

P-121 AN INTEGRATED CARE SYSTEM (ICS) APPROACH TO HOSPICE STRATEGIC DEVELOPMENT – USING LOCAL AND NATIONAL TOOLS TO DEVELOP STRATEGIC PRIORITIES

Sarah Onions, Debbie Westwood. *St Richard's Hospice, Worcester, UK*

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Background Many health providers saw dynamic, responsive service change during the COVID-19 pandemic (Lewis, Pereira, Thorlby et al. Understanding and sustaining the health care service shifts accelerated by COVID-19. The Health Foundation, 2020), and hospices were no exception (Van Langen-Datta, Driscoll, Fleming, et al. Compromised connections: The impact and implications of Covid-19 on hospice care in the West Midlands and nationally. Marie Curie, 2022). The introduction of integrated care systems (ICSs) encourages system partners to work collaboratively and therefore it's important to reflect on hospice service provision in relationship to the local palliative care health economy.

Aim To use local and national tools to inform a hospice's strategic review, including hospice clinical services, population demographics, projections and qualitative evidence to redefine the hospice provision of care and strategic direction.

Method

Local tools

1. Hospice strategic needs analysis (SNA).
2. ICS palliative and end of life care strategic needs analysis.
3. Patient and carer evaluation.
4. System partner consultation.

National tools

- Ambitions framework (National Palliative and End of Life Care Partnership, 2021)
- NHS England and Improvement (NHSEI) model of Universal Palliative and End of Life Care which builds on the NHSEI Comprehensive Model for Personalised Care.

Results

Hospice SNA Hospice – clinical services performance data.

ICS SNA – ICS data and projections showing an aging multi-morbid population, rising dementia, frailty and projected increase in deaths.

Patient and carer evaluation – Community's view of our services and their needs.

System partners consultation – ICS end of life board and network, primary care networks, community and acute trust exploration of needs and expectation of services.

The national Ambitions Framework – Hospice review using the six dimensions identifying gaps and areas to improve.

NHSEI universal model – Visualisation of our generalist, targeted and specialist offer for inpatient, living well, community, family support and education, demonstrating complexity of services.

Conclusion These local and national tools provided breadth to the strategic review allowing celebration of successes, identification of gaps and areas for improvement. The national tools more importantly opened up helpful strategic discussions based on our provision of care within the ICS, ideas for collaboration and development of our strategic priorities.

P-122 GATHERING POPULATION FEEDBACK AT THE END OF LIFE

¹Karen Chumbley, ²Mandy Wearne, ¹Tim Clifton, ¹Sarah May, ³Philip Martin, ³Sally Burley, ¹David Traynier, ⁴Sarah Rose, ⁴Keith Ellis. ¹*St Helena, Colchester, UK*; ²*Inspiration NW Ltd, Crewe, UK*; ³*Always on Mobile Ltd, Truro, UK*; ⁴*Suffolk and North East Essex ICB, UK*

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Background Capturing feedback about the quality of end-of-life care (EoLC) is challenging and historically dominated by bereavement studies. Locally we have an integrated population outcome-based accountability model for EoLC designed to improve 10 priority co-produced outcomes. Only six of these outcomes had a relevant pre-existing data source to enable programme monitoring.

Aim To design and implement a feedback system for patients approaching the end of life, aligned to priority outcomes, to inform the population-based EoLC programme.

Method A working group was created including the hospice, the integrated care system business intelligence team, and a patient feedback business consortium. Appropriate information-sharing agreements were created to support data flow. People are recruited for the survey via telephone after being identified by their registration on the Electronic Palliative Care Coordination System.

Consenting participants are sent a monthly survey by text asking them to score their experience of the sensitivity of the initial conversation about their priorities, the dignity with which they have been treated, the perception of care provision for their needs, symptom control and satisfaction with carer support. Free text comments on the best and worst of their experience are requested.

Results 187 people have been recruited so far. Half of the respondents are patients and half are carers. Response rates vary from 12–23% each month. Answers are pseudo-anonymised and passed to the hospice and then relinked to their diagnostic group and Primary Care Network registration. This data passed to the Data Services for Commissioners Regional Offices (DSCRO) and through to the Alliance EoLC dashboard.

Respondents report the following outcomes are achieved all or most of the time:

- Sensitive care plan conversations: 89%
- Satisfaction with carer support: 92%
- The right care for their needs: 90%
- Pain and symptoms managed well: 87%
- Treated with dignity and respect: 98%.

P-123 MORTALITY REVIEW – LEARNING FROM DEATHS IN PALLIATIVE CARE SETTINGS

Ross Chirgwin, Julia Thompson. *St Helena Hospice, Colchester, UK*

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Background Mortality review is a means of reviewing the quality of care patients receive at or near the time of death (National Quality Board. National guidance on learning from deaths: A framework for NHS Trust on identifying, reporting, investigating, and learning from deaths in care. 2017). This is

advocated across all healthcare settings and the results can highlight deficits in service provision, knowledge, and skills (Care Quality Commission. Learning from deaths – A review of the first year of NHS trusts implementing the national guidance. 2019). This learning can then be used to inform service delivery and educational needs.

