Southport and Ormskirk NHS Trust

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Southport and Ormskirk Hospital is based across 2 sites which have a combined total of 497 beds (455 general and acute, 27 maternity beds and 15 critical care)

About the project

The focus of the Building on the best programme within Southport and Ormskirk Hospital has been to improve practice across all four work streams of symptom control, shared decision making, cross boundary communication and out patients department. As an integrated service working cross boundary, it was important that all these areas were addressed to improve the service as a whole and meet with the six ambitions for end of life care (NHS, 2015). The four work streams, at any one time, can impact on one another and therefore could not be improved in isolation, for example advance care planning impacts on all four streams.

Impact

Over the period of the BotB project there has been a:-

- 30% increase in patients known to the Supportive and Specialist Palliative Care Services (SSPCS);
- 36% increase in the number of hospital patients known to be GSF registered;
- 29% increase in the number of patients known to SSPCS who come from care homes;
- 50% increase in the number of patients known to the Transform Team
- 153% increase in the number of GSF registrations prompted by the hospital services;
- a small decrease in the number of patients having a conversation about REoLT but an increase of 43% actually achieving REoLT;
- an increase of 11% deaths in hospital in line with increase in all area deaths in all setting
- an increase of 15% of all hospitals death who had an individual plan for the care of those thought likely to be dying developed with them and their family to support their care according to the new priorities for care of the dying;
- 64% of all hospital deaths achieving their preferred place of care - an increase of 27% of all hospital deaths

If the number of people who had a successful REoLT, had died in hospital – this would have increased the hospital deaths over the three years to result in 1064 people dying in hospital in 2017/18 compared to 950.

No. hospital patients	2015/16	2016/17	2017/18
Hospital prompted GSF registration	302	425	764
Documented REoLT conversation	417	350	410
Successful REoLT	80	99	114
No. deaths in hospital	857	935	950
Individual Plan for the Care of those thought likely to be Dying developed with patient & family	41%	49%	56%
Hospital deaths who achieved PPC	37%	41%	64%

Areas

1. SHARED DECISION MAKING

a) Anticipatory Clinical Management Planning in particularly in Frailty

2. SYMPTOM MANAGEMENT

a) Improved access to analgesia when required (oramorph released from 'Controlled Drug status')
b) Ward Pain Free Pledges
c) pain education programme, care plans and monitoring charts
d) Opioid administration timing
e) Safe & effective delivery of continuous subcutaneous infusion
f) Symptom management of those thought likely to be dying

3. CROSS BOUNDARY COMMUNICATION

a) GSF Registrations and notification to GPs
b) Rapid End of Life Transfers (REoLT)
c) Respiratory Ward Collaboration

4. OUTPATIENTS

a) Recognition of End of Life
b) Education: End of Life Skillset Challenge
c) "Hello my name is …. "campaign
d) "Who would know?" posters
e) Raising staff interest in being involved

For results, see the full case study

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