Optimising Quality of End of Life

CURRENT SITUATION: Around 55,000 people in Scotland die each year, 70% of these are among people aged over 70 years and half currently die in hospital. Around 220,000 people each year are bereaved. The experience of decline, death and bereavement is a central feature of later life and thus optimising the quality of the end of life is an important part of Reshaping Care for Older People. To date this has been focused on influencing health and social care infrastructure and introducing systems and processes designed to improve palliative care. But service improvement is constrained by wider social and cultural taboos against addressing decline, death, dying and bereavement and planning ahead for a good death.

Inputs
- Older people & their families
- Carers
- Friends
- Volunteers
- Health and social care professionals
  - Businesses (funeral industry, care homes, legal & financial advisors)
  - Spiritual, Religious & Arts organisations
  - Scottish Government policy makers
  - Leaders/ champions
  - Local communities
  - Local Authorities
- CPPs
- NHS
- Third sector
- Resources
  - Staff
  - Budget
  - Technology
  - Buildings
  - Contacts and relationships
  - Knowledge and expertise
  - Research
  - Evaluations

Activities/Outputs
- Active promotion of more openness, and dialogue about death, dying and bereavement including in public policy
- Information and advice provided about end of life issues to encourage advance planning – financial, medical, legal and spiritual arrangements e.g. Power of Attorney, Wills, Advance Directives, funeral arrangements
- Advance care planning
- Implement existing policy and guidance:
  - Living and Dying Well
  - Shaping Bereavement Care
  - Recommendations
  - Scottish Patient Safety Prog approach to caring for patients deteriorating in hospital
- Develop and implement palliative care clinical guidelines for generalists
- Share patient information across health & care services (electronic Key Information Summary – eKis)
- Use evidence and experience to improve approach to care in last days and hours of life
- Systems, processes and resources are available to allow staff the time and support needed to apply new practice of providing good end of life care

Reach
- Older people who are healthy, active and independent including carers
- Older people who are at risk/ in transition including carers
- Older people who are frail, who have a long-term progressive condition, or who have high support needs, and their carers

Short term Outcomes
- More people aware of benefits of advance planning for decline, death and bereavement
- More people have access to information and practical planning and advice services
- More people use end of life planning and advice services and discuss and plan for their decline death with family and friends in a constructive way
- Increased recognition of cross-cutting social impacts of decline and death
- Staff have the skills and knowledge to deal with the physical, psychosocial and emotional needs of people approaching end of life and their families; staff feel more comfortable to engage in and initiate discussions with older people and their families
- More people identified as approaching end of life and have Anticipatory Care Plans (ACP) including Key Information Summaries
- More old people ‘die well’ in a place of their choice
  - With pain/other symptoms controlled
  - In a place of their choice
  - With dignity maintained
  - With their end of life care wishes respected

Medium term Outcomes
- Social Environment is more age-friendly
  - Talking about and planning for decline, death and dying is perceived as normal and encouraged within families and communities
  - Families and communities know how to help and support people in times of increased health need;
  - People get the support they need from formal services and from their family and community
- Systems work better for older people
  - Care staff are more responsive to people’s physical and spiritual needs relating to decline, death, dying and bereavement
  - People have more opportunities to discuss and plan for their decline and death with H&SC professionals and relatives (including DNACPR and ACP)
  - More people have anticipatory care plans (including ACP using EKis) within health and social care,
  - The organisational cultures are more supportive of staff responding to the needs of a dying person and their family
  - Reduced unplanned hospital admissions among patients with multi-morbidities

RISKS AND ASSUMPTIONS