A population approach to end of life care

Creating a **human learning system** to improve the quality of end of life care

Kenny Steele Chief Executive Highland Hospice

End of Life Care Together is a partnership of Highland organisations with the aim of improving palliative and end of life care for people when it matters most

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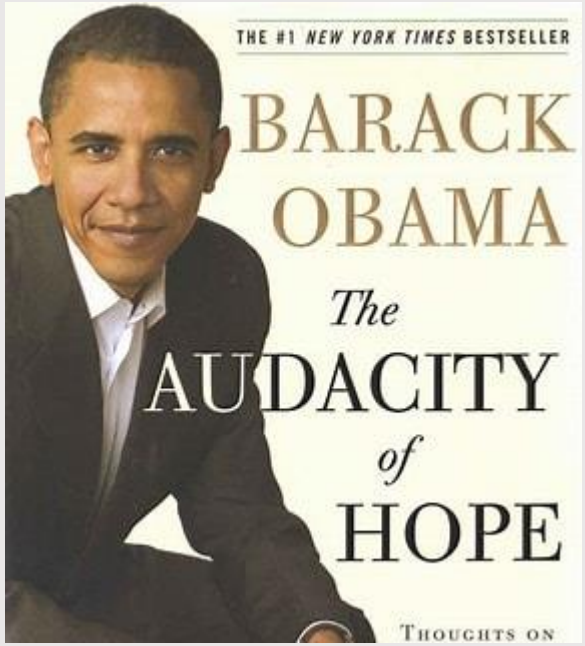

Time to be audacious?

The case for change

- Lots of people die in hospital (nearly 1 in 2)
- Most people don’t want to
- Hospital EOLC is more expensive than community EOLC

The numbers

- 15% - average total health care spend in last year of life- £100m for NHSH
- 75% of this is hospital expenditure
- Emergency admissions to hospital in last 3 months of life is rising
- It is evidenced that 20-40% of admissions in last year of life are avoidable if community resource is available

Where is the annual report accounting for this expenditure, the quality of service and a plan for the improvements needed?

Learning from others

- Whole system change- Complex!!!!! (Google Prof Toby Lowe)
- Leadership and strategic partnership
- Resource
- Building a coalition of the willing
- Focus on population not organisation
- Concentrate on what needs to change
- Accounting for value

Making it happen

Over to Michael……

Stories….

a population approach to end of life care

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Michael Loynd Macmillan Clinical Programme Director

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"I'll read the book you say the words"

"Tell me the story of us"

