

Service Quality Review – Palliative Care



Agenda Item: 18

Reference: 12B.016

Board Meeting: 30 January 2012

<p>Summary</p>	<p>The Palliative Care Service Quality Review is the eighth in the programme of ten reviews.</p> <p>A Palliative Care Service Quality Review Working Group was established to ensure the contribution of a range of NHS Direct staff with particular expertise in palliative care to the Quality Review.</p> <p>Currently NHS Direct has just one dedicated palliative care service, the Palliative Care Line, run by West Yorkshire Urgent Care (WYUC). However, patients contacting NHS Direct or commissioned services provided by NHS Direct may be calling with palliative care/end of life-related requirements.</p> <p>The review has been carried out according to the prescribed format and focuses on the areas of Patient Safety, User Experience, Clinical Effectiveness and Cost Effectiveness.</p> <p>The review provides NHS Direct with assurance of the quality of its palliative care offering, but does recommend actions which, if implemented, will positively contribute to the delivery and quality of the service. The report also recommends actions which will contribute to the development of future services.</p> <p>These recommendations and others from previous SQR will be reviewed by the Service Quality Review Group and are considered by each Directors senior representative as to whether they should be taken forward as an action or not. It is noted on the action log why it is or is not being taken forward, closed if that is what is decided or given an owner with a deadline if agreed to progress.</p> <p>The respective directors delegated leads are collectively reviewing the SQR action log in totality and deciding with the current climate in mind whether the action still applies or not and whether we have the necessary resources applied to them</p> <p>This paper has been considered and discussed at the Clinical Governance Committee.</p>
<p>Issues to be considered</p>	<p>Whether all relevant aspects of palliative care provided by NHS Direct have been reviewed appropriately.</p> <p>Whether the recommended actions identified are relevant and necessary.</p> <p>The report outlines recommendations relating to:</p> <ul style="list-style-type: none"> • Patient Safety • User Experience • Clinical Effectiveness • Cost Effectiveness
<p>Action required</p>	<p>The Clinical Governance Committee recommends that the Board endorses the recommended actions</p>
<p>Accountable Executive Director</p>	<p>Tricia Hamilton, Clinical Director/Chief Nurse</p>
<p>Author of Paper</p>	<p>Shirley Large, Head of Research and Clinical Audit</p>
<p>Date prepared</p>	<p>28 November 2011</p>

Executive Summary

This review has been carried out according to the prescribed format and focuses on the areas of Patient Safety, User Experience, Clinical Effectiveness and Cost Effectiveness.

Themes which emerged from the review and require further action are: 1) training, 2) systems and processes, 3) increasing knowledge and understanding of care needs, quality of care, patient satisfaction, experience and outcomes, and 4) considerations for the future. The recommendations for each of these areas are outlined below:

1) Training issues

- a) Include in the Role Preparation Programme i) training on the needs and difficulties of patients receiving palliative care and ii) guidance on how to manage/direct patients who have been given the Palliative Care Line number by their GP/District Nurse but have called the 0845 or WYUC services direct.
- b) Consider the appropriateness of mandating the End of Life Workbooks for mandatory training.

2) Systems and processes

- a) Continue to develop the SystemOne risk register and respond to any issue identified through the development of appropriate policies.
- b) Risk-assess the palliative care information reception and retrieval procedures to ensure robust data processes.
- c) Identify whether there is a requirement for an Equality Impact Assessment(EIA) to be completed for the Palliative Care Line.
- d) Explore how to demonstrate to commissioners that Palliative Care Line patients who register as abandoned calls do gain access to the service.
- e) If required, ensure more accurate charging and costing information relating to palliative care calls.

3) Increasing knowledge and understanding of care needs, quality of care, patient satisfaction, experience and outcomes

- a) Explore the appropriateness of a separate process to capture satisfaction data for palliative care calls and the Palliative Care Line, perhaps including the views of carers.
- b) When the patient outcomes and experience survey is introduced into WYUC in early 2012, explore whether there is a need to differentiate the patient experience and outcome data of patients using the Palliative Care Line.
- c) Continue to report the number of West Yorkshire Urgent Care calls that are audited through Verint. This will ensure that the calls audited are sufficient to meet the contract KPI (0.1%) and that the results of call audits can be made available to the commissioners, if requested.
- d) Draw on evidence from the opioids prescribing clinical audit to inform the inclusion of exceptions to the prescribing standards.
- e) Ensure that the Palliative Care Clinical Audit is undertaken.
- f) Provide reports from the Urgent and Emergency Care Clinical Audit to the organisation and commissioners on a quarterly basis from March 2012.
- g) Initiate benchmarking for GPs on their clinical sorting and other performance measures as recommended in the Urgent and Emergency Care Clinical Audit Toolkit (also highlighted in the WYUC Service Quality Review).
- h) Ensure palliative care is included in the horizon scanning and gap analysis process undertaken by the Content Development Team to identify potential content and system changes.

- i) Explore the appropriateness of including separate questions in the staff survey to capture the experience of staff handling palliative care calls or staffing the Palliative Care Line.

4) Considerations for the future

- a) Standardise the information required from Primary Care regarding end of life/palliative care plans for patients in line with National Guidance.
- b) Consider having a named clinician engaging with sites developing the End of Life Registers in order for NHS Direct to be fully aware of how the registers may impact on processes within the organisation, including the NHS 111 services.
- c) Review the feasibility of NHS Direct utilising the End of Life Care Quality Assessment Tool.

The review provides NHS Direct with assurance of the quality of its palliative care offering, but does recommend actions which, if implemented, will positively contribute to the delivery and quality of current and future services.

Recommended Actions

The table below summarises the recommended actions. These recommendations come from the main body of the report, sections 3 to 6.

Section	Issue	Recommended Action	Owner	Timescale	Executive Owner	Business Case Required? (Y/N)
Patient Safety						
3.3	Not all staff outside the WYUC area are aware of the Palliative Care Line service and may not transfer or re-direct patients appropriately	Ensure that the Role Preparation Programme (RPP) includes i) training on the needs and difficulties of patients receiving palliative care and ii) guidance on how to manage/direct patients who have been given the Palliative Care Line number by their GP/District Nurse but have called the 0845 or WYUC services direct.	Janet Haslam	End of March 2012	Tricia Hamilton	
3.6	Patient data is entered onto two electronic systems, CAS and SystemOne.	Continue to develop the SystemOne risk register and address the risks identified on it through the development of appropriate policies.	5.4 WYUC SQR Action Log			
3.6	Faxing across service providers can result in simple data input errors with potential for records to be lost.	Risk-assess palliative care information reception and retrieval procedures to ensure robust data processes.	Jacqui Jedrzejewski	End March 2012	Tricia Hamilton	
3.7	Staff should be trained in communication skills; management of end of life issues; assessment of the person's needs and preferences; advanced care planning and symptom control (DH, 2008)	Consider the appropriateness of End of Life Workbooks becoming part of mandatory training.	Janet Haslam	End of March 2012	Tricia Hamilton	

