

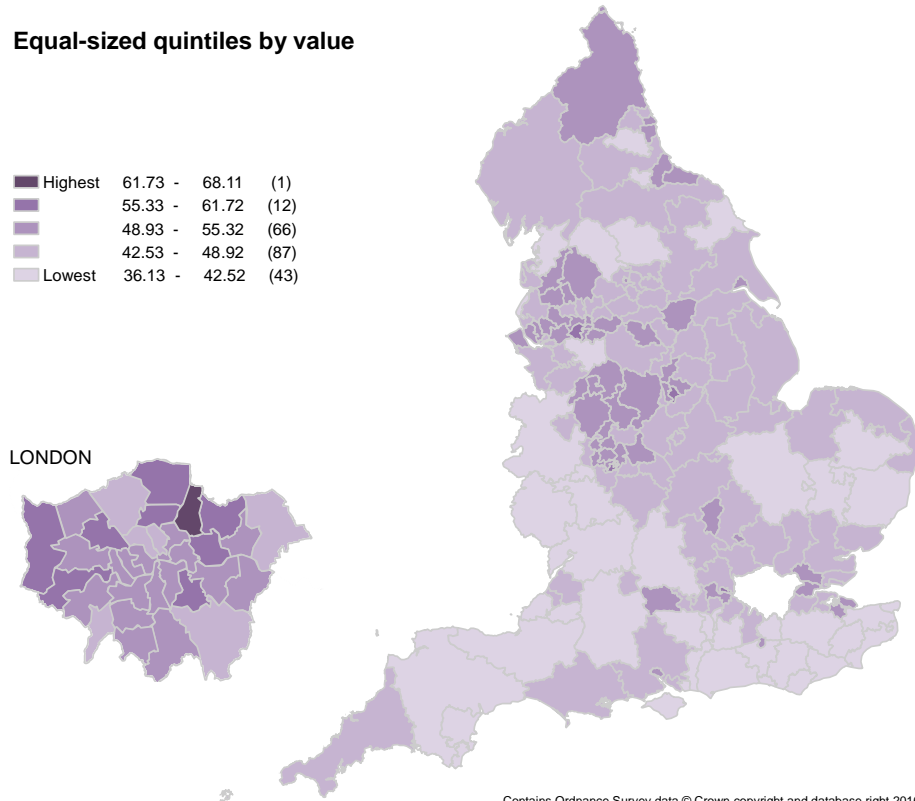
SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

Map 11: Variation in the proportion of all people who died in hospital by CCG (2015)

Equal-sized quintiles by value

■ Highest	61.73 - 68.11	(1)
■	55.33 - 61.72	(12)
■	48.93 - 55.32	(66)
■	42.53 - 48.92	(87)
■ Lowest	36.13 - 42.52	(43)

LONDON

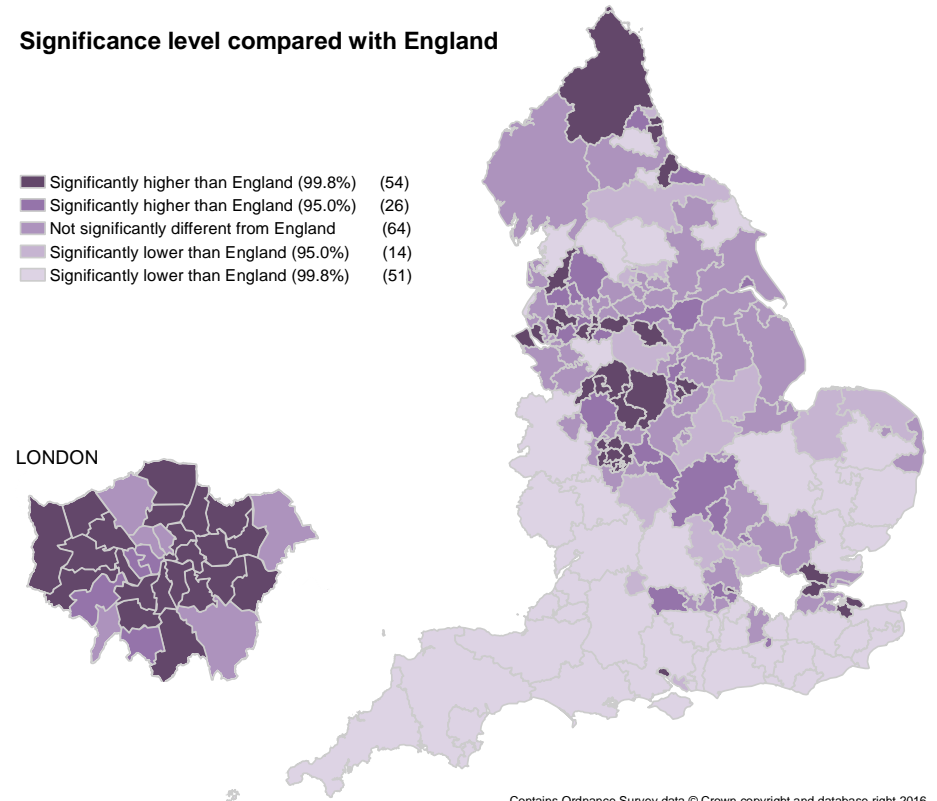


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Significance level compared with England

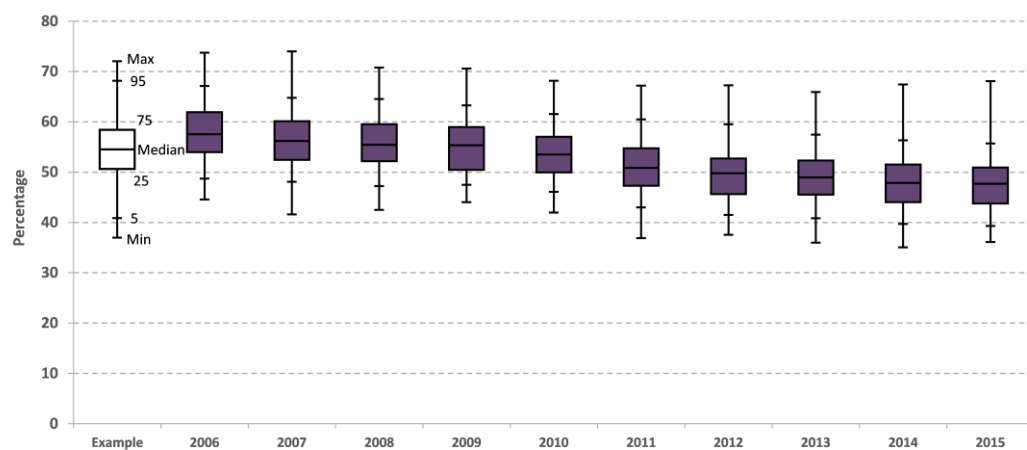
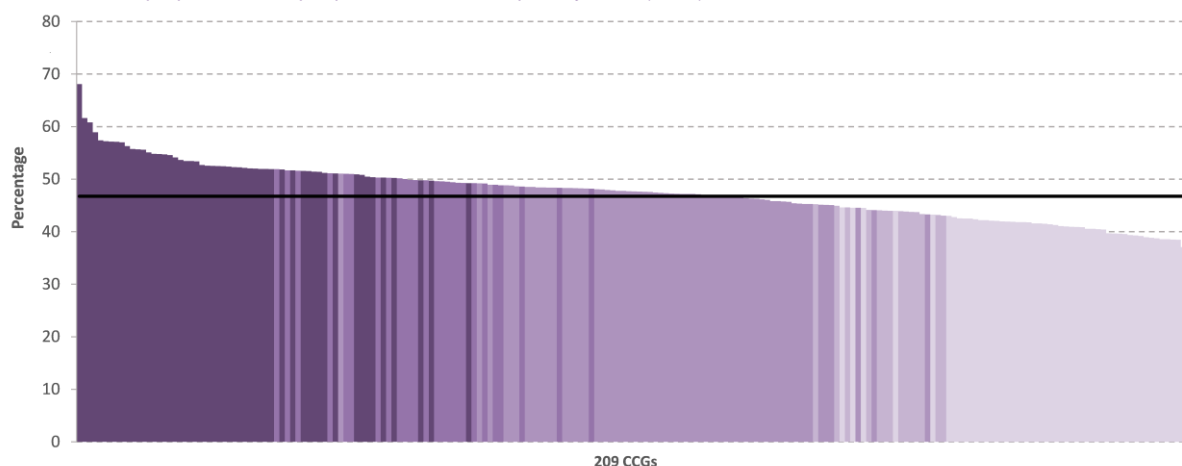
■ Significantly higher than England (99.8%)	(54)
■ Significantly higher than England (95.0%)	(26)
■ Not significantly different from England	(64)
■ Significantly lower than England (95.0%)	(14)
■ Significantly lower than England (99.8%)	(51)

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Variation in the proportion of all people who died in hospital by CCG (2015)



Max - Min (Range)		29.2	32.4	28.3	26.6	26.2	30.3	29.7	30.0	32.4	32.0	No significant change
95th - 5th Percentile		18.4	16.7	17.3	15.8	15.5	17.5	18.0	16.6	16.6	16.4	No significant change
75th - 25th Percentile		8.0	7.7	7.4	8.5	7.1	7.4	7.1	6.8	7.5	7.1	No significant change
Median		57.5	56.2	55.4	55.3	53.5	50.8	49.8	49.0	47.9	47.7	DECREASING Significant

## Introduction

Hospital is the most common place of death. There is an emphasis on the importance of improving the quality of end of life care in all settings<sup>1,2,3</sup>, including hospitals<sup>4</sup>. As described in the introduction, demographic and disease related factors influence the chances of a person dying in hospital, but so also does community end of life care provision.