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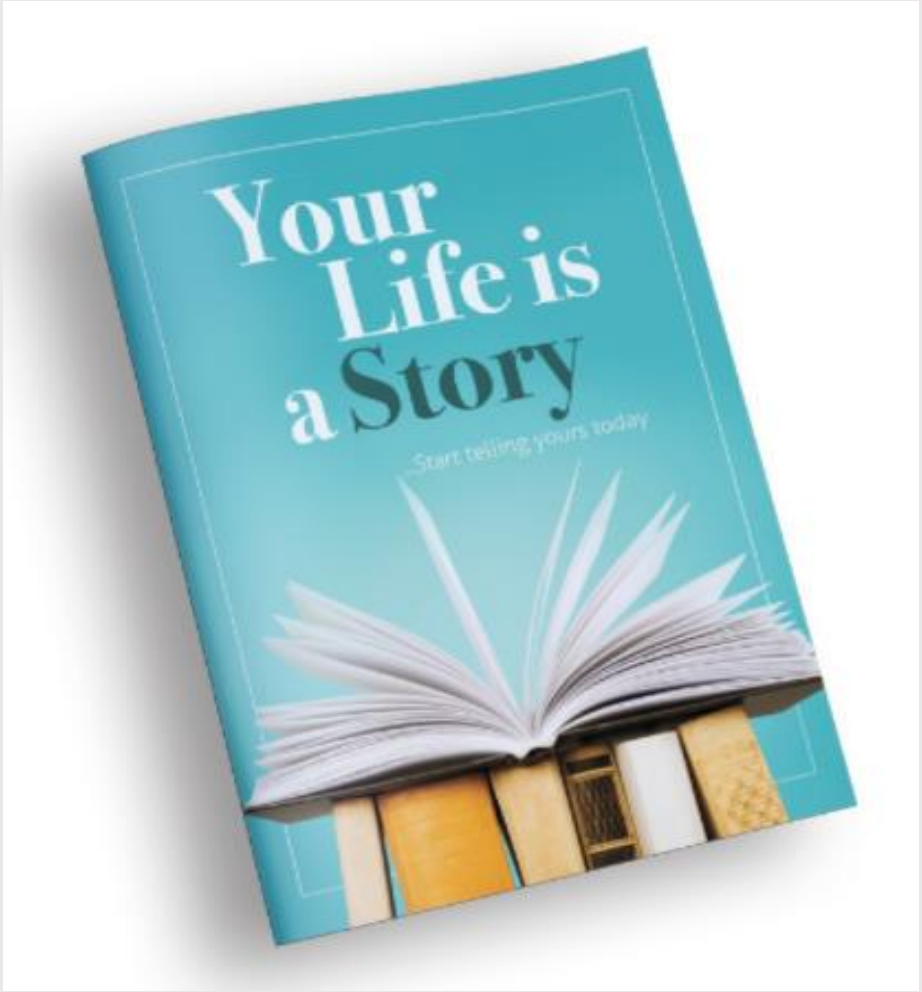

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The Highland Council
Comhairle na Gàidhealtachd

Marie Curie
Care and support through terminal illness

ScottishCare
Voice of the independent care sector

Connecting Carers
A better life for unpaid carers in Highland

NHS Highland

Highland Hospice

MACMILLAN CANCER SUPPORT

Scottish Ambulance Service
Taking Care to the Patient

HSCN

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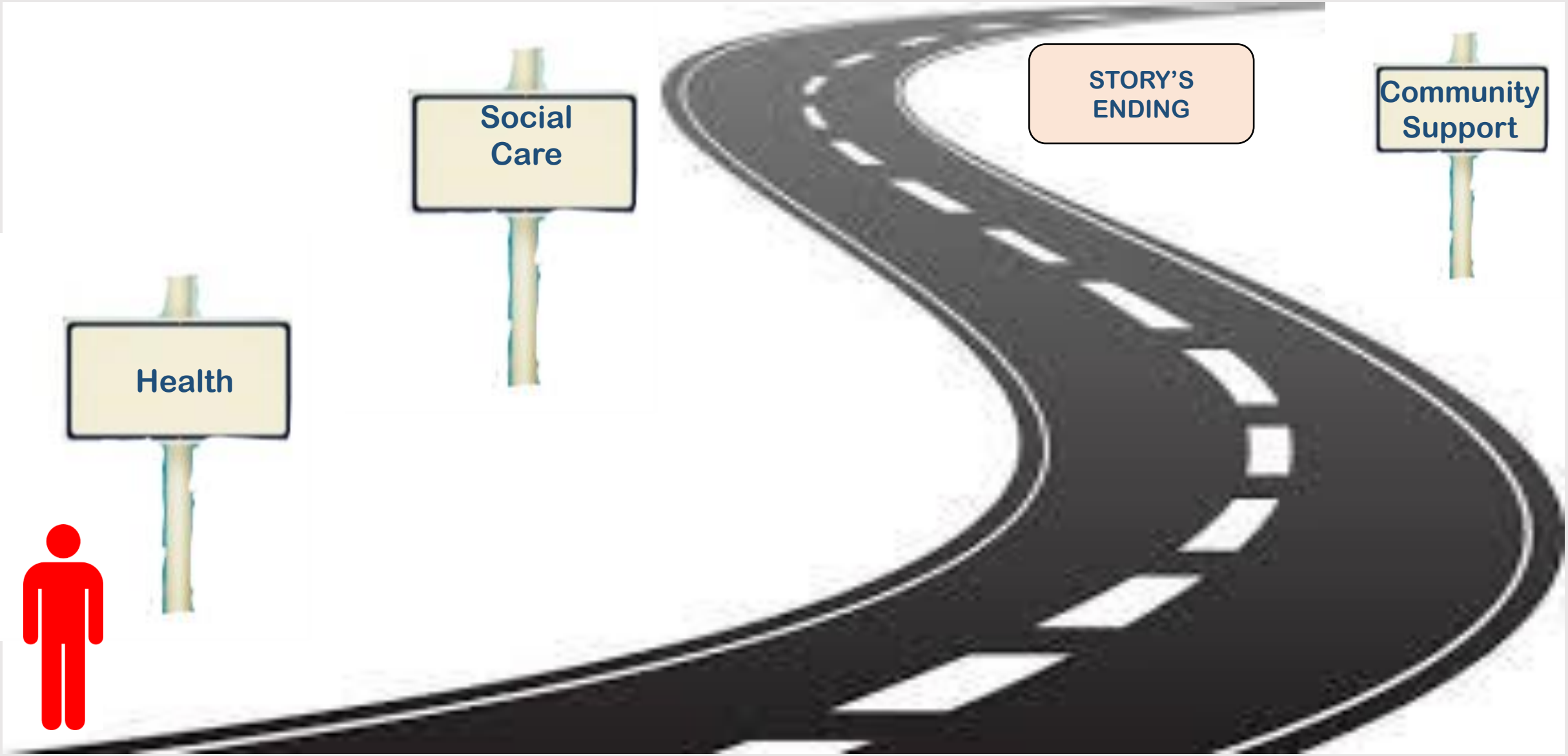

