End of Life
Early Identification Toolkit

Helpful resources to aid consistent Identification of EOL patients in BSW

BSW EOL Care Alliance

Introduction

- We know that between 70 and 90% of all deaths can be anticipated. These patients will need palliative care.*
- In BSW, we have only recognised between 10 and 43% of patients as palliative before they died.
- Check out the live data** to see how your surgery is performing compared to your neighbours.
- By implementing this toolkit, we want to initially identify 1000 more patients across BSW – that's a 50% increase on current numbers.
- We know that in primary care, you are time and resource poor but patient-rich…

* https://www.goldstandardsframework.org.uk/evidence

** You will need to request access to this dashboard. Please note it is still work in progress and improvement are being made to its design and functionality - feedback is very welcome!

Using this toolkit

This toolkit is modular, but can also be followed in a step-by-step approach:

- Identification
- Validation
- Conversations
- ReSPECT
- Palliative MDT & ICR

Explainer video:

Your role is crucial

By making these changes, you can:

- Reduce the number of end-of-life crises – these are distressing and resource-intensive emergencies.
- Improve staff morale and patient care.

Good palliative care is deeply meaningful work, and it is our last chance to do right by our patients.

We all suffer when we get it wrong.

Identification

The EARLY Identification Tool is an add-on to your EHR.
It runs a report searching for SNOMED CT Codes that indicate someone is likely to benefit from advance care planning.

- The Tool will recognise multiple risk factors in long-term conditions including hospital admissions, frailty, and other prognostic indicators.*
- The report should then be validated by a clinician to identify those who you recognise as needing support and follow-up.
- Save time, use automation to pick up on patients who may need a more proactive approach.
- The tool runs on EMIS, SystmOne and Vision web.

Introduction video

Simple, free, click here to install

We recommend running this report every 6–12 months to identify patients who would benefit from Advance Care Planning.

* https://www.cheshire-epaige.nhs.uk/knowledge-base/category/identifying-people-approaching-the-end-of-life/early-project/

Verification

SPICT-4ALL is a useful tool that identifies objective signs that a patient's prognosis is poor and they would benefit from advance care planning.

- It uses non-medical terms, so as well as being useful for clinicians it can also empower family members, patients or care staff to seek out conversations proactively.
- This tool is also useful if you wish to validate patients on an EARLY Identification Tool report or have a patient with a specialist-led long-term condition and wish to understand if they have a poor prognosis and could benefit from advance care planning.
- Remember as well:
  - Would you be surprised if they died in the next 12 months?
  - Are they telling you they are worried about their future?
  - These are trigger events for advance care planning.
- Consider hanging the SPICT-4ALL page on your consultation rooms' notice boards. This can act as a useful prompt to flag patients who could benefit from palliative care.
- To help patients and their family reflect on their wishes and needs proactively, consider hanging this poster in your waiting room.

Conversations

Starting the conversation around palliative care or advance care planning can often feel challenging. By changing the framework from “What’s the matter with you?” to “What matters to you?” these conversations are easier to begin and follow-up.

Patient Information

Here are guides, posters and leaflets for your patients, their families and communities to help them consider wishes and what matters to them ahead of a consultation and come prepared.

What Matters to You

You can sign your practice up to the What Matters To You Charter. This provides resources that support embedding and incorporating “What Matters To You” as a principle on multiple levels.

Having Conversations

- Here are resources on how to improve these conversations for all HCPs.
- This video shows different examples of good and bad scenarios to learn from, and here are practical resources on using WMTY in these conversations.
- Print these keycards with useful phrases when having conversations about palliation or dying.

Conversations

Useful tips

– Remember these conversations can be opportunistic and done in ‘chunks’ over more than one consultation! Don’t feel pressured to complete it in one sitting.

– Many of these conversations are shorter than you think. Especially with advance preparation from the patient and their loved ones.

– Reflect on conversations: ‘Our Phrases Are Our Tools’ so refine and improve on them! What could have been phrased differently? Have I asked a colleague what phrases they use in this situation?

Training Resources & Courses

To support upskilling and training other primary care team members, here are e-learning resources that can support them feel more confident starting these conversations. Topics include:

- Advance care planning
- Assessment in end-of-life care
- Communications skills

Dorothy House Hospice Care is one of the leading local providers of education and training for end of life care. Their education programme for health and social care professionals strives to build confidence and competence in anyone working with end of life and palliative patients. Learn more about the training courses on offer here.

ReSPECT

Now you've had a meaningful ACP conversation, you need to ensure it is suitably recorded.

- The ReSPECT plan was rolled out in BSW in 2021 to capture clinical recommendations and patient wishes.
- You can now manage this digitally, ensuring anyone playing a part in a patient's care can always access this vital record.

ReSPECT top tips

Guide for clinicians

– Digital ReSPECT User Guide

– Digital ReSPECT cribsheet

– The BSW ReSPECT policy
Section 8 outlines what counts as a valid form, and who can complete and sign it.

Palliative MDT & ICR

To make your MDTs more effective and less time consuming, use this new GSF Dashboard via the ICR.

- This dashboard can filter your patient data by key criteria including:
  - GSF stage
  - diagnosis
  - patient wishes
- It clearly identifies gaps in EOL preparation and makes data extraction for audits quicker and easier.

GSF Dashboard User Guide

EOL ICR Care Plan Cribsheet

Prepared for the BSW EOL Care Alliance

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