## Trends and magnitude of variation

On average, just under half (46.7%) of all deaths in England in 2015 occurred in hospital, with a variation of between two thirds (68.1%), and one third (36.1%) of deaths by CCG, a 1.9-fold difference. The median value by CCG decreased significantly from 57.5% in 2006 to 47.7% in 2015, with no significant change in any of the 3 measures of variation.

## Local considerations

Commissioners and providers should review this map and underlying data in combination with data on end of life care in hospitals (maps 11 to 18), cause of death (maps 4 to 9) and demographic data (maps 1 to 3). Local data on general and specialist palliative care provision in hospitals and community settings and wider social care support in their locality should also be explored.

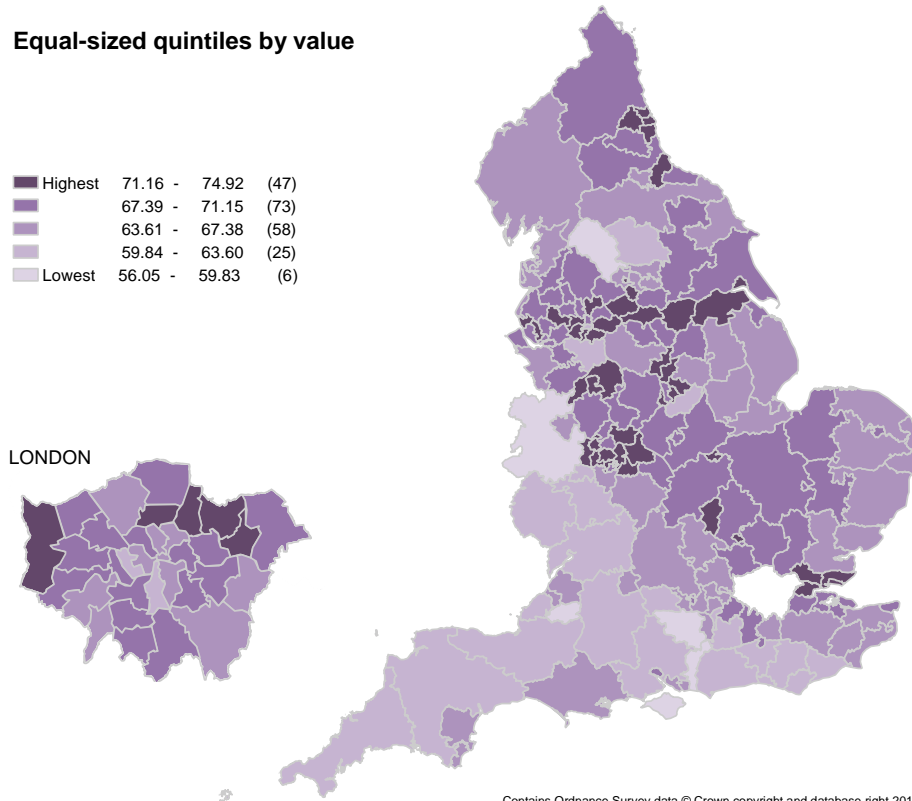
SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

**Map 12:** Variation in the proportion of all people admitted into hospital during the last 90 days of their life by CCG (2015)

**Equal-sized quintiles by value**

■ Highest	71.16 - 74.92	(47)
■	67.39 - 71.15	(73)
■	63.61 - 67.38	(58)
■	59.84 - 63.60	(25)
■ Lowest	56.05 - 59.83	(6)

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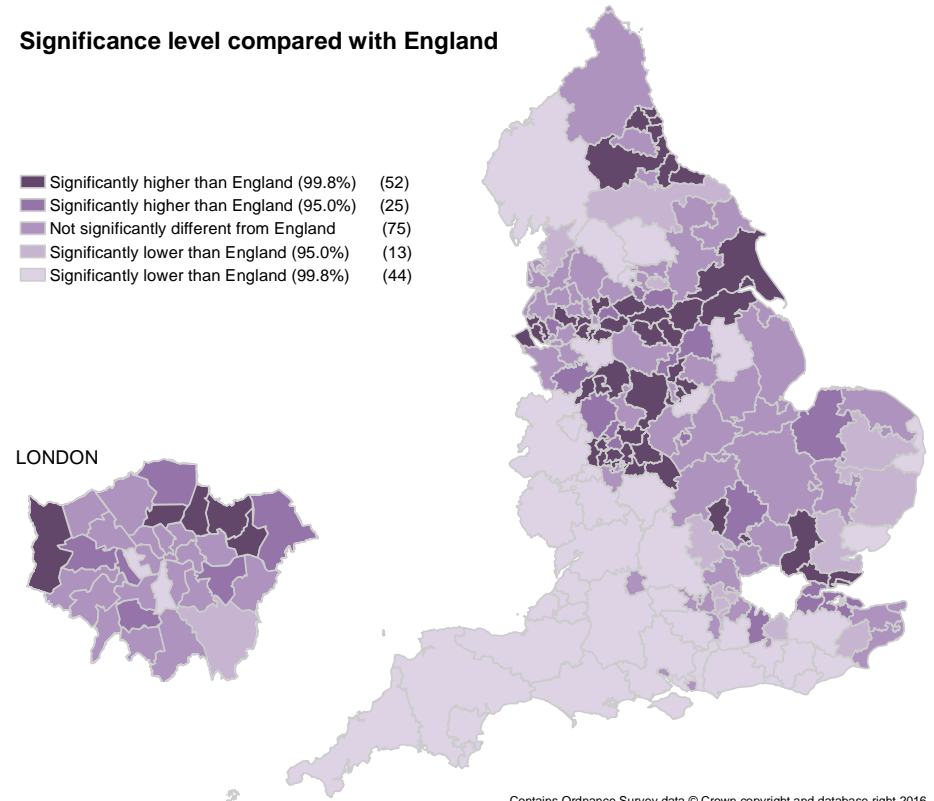


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**Significance level compared with England**

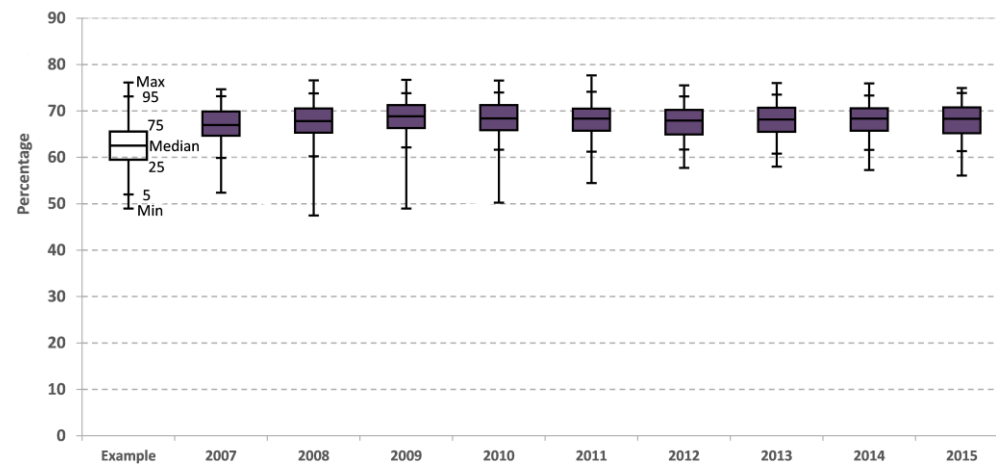
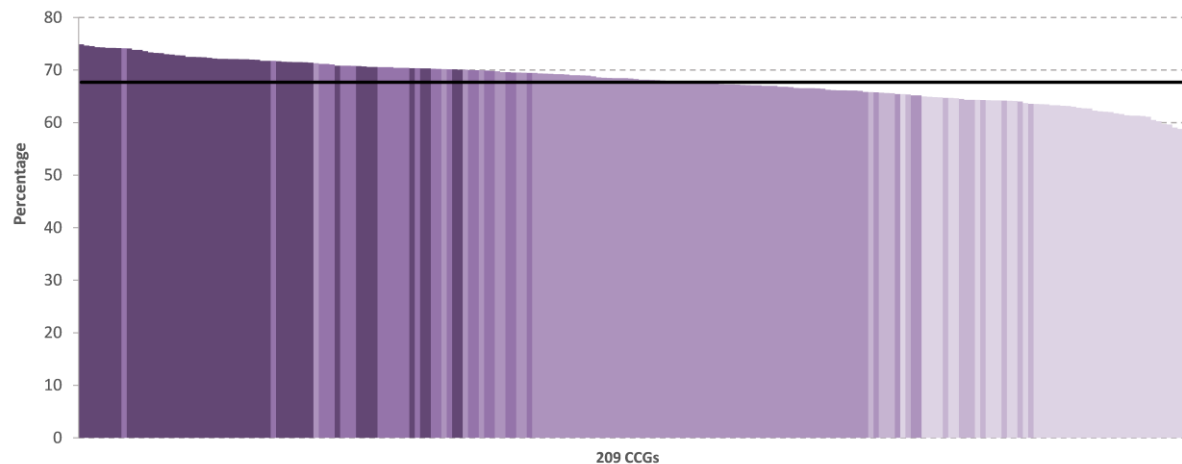
■ Significantly higher than England (99.8%)	(52)
■ Significantly higher than England (95.0%)	(25)
■ Not significantly different from England	(75)
■ Significantly lower than England (95.0%)	(13)
■ Significantly lower than England (99.8%)	(44)

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Variation in the proportion of all people admitted into hospital during the last 90 days of their life by CCG (2015)



Max - Min (Range)		22.3	29.1	27.7	26.3	23.2	17.8	18.0	18.6	18.9	NARROWING Significant
95th - 5th Percentile		13.3	13.6	11.7	12.4	12.9	11.4	12.7	11.7	12.5	No significant change
75th - 25th Percentile		5.2	5.3	5.0	5.4	4.7	5.3	5.2	4.8	5.6	No significant change
Median		67.0	67.8	68.9	68.4	68.4	67.9	68.1	68.4	68.3	No significant change

## Introduction

Approximately two-thirds (67.7%) of all those who died in England in 2015 had a hospital admission during the last 3 months of their lives. Many could have been admitted with life-threatening conditions. Some may be clearly entering the end of life. This highlights the importance of improving the quality of care in hospitals, in addition to improving community provision<sup>1 2</sup>. The importance of careful hospital discharge planning for end of life care is set out in NICE guideline NG27<sup>3</sup>. These recommend offering palliative care services according to needs, consideration of referral to a palliative care team, and ensuring that end of life care is assessed and communicated with the patient's GP.