Aims To review the deaths of patients dying within their own home, hospice, hospital, and care home setting. Highlighting exemplary or poor experiences and exploring factors which contributed towards patients dying contrary to a patient's preferred place of death (PPD).

Method Each month a multidisciplinary team met to review patients chosen at random by a non-clinical team member. Patients' records were reviewed using an audit tool devised by the team evaluating areas including recognising dying, communication, symptom control, advance care planning (ACP), and PPD.

Results

- Between April 2022 and March 2023 a total of 40 patients were reviewed.
- 90% of patients discussed had ACP discussions documented.
- 72.5% of patients had achieved their PPD.
- For the majority of patients, there was excellent documentation regarding recognising dying and communication with families.
- Timely symptom control was being achieved by collaborative working.
- Patients in residential settings often had limited input from specialist palliative care.

Conclusion The data highlighted some excellent examples of care, and also identified some areas of improvement to action which included:

- Advocating earlier referrals into the hospice, ACP discussions and use of the electronic palliative care register.
- Recommending ACP is reviewed and updated regularly particularly RAG status when patients are deteriorating.
- Promoting clear documentation specifically regarding communication with family members.
- Encouraging early referral to the hospital palliative care team for patients admitted to an acute hospital to enable timely assessment.
- Promoting specialist palliative care services within local residential homes with support from the hospice education team.

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A CASE NOTE REVIEW: TESTING A PROCESS AND GATHERING DATA ACROSS THE INDEPENDENT HOSPICE SECTOR TO UNDERSTAND THE QUALITY AND OUTCOMES OF END OF LIFE CARE

Julia Russell, Stuart Duncan, James Standbridge. *Hospice UK, London, UK*

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Background The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of end of life care in acute, community hospitals and mental health settings in England, Wales and Northern Ireland which comprises four separate elements, one of which is a case note review using a pre-designed template. Hospice UK amended the tool (with permission) to align with hospice care, and with the encouragement of the Executive Clinical

Leads in Hospice and Palliative Care (ECLiHP) Executive, member hospices were invited to take part.

Aims (1) To test the suitability of the NACEL case note review tool for the independent hospice sector, and (2) To understand the level of care being experienced by those dying during their hospice admission, and of those important to them.

Methods Several iterations of the template were tested using Plan Do Study Act (PDSA) methodology, 81 hospices registered interest and 69 hospices undertook a review of deaths that occurred from 1 – 21 February 2023 and submitted their data.

Findings 54% (n=37) of hospices returned feedback; 95% stated they had all the information they needed, 100% stated they could access the online form.

“It was a very useful exercise which highlighted to us that we don't write down everything in enough detail...” and “there were too many questions so it took a long time to review each set of notes”.

Of the 650 case notes reviewed, 56 graphs of aggregated data were created in a report so that hospices are now able to use the data for their own improvement plans.

Conclusion This collaborative exercise was the first across independent hospices, and highlighted several areas of practice hospices can include in their improvement plans. In terms of the process, while overall successful, iterative changes could be made if further rounds of audit are considered.

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END OF LIFE INPATIENT UNIT ADMISSION... OR NOT? A REVIEW OF HOSPICE ADMISSIONS

Karen Bartlam, Elizabeth Williams, Didi Petit dit de la Roche, Karolyn Hallam, Nicky Wood. *Isabel Hospice, Welwyn Garden City, UK*

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Background It is widely recognised that accurately diagnosing end of life can be challenging (Taylor, Dowding, Johnson. *BMC Palliat Care*. 2017;16:1–1; National Institute for Health and Care Excellence. Care of dying adults in the last days of life. [NG31], 2015) and deciding when to refer for end of life care at a hospice inpatient unit (IPU) is often difficult. However, it is important to optimise end of life care, ensure patients' preferred place of death (PPD) is met, families' expectations can be managed and that patients can be transferred safely (National Institute for Health and Care Excellence. End of life care for adults: service delivery. [NG142], 2019).

Aims Analysis of IPU admissions, including days until death, to calculate the appropriateness of admissions for end of life care. Analysis of symptom control admissions to determine whether these became end of life and implications regarding end of life diagnosis.

Methods Data extracted from electronic records of patients admitted July to December 2022. Split into end of life care and symptom control arms, and then calculated the length of stay also split between those dying in IPU and those discharged and produced frequency charts.

Results Total of 81 admissions July-Dec. 2022:

- End of life. 36 (44%), of these 34 (94%) died in hospice, 2 discharged.
- Symptom control. 45 (56%), of these 30 (67%) died in hospice, 15 (33%) discharged.