Section	Issue	Recommended Action	Owner	Timescale	Executive Owner	Business Case Required? (Y/N)
User Experience						
4.1	The process for capturing patient satisfaction data for palliative care calls is not differentiated within the WYUC patient survey. Patients who use the Palliative Care Line only use it for a short period of time and may not be in a position to give feedback. It may be that carers could be approached to give their feedback on the Palliative Care Line.	Explore the appropriateness of a separate process to capture satisfaction data for palliative care calls and the Palliative Care Line, perhaps including the views of carers.	Elizabeth Kawonza	TBC	Tricia Hamilton	
4.1	It is essential to collect patient experience and outcome data to ensure a process of continuous quality improvement. Patient experience and outcome data will become increasingly important for commissioners procuring future services	When the PROMs and PREMs survey is introduced into WYUC in early 2012, explore whether there is a need to differentiate the patient experience and outcome data of patients using the Palliative Care Line. Note: Unable to implement patient experience and outcome measure in WYUC at this stage because patient satisfaction survey undertaken continuously	Teresa Davis	Action to be reviewed May 2012	Brian Gaffney	
4.1	Establish whether there is an EIA requirement for the Palliative Care Line.	Identify whether there is a requirement for an EIA to be completed for the Palliative Care Line.	Brendan Carey	Awaiting response	Ruth Rankine	

Section	Issue	Recommended Action	Owner	Timescale	Executive Owner	Business Case Required? (Y/N)
4.2	In the staff survey, responses from staff handling palliative care calls or staffing the Palliative Care Line are not differentiated from the responses of staff providing the core 0845 service.	Explore the appropriateness of including separate questions in the staff survey to capture the experience of staff handling palliative care calls or staffing the Palliative Care Line.	Anna Turner	Deemed inappropriate – if necessary a small-scale survey of staff could be arranged but this should be reviewed in line with new organisational objectives post April 2013.	Roger Rawlinson	
Clinical Effectiveness						
5.1	WYUC commissioners are currently seeking assurance that all Palliative Care Line patients can access the service.	Explore a way of demonstrating to commissioners that Palliative Care Line patients who register as abandoned calls do gain access to the service.	Lynne Matthews	Awaiting response	Keith Gait	
5.1	There is no standard national process for NHS Direct to directly have access to, or pass care plans (or patient passports) across all service boundaries twenty-four hours a day.	Standardise information required from Primary Care regarding end of life/palliative care plans for patients in line with National Guidance.	DDNs	Awaiting response	Tricia Hamilton	

Section	Issue	Recommended Action	Owner	Timescale	Executive Owner	Business Case Required? (Y/N)
5.1	Evaluation of the pilots for the End of Life Care Registers highlights the potential for the effective coordination of the care required to allow patients to be cared for in their place of choice (DH, 2011).	Consider having a named clinician engaging with sites developing the End of Life Registers in order for NHS Direct to be fully aware of how the registers may impact on processes within the organisation, including the NHS 111 services.	Lynne Parkes Stuart Toulson Lesley Selfe	Awaiting response	Tricia Hamilton	
5.1	The percentage of audited calls required to be assessed as satisfactory for the Local Quality Requirement should be >95%. The 0.1% target for reviewing WYUC calls was met in July.	Continue to report the number of WYUC calls that are audited through Verint. This will ensure that the calls audited are sufficient to meet the contract KPI (0.1%) and that the results of call audits can be made available to the commissioners, if requested.	7.1 WYUC SQR Action Log			
5.2	Palliative care is not a topic that is routinely considered when conducting a literature search for new clinical guidelines. Palliative care is not currently included in the gap analysis.	Palliative care to be included in the horizon scanning and gap analysis process undertaken by the Clinical Development Team in order to identify any changes to the system required.	Val Sumner	Awaiting response	Tricia Hamilton	
5.5	Currently, the opioids prescribing clinical audit indicates that WYUC prescribing standards for strong opioids are not being met.	Discussions to take place with WYUC regarding opioid prescribing in palliative care. Discussions to draw on evidence from the opioids prescribing clinical audit to inform the inclusion of exceptions to the prescribing standards.	Anne Joshua	January 2013	Brian Gaffney	

Section	Issue	Recommended Action	Owner	Timescale	Executive Owner	Business Case Required? (Y/N)
5.5	WYUC Local Quality Requirement (LQR) 4.3 states that there should be a minimum of two clinical audits per year which should reflect local and national priorities agreed with the PCT.	Ensure that the Palliative Care Clinical Audit is undertaken.	Andy Lee	March 2013	Brian Gaffney	
		Reports from the Urgent and Emergency Care Clinical Audit to be made available to the organisation and commissioners on a quarterly basis.	Shirley Large	May 2012	Brian Gaffney	
5.6	Medacs GPs are only benchmarked based on the number of calls they handle per hour.	Benchmarking GPs on their clinical sorting and other performance measures recommended in the Urgent and Emergency Care Clinical Audit Toolkit should be implemented as highlighted in the WYUC SQR.	Andy Lee	Awaiting response	Brian Gaffney	
5.6	An online self-assessment tool has been developed for the National End of Life Care Intelligence Network, to help commissioners and providers of end of life care monitor the quality of services (ELCQuA, 2011).	Review the feasibility of NHS Direct utilising the End of Life Care Quality Assessment Tool.	Palliative Care Group	Awaiting response	Tricia Hamilton	
Cost Effectiveness						

Section	Issue	Recommended Action	Owner	Timescale	Executive Owner	Business Case Required? (Y/N)
6	There is currently a lack of reporting on palliative care calls within NHS Direct.	If more accurate charging and costing information relating to palliative care calls is required, NHS Direct systems need to be amended so that palliative care calls are specifically identified and reported on.		This action has not been allocated at this stage. The action will be allocated if this is felt to be a requirement by the Executive Team.		

1. Introduction

In June 2010 the NHS Direct Board agreed a programme of Service Quality Reviews. The Palliative Care Service Quality Review is the eighth in the programme of ten reviews. (See Appendix 1 for the Terms of Reference for the Palliative Care Service Quality Review.)

A Palliative Care Service Quality Review Working Group was established to ensure the contribution of a range of NHS Direct staff with particular expertise in palliative care to the Palliative Care Service Quality Review.

The review focuses on:

1. Patient safety
2. User experience
3. Clinical effectiveness
4. Cost effectiveness

Each section of the review will systematically identify:

- The processes in place to provide assurance within each area.
- The outcomes, where known, for each area.
- The issues that were identified during the review and the recommendations emerging from these issues.

The recommended actions are referenced throughout the text, and summarised in the *Recommended Actions* table at the head of this report.

2. Palliative Care Overview

2.1 Definition

The World Health Organisation (WHO) describes 'palliative' or 'end of life care' as the care given to those suffering a life-threatening illness.

'Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment of pain and other problems, physical, psychosocial, and spiritual.' (WHO, 2011)

The term palliative care is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications (WHO 2011). End of life care is applied specifically when people are 'approaching the end of life', when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions.
- general frailty and coexisting conditions that mean they are expected to die within 12 months.
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition.

Quality of life is at the heart of palliative and end of life care and incorporates a holistic assessment of the needs of patients and families. Traditionally, the term 'palliative' related only to those suffering cancer, but it is now applied to everyone in the end stages of life, irrespective of diagnosis (Dorothy House Hospice, 2011). The inclusion of all those who are in the end stages of their life is reflected in the working definition of end of life care taken from the National Council for Palliative Care (2006) used in the Department of Health's *End of Life Care Strategy* (2008).