## Trends and magnitude of variation

Just over two-thirds (67.7%) of all those who died in England in 2015 had been admitted into hospital in the last 90 days of their life, with a variation of between three quarters (74.9%), and just over half (56.1%) by CCG, a 1.3-fold difference. There was no significant change in the median for CCGs which in 2015 was 68.3% but the variation in the maximum to minimum range narrowed significantly between 2007 and 2015.

## Local considerations

Commissioners and providers should review this map and underlying data in combination with maps looking at end of life care in hospitals (11 to 18), cause of death (maps 4 to 9) and demographic data (maps 1 to 3). Local data on general and specialist palliative care provision in hospitals and community settings and wider social care support should also be explored.

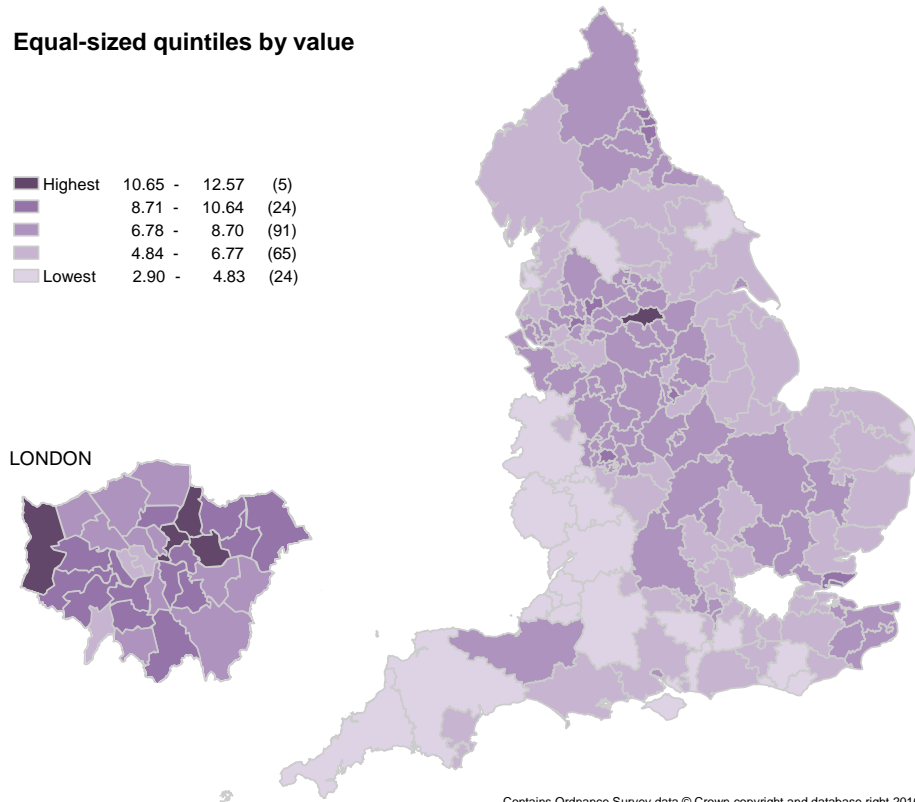
SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

**Map 13:** Variation in the proportion of people who have 3 or more emergency hospital admissions during the last 90 days of life by CCG (2015)

**Equal-sized quintiles by value**

■ Highest	10.65 - 12.57	(5)
■	8.71 - 10.64	(24)
■	6.78 - 8.70	(91)
■	4.84 - 6.77	(65)
■ Lowest	2.90 - 4.83	(24)

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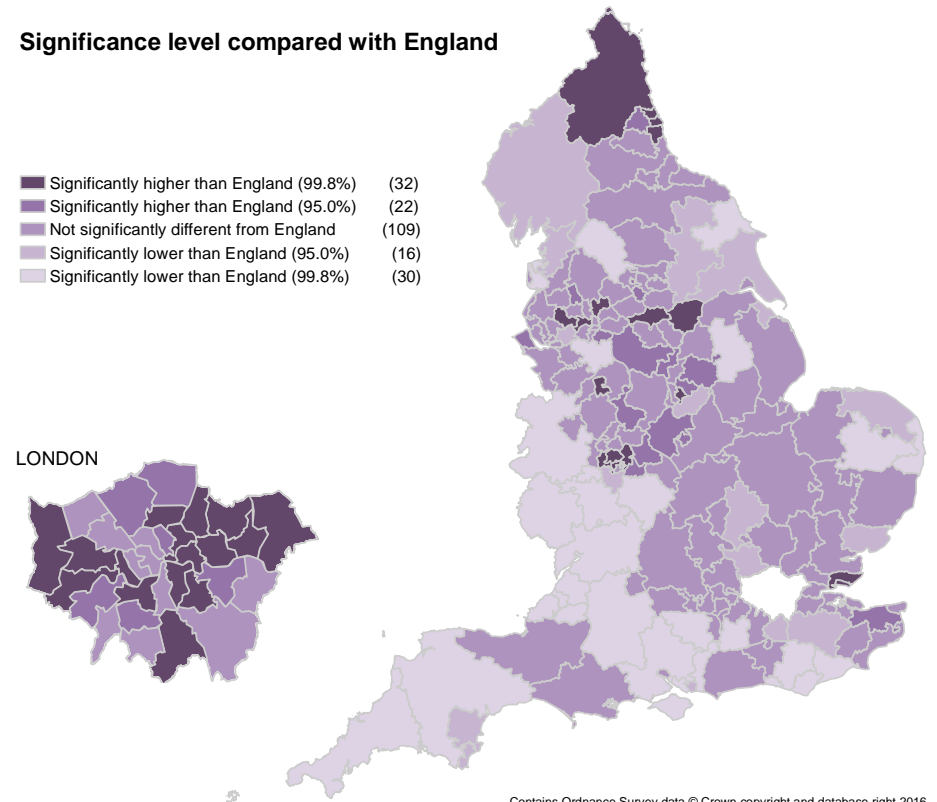


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**Significance level compared with England**

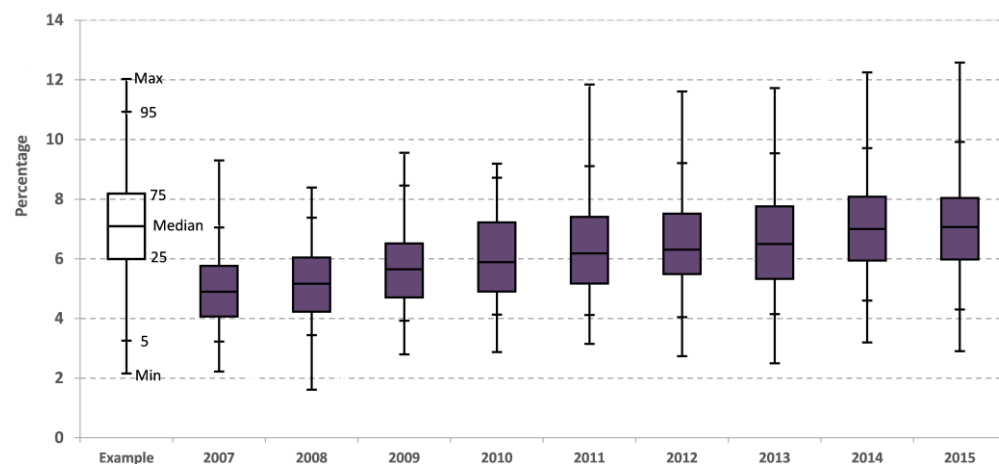
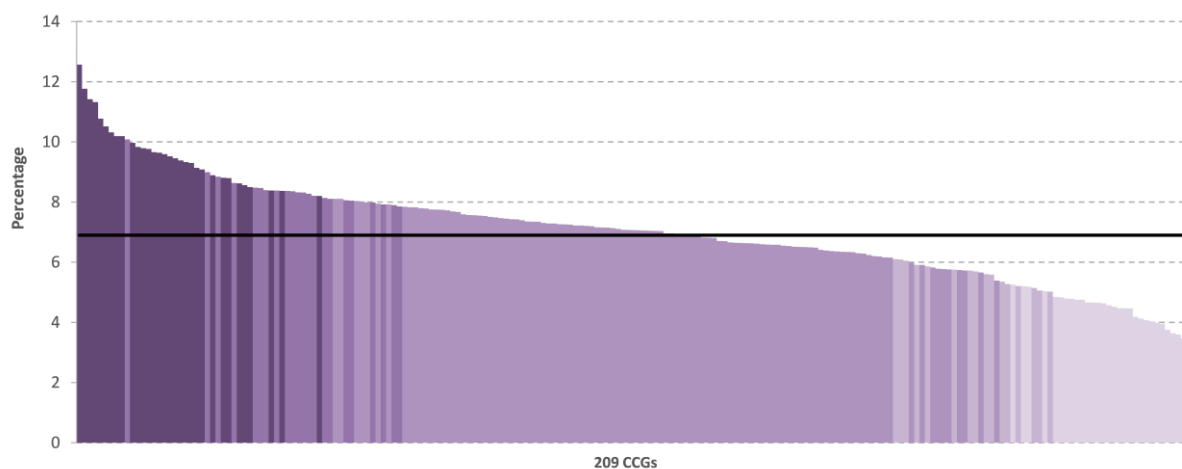
■ Significantly higher than England (99.8%)	(32)
■ Significantly higher than England (95.0%)	(22)
■ Not significantly different from England	(109)
■ Significantly lower than England (95.0%)	(16)
■ Significantly lower than England (99.8%)	(30)