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Donnie's Story

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Scottish Ambulance Service

OOH Primary Care

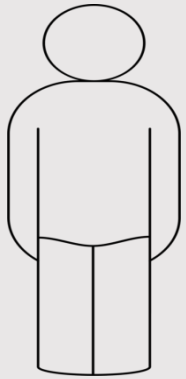
General Practitioner

Emergency Department

Hospice Consultant

Respiratory Nurse Specialist

Donnie



Carers

Scheduled Services

Macmillan Nurse

Marie Curie

Oncologist

Community Nurse

NHS 24

Direct Admission

Respiratory Consultant

CPN

Unscheduled Care Services

Hospice Professional to Professional line

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What to include in the final chapter

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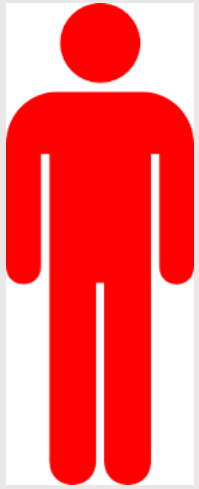
That my family member, or person I was supporting at end of life had their pain and symptoms addressed controlled and managed

My care preferences are written into care plans that are accessible to everyone involved in the delivery of my care

I / my family / carer receive access to palliative care services where required during the day and at night

That it was recognised that I was in the last year of life in a timely manner



As a family member or carer supporting an individual during and after their end of life I felt supported by the services involved