2.2 Palliative care in NHS Direct

NHS Direct has only one dedicated palliative care service, called the Palliative Care Line, which is run by West Yorkshire Urgent Care (WYUC). However, patients contacting NHS Direct or commissioned services provided by NHS Direct may be calling with palliative care/end of life-related requirements.

2.3 Policy and guidance

A national strategy promoting high quality of care for all adults at the end of life has been launched following consultation between health and social care professionals, patients, carers and the public. The End of Life Care Strategy provides a framework to support local health and social care services to provide better end of life care in any applicable setting (DH, *End of Life Care Strategy*, 2008).

Government policy directs that patients should have better choice and involvement in planning the care they receive for their conditions: 'Shared decision-making will become the norm: *no decision about me without me*' (DH, *Equity and excellence: Liberating the NHS*, 2010, p3).

Involving patients in decision making early and providing information and appropriate care has been found to result in less active treatment in the late stages of illness, reduced A&E admissions and significantly reduced hospital admissions in end-stage care.

The End of Life Care Strategy calls for the formulation of local 'end of life care registers' of patients who are approaching death. Through the use of information technology these registers should be accessible to all the services that may be required to support those on them (DH, *End of Life Care Strategy*, 2008, p12, s.14).

Care planning should involve multidisciplinary teams, patient and carers. Ideally, patients and carers should have a single point of access connecting them to helplines and palliative outreach and rapid response teams for support twenty-four hours a day. Out-of-hours (OOH) services are recognised as services required occasionally by patients at the end of life and must therefore be equipped to deliver gold standard care to these patients. When contact is made with OOH service providers, protocols should be set to bypass routine assessments, transferring the end of life care patient quickly to a clinician.

Staff should be trained in communication skills, the management of end of life issues, assessment of the person's needs and preferences, and advanced care planning and symptom control (DH, *End of Life Care Strategy*, 2008, p118).

Key points within the End of Life Care Strategy recommendations and the professional guidance relating to palliative care that particularly relate to NHS Direct include:

- Recommendations relating to the effective communication of agreed care plans and all relevant patient and carer details. This is considered vital to ensure good continuity of care without delay or the need for the repetition of information.

- General nursing and medical services should have access to specialist services for advice at all times.
- With the assistance of cancer and end of life care networks, staff supporting and caring for patients and families should receive training to enhance their knowledge and skills in the subject.
- Patient and carer support through access to high-quality information and care should be provided twenty-four hours a day.

More recently, the third annual report of the End of Life Care Strategy has been published, reporting good progress across most areas of the strategy (DH, *End of Life Care Strategy: The Third Annual Report*, 2011).

3. Patient Safety

3.1 Safe Practice

Processes and data sources

The NHS Direct decision support software teleguides and algorithms are developed taking into account national clinical guidelines and evidence-based practice. The NHS Direct Clinical Content and Development Support Officer routinely scans published literature and research to ensure the system remains contemporary and up-to-date with best practice. A gap analysis is completed as indicated and, if required, a business case developed for inclusion of the update in future releases. Where there is a high priority gap in system content changes can be made within twenty-four hours. The decision support software clinical content does not contain end of life care-specific information as any assessments and advice are based on the presenting symptom and the patient's medical history. There is a request for change process in place for end users to make recommendations regarding the functionality or clinical content of the decision support software.

The Clinical Development Team maintains a change sheet that identifies any system changes made, such as new clinical releases.

Pharmacist Advisors may take calls related to palliative care, which are usually in relation to pain relief and how to manage strong opioids. Pharmacist Advisors use the information available from *palliativedrugs.com* as the key reference source for advice on palliative care medicines.

3.2 Appropriate and timely onward referral

Processes and data sources

In end of life care it is essential that a transfer to 999 or emergency care is not made inappropriately. Patients with an end of life care plan may have a 'special note' attached to their Health Record indicating the actions that need to be taken in given circumstances. This may be a full care pathway or instruction to directly transfer the call to an out-of-hours provider. Patients may be directly transferred to an out-of-hours provider for further assessment and treatment, dependent upon whether there is a direct transfer policy agreement or a specific care pathway in place.

3.3 Access to service

Processes and data sources

NHS Direct provides a palliative care helpline as part of its contract with West Yorkshire Urgent Care. Whilst the number of expected contacts related to palliative care is not specified within the WYUC contract, they are included within the anticipated 283,000 out-of-hours GP call handling and triage calls per year.

NHS Direct currently receives approximately 400 end of life care calls each month on the Palliative Care Line. The number of palliative care calls received on the 0845 line is not recorded.

Outcomes

Patients are provided with the Palliative Care Line number in the West Yorkshire Urgent Care region on the implementation of an end of life care pathway. In a random sample of WYUC contacts over a one-month period in 2011, 11% of patients with end of life care were recommended a home visit (information from the RGCL, WYUC).

There is no dedicated palliative care contact line or end of life care-specific assessment process (other than specified in special notes) in the 0845 46 47 service or the other commissioned services.

3.3.1 Equity of access

Processes and data sources

The Palliative Care Line is only available to patients living within the commissioning area (West Yorkshire) who have been selected by their GP or District Nurse. WYUC staff raised a concern that patients and carers who are assigned to the Palliative Care Line service but call the core 0845 46 47 or WYUC number may not be appropriately transferred or 'handled'. Not all staff outside the WYUC area are aware of the Palliative Care Line service and may not transfer or re-direct callers appropriately. In addition, callers to the core 0845 service may experience CSPT, which is not deemed appropriate for patients at this stage of care.

The core 0845 service has the facility to provide a palliative care service and this is reflected in the *Special Notes Policy*. However, this service can only be provided where the service is commissioned and GPs have provided notes about identified patients. Patients are given details of the dedicated phone number to call by their GP - this number is distinct from the NHS Direct 0845 number. The patient's GP or District Nurse completes a form containing pertinent details about the patient to be entered onto CAS and SystemOne.

Patient access is dependent on GP or District Nurse referral. This could mean that some palliative care patients do not have access to this service.

By its nature, the service is restricted to the client group it serves. However, the West Yorkshire Palliative Care Line serves a great many patients as it covers five PCT areas and may well offer useful experiences and information for a potential roll-out as a value-added service in NHS 111.

A new online Patient Decision Aid (PDA) which is an aid to end of life planning for those in end-stage kidney disease is due for launch in late 2011. The PDA is likely to be available to all users of the NHS Direct website, although this is still to be confirmed. The purpose of the PDA is to explain the pros and cons of planning for end of life care, if the patient is ready to do so. It highlights different topics that may need to be considered when planning end of life care (e.g.

benefits; appointing a power of attorney; resuscitation instructions; deciding where to end your life – hospice/home/hospital).

Recommendations

- Ensure that the Role Preparation Programme (RPP) includes i) training on the needs and difficulties of patients receiving palliative care and ii) guidance on how to manage/direct patients who have been given the Palliative Care Line number by their GP/District Nurse but have called the 0845 or WYUC services direct.

