is responsive to individuals & their carers needs & choices	Each individual within a dignified care environment wherever that may be, will have access to specialist palliative care advice 24/7 and access to tailored information as well as access to spiritual care	The dying phase is recognised and the person dying can be confident that their wishes, preferences and choices will be reviewed and acted upon and that their families & carers will be supported throughout	A system is in place that ensures the ongoing emotional & practical needs of families & carers are supported after death. Verification and certification of death is timely, including notification to coroner

Spread of innovation



Programme Progress

Community engagement Patient Experience, Safety, Effectiveness Supporting Improved Quality & Productivity

Dying Matters Awareness Week Delivered

Media mentions Q1 562.

Organizational members 1,152

Page impressions 270,491,

Twitter Followers 9,920

EoLC conversations training

69 Acute Trusts Teams involved

Resources disseminated

Site visit programme underway

Regional cluster events planned Sept – Dec

Community Hospital sign up

Baseline data summary completed

Website NHS IQ

Twitter #nhseolcare

AMBER Faculty Delivered workshops in May & July

Monthly Network calls

Updated website content

On-going implementation support x 32 hospitals

User focus groups

Quality end of life care for all (QELCA)

Evaluation completed

Train the trainers May / Sept x 10 trainers

End of Life care facilitators and champions Network established

www2.hull.ac.uk/fass/eolc.aspx

Measurement for Improvement

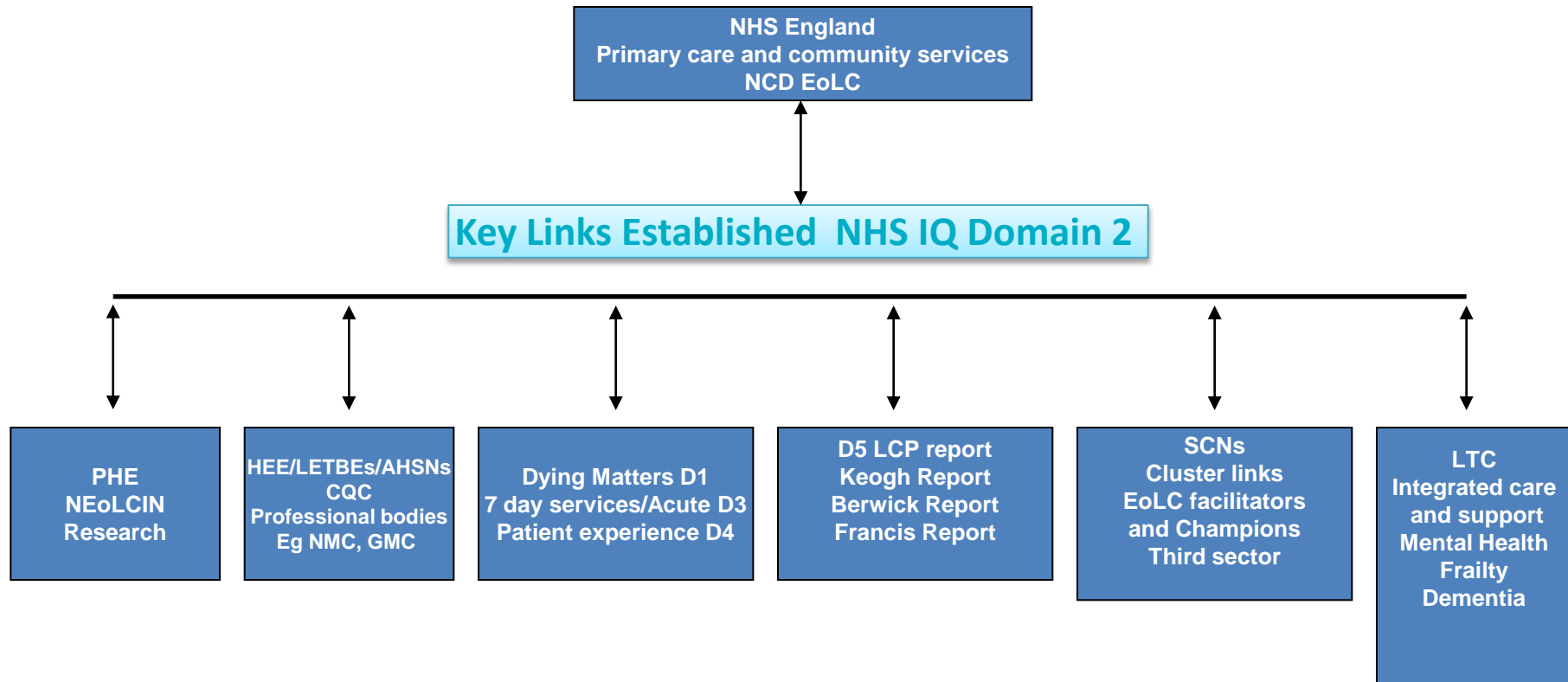
Baseline completed

Evaluation underway

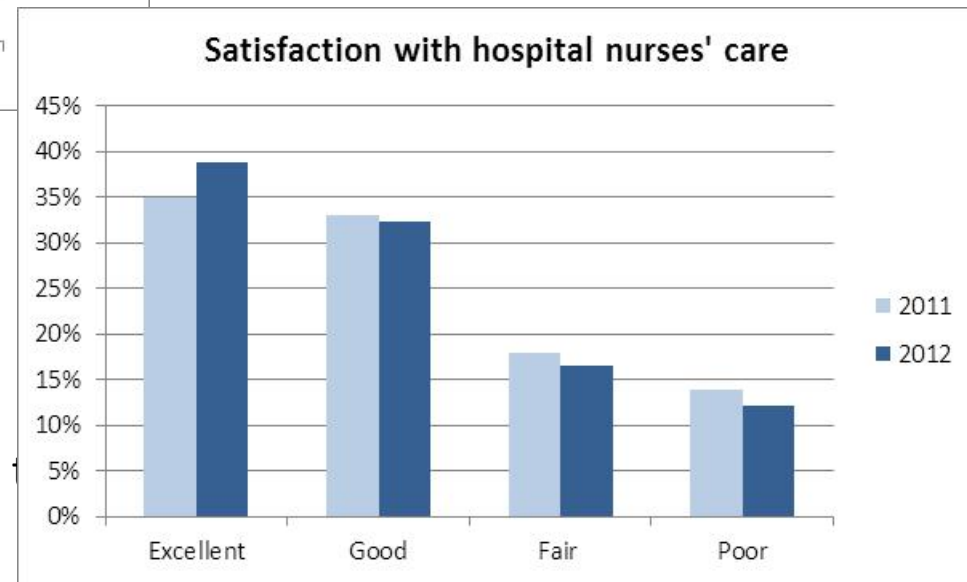
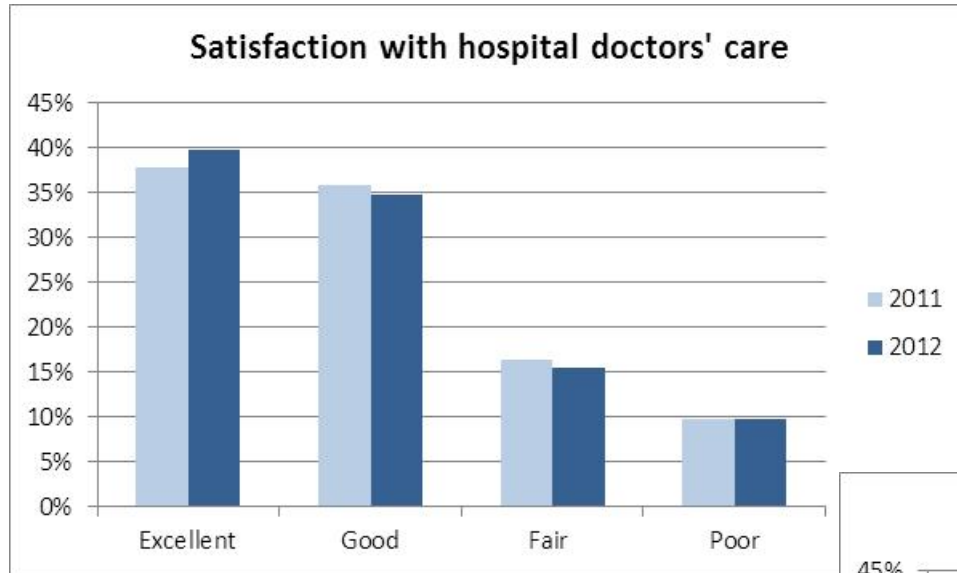
VOICES (2012) Survey Published