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Variation in the proportion of people who have 3 or more emergency hospital admissions during the last 90 days of life by CCG (2015)



Max - Min (Range)		7.1	6.8	6.8	6.3	8.7	8.9	9.2	9.1	9.7	WIDENING Significant
95th - 5th Percentile		3.8	3.9	4.5	4.6	5.0	5.2	5.4	5.1	5.6	WIDENING Significant
75th - 25th Percentile		1.7	1.8	1.8	2.3	2.2	2.0	2.4	2.1	2.1	No significant change
Median		4.9	5.2	5.6	5.9	6.2	6.3	6.5	7.0	7.1	INCREASING Significant

## Introduction

The End of life care strategy recognised that people who are approaching the end of life need access to care and support 24/7, and that when community services are unable to respond to these needs, patients may be admitted to hospital as an emergency<sup>1</sup>. Emergency hospital admissions can be disruptive and distressing for patients and their carers<sup>2</sup>. Advance care planning and access to palliative care can reduce hospital admissions<sup>3,4</sup>. NICE guideline [NG94] recommends offering advance care planning to people in the community and in hospital who are approaching the end of life and are at risk of a medical emergency<sup>5</sup>. In addition local community services should be configured so that they can be responsive to patient's urgent end of life care needs.

## Trends and magnitude of variation

On average, 1 in 14 (6.9%) of all those who died in England in 2015 had 3 or more emergency hospital admissions during the last 90 days of life, with a variation from 1 in 8 (12.6%) to 1 in 34 (2.9%) by CCG, a 4.3-fold difference. The CCG median increased significantly from 4.9% in 2007 to 7.1% in 2015, and both the maximum to minimum range and 95<sup>th</sup> to 5<sup>th</sup> percentile range widened significantly. This increasing trend is of great concern because of the distress this can cause to patients and families.

## Local considerations

Commissioners and providers should review this map and underlying data in combination with hospital maps (11 to 18), local data on general and palliative care provision in hospitals and community settings, social care data and local initiatives to avoid unnecessary hospital admissions at end of life.

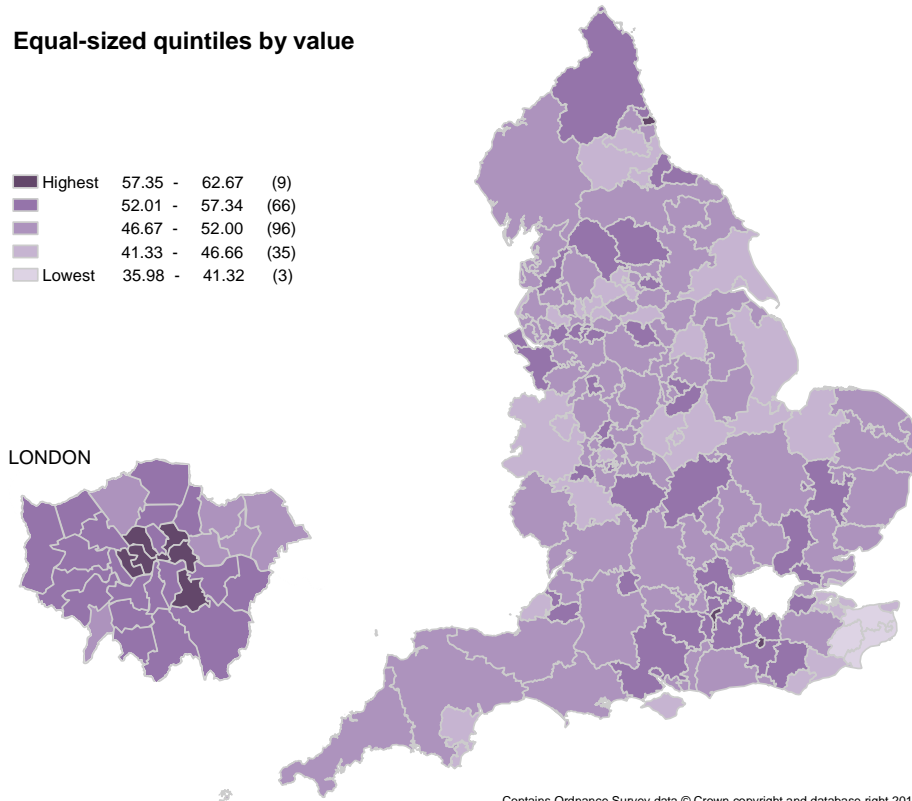
SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

**Map 14:** Variation in the proportion of hospital admissions ending in death in hospital which are 8 days or longer by CCG (2015)

**Equal-sized quintiles by value**

■ Highest	57.35 - 62.67	(9)
■	52.01 - 57.34	(66)
■	46.67 - 52.00	(96)
■	41.33 - 46.66	(35)
■ Lowest	35.98 - 41.32	(3)

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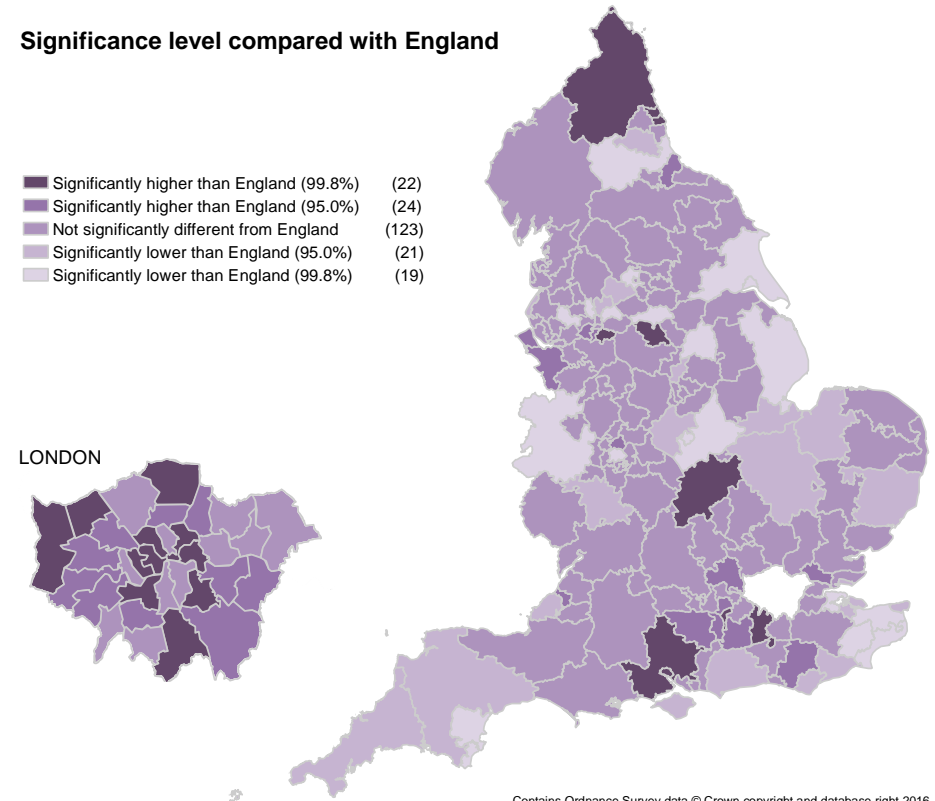


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**Significance level compared with England**