3.4 Process and monitoring

Processes and data sources

The Palliative Care Line is a dedicated line available to selected patients in the West Yorkshire area. The system for handling calls is described in the document *Procedure for the handling of WYUC Palliative Care enquiries within NHS Direct V1.3, Dec 2010* (see Appendix 1). This document describes a disposition for response within 10 minutes for calls where there is an active service provider rota. Should this timescale be breached there is further advice to escalate the call to the GP.

A further guidance sheet - *Palliative Care Calls in Contingency* - describes the process for inbound call flow in contingency (Appendix 1).

Outcomes

The Palliative Care Line has its own set of Key Performance Indicators. They are included in the WYUC suite of reports provided by the Service Performance Centre. Palliative care calls to the 0845 service can be reported on where the call is known, but these calls do not have their own unique identifier within the reporting system and therefore cannot be routinely reported.

3.5 Patient safety culture

3.5.1 Complaints process

Processes and data sources

Investigation of, reporting on, and improving from complaints relating to the Palliative Care Line is conducted and managed according to the standard NHS Direct policies on managing complaints. However, there is a tacit understanding that any complaints from this patient group are fast-tracked through the complaints system.

In addition to the national NHS Direct procedures, the local Clinical Governance Lead (RCGL) managing the West Yorkshire Urgent Care Service (WYUC) takes part in quarterly Complaints Managers' meetings with stakeholders from the participating PCTs. Incidents and complaints are also discussed with stakeholders and commissioners within the Clinical Governance meetings held in West Yorkshire relating to the whole WYUC service.

Investigations are carried out in accordance with the guidance given in the *National Complaints and Feedback Policy CL016* and accompanying Guidance and Procedures documents.

All complaints are recorded in Datix. Datix is the central database for all complaints and feedback within NHS Direct. Following an investigation, any learning and actions from the investigation are documented within the Datix record and monitored for completion by the RCGLs in the appropriate Division.

Outcomes

Distinct reports on the Palliative Care Line are produced by the local Clinical Governance Lead on a monthly, quarterly and annual basis. Complaints relating to the Palliative Care Line are included in overall totals for the monthly NCGT report but are not reported separately.

3.5.2 Incidents

Processes and data sources

Regional Clinical Governance Leads manage the investigation and reporting process for their commissioning areas. Information about lessons learned and actions are held on Datix with the incident reports and other relevant documents.

Reports on the number and nature of the incidents, as well as lessons learned, are reported to the Board and Clinical Governance Committee by the National Clinical Governance Team (NCGT). NCGT staff also report serious incidents to the National Patient Safety Agency on a rolling basis as part of required Care Quality Commission reporting.

Outcomes

NHS Direct routinely classifies all deaths as Serious Incidents Requiring Investigation (SIRIs). However, in the case of palliative care patients, death is not an unexpected outcome and thus not all deaths for this patient group are classified as SIRIs. However, where there is any suggestion of something having gone wrong a SIRI is recorded and standard procedures for the reporting and investigation of incidents are followed.

3.6 Patient data

Processes and data sources

Several policies are in place within the organisation that cover various aspects of the safe use of patient data in the context of the Palliative Care Line.

- Special Notes: NP028A
- Special Notes Information Sharing Agreement: CL019
- Confidentiality Policy: IG002
- Records Management Policy: IG003
- Information Governance Policy: IG001

Two leaflets are available for service users: *Patient Information* and *Special Notes*.

The procedure for passing patient information to the Palliative Care Line from GPs and District Nurses is by Safe Haven fax. Patient information forms are sent from Monday to Saturday only. The forms are screened and checked by the local specialist NHS Direct team, who understand what information is required and can identify incomplete forms and then retrieve any required data from the care provider. The data is entered onto two electronic systems, CAS and SystemOne; again, specialist knowledge is deemed necessary here as simple input errors can result in records being lost. Hard copies are kept in a locked cabinet accessed only by Shift Leads.

In the core service, special notes can be made for patients receiving palliative care. These notes must be provided by the GP or care giver. The experience of the Palliative Care Line in WYUC may inform how to make the most effective use of this function in special notes.

Recommendations

- Continue to develop the SystemOne risk register and address the risks identified on it through the development of appropriate policies as outlined in the WYUC SQR.
- Risk-assess the palliative care information reception and retrieval procedures to ensure robust data processes.

3.7 Safe practitioners

3.7.1 Staff induction and role preparation

Processes and data sources

NHS Direct provides a comprehensive induction and role preparation programme that encompasses communication and negotiation skills along with system navigation and governance elements (statutory and mandatory training). A significant proportion of the role preparation is focused upon using critical thinking and decision making skills to reach clinically effective outcomes for patients.

Competency checks are performed during training and prior to independent practice. Preceptor support is provided during training and during the transition from the training environment to the live environment.

3.7.2 Staff development

Calls are reviewed by supervisors, self and peers as part of quality and performance monitoring. NHS Direct has in place a call review process by which each frontline advisor can expect to have a minimum of 3 call reviews per month. Feedback is provided via a feedback form and the advisor's Team Manager. The advisor can review the call review via the voice recording system and take action on any areas of development that have been identified.

There is a structured and embedded system of performance appraisal and clinical supervision - based around the NHS Knowledge and Skills Framework (KSF) - that responds to the individual training and professional development needs of staff.

Outcomes

Each colleague has a current Personal Development Plan (PDP) agreed at their personal review. The PDP, in conjunction with their KSF outline, describes the knowledge and skills that staff need to apply in order to deliver high quality services. A PDP can involve a variety of learning methods, including formal training, on the job training, work shadowing, e-learning and academic study.

3.7.3 Staff training

Currently, training on the management of end of life care for patients is not mandatory to practice, but is available for continuing personal and professional development. Due to the infrequent involvement of NHS Direct in providing services for end of life care, an approach was taken that learning resources and access to end of life care training would be made available to staff in line with the recommendations from the End of Life Care Strategy (2008). Staff should be trained in communication skills; the management end of life issues; assessment of the person's needs and preferences; advanced care planning and symptom control (DH, 2008). Training was developed in partnership with a hospice training provider and encompasses pertinent learning for those providing care through remote clinical assessment.

There are workbooks for Nurse Advisors and Health Advisors that can be used as standalone learning activities or as a prerequisite for face-to-face training. The workbooks have been developed to support the front end of care delivery and nurse assessment.

Whilst end of life care is not a mandatory training requirement, advisors will undertake training related to 'special notes' during their role preparation period. Health Advisors and all those who provide access to the service are trained to recognise the 'special note' icon, how to access it and what considerations will be required to inform the subsequent assessment.

There are a number of 'End of Life Care Champions' within the organisation whose role is to ensure that staff are able to incorporate best practice in end of life care into their everyday work. They are also available to facilitate training on end of life care and to raise awareness of other end of life care training opportunities and current research.

Outcomes

Effective use of special notes can result in a patient who in normal circumstances would receive a 999 outcome being able to stay at home for ongoing treatment and/or advice to manage presenting symptoms.

Recommendations

- Consider the appropriateness of End of Life Workbooks becoming part of mandatory training.

3.7.4 Clinical environment and infrastructure

NHS Direct employs Health Advisors, Nurse Advisors, Dental Nurse Advisors, Health Information Advisors and Pharmacist Advisors. All staff groups may come into contact with end of life patients during their clinical and operational work. The roles each have a competency framework that describes the knowledge, skills and behaviours required of their role. The competency frameworks have been benchmarked against those provided by the Skills for Health standards – this was an internal process.