DIUPR 43.1%

Building key strategic partnerships



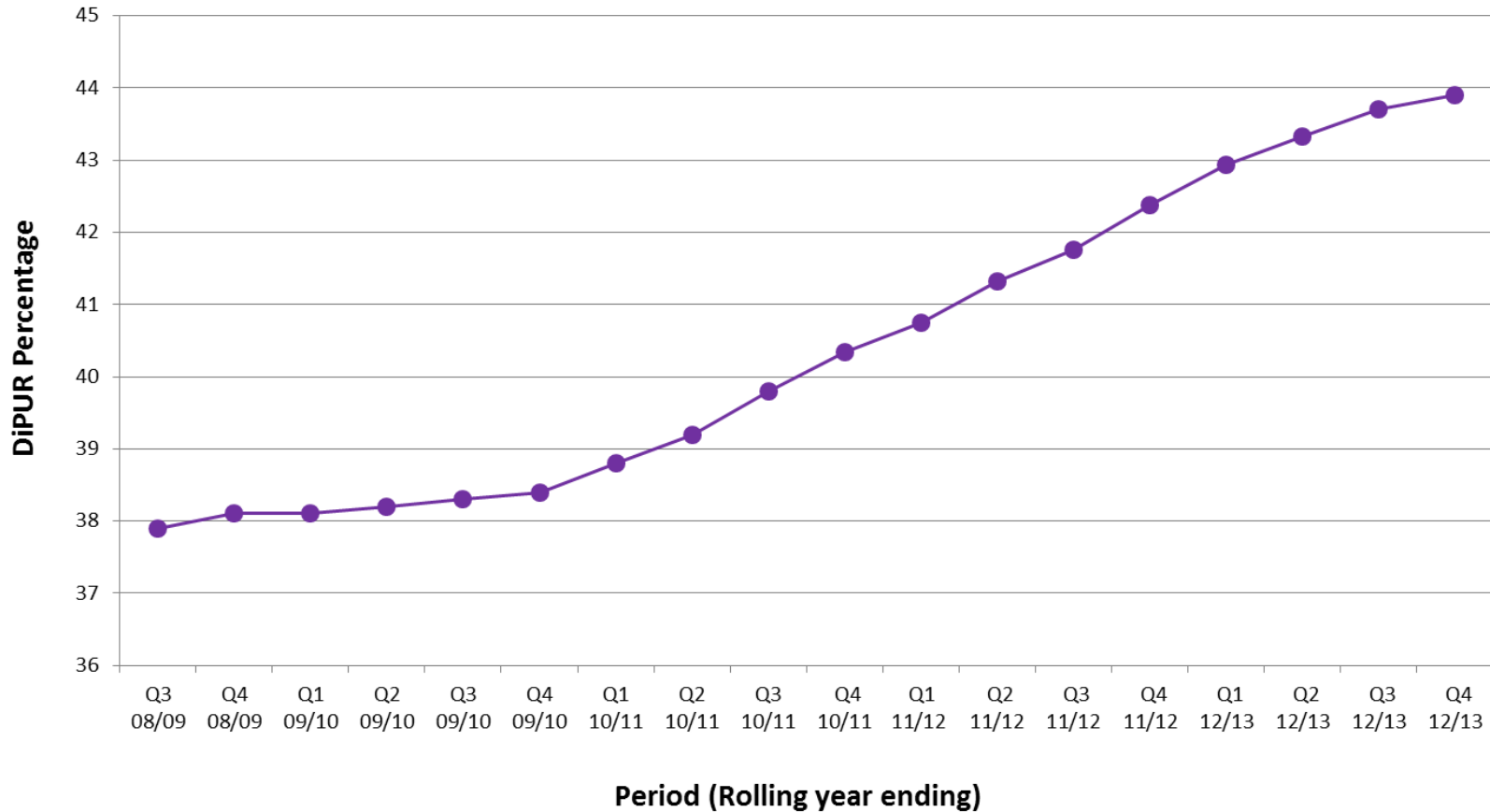
Improving quality of care



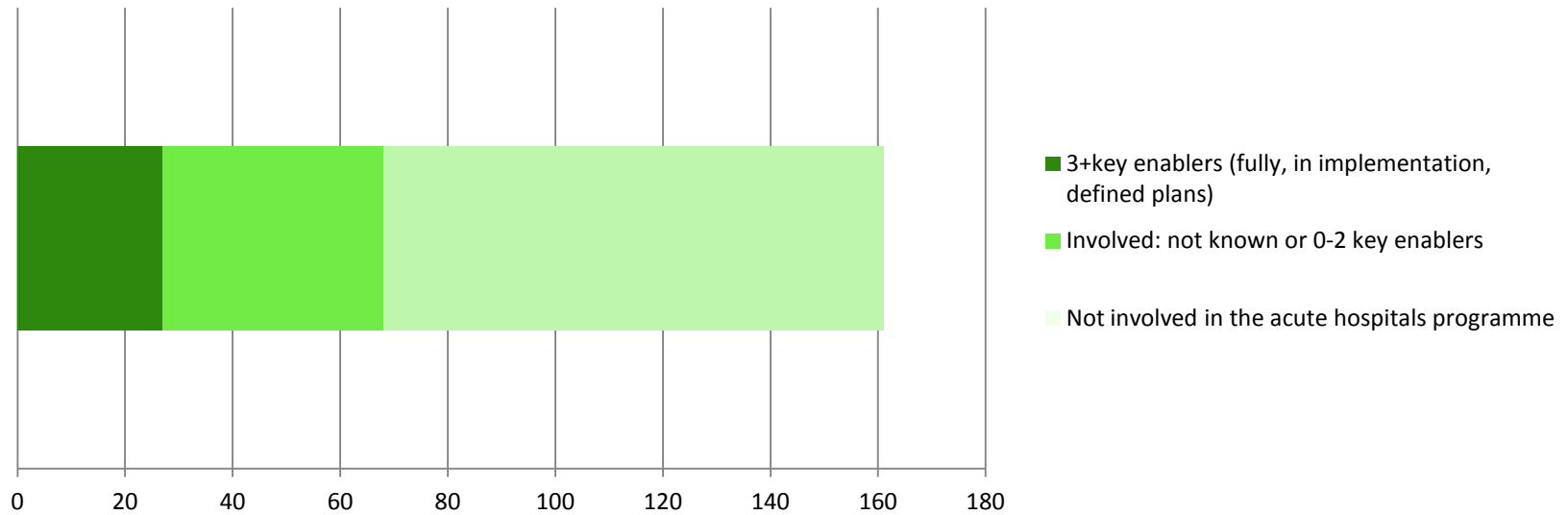
Quality of care in patient's last admission
VOICES survey 2011, 2012

Improving the quality of care

Deaths in usual place of residence (DIUPR)
Trend Q3 2008/09 to Q4 2012/13



Adoption of the key enablers



Sustainable transformation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21

Trust action plan
for the delivery of high quality end of life care



Training: Promote & enable end of life care training opportunities



Monitor the quality and outputs of end of life care



Patient involvement



Key: specific wording depends upon the Trust wide plan

- Not developed
- Partially developed
- In place, in implementation and review

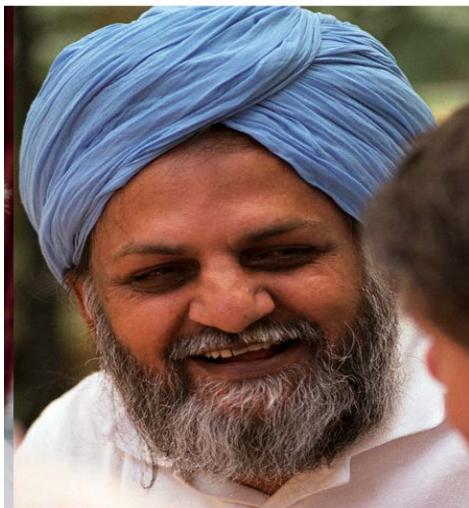


INDEPENDENT
REVIEW OF THE
LIVERPOOL
CARE PATHWAY

**MORE CARE,
LESS PATHWAY**
A REVIEW OF THE
LIVERPOOL CARE
PATHWAY

End of Life Care Strategy: Moving Forward

- Develop and maintain a shared understanding and purpose for end of life care
- Ensure patients and carers feel supported and able to manage their care at end of life
- Professionals feel supported and able to learn and to provide care with compassion
- Address inequity and variations in practice
- Develop and improve the systems that support efficient and effective palliative care.



Our shared purpose

Does this improvement meet our shared NHS purpose?



Thank you

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enquiries@nhsiq.nhs.uk

www.england.nhs.uk/nhsiq



Twitter

#nhsiqeolcare

***Improving health outcomes across England
by providing improvement and change expertise.***