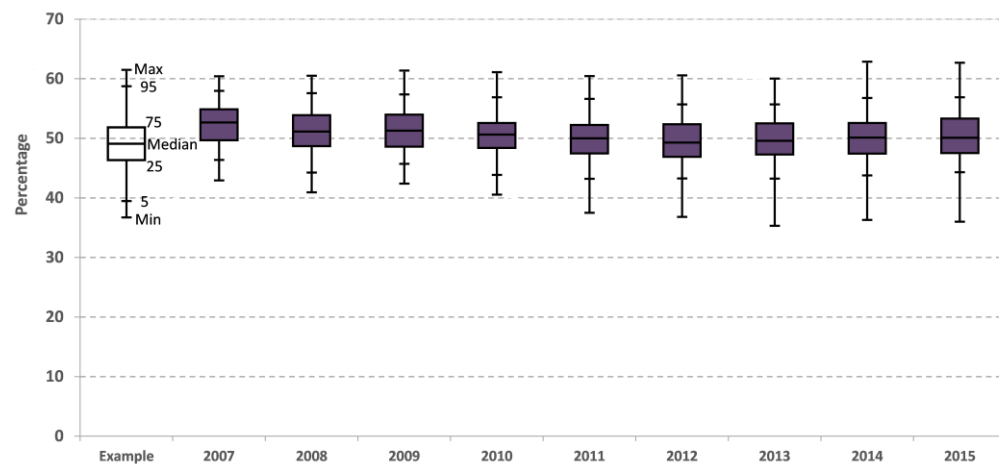
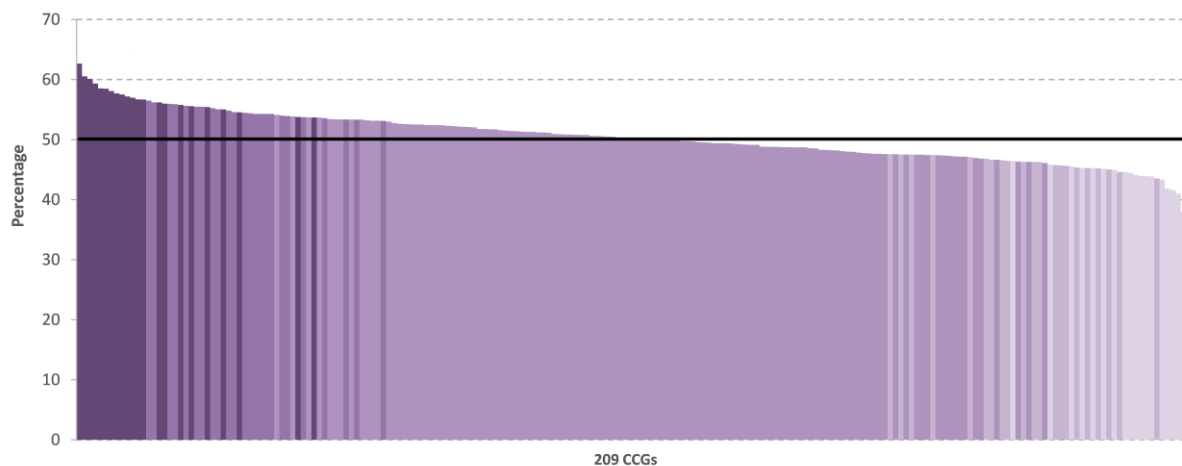
■ Significantly higher than England (99.8%)	(22)
■ Significantly higher than England (95.0%)	(24)
■ Not significantly different from England	(123)
■ Significantly lower than England (95.0%)	(21)
■ Significantly lower than England (99.8%)	(19)

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Variation in the proportion of hospital admissions ending in death in hospital which are 8 days or longer by CCG (2015)



Max - Min (Range)		17.5	19.6	19.0	20.6	22.9	23.7	24.7	26.6	26.7	WIDENING Significant
95th - 5th Percentile		11.6	13.3	11.6	13.0	13.4	12.4	12.5	13.0	12.6	No significant change
75th - 25th Percentile		5.2	5.2	5.4	4.2	4.8	5.5	5.2	5.1	5.8	No significant change
Median		52.7	51.1	51.3	50.6	50.0	49.3	49.6	50.1	50.1	DECREASING Significant

## Introduction

A large proportion of hospital admissions ending in death which are 8 days or longer could indicate that co-ordinated care plans is not in place. There is evidence from a national survey of the bereaved that there is significant room for improvement in the co-ordination of care between hospital, GP and community services<sup>1</sup>. NICE guideline [NG27]<sup>2</sup> outlines the importance of careful hospital discharge planning for palliative and end of life care.

## Trends and magnitude of variation

The map and column chart display the latest period (2015), during which CCG values ranged from 36.0% to 62.7%, which is a 1.7-fold difference between CCGs. The England value for 2015 was 50.1%.

The box plot shows the distribution of CCG values for the period 2007 to 2015 calendar years. The maximum to minimum range widened significantly. The CCG median decreased significantly from 52.7% in 2007 to 50.1% in 2015.

## Local considerations

Commissioners and providers should review this map and underlying data in combination with hospital maps (11 to 18), demographic data (maps 1 to 3) and cause of death (maps 4 to 9). They should also explore local data on palliative care provision in hospitals and community settings in combination with local social care provision and data on delayed transfers of care<sup>3</sup>.



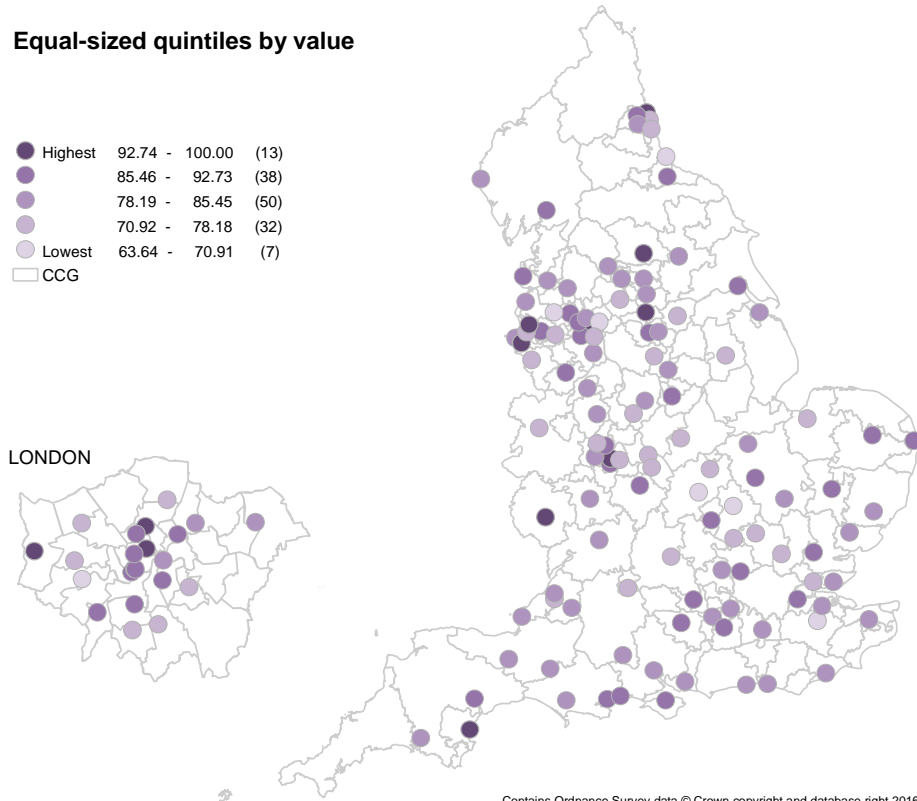
SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

**Map 15:** Variation in proportion of all people who died in hospital that had documented evidence of recognition that they would probably die in the coming hours or days by acute hospital trust site (2015)

**Equal-sized quintiles by value**

- Highest 92.74 - 100.00 (13)
- 85.46 - 92.73 (38)
- 78.19 - 85.45 (50)
- 70.92 - 78.18 (32)
- Lowest 63.64 - 70.91 (7)
- CCG

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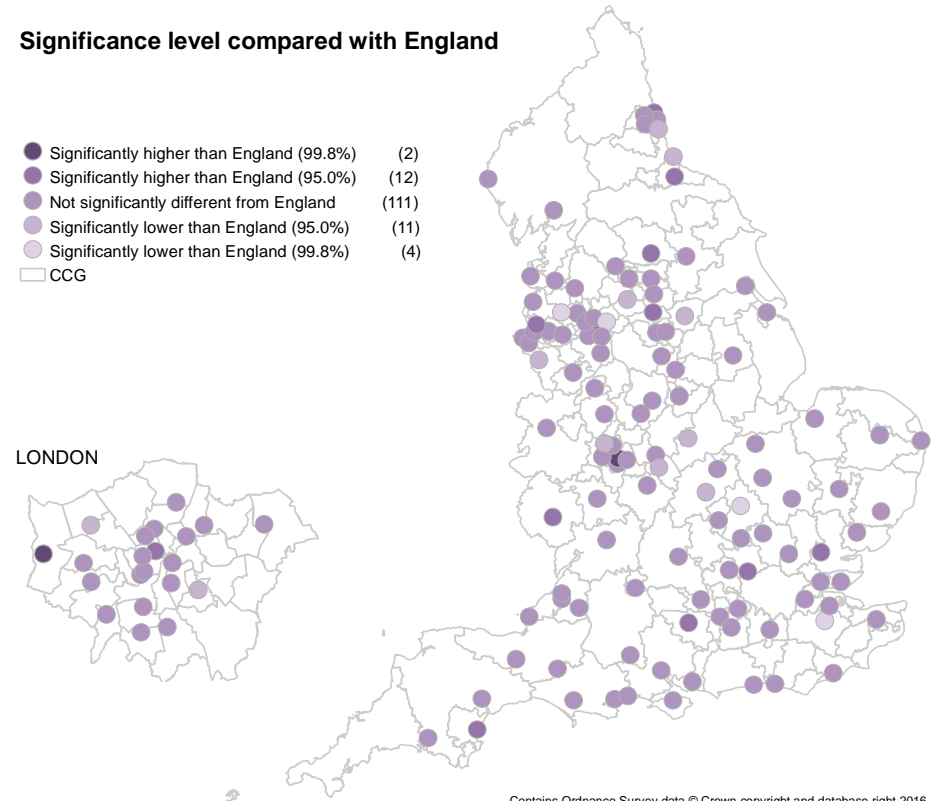


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**Significance level compared with England**

- Significantly higher than England (99.8%) (2)
- Significantly higher than England (95.0%) (12)
- Not significantly different from England (111)
- Significantly lower than England (95.0%) (11)
- Significantly lower than England (99.8%) (4)
- CCG

