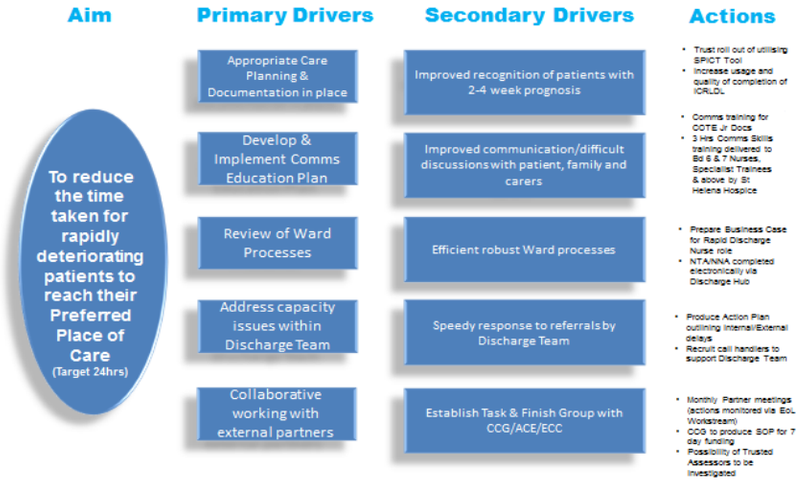
# End of life care improvement collaborative

Colchester Hospital University NHS
NHS Foundation Trust

## Why focus on EOLC?

**Time taken to discharge our rapidly deteriorating patients is too long**

- **Project Team comprises the End of Life Workstream group to include:**
  - **Director of Nursing**
  - **Clinical Lead**
  - **Nursing Lead**
  - **Operational Lead**
  - **Transformational Lead**




## Tests of Change so far:

- **Pilot of using Order Comms to complete NTA & NNAs**
- **Introduction of Rapid Discharge Assessor role across all Wards**

## What have we learnt?

- **That a co-ordinated approach to discharge this cohort of patients is needed**
- **Our internal processes need to be slicker**
- **Collaborative working with external partners is key**

## The tests we are planning next:

- **Measure average time taken from receipt of referral to discharge a patient by the Rapid Discharge Nurse Assessor**
- **Monitor average length of stay of this cohort of patients following recruitment to Discharge Nurse Assessor role**

## Rapid improvement cycle

The aim of this programme is to:

- Improve the experience and quality of care received by patients at end of life.
- Learn about quality improvement tools and techniques and put into practice.
- Share best practice
- Improved CQC ratings for EOLC


The IHI Breakthrough Series Collaborative model provides a framework to enable rapid testing of changes to learn, adapt and plan for scale up and spread of the work.

| | Jan | Feb | March | April | May | June |
|---|---|---|---|---|---|---|
| Time taken to discharge rapidly deteriorating patients (last weeks of life) to their preferred place of care from time of referral to complex discharge team | 251 hrs | 176 hrs | 247 hrs | 325 hrs | 189 hrs | 118 hrs |

NHS Improvement

| Aim | Primary Drivers | Secondary Drivers | Actions |
|---|---|---|---|
| **To reduce the time taken for rapidly deteriorating patients to reach their Preferred Place of Care (Target 24hrs)** | Appropriate Care Planning & Documentation in place | Improved recognition of patients with 2-4 week prognosis | • Trust roll out of utilising SPICT Tool<br>• Increase usage and quality of completion of ICRLDL |
| | Develop & Implement Comms Education Plan | Improved communication/difficult discussions with patient, family and carers | • Comms training for COTE Jr Docs<br>• 3 Hrs Comms Skills training delivered to Bd 6 & 7 Nurses, Specialist Trainees & above by St Helena Hospice |
| | Review of Ward Processes | Efficient robust Ward processes | • Prepare Business Case for Rapid Discharge Nurse role<br>• NTA/NNA completed electronically via Discharge Hub |
| | Address capacity issues within Discharge Team | Speedy response to referrals by Discharge Team | • Produce Action Plan outlining internal/External delays<br>• Recruit call handlers to support Discharge Team |
| | Collaborative working with external partners | Establish Task & Finish Group with CCG/ACE/ECC | • Monthly Partner meetings (actions monitored via EoL Workstream)<br>• CCG to produce SOP for 7 day funding<br>• Possibility of Trusted Assessors to be investigated |