West Yorkshire Urgent Care hold annual benchmarking procedures for end of life care contacts. This involves the review of a random selection of end of life care contacts and subsequent review of the outcome.

Individual advisors' clinical outcomes are benchmarked internally by way of the balanced scorecard; however, this is generic to all calls and not specific to end of life calls.

NHS Direct participates in the annual Contact Centre Association (CCA) accreditation process by which the service is benchmarked against CCA standards.

4. User Experience

4.1 Patient

Processes and data sources

In general, patient satisfaction is captured in NHS Direct through patient satisfaction surveys and feedback. The process for capturing patient satisfaction data for palliative care calls is not differentiated from that for the wider service. The processes for collecting patient satisfaction and feedback are outlined in the Urgent Contacts Service Quality Review (NHS Direct, 2011).

IFFR have been commissioned to conduct a patient satisfaction telephone survey for WYUC (this is currently being brought in-house). Ninety-one percent of those surveyed were 'very satisfied' or 'fairly satisfied' with the service they received (WYUC Service Quality Review). Callers who use the Palliative Care Line are given the same opportunity to take part in the WYUC satisfaction survey as other callers. However, results from the WYUC patient satisfaction survey are not differentiated by the line used or type of call. A recent Service Quality Review of WYUC recommended that more focus should be given to capturing feedback from WYUC patients to feed into further development of the service (Mynors Suppiah, 2011).

4.1.1 Complaints

Twenty-five complaints were received about the Palliative Care Line in 2010-11 (reported 4/10/11). Eighteen of these were upheld and one was partially upheld. The majority of complaints originated from health professional feedback (19). For those upheld, most cases related to delays in assessment, delays in receiving medication or delayed visits by a GP or District Nurse (12). In one case ambulance and police were called inappropriately for an expected death.

Following an investigation into complaints, any learning and actions are documented within the Datix record and monitored for completion by the Clinical Governance Leads in Division. Examples of learning and actions include extra training for staff, feedback to GPs, and a recommendation that a handover period for GP time should be established at the beginning and end of the OOH period. Issues raised in complaints and compliments are discussed by the WYUC Clinical Review Group and are used to improve the service.

The Clinical Governance Lead for WYUC reported that the majority of complaints occur when calls are taken outside of the WYUC region. Sometimes patients may not call the dedicated Palliative Care Line and these calls can be handled nationally and have a higher chance of being handled incorrectly.

Palliative care calls are reviewed through the generic call review process. The generic call review process has a section specifically focusing on measuring empathy. This is generally reviewed by Team Managers. If there is an incident or complaint related to the Palliative Care Line then calls are reviewed by the Clinical Governance Lead for WYUC. Empathy would be considered as part of this. All staff receive SCAN (Screening, Caring, Action/Advice, Next steps) training following induction, which includes both the understanding of, and use of, empathy.

Outcomes

Patients who use the Palliative Care Line only use it for a short period of time and may not be in a position to give their feedback. It may be that carers could be approached to give their feedback on the Palliative Care Line.

It is essential to collect patient experience and outcome data to underpin the process of continuous quality improvement. Patient experience and outcome data will become increasingly important for commissioners when procuring future services.

Where palliative care patients are triaged out-of-area due to service delivery models, the Clinical Governance Lead for West Yorkshire Urgent Care reported that in-sourced service providers are often unaware of the needs of palliative care patients, and that the special note attached to the Health Record may not be acted upon. As previously noted, this can result in the patient not having the appropriate end of life care pathway.

Recommendations

- Explore the appropriateness of a separate process to capture satisfaction data for palliative care calls and the Palliative Care Line, perhaps including the views of carers.
- When the PROMs and PREMs survey is introduced into WYUC in early 2012, explore whether there is a need to differentiate the patient experience and outcome data of patients using the Palliative Care Line.

4.1.2 Equality Impact Assessment

Equality Impact Assessments (EIAs) are carried out on new NHS Direct services, on significant changes to NHS Direct services, or on significant changes to the purpose or structure of functions within NHS Direct. EIAs are only carried out on discrete services. EIAs have been completed for the 0845 service and for the pilot NHS 111 services. Currently, the focus for carrying out EIAs is on access and NHS 111.

A Patient and Public Involvement Access Issues Group provides feedback to NHS Direct on issues relating to equality of access and improvement of access to NHS Direct services. A range of organisations are represented on this group, which meets quarterly.

Outcomes

An EIA could be carried out on the Palliative Care Line. However, to do so it would be necessary to understand whether the data captured, that is specific to palliative care, is sufficient to be able to complete an EIA.

Recommendations

- Identify whether there is a requirement for an EIA to be completed for the Palliative Care Line.

4.2 Staff

Process and data sources

A staff survey is carried out annually by Quality Health. The 2011 staff survey highlighted areas where NHS Direct is achieving good results, as well as a number of management actions. Responses from staff handling palliative care calls or staffing the Palliative Care Line were not differentiated from the responses of staff providing the core 0845 service.

4.2.1 Support mechanisms

The support offered to staff taking palliative care calls and those handling calls on the Palliative Care Line is the same as for the core service. Staff have access to support from their Shift Manager, Team Manager, peers, Clinical Leads, and Right Core. They can also be given reflection time.

4.2.2 Staff feedback

Anecdotal reports suggest that the majority of staff that work on the Palliative Care Line enjoy their work. Staff feedback is captured through the same channels as for the core service.

Outcomes

There are a number of measures in place to support staff. There is a generalised national staff survey; however, this does not specifically capture staff experience of dealing with palliative care calls. Feedback from staff handling these calls could be used to develop the service provided to palliative care patients.

Recommendations

- Explore the appropriateness of including separate questions in the staff survey to capture the experience of staff handling palliative care calls or staffing the Palliative Care Line.

4.3 Stakeholders

4.3.1 Commissioner views

There is evidence of clear, structured processes for feedback from commissioners for services such as WYUC (NHS Direct, 2011). However, it is not clear how commissioner views are incorporated into the Palliative Care Line service. Regional Directors, Regional Heads of Service Development and Key Account Managers are responsible for liaising with commissioners locally and developing two-way communications (NHS Direct, 2011).

The National Council for Palliative Care, in their document *Commissioning End of Life Care. Act & Early: initial actions for new commissioners*, highlight that the commissioning of end of life care should be linked to the planning for long-term conditions, care of the elderly, dementia and carer support planning. This guidance makes a number of recommendations for commissioners of end of life care services. NICE is also due to produce new end of life care commissioning guidance in December 2011 (The National Council for Palliative Care, 2011).

4.3.2 Healthcare professional views

A Clinical Review Group for WYUC, made up of NHS Direct, Care UK, Local Care Direct, hospital palliative care consultants, District Nurses, Macmillan Nurses and others involved in palliative care, meets formally every three months. During this meeting patient journeys are discussed. The patient journeys are reviewed from when the call comes into the service, and look at how the call is processed, timescales and special care notes.

The views of the health professional staff who attend these meetings are used to inform the development of the service. There is also a monthly meeting of District Nurses. The Clinical Governance Lead for WYUC has regular meetings with staff from the different PCTs. Clinical experts are engaged through the Palliative Care Group.

