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DEMONSTRATING QUALITY THROUGH ADVANCED CARE PLANNING

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The National End of Life Strategy set out a particular focus on the care planning of patients at the end of life and with one of the key 10 objectives that individual needs will be documented, reviewed and acted upon in relation to advanced care plans. Specific quality markers and measures for end of life

care were published by the department of health in 2009. In relation to advanced care planning these identified a requirement that people approaching the end of life are offered a care plan and that individuals' preferences and choices, when they wish to express them, are documented and communicated to the appropriate professionals.

Significant work has gone on over the past 18 months by the community specialist palliative care team at St John's Hospice to develop policy and guidance, patient documentation and information, and a dedicated database to record whether discussions around patient plans and preference have taken place. This has enabled the team to be in a position to report this as one of three key commissioning for quality and innovation (CQUINS) targets, set jointly with commissioners, which enables quality to be recognised and linked to additional funding. Results for the first full year have been very positive in demonstrating over 85% of patients have had opportunities to discuss and document their advance care plans.

This presentation will explore the challenges in seeking to implement advanced care planning for patients. The need to quantify advanced care planning with patients for commissioners is a particular challenge to be meaningful, informative and transparent. The work by the community specialist team in recording a number of items related to patient preferences may be seen as a precursor to end of life registers that the team are currently involved in as part of both a local and national pilot.