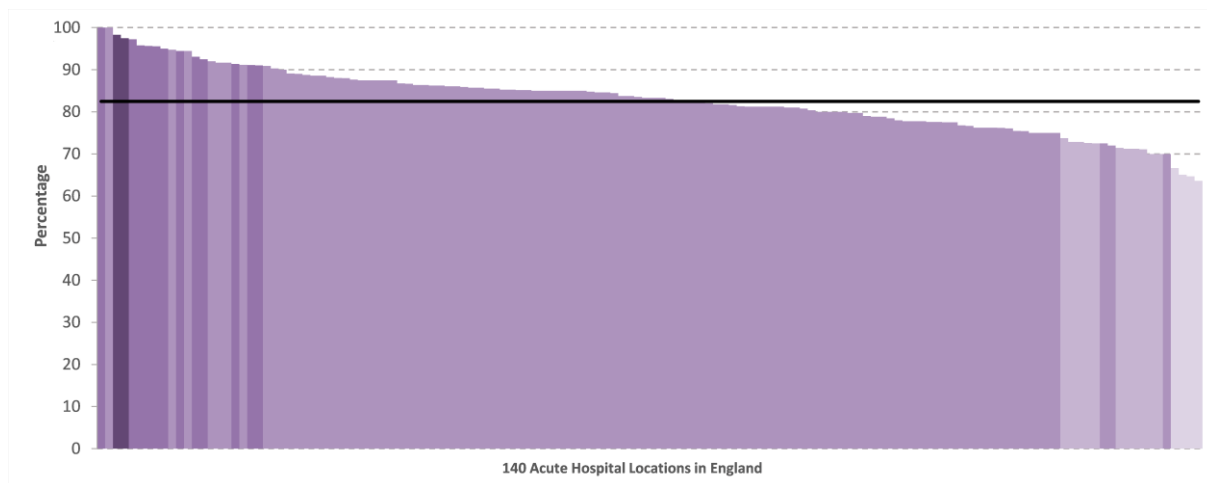
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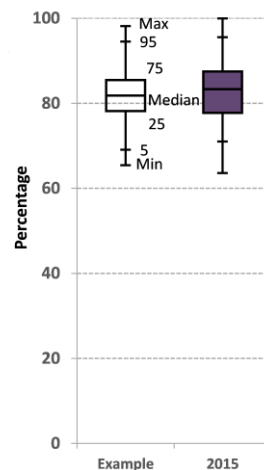
n = 140 acute hospital sites in England. Please refer to the metadata guide for further details.

Variation in proportion of all people who died in hospital that had documented evidence of recognition that they would probably die in the coming hours or days by acute hospital trust site (2015)



## Introduction

The 1<sup>st</sup> of the 5 priorities of care for the dying person as set out in 'One Chance to Get it Right'<sup>1</sup> is that 'the possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's need and wishes, and these are regularly reviewed and decisions revised accordingly'. NICE guideline [NG31] provides guidance on recognising when a person may be in the last days of life<sup>2</sup>. NICE quality standard [QS144] defines how documented evidence of the recognition that a patient was in the last days of life should be measured<sup>3</sup>. The Royal College of Physicians (RCP) End of life care audit – dying in hospital<sup>4</sup> collected data on this measure from hospital sites across England.



Max - Min (Range)		36.4
95th - 5th Percentile		24.5
75th - 25th Percentile		9.8
Median		83.3

## Magnitude of variation

The map and column chart display the latest period (2015), during which hospital values ranged from 63.6% to 100.0%, which is a 1.6-fold difference between acute hospital sites. The England value for 2015 was 82.5% while the median value by acute hospital site was 83.3%.

## Local considerations

Local commissioners and providers should review this map alongside the other audit maps (16,17 and 18), the RCP End of life care audit – dying in hospital national report<sup>4</sup>, and data on local arrangements and systems to enhance the recognition of adults entering the last days of life so that timely conversations and individualised care planning takes place.

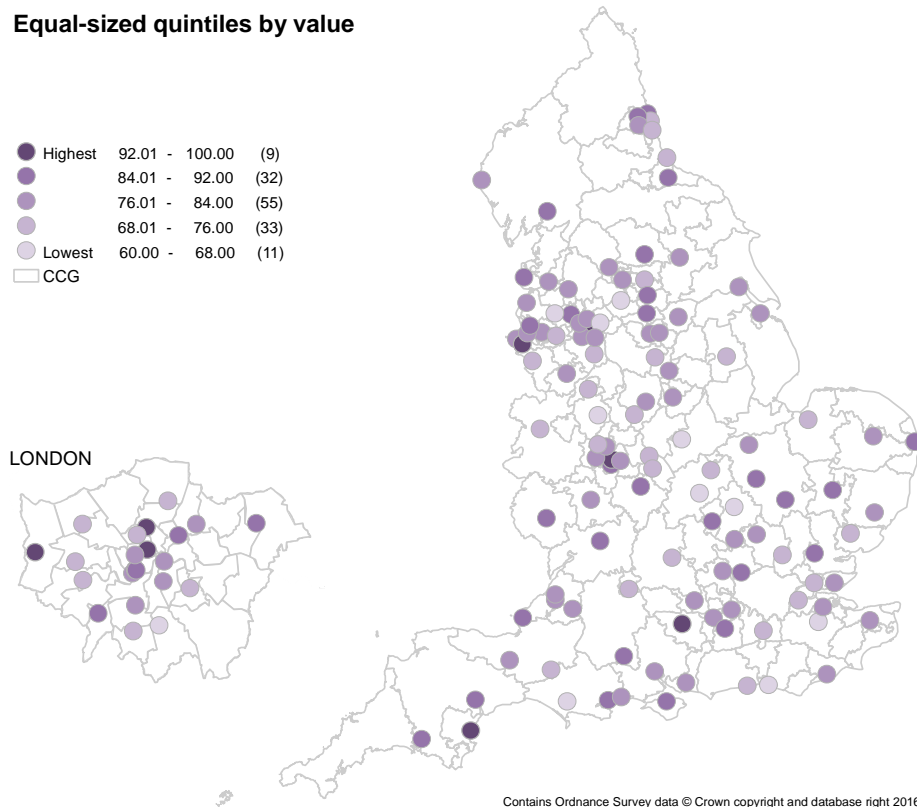
SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

**Map 16:** Variation in the proportion of all people who had documented evidence that a health professional had recognised during the last episode of care the person was dying and had discussed this with a nominated person(s) important to the dying person by acute hospital trust site (2015)

Equal-sized quintiles by value

- Highest 92.01 - 100.00 (9)
- 84.01 - 92.00 (32)
- 76.01 - 84.00 (55)
- 68.01 - 76.00 (33)
- Lowest 60.00 - 68.00 (11)
- CCG

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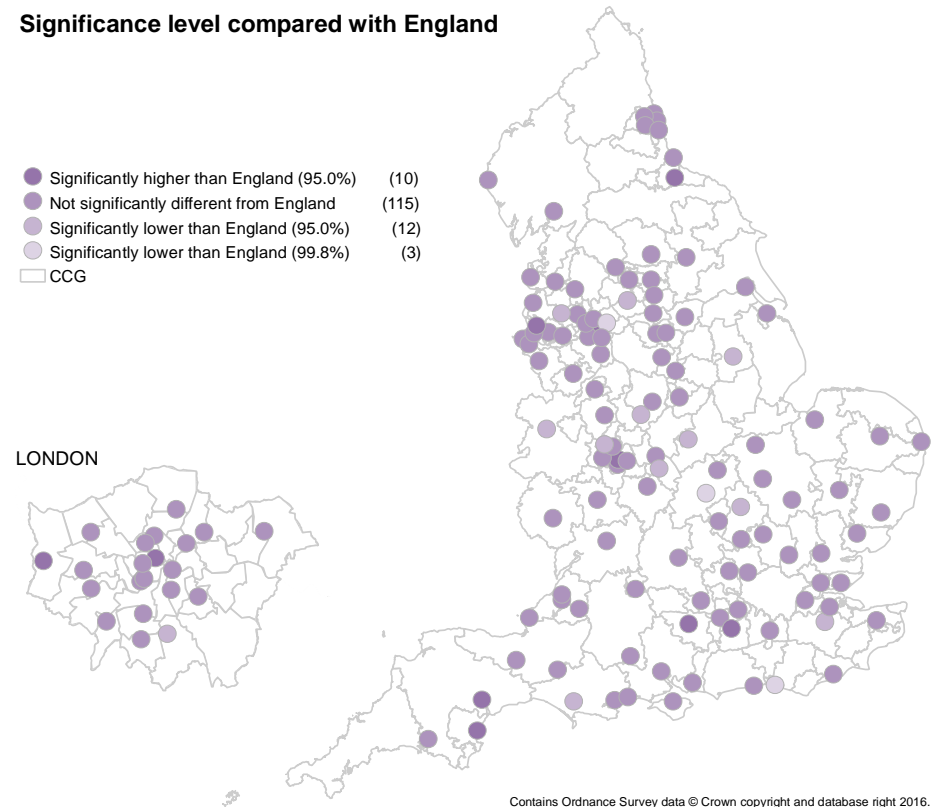


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Significance level compared with England

- Significantly higher than England (95.0%) (10)
- Not significantly different from England (115)
- Significantly lower than England (95.0%) (12)
- Significantly lower than England (99.8%) (3)
- CCG

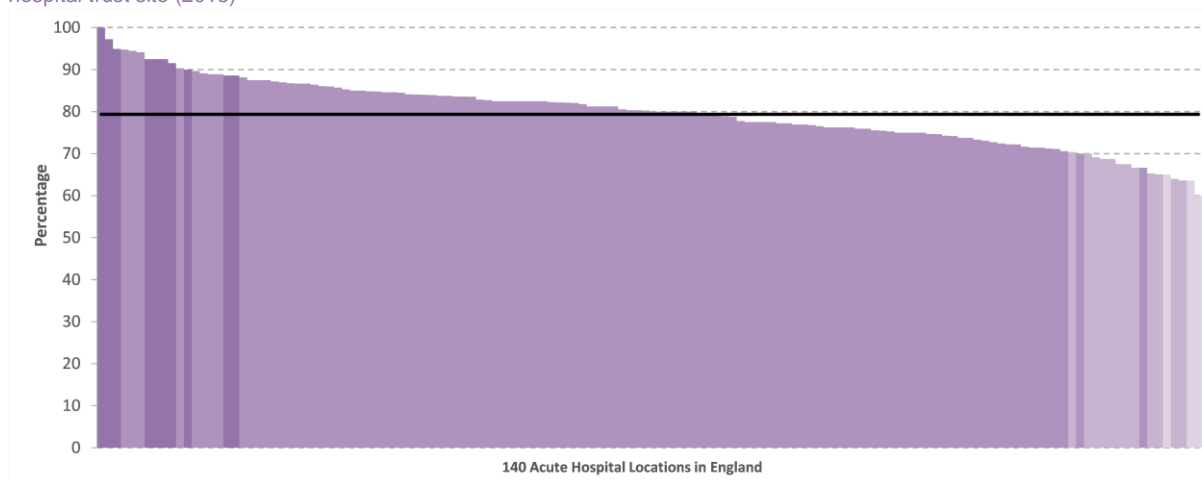
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n = 140 acute hospital sites in England. Please refer to the metadata guide for further details.