There is a dedicated email inbox for health professional feedback about the Palliative Care Line.

4.3.3 Stakeholder survey

NHS Direct commissions an annual Stakeholder Survey to ascertain the views of stakeholders. The most recent survey (2011) was conducted by Jigsaw Research. This survey does not differentiate the views of stakeholders for particular commissioned services. Sixty-four percent of stakeholders rated the overall performance of NHS Direct as 'good', 'very good' or 'excellent' (Jigsaw Research, 2011).

5. Clinical Effectiveness

5.1 Clinical outcome

5.1.1 Outcome measures

Processes and data sources

Currently, the only commissioner-set outcomes NHS Direct has for palliative care are those for the Palliative Care Line attached to the West Yorkshire Urgent Care service. All other commissioned services use the National Quality Requirement to frame their Service Level Agreement. The Palliative Care Line accounts for 1.5% of calls through WYUC.

There are only two palliative care targets for WYUC Palliative Care Line patients, namely the access targets of 0% abandonment rate and $\geq 95\%$ answered within 60 seconds. Performance data for April 2010-March 2011 is set out in the table below, along with an example of daily data.

KPI Standard				April 2010-March 2011	04/09/11	05/09/11	06/09/11	07/09/11	08/09/11
Palliative Care Calls Offered	N/A	N/A	N/A	5173	31	21	11	10	8
Palliative Care Calls Answered	N/A	N/A	N/A	5096	31	21	10	10	8
Palliative Care Calls Abandoned	N/A	N/A	N/A	26	0	0	1	0	0
Palliative Care Calls Answered within 60 Seconds	N/A	N/A	N/A	4920	31	21	10	9	8
Palliative Care Calls Abandoned %	0%	N/A	> 0%	0.5%	0%	0%	9.1%	0%	0%
Palliative Care Calls Answered within 60 Seconds %	$\geq 95\%$	$\geq 90\%$	<90%	96.5%	100%	100%	100%	90%	100%

Outcomes

From the data above it can be seen that on occasion there are abandoned calls. Unfortunately, we are unable to accurately determine whether these patients called back and were answered, though the 15 minute slot information on Norbit indicates that this is probably the case. The commissioners are seeking assurance that these patients do get through - currently we are unable to demonstrate this.

Recommendations

- Explore a way of demonstrating to commissioners that Palliative Care Line patients who register as abandoned calls do gain access to the service.

5.1.2 Patient information

Processes and data sources

As yet there is no standard national process for NHS Direct to directly have access to, or pass care plans (or patient passports) across all service boundaries, twenty-four hours a day. However, for all commissioned services, including NHS 111 and WYUC, there is a Special Notes process. This was originally introduced in response to issues involving terminally ill patients being sent ambulances and taken to A&E inappropriately due to NHS Direct not being able to access the patient Health Record held by the patient's GP surgery.

For the WYUC Palliative Care Service, the long-term conditions team enters details relating to treatment and ongoing care provided by the patient's GP or other healthcare provider onto the Health Record for CAS and SystmOne (see *Handover* and *Not for resuscitation* forms in Appendix 1). The team's role in liaising with the healthcare professional providing the information is vitally important as the notes provided to NHS Direct by the healthcare professional can vary greatly, from being very informative to having scant detail regarding diagnosis, treatment plan and resuscitation information.

Outcomes

At present, the West Yorkshire Urgent Care commissioned service has the most comprehensive system for processing and managing palliative care patients, whereby patients or carers who call WYUC do not have to undergo telephone triage. Palliative care-related calls are transferred using CAS and SystmOne processes to request contact from a doctor within 10 minutes (Appendix 1). WYUC also provides patients in the end of life stage of their condition with specialist advice from consultants and palliative home care community nursing teams, and out-of-hours care from services such as Local Care Direct and Care UK.

Recommendations

- Standardise information required from Primary Care regarding end of life/palliative care plans for patients in line with National Guidance.

5.1.3 Registers

Processes and data sources

There are currently several pilots regarding End of Life Care Registers around the country. Evaluation of the pilots for the End of Life Care Registers has highlighted the potential for effective coordination of the care required to allow patients to be cared for in their place of choice (DH, 2011).

Outcomes

NHS Direct is currently involved in discussions with the team responsible for the End of Life Care Register pilot in the South West to understand the role NHS Direct can play in supporting patients on the register and accessing information regarding patients' continuing care and end of life plan.

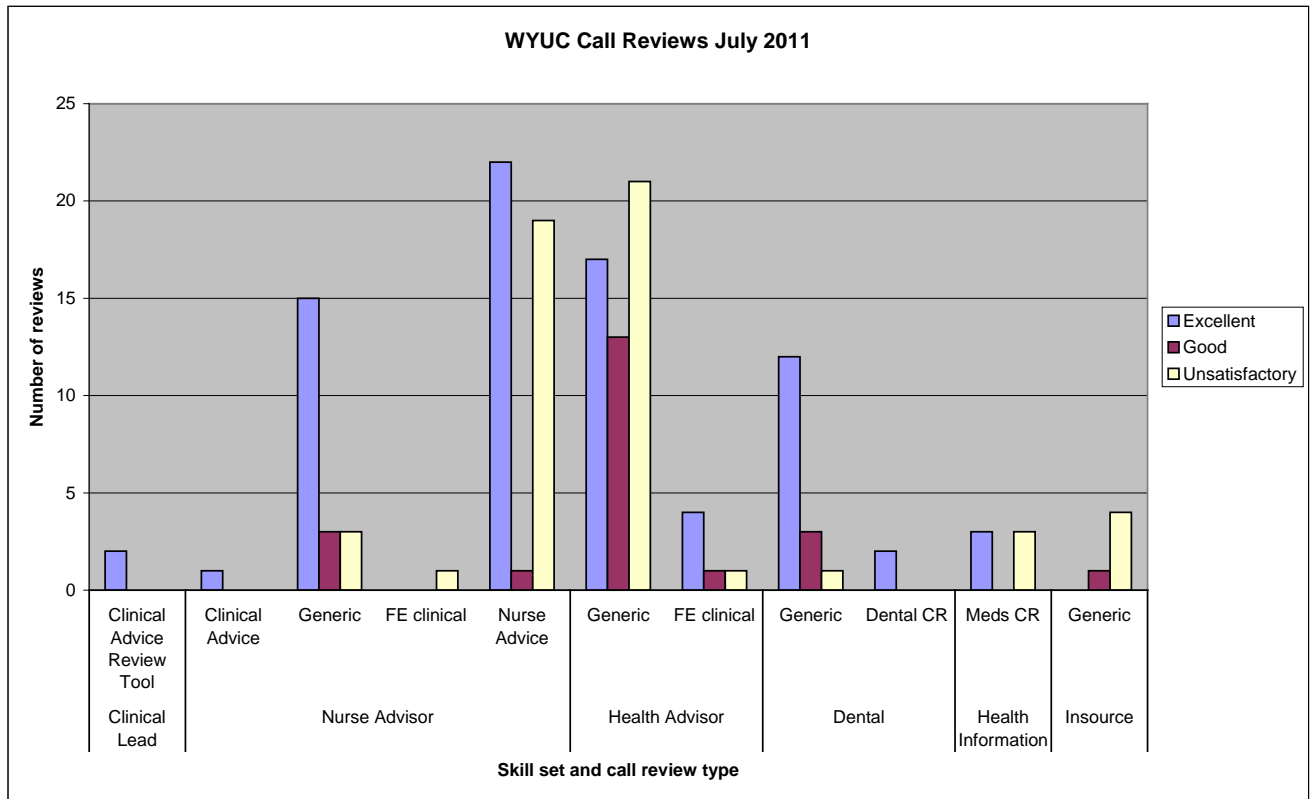
Recommendations

- Consider having a named clinician engaging with sites developing the End of Life Registers in order for NHS Direct to be fully aware of how the registers may impact on processes within the organisation, including the NHS 111 services.

