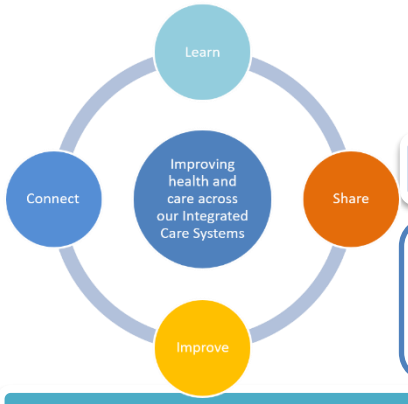


CASE STUDY - Continuous Quality Improvement
Palliative and End of Life Care Getting to Outstanding

BACKGROUND……. WHO, WHAT, WHY?

Project led by: Prof Derek Willis (MD Severn Hospice)
Service/Team: System Palliative and End of Life Care (PEoLC) Clinical Development Group/Getting To Outstanding Project Group
Initially NHSE National PEoLC Team supported the improvement initiative with the aim to increase the number of people predicted to be in the last year of life added to GP Practice Palliative registers and an increase in the number of people on the registered offered an Advance Care Plan

AIM

To increase the number of people on GP Practices Palliative Care Registers by 10% by March 2024.

The data that triggered this work was that Nationally, on average, 1% of the population will die and a proportion of these (could be as high as 0.6%) could be predicted to be in the last year of life

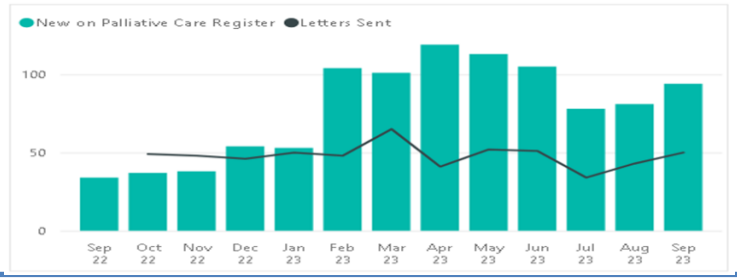
In 2022/23 – nationally there were 0.46% of the population on a GP register for STW this was 0.35% and the difference between these figures could equate to about 500 people not identified as in the last year/months of life and if we increase this to 0.6% it could be as many as 1000

In order to improve the experience of care for patients and their families/loved ones by better coordination, proactive assessment and care planning and people dying in their preferred place.

APPROACH

- Introduce standard sentence and EMIS code to patient letters
- PDSA to support test of change
- Commenced with Hospice Consultants and 1 GP Practice
- Extended to all GP Practices with the inclusion of Care Homes
- Data Sharing Agreement with all GP Practices to extract data on a monthly basis
- Measure the number of new people added to the register in month

MEASURED OUTCOMES



In Sep 22, 1,787 (0.36%) people were on an Palliative Care Register, one year on, there are 2,136 (0.42%)

CHALLENGES

Engaging with Non clinical teams/staff to develop processes to collect data
Lack of confidence of Care Home team to be explicit in prognosis

NEXT STEPS

1. Remeasure monthly
2. Onboard other services – Community Hospitals, Acute Services
3. Communication via System PEoLC Steering Group

OPPORTUNITY FOR SHARED LEARNING

Linking Specialist teams with GP practices to understand if a standardized format to patient letters and a smaller number of Clinical Codes could support patient care e.g. Diabetes, Renal Disease, Frailty.

Get in touch with your system QI ideas, to share your QI story, general QI queries or to join us at our quarterly system Quality Improvement Network events
Email us: systemCQI@mpft.nhs.uk

Case Study No: 0005