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Story of the pandemic

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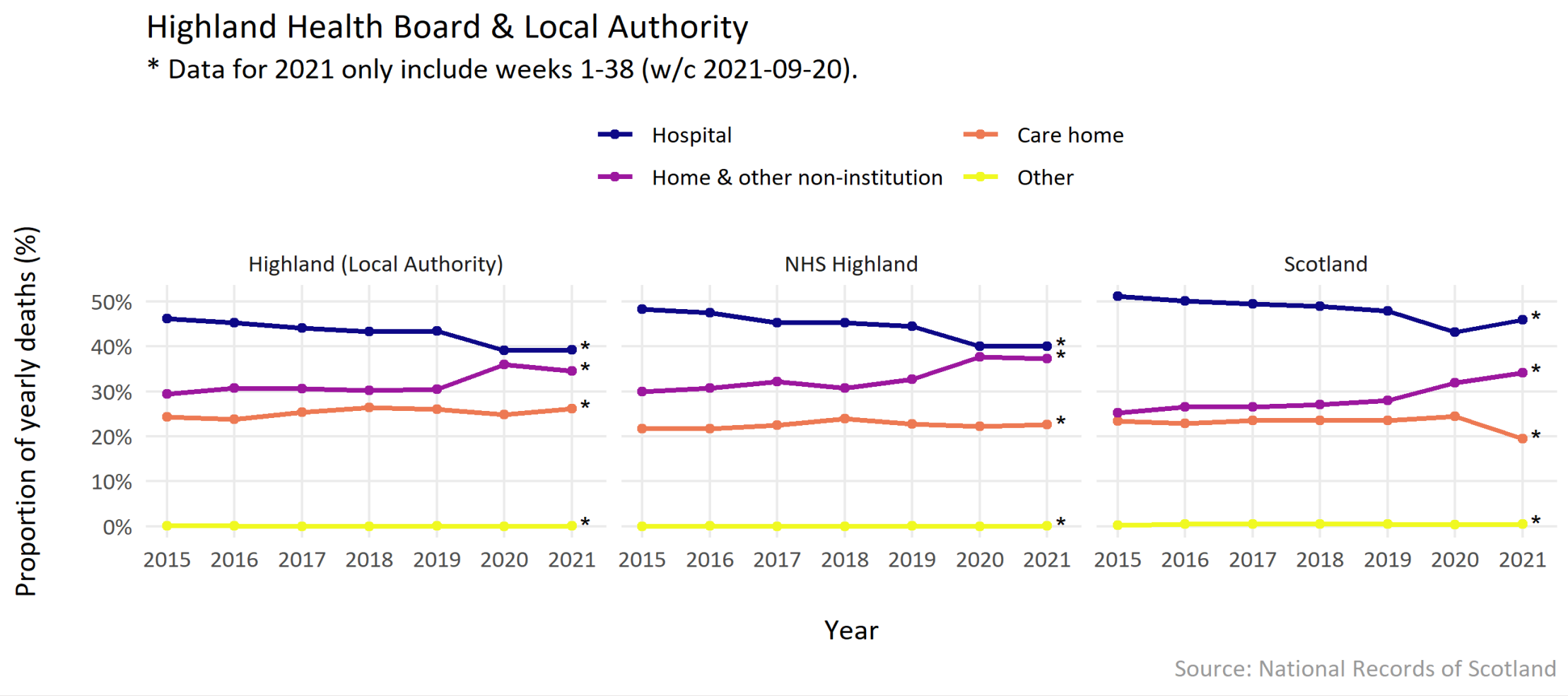