5.1.4 Call review

Processes and data sources

The local quality requirement in the WYUC contract is that 0.1% of WYUC calls should be audited; this is less than the National Quality Requirement and NHS Direct’s own requirement (set by East of England SHA), which are both 1%. It is not possible to access information regarding the quality of calls undertaken for patients specifically using the Palliative Care Line; however, data for call reviews for patients using the WYUC service in July 2011 is outlined in the chart below.



A selection of calls for each GP is reviewed six weeks after their initial training. Thereafter, a minimum of two calls per month or 1% of calls received (whichever is greater) are monitored. If there is concern about a GP or the GP regularly works over 60 hours per week then 5% of calls received are monitored (see WYUC Service Quality Review). Calls are reviewed using the RCGP Clinical Audit Tool. The Medical Director for WYUC re-audits a small proportion of calls to quality-assure the audit process.

Outcomes

In July 2011, 65% of calls reviewed for patients who accessed the WYUC service were deemed good or excellent. The percentage of audited calls required to be assessed as satisfactory for the Local Quality Requirement is >95%. The 0.1% target for reviewing WYUC calls was met in July.

Review of Medacs GP appears to be effective; in late 2010 the review process identified that calls were not being audited satisfactorily by a temporary Clinical Lead that Medacs had supplied to cover maternity leave. As a result, the Clinical Lead was replaced. The WYUC service review reported that there is no routine feedback to Medacs GPs on call audits unless there is a problem. Following the review, call audits and feedback is now planned on a quarterly basis (from Q4 2011). Routine feedback, not only in event of a problem, will be delivered.

Recommendations

- Continue to report the number of WYUC calls that are audited through Verint. This will ensure that the calls audited are sufficient to meet the contract KPI (0.1%) and that the results of call audits can be made available to the commissioners, if requested, as outlined in the WYUC SQR.

5.2 Implementation of Guidance and Policy

Processes and data sources

NHS Direct has a procedure in place (CL056) that describes how clinical guidelines - such as NICE - are taken into account when developing the Clinical Decision Support Software (CDSS). However, palliative care is not a topic that is routinely considered when conducting a literature search for new clinical guidelines. This is because the protocols and algorithms used in the CDSS are primarily concerned with identifying symptoms and their management. A NICE quality standard for end of life care is currently being developed and is due to be published in November 2011 (NICE, 2011). Currently, palliative care is not included in the gap analysis undertaken by the Clinical Development Team (CDT).

Outcomes

Medacs GPs and Nurse Advisors within West Yorkshire have direct access to SystmOne and can therefore access patients' GP records. For those patients who are assessed by a Medacs GP, the notes of the consultation go directly into the patient's record on SystmOne, provided that their GP uses SystmOne. For those that do not, an electronic fax facility exists.

Recommendations

- Palliative care to be included in the horizon scanning and gap analysis processes undertaken by the CDT in order to identify any changes to the system required.

5.3 Up-to-date printed patient materials

Processes and data sources

NHS Direct currently provides information on request to members of the public and health professionals twenty-four hours a day, seven days a week. The information available covers many forms of cancer and life-limiting conditions. Condition support organisations such as those for Alzheimer's and motor neurone disease frequently provide appropriate source information

relating to end of life care. Information covers a wide range of themes, and includes information regarding advanced care planning and directives for issues such as resuscitation or treatment discontinuation. NHS Direct library staff link to such organisations and are informed via email of any information updates.

Outcomes

Library staff monitor NICE guidance and DH policies monthly for any changes to policy. Any additional paper resources are reviewed annually to ensure that only correct, up-to-date information is given. On request, information may be provided by Health Information Advisors / Library Resource Assessors via telephone, post, or email.

5.4 Palliative care research

Processes and data sources

Though no specific research has been conducted on NHS Direct services regarding palliative care provision, there have been several papers that have researched remote provision of palliative care. A study by Roberts et al (2007) identified that many people in the end stage of life are cared for at home by family, friends and carers supported by community services. However, outside of usual working hours for community services, carers are left to manage changing needs alone.

Outcomes

The Canadian article by Roberts et al (2007) draws attention to an innovative, local telephone-based health information and triage call centre. Specialising in palliative care, this nurse-led telephone health line offered out-of-hours support to dying patients and their families, improving symptom management and thereby reducing the need for emergency and urgent hospital-based interventions. The article concluded that there was much to be learned about using technology to achieve the greatest sustainable access to those in need of end of life care in the community.

5.5 Clinical audit

Processes and data sources

There have been no specific clinical audits conducted on the provision of palliative care by NHS Direct. WYUC Local Quality Requirement (LQR) 4.3 states that there should be a minimum of two clinical audits per year, which should reflect local and national priorities agreed with the PCT.

The WYUC service was scheduled to undertake a clinical audit regarding palliative care advice received by patients calling the Palliative Care Line. This audit was postponed from 2011 due to commissioner demands for other audit work. The Joint Providers Clinical Governance meeting has agreed to begin planning an audit programme for 2012-13 in January 2012 and include the palliative care advice audit that was postponed from 2011.

A clinical audit related to the prescribing of strong opioids (morphine, oxycodone, diamorphine, methadone, fentanyl, buprenorphine) has been conducted. Although these medicines are not exclusively used in palliative care, it is assumed that for WYUC/Palliative Care Line users they have been prescribed for palliative care. The prescribing standards for the prescribing of strong opioids include a review of whether the prescription fulfills the legal requirements for remote prescribing.

The NHS Direct Research and Clinical Audit Programme of Work 2011/12 includes provision for a clinical audit of Urgent and Emergency Care across all services using the RCGP Urgent and Emergency Care Toolkit.

Outcomes

Although the commissioners indicated satisfaction with the results of the clinical audit related to the prescribing of strong opioids, the WYUC prescribing standards for strong opioids are not being met. However, in palliative care there are usually very good reasons why a prescription are is written outside guidelines – usually because it is in the patient’s best interests.

The prescribing reports indicate that there are still some prescriptions that NHS Direct is issuing for Schedule 2 & 3 controlled drugs that would require the dispensing pharmacist to have the original prescription at the time of dispensing. This means that it would be illegal for the pharmacist to dispense the prescription using the faxed copy. As it takes three days for the original prescription to arrive at the pharmacy, it would be clinically inappropriate for the patient to wait this long for their prescription. Those conducting the audit relating to the prescribing of strong opioids considered that if there was more dialogue with the patient’s GP and with Medacs then more support for prescribing in palliative care could be given. A discussion may then be entered into with WYUC in order to set more appropriate standards.

