

**National Implementation Advisory Group for the Strategic Framework for Action on Palliative and End of Life Care
Tuesday 25 April 2017**

**Paper for Discussion
Data Subgroup – Proposed Work**

Item status:

For information

For discussion

For decision

Key issues:	Commitment 9 - Support improvements in the collection, analysis, interpretation and dissemination of data and evidence relating to needs, provision, activity, indicators and outcomes in respect of palliative and end of life care.
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Action/Outcome Required:	<p>This paper sets out a suggested way forward for the Data Subgroup to take forward the commitment set out in the SFA.</p> <p>We ask the group to:</p> <ul style="list-style-type: none"> • Listen to the accompanying presentation. • Discuss and agree in this is a helpful manner in which to proceed with the data work. <p>Following the meeting the document will be circulated again to the group for any further comments/ suggestions.</p>
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Handling at meeting:	Paper for information and discussion.
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Relevant Background:	Strategic Framework for Action on Palliative and End of Life Care (SFA) (http://www.gov.scot/Publications/2015/12/4053)
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**Data outputs and recommended priorities for 2017/18
Palliative and End of Life Care**

**For submission to the National Implementation and
Advisory Group (NIAG)**

March 2017

Table of Contents

1. Introduction.....	1
2. Developing routine analytical outputs	2
2.1. Location of death.....	2
2.2. Rank days before death for hospice referrals	2
2.3. Develop last six months of life information	2
2.4. Trajectory of activity/resource use over last 12 months of life	3
2.5. End of life classification matrix and journeys	3
3. Addressing data gaps.....	4
3.1. Routine access to Anticipatory Care Plans (ACPs)	4
3.2. Key Information Summary (KIS)	4
3.3. Inpatient hospice data.....	5
3.4. Hospice at Home data.....	5
3.5. Third sector community care.....	5
3.6. Quality of care.....	6
3.7. Hospital and community based palliative care nursing.....	6
4. Priorities for 2017/18	8
Appendix A1 – Location of Death Example Output.....	15
Appendix A2 – Rank Days Before Death for Hospice Referrals Example Output	16
Appendix A3 – Develop Last 6 Months of Life Information Example Output.....	17
Appendix A4 – Last 12 Months of Life Trajectories Example Output.....	18
Appendix A5 – End of Life Classification Matrix and Journeys Example Output	19
Appendix A6 – Strathcarron Hospice at Home Service Evaluation Example Output	20
Appendix B – Definitions of Palliative and End of Life Care.....	21
Appendix C – Acronyms.....	22

1. Introduction

This paper builds on the initial report produced in November 2016 by the NIAG data subgroup, called '*Report on current availability of data to support Commitment 9 of Palliative and End of Life Care (PEoLC) Strategic Framework*'. That report summarised what is currently known about PEoLC in Scotland based on nationally available information and focussed on: identification of patients with PEoLC needs, PEoLC activity and patient and family experiences. (Please see Appendix B for definitions of Palliative Care and End of Life Care. Although various definitions are available, Marie Curie descriptions have been referred to for the purposes of this report).

Based in part on that information, and following further detailed discussion between members of the data subgroup, this report provides recommendations for key work priorities for 2017/18 and beyond. This involves:

1. Describing analyses which could be routinely performed at present and released either to the public and/or as management information.
2. Outlining work which would need to be undertaken in order to fill what are considered to be the most significant data gaps (as a precursor to developing analyses).
3. Scoping work required to assess those areas that are still not well defined or understood by the group.

Estimated resource implications have been provided for certain pieces of work to help demonstrate the funding that will be required if they are to be taken forward although these should be considered indicative only at this stage.

Whether describing analyses which can be performed presently or work to be undertaken in the future, linking different datasets using patient identifiers – and resolving any Information Governance issues this raises - will play a crucial role in ensuring the creation of detailed and informative bespoke reports. This will provide the evidence base required to support the design, delivery and benchmarking of PEoLC services, as well as the means for monitoring quality improvement.

Although the main focus of this report is older people PEoLC, developments in the collection and analysis of data for babies, children and young people are also required. While many of the outputs described in this report will cover all ages (or allow stratification for all age groups), it is expected that this area will be covered more in-depth through a separate project due to be undertaken by ISD and the Children's Hospice Association Scotland (CHAS).

2. Developing routine analytical outputs

In addition to what is publicly released by various organisations, there are a number of other data analyses which could be routinely carried out based on data which is already available. The majority of this work would relate to EoL care as it is very difficult to identify patients in receipt of palliative care using existing and readily accessible datasets. Details of these analyses are provided below with the corresponding data outputs in [Appendices A1 to A6](#).