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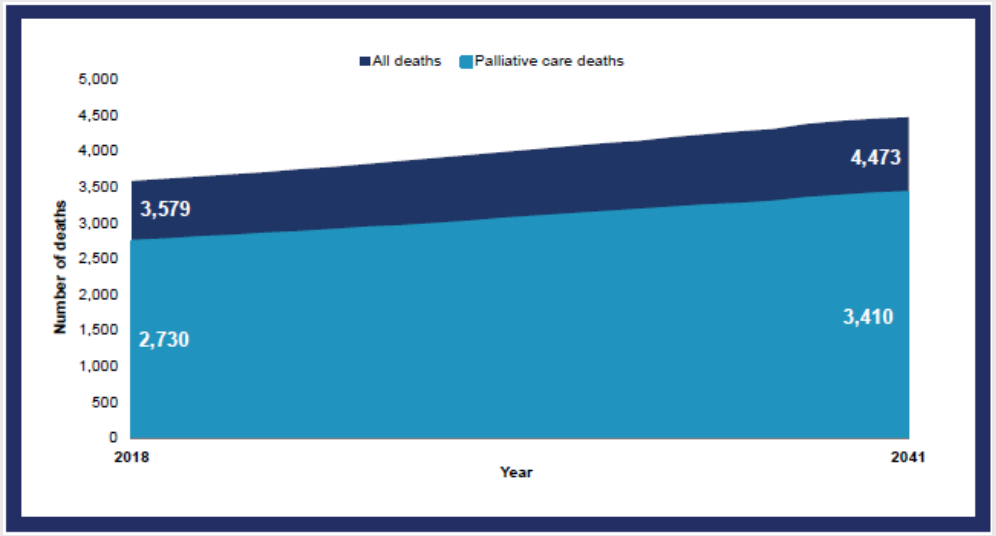
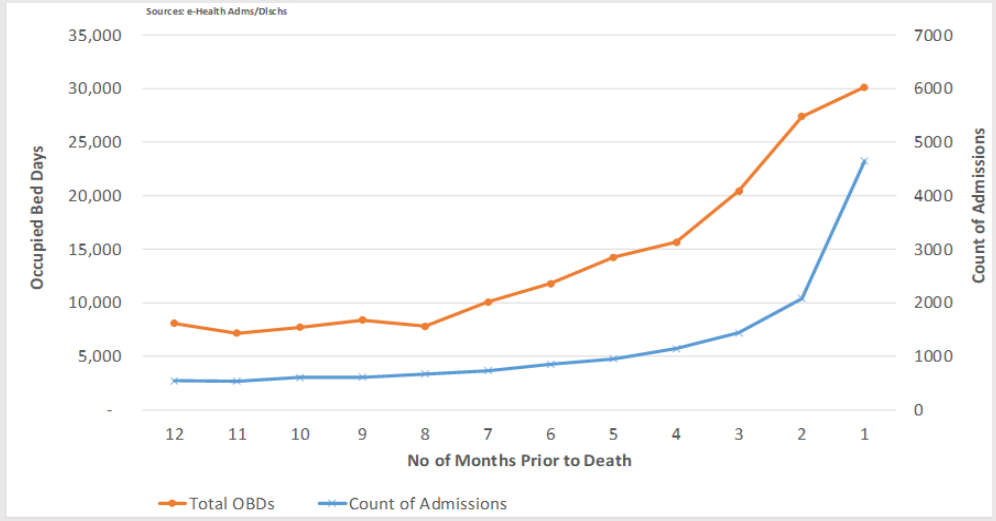
Story by numbers





- The number of people with palliative care needs is projected to increase and is increasing in Highland (***Fig1***)
- People currently spend averagely over a month of their last year of life life in hospital 60% in the last 3 months 31% in the last month
- 55-60% of emergency admissions are in the last 3 months of life (***Fig2***) up to 25% of all unscheduled activity
- Unscheduled Care Activity in last year of life to NOSEA:
  I. 95% of people contact unscheduled care services
  II. 56400 contacts across 1 year
  III. 64% in OOH period
- 75% of spend in Secondary care £8500 per person
- Evidence that up to 40% of hospital admissions / bed days could be reduced
- Its not preferred place of death unless there are a suite of options to make that preference against or the provision of services to support this in community