Work has already commenced on the Urgent and Emergency Care Clinical Audit and will include WYUC by March 2012.

Recommendations

- Discussions to take place with WYUC commissioner medicines management team regarding opioid prescribing in palliative care. Discussions to draw on evidence from the opioid prescribing clinical audit in order to agree guidance for strong opioid prescribing standards and ensure Medacs GPs follow the prescribing guidance.
- Ensure that the Palliative Care Clinical Audit is undertaken in 2012 for completion by March 2013.
- Reports from the Urgent and Emergency Care Clinical Audit to be made available to the commissioners on a quarterly basis from March 2012.

5.6 Benchmarking

Processes and data sources

The clinical content of the decision support software is benchmarked against current national best practice guidance, such as that produced by the National Institute of Clinical Excellence. NHS Direct is a stakeholder within these reviews to ensure that remote clinical assessment is taken into consideration in any guidance produced.

The RCGP Clinical Audit Toolkit recommends that individual clinical practitioners should be benchmarked against each other on their clinical sorting and other performance measures. All front line NHS Direct staff are benchmarked regarding outcome, performance and call length and this is recorded in the Balanced Scorecard. Medacs GPs are ranked based on the number of calls they handle per hour, but otherwise this comparative approach is not used.

An online self-assessment tool has been developed for the National End of Life Care Intelligence Network to help commissioners and providers of end of life care monitor the quality of services (ELCQuA, 2011). This tool is not currently mandatory, although it may be beneficial to the

organisation to carry out the assessment. The tool enables progress to be assessed against a set of core specifications based on the Department of Health's *End of life care strategy: quality markers and measures for end of life care* (DH, 2009). The End of Life Care Quality Assessment Tool helps organisations to:

- Plan and monitor your priorities for end of life care.
- Assess your services in a local and national context.
- Share good practice with other organisations.
- Enable the best investment decisions for patients.
- Gather the information you need to complete CQC and other assessments for use by health and social care organisations providing and commissioning end of life care.

Outcomes

From 2012, the Research and Clinical Audit Team will be reporting on a quarterly basis against the RCGP Urgent and Emergency Care Toolkit in order for the urgent and emergency care services that NHS Direct provides to be benchmarked directly against other urgent and emergency care providers.

Recommendations

- Benchmarking GPs on their clinical sorting and other performance measures recommended by the RCGP should be implemented, as highlighted in the WYUC SQR.
- Review the feasibility of NHS Direct utilising the End of Life Care Quality Assessment Tool.
- Reports from the Urgent and Emergency Care Clinical Audit to be made available to the organisation and commissioners from March 2012.

6. Cost Effectiveness

6.1 Charging

Palliative care calls are not recorded separately in the organisation, apart from in West Yorkshire Urgent Care (WYUC). The majority of the cost effectiveness section of this report will analyse the cost of the palliative care calls handled by the WYUC service, and the income generated from those calls.

NHS Direct takes approximately 5,000 palliative care calls per annum through the WYUC service. These calls are charged back to the commissioners within the "GP OOH Call Handling & Triage" line in the contract. This line consists of Out-of-Hours calls, Palliative Care calls, Healthcare Professional calls, Protected Learning calls and NHSD - Streamed to Clinician calls. The overall rate that is charged back to the commissioners is a blended call charge for all of these types of call. The rate charged fluctuates according to the number of calls the WYUC service takes.

6.2 Costs

Estimated costs of the service are reported through our Service Line Reporting (SLR).

6.3 External savings

Whilst it is very difficult to attribute a financial value to the palliative care calls that NHS Direct answers both through WYUC and its other services, the King's Fund has said: By delivering more care outside the acute setting, and reducing the number of deaths in hospital by a projected 60,000 per year by 2021, the Palliative Care Funding Review estimated that savings of approximately £180 million per year could be made (Hughes-Hallett *et al* 2011).

This research shows that palliative care delivered outside the acute setting is an important and cost effective service that can make a significant impact on the costs for acute hospital trusts.

6.4 Benchmarking

At present there is no benchmarking information available.

6.5 Recommendations

There is currently a lack of reporting on palliative care calls within NHS Direct. If the organisation wants / requires more accurate charging and costing information relating to palliative care calls then this issue needs to be addressed so that palliative care calls are recorded in the systems used by NHS Direct.

7. References

Department of Health (2008), *End of Life Care Strategy - promoting high quality care for all adults at the end of life*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277 [Accessed August 2011]

Department of Health (2009), *End of life care strategy: quality markers and measures for end of life care*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101681 [Accessed 26th October 2011]

Department of Health (2010), *Equity and excellence: Liberating the NHS*. Cm7881. TSO. London.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf [Accessed 9th August 2011]

Department of Health (DH), Lansley, A. (2010a). Health Secretary announces review into palliative care funding. A review announcement.
http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_117330 [Accessed 9th September 2011]

Department of Health, (2011), *End of Life Care Strategy: The Third Annual Report*

Dorothy House Hospice (2011), *End of Life Care Training for NHS Direct Nurse Advisors. Workbook*.
<http://intranet/NewTeamSites/LearningandDevelopment/CAS%20Training%20End%20of>

[%20life/Nurse%20Avisor%20-%20Workbook%20with%20boxes.pdf](#) [Accessed 31st August 2011]

ELCQuA. (2011), *End of Life Care Quality Assessment (ELCQuA) Tool*
<http://www.endoflifecare-intelligence.org.uk/resources/tools/elcqua.aspx> [Accessed 26th October 2011]

Jigsaw Research (2011), *NHS Direct Stakeholder Research 2011*

King's College London (2011), *News: Major palliative care funding review published*
<http://www.kcl.ac.uk/newsevents/news/newsrecords/2011/07July/Major-palliative-care-funding-review-published.aspx> [Accessed 13th September 2011]

Mynors Suppiah (2011), *Service Quality Review for NHS Direct: West Yorkshire Urgent Care*

NHS Direct (2011), *Urgent Contacts Service Quality Review*




NICE (2011), *End of Life Care*
<http://www.nice.org.uk/guidance/qualitystandards/indevelopment/endoflifecare.jsp>
 [Accessed 26th October 2011]



Roberts, D., Tayler, C., MacCormack, D. & Barwich, D. (2007), *Telenursing in hospice palliative care*. Canadian Nurse. 103:5, pp24-7

The National Council for Palliative Care (2011), *Commissioning End of Life Care: Act & Early, initial actions for new commissioners*
http://www.endoflifecareforadults.nhs.uk/assets/downloads/A_E_layouts_art_with_links.pdf [Accessed 26th October 2011]

World Health Organisation (2011), *Definition of Palliative Care*
<http://www.who.int/cancer/palliative/definition/en/> [Accessed 6th September 2011]

8. Appendix 1

Document	File
Palliative Care Terms of Reference	 Palliative Care SQR - Terms of Reference.c
Procedure for the Handling of WYUC Palliative Care Enquiries within NHS Direct V1.3, Dec 2010	 WYUC Palliative Care Enquiries within NHSE
Palliative Care Calls in Contingency	 Palliative Care Calls in Contingency.doc

Handover Form	 Handover form 2011v2 .doc
Not for Resuscitation Form	 DNACPR16years v11 Aug 2010w pdf(11 08