2.1. Location of death

Analysis: Number of deaths per year in Scotland and by Partnership, broken down by location e.g. hospital, home, care home or hospice/palliative care unit. Similar to existing publication focussed on cancer deaths. See [Appendix A1](#) for example output. Carry out similar analyses but focussing on where patients die if resident at home or a care home, examining the proportion of each which die in hospital.

Data Source: NRS deaths and SMR01.

Release: Management Information to partnerships, GPs and policy leads via Source and PCI (Primary Care Information). Updated annually.

Resource: Initial 20 days, Senior Information Analyst followed by 4 days/year.

2.2. Rank days before death for hospice referrals

Analysis: Length of time from hospice admission to patient death, present the average length of inpatient stay by hospice, long term conditions (LTCs) and cause of death. See [Appendix A2](#) for example output.

Data Source: NRS deaths and SMR01.

Release: Management information to partnerships, hospice providers and policy leads via Source and Excel. Updated annually.

Issues: Not all hospices submit inpatient data to SMR01, the data is not always up-to-date and it is unclear how complete the data submissions are. Investigation required.

Resource: Initial 20 days, Senior Information Analyst followed by 4 days/year.

2.3. Develop last six months of life information

Analysis: Current ISD publication divides the last 6 months of life into hospital bed days and time spent in the community. Develop this by including a further breakdown of hospital and community (e.g. time spent in large/community hospital, care home, supported at home or not supported at home). See [Appendix A3](#) for an example.

Data Source: NRS deaths, SMR01, SMR04 and Source Social Care.

Release: Management information updated annually made available to partnerships, GPs and policy leads via Source and PCI.

Issues: Dependent on improvements in data completeness and quality of Source Social Care returns.

Resource: Initial 20 days, Senior Information Analyst followed by 4 days/year.

2.4. Trajectory of activity/resource use over last 12 months of life

Analysis: ISD currently releases management information to each Partnership showing a variety of breakdowns e.g. LTCs, costs, deprivation. Can be enhanced further by using existing data, such as diagnosis at death, and incorporating Source Social Care and District Nursing activity/costs data.

Data Source: NRS deaths, SMR01, SMR04, Source and District Nursing.

Release: Management information to partnerships and policy leads via Source. Updated annually. See [Appendix A4](#) for examples.

Issues: Dependent on improvements in data completeness and quality of Source Social Care returns.

Resource: Initial 30 days, Senior Information Analyst followed by 5 days/year.

2.5. End of life classification matrix and journeys

Analysis: Various patient cohorts and demographics are presented in the patient classification matrix which helps to highlight the service utilisation associated with EoL patients set within the context of the overall population and other defined groups. The journeys of specific patients or groups of patients (from GP Practice clusters or whole Partnerships) can then be drilled into to examine EoL journeys in more detail. See [Appendix A5](#) for examples.

Data Source: NRS deaths, SMR01, SMR04, A&E, Prescribing, Source Social Care and District Nursing.

Release: Management information, updated routinely, available to partnerships and GPs via Source and PCI.

Issues: Technical and methodological aspects of journey mapping may take some time to finalise.

Resource: Already resourced through separate programme.

3. Addressing data gaps

This section describes the most significant gaps in PEOC data and the steps that will be required to fill them, noting ongoing developments which will provide some of the necessary information in the future.

3.1. Routine access to Anticipatory Care Plans (ACPs)

The majority of the analysis described in section two relates to EoL care as it is currently very difficult to obtain a national picture of how much of this is palliative. As discussed in the previous report, one of the main ways in which palliative care need can be identified is in an ACP. These are produced by GPs in conjunction with their patients and contain notes relating to their health and care needs, including any palliative care requirements.

Proposal: Gain access to ACP information through the Scottish Primary Care Information Resource (SPIRE) project. SPIRE will collect data from GP systems and will be available to practices Scotland wide by the end of 2017.

Process and issues: Work with pilot sites to obtain initial relevant data extracts. A number of GPs have already agreed to help with this work. Time will be required to obtain access and navigate any information governance issues, working closely with the ISD Primary Care team and the GPs themselves.

Outcomes: Develop knowledge and understanding of what SPIRE is capable of extracting and pilot data extracts from a number of practice populations. Initial analyses would then focus on:

- Number and rates of people with identified palliative care needs.
- Analysis of variation across GP practices, clusters, partnerships and other geographies.
- Linkage with death records to identify the number of people who died at their preferred location.
- Linkage with Source data to allow cross referencing of outputs in section 2 with record of ACP.

Resource: 60 days, Senior Information Analyst to attend relevant meetings, liaise with GPs, overcome potential described issues and create initial outputs.

3.2. Key Information Summary (KIS)

ACP details are recorded in the patient KIS along with other information such as diagnoses and long term conditions. With the permission of the patient, the KIS is created through discussion between them and the GP but can then be viewed and (in some cases) edited by other healthcare professionals such as hospital A&E staff/consultants. Data contained in the KIS