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Population Value Approach

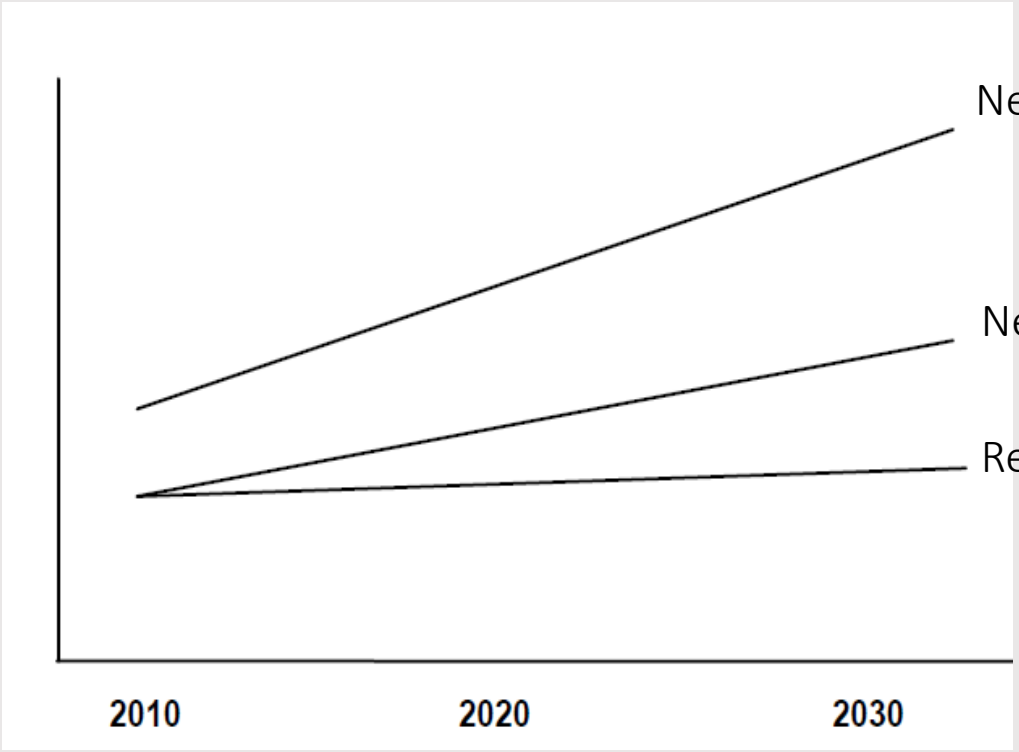
1. Does this represent value based on the priorities and outcomes that matter to this population in Highland or the individual

2. Does it represent value to the wider community providing equity of access to services and support

3. Value in how the collective resource is assigned and allocated to people at End of Life

Principles

If we do nothing, need and demand will increase by about 20% in the next decade and resources will not