Variation in the proportion of all people who had documented evidence that a health professional had recognised during the last episode of care the person was dying and had discussed this with a nominated person(s) important to the dying person by acute hospital trust site (2015)



## Introduction

The 2nd of the 5 priorities of care for the dying person in 'One Chance to Get it Right'<sup>1</sup> is that 'sensitive communication takes place between staff and the dying person, and those identified as important to them'. NICE guideline [NG31] provides guidance on establishing and responding to the communication needs of dying patients and those important to them<sup>2</sup>. This indicator reports on data from acute hospital sites collected by the Royal College of Physicians (RCP) End of life care audit – dying in hospital<sup>3</sup>.

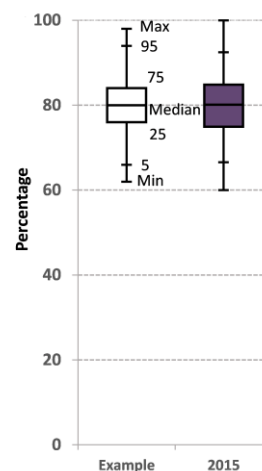
## Magnitude of variation

In 2015 for 79.4% of patients audited (and a median by acute hospital sites of 80.1%) there was documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had

been discussed with a nominated person(s) important to the patient. The variation between acute hospital sites was 60.0% to 100.0%, which is a 1.7-fold difference. Analysis presented in the full audit report showed that when sudden/unexpected deaths were excluded, and analysis was restricted to those where there was recognition that the patient was imminently dying, the proportion of patients with documented evidence increased (95%)<sup>3</sup>.

## Local considerations

Local commissioners and providers should review this map alongside the other audit maps (15,17 and 18), the RCP End of life care audit – dying in hospital national report<sup>3</sup>, and data on local arrangements and systems to ensure appropriate communication about recognition that a patient is thought to be imminently dying. Training on 'breaking bad news' is key to improving the quality and frequency of communication about dying.



Max - Min (Range)		40.0
95th - 5th Percentile		25.9
75th - 25th Percentile		9.9
Median		80.1

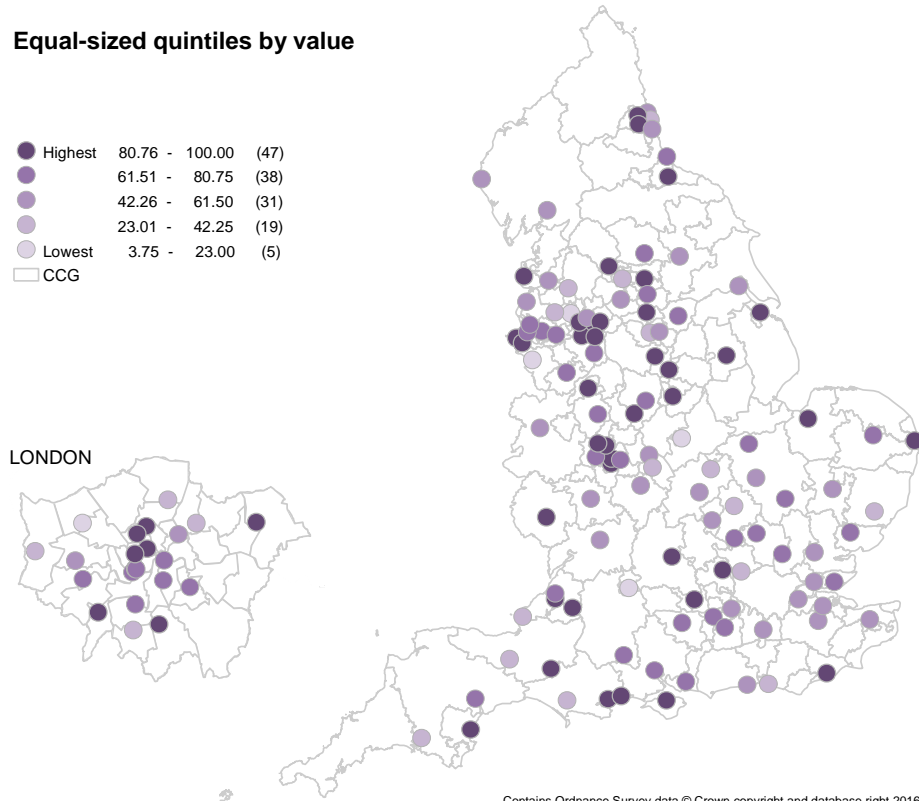
SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

**Map 17:** Variation in proportion of all people who died in hospital that had documented evidence in the last 24 hours of a holistic assessment of their needs regarding an individual plan of care by acute hospital trust site (2015)

Equal-sized quintiles by value

- Highest 80.76 - 100.00 (47)
- 61.51 - 80.75 (38)
- 42.26 - 61.50 (31)
- 23.01 - 42.25 (19)
- Lowest 3.75 - 23.00 (5)
- CCG

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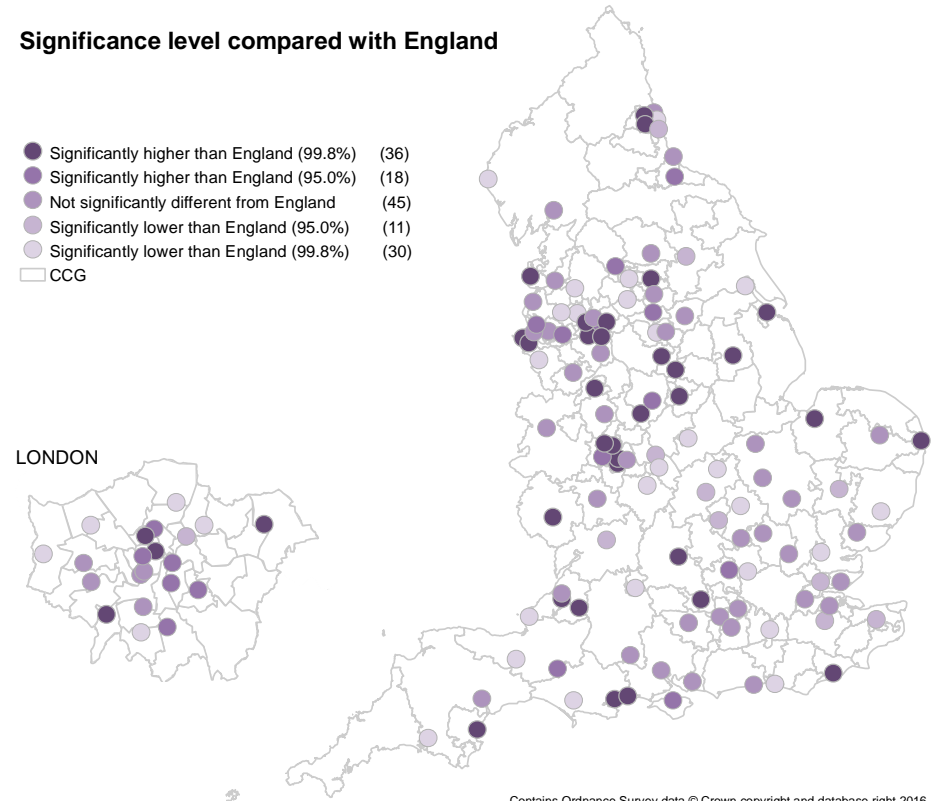


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Significance level compared with England

- Significantly higher than England (99.8%) (36)
- Significantly higher than England (95.0%) (18)
- Not significantly different from England (45)
- Significantly lower than England (95.0%) (11)
- Significantly lower than England (99.8%) (30)
- CCG

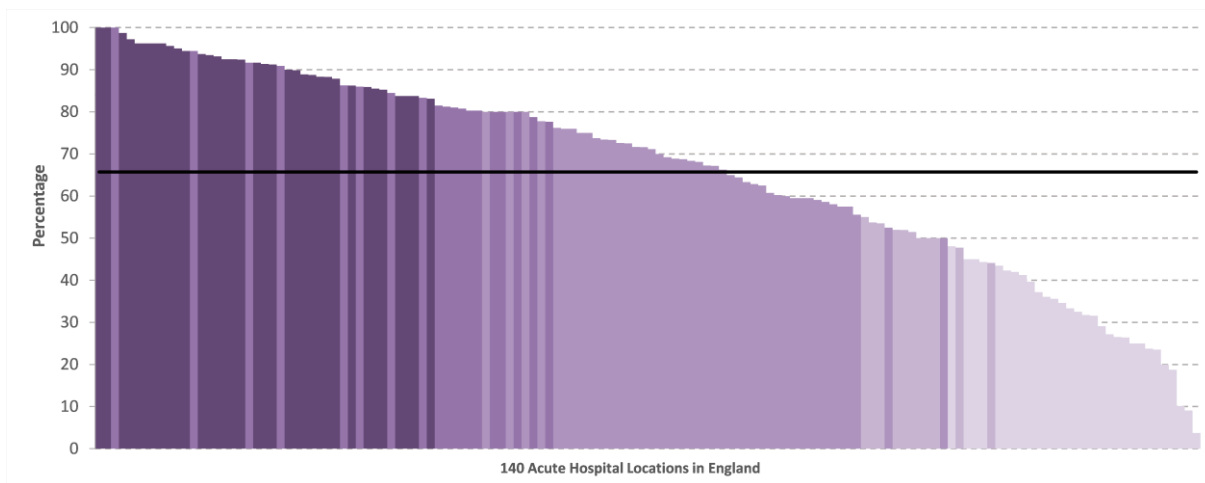
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n = 140 acute hospital sites in England. Please refer to the metadata guide for further details.

