Blog – Reflections on end of life care commissioning
Dr Clare O’Sullivan Sutton CCG

When we set up a new team of specialist palliative care nurses working in Sutton’s care homes we decided early on that it was important to include Advance Care Planning as a key performance indicator.

One of the roles of the care home team was to help identify residents who are moving towards the end of life and, where appropriate, ensure that they have an advance care plan which families know about, that they have a Coordinate my Care record and that anticipatory medication is ready.

We set key performance indicators for the team including the percentage of residents offered advance care planning and the percentage of residents with a Coordinate my Care record. We kept these as separate indicators as some residents may want an advance care plan but not an online record.

As a result of this initiative, we found that the percentage of people offered advance care planning in nursing homes increased from 29% in 2014 to 80% in 2018 and that the percentage of residents with a Coordinate my Care record increased from 27% in 2014 to 65% in 2018. A year later we extended the team to support residential homes, and we are now also seeing impact here too. This has required increased support, as staff are not clinically trained, but the aim is for Advance Care Planning to be embedded as a routine part of admission and settling policies so that residents’ wishes and preferences are known.

We are also including Coordinate my Care in our primary care contract. When the Personal Medical Services contract was renegotiated last year, I was pleased that End of Life care was included within the key performance indicators. This was the result of lobbying from myself, using data to highlight a potential reduction in admissions and proposing a potential future QUIPP (quality innovation, productivity and prevention) project.

The Local Medical Committee negotiated with the CCG and now we have a system commitment to good quality end of life care which is linked to funding. Payment is upon evidencing specifics around education, extra multidisciplinary team meetings, creating Coordinate my Care records, and ‘after death’ reviews (including updating place and date of death on Coordinate My Care).
The team and clinicians I work with are passionate about end of life care. Including metrics on Coordinate my Care into key performance indicators has helped to ensure advance care planning conversations are documented and can be shared with the urgent care services.

Local clinical leadership championing end of life care and using the evidence base to highlight potential cost savings was key to getting these key performance indicators into contracts. We still have work to do and we can use our indicators to support and monitor future improvements.

Getting care right at the end of life and supporting people to dying in their place of choosing is extremely valuable not only for the person, but also their families and the wider NHS.

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