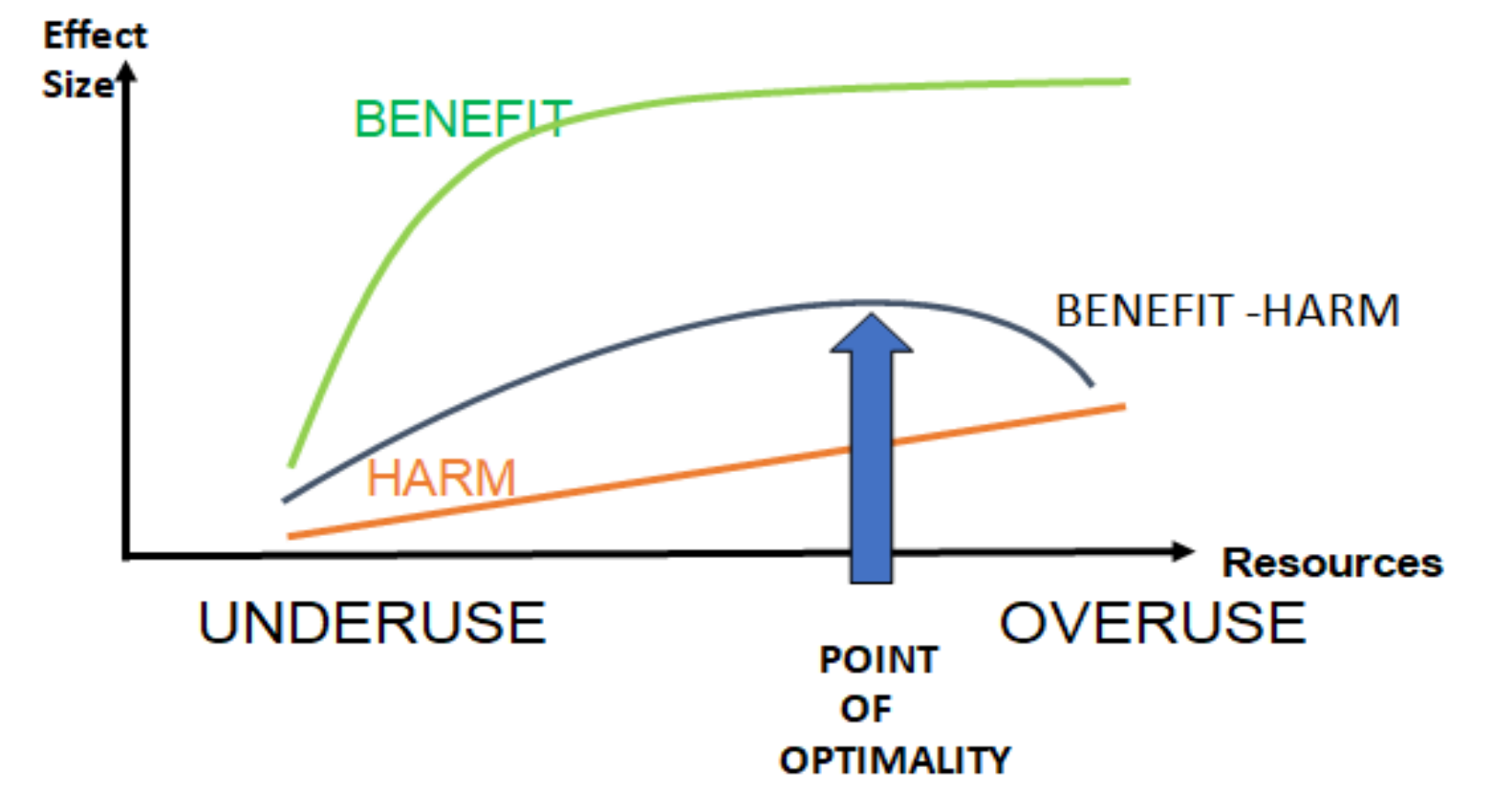
Prof Sir Muir Gray 3v Oxford Centre for Triple Value Health

There are four main causes for the increase in need and demand

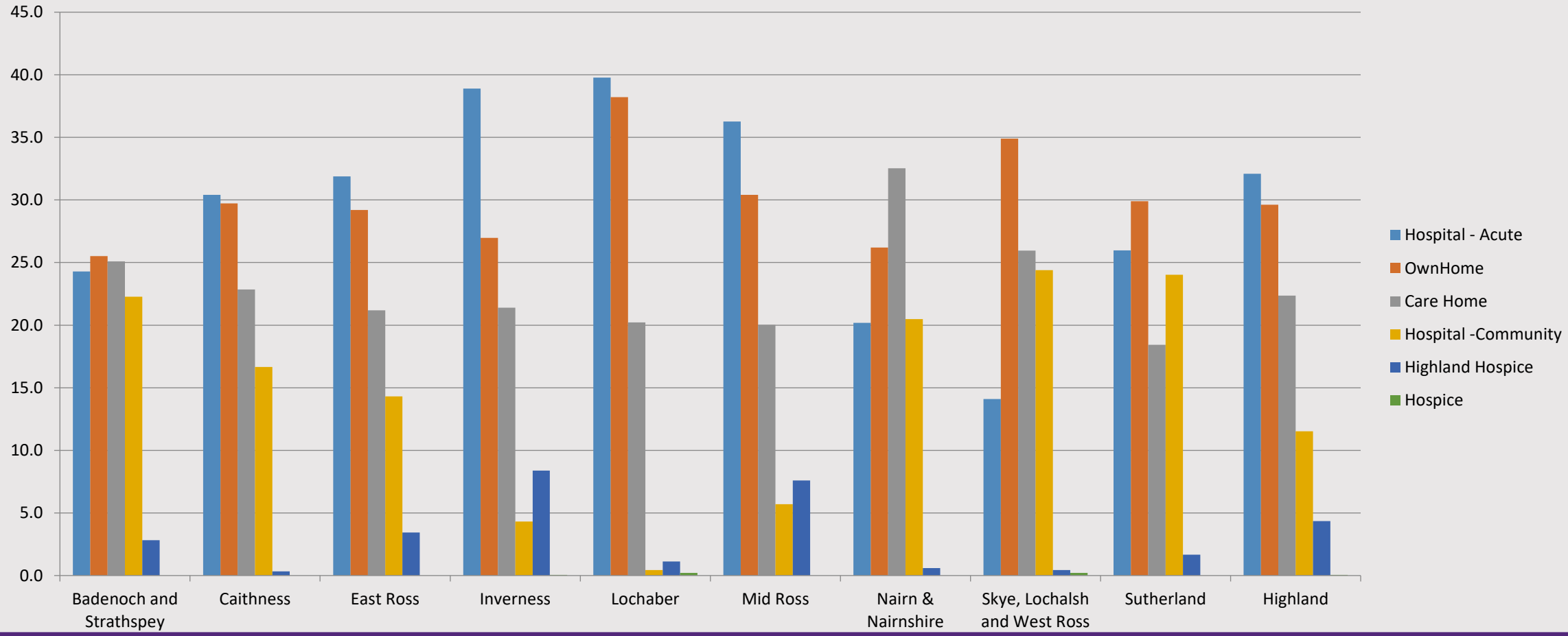
1. Population ageing
2. Development of new expensive but effective interventions
3. The ‘increasing volume and intensity of clinical practice’
4. Clinical and personal mismatch between perceived demand and actual need