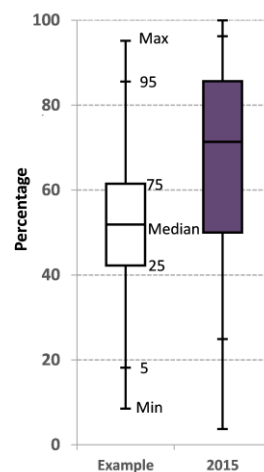
Variation in proportion of all people who died in hospital that had documented evidence in the last 24 hours of a holistic assessment of their needs regarding an individual plan of care by acute hospital trust site (2015)



## Introduction

The 5<sup>th</sup> of the 5 priorities of care for the dying person in ‘One Chance to Get it Right’<sup>1</sup> is that ‘an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion’. NICE guideline [NG31] provides guidance on how to develop an individualised care plan for a dying patient<sup>2</sup>. NICE quality standard [QS144] defines how to measure whether adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan<sup>2</sup>.

This indicator reports on data collected from acute hospital sites across England by the Royal College of Physicians (RCP) End of life care audit – dying in hospital<sup>3</sup>.



Max - Min (Range)		96.3
95th - 5th Percentile		71.3
75th - 25th Percentile		35.6
Median		71.4

Of the key symptoms that are often present in the last hours or days of life, the audit found documented evidence that pain was controlled in 79%, agitation/delirium in 72%, breathing difficulties in 68%, noisy breathing/death rattle in 62% and nausea/vomiting in 55%<sup>3</sup>.

## Magnitude of variation

In 2015, 65.7% of patients audited in acute hospital sites in England (and a median by acute hospital site of 71.4%) had documented evidence in the last 24 hours of a holistic assessment of their needs regarding an individual plan of care. The variation between acute hospitals was 3.8% to 100.0%, which is a 26.7-fold difference. Data presented in the full audit report shows that when sudden/unexpected deaths were excluded, and analysis was restricted to those with a length of stay of 24 hours or more, the result increased to 73% of patients<sup>3</sup>.

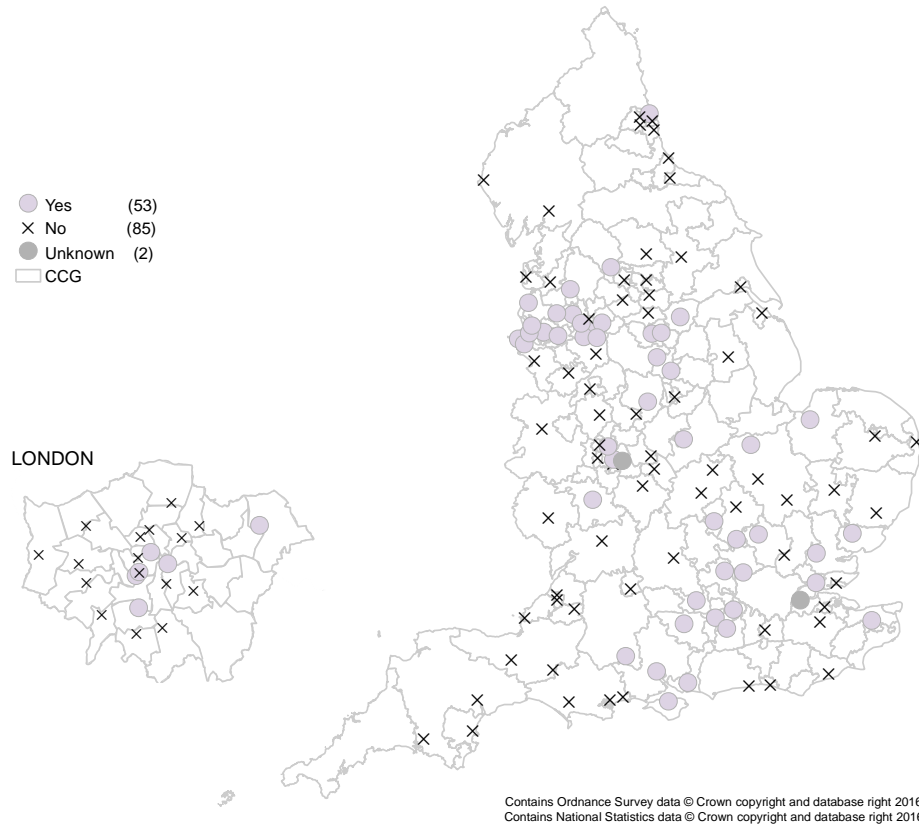
## Local considerations

Local commissioners and providers should review this map alongside other audit maps (15, 16 and 18), the RCP End of life care audit – dying in hospital national report<sup>3</sup>. They should also consider data on local arrangements and systems to ensure that adults in the last days of life have a holistic assessment of their needs and individualised care plans. Opportunities should also be offered to discuss, develop and review these plans.

## SECTION 2: THE ROLE OF HOSPITALS IN PALLIATIVE AND END OF LIFE CARE

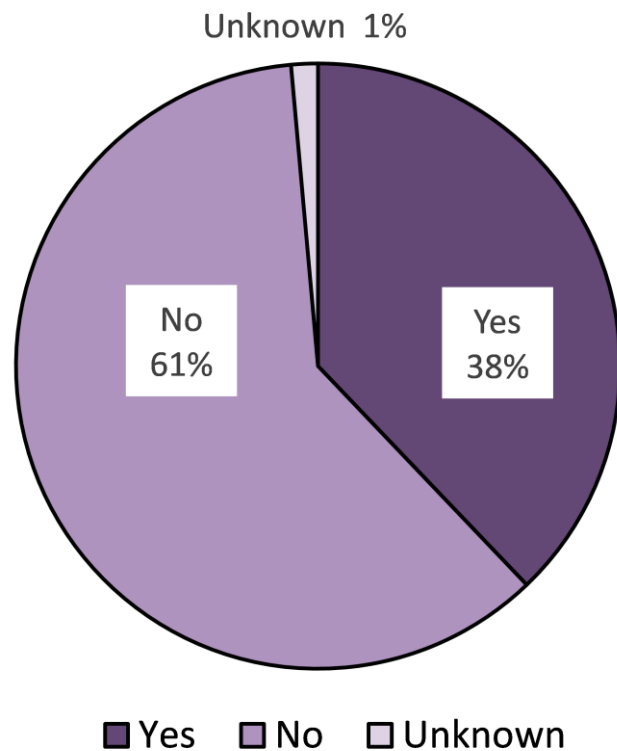
## Map 18: Variation in provision of face-to-face access to specialist palliative care at least 9am to 5pm, Monday to Sunday by acute hospital trust site (2015)

### Presence of provision



n =140 acute hospital sites in England. Please refer to the metadata guide for further details.

Variation in provision of face-to-face access to specialist palliative care at least 9am to 5pm, Monday to Sunday by acute hospital trust site (2015)



## Introduction

The 5<sup>th</sup> of the 5 priorities of care for the dying person in 'One Chance to Get it Right'<sup>1</sup> set out the requirement for an individual care plan (map 17). The accompanying implementation guidance for service providers and commissioners states that 'there must be prompt referral to, and input from, specialist palliative care for any patient and situation that requires this' and that 'service providers and commissioners are expected to ensure provision for specialist palliative medical and nursing cover routinely 9am to 5pm 7 days a week and a 24 hour telephone advice service'.

This map reports on data from acute hospital sites across England collected by the Royal College of Physicians (RCP) End of life care audit – dying in hospital<sup>2</sup>. The map and pie chart describes the analysis of this audit data.

## Magnitude of variation

The RCP End of life care audit – dying in hospital, conducted in 2015 asked providers - 'Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?'. Of the 140 acute hospital sites included in our analysis, 38% replied yes, 61% replied no and 1% did not reply.

The full audit report provides more data on specialist palliative care telephone advice provided by hospitals. 11% of trusts offered a 24/7 service, 39% offered only a Monday to Friday, 9am to 5pm service, and 49% offered a service covering more than Monday to Friday 9am to 5pm but less than 24/7<sup>2</sup>.

## Local considerations

Local commissioners and providers should review this map alongside the other audit maps (15, 16, 17), the RCP End of life care – dying in hospital national report<sup>2</sup>. They should also look at data on local arrangements and systems to ensure access to specialist palliative medical and nursing cover - 9am - 5pm 7 days a week and a 24 hour telephone advice service. Additional guidance is provided in 'Specialist Level Palliative Care: Information for commissioners'<sup>3</sup>.