We don’t talk anymore – improving communication of advance care planning on transfer of care

East & North Herts CCG

- Population c 600,000 registered at 57 GP practices
- Specialist Palliative Care providers
  - Lister Hospital, East & North Herts NHS Trust (720-bed DGH)
  - Two hospices
  - Hertfordshire Community Trust
- IT systems don’t communicate
  - SystmOne, Lorenzo, Nervecentre, EMIS

The numbers

- 47% of deaths in ENH CCG occur in hospital although the majority of people would choose to die in their own home
- 48% of people over 85 die within one year of hospital admission
- ENHT mortality review 2016 indicated that up to 20% of those who died in the Trust could have been cared for in an alternative setting

The Project

- A key method to improve end of life care, including the prevention of unwanted or inappropriate hospital admissions at the end of life, is through early identification of patients in the last year of life and undertaking Advance Care Planning (ACP).
- The Botb work stream planned to review the current communication of end of life status and ACP for elderly care patients and work with teams to increase identification and transfer of information on discharge from the Trust

Who, What, Where

- Joint project between Palliative Care and Elderly Care Teams
- Teaching on:
  - Identification, communication and ACP
  - Pilot on Frailty ward
  - Use of SPICt tool to identify patients appropriate for supportive and palliative care
  - Ward team to introduce future care planning concept
  - Include basic ACP information in discharge summary

Outcomes - Before & After

<table>
<thead>
<tr>
<th>ACP info in discharge summary</th>
<th>Pre-pilot %</th>
<th>Post-pilot %</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNACPR</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>ACP</td>
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<td>17</td>
</tr>
<tr>
<td>GSF</td>
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<td>Anticipatory meds</td>
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<td>7</td>
</tr>
</tbody>
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Key learning

- Process changes in isolation may not be successful in changing practice and improving outcomes
- There needs to be clarity and commitment from all stakeholders and this includes managing unrealistic expectations
- Unrelated organisational changes (new EPR implementation) can have unintended consequences for care and communication

Key messages

- Champions are essential to support and sustain new initiatives
- Be flexible – large and small changes happen in healthcare every day and you need to be able to adapt
- Be patient and persistent to grow small changes into big ones
- Keep Building on the best

For full case study, visit www.hospiceuk.org/BoTb