Prof Sir Muir Gray 3v Oxford Centre for Triple Value Health

Donabedian's great insight is that for individuals and populations there can be too much and too little health and social care.



Is there variation in where people die in Highland? 18'-19'



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Screening Identification

- Anticipal

- GP Partnership Proposal
- Stage 1 / Stage 2

- Electronic Whole System Anticipatory Care Plans

Monitoring and Coordination

- Prognostic Stratification and regular monitoring of palliative care registers and identification points
- Referral to central coordination service of those at risk of dying in the next 12 months
- Coordination 365 days a year 8am-6pm
- Robust handover to enhanced Palliative care Helpline 6pm to 8am

Enhanced Community Provision

- Community Services
- Third Sector Supports
- OOH social care
- Linked to coordination
- Marie Curie

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Evaluation / Data Intelligence

- Linkage of data
- Prospective Dashboard
- Accounting for Value Report
- Measuring Success / Measuring Unmet Need
- Developing an infrastructure to support continuous service value improvement

End of Life Care Together Service Transformation

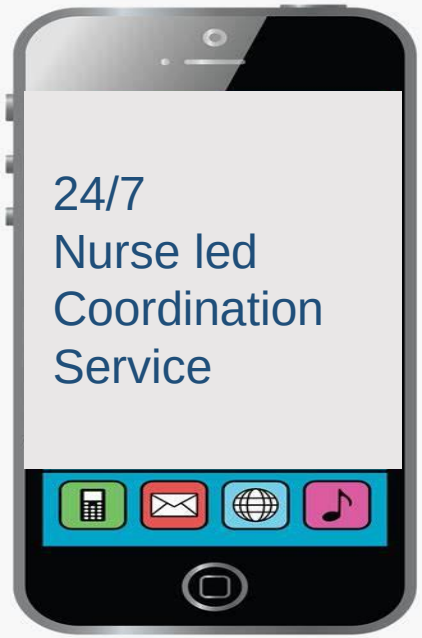
One person

Earlier Increased Identification & monitoring of those in the last year of life

One plan

Widely digitally accessible, single source of truth care plans, with patient access

One number to phone



One chance to get it right

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This poster is part of the SPPC Poster Parade 2021

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https://youtu.be/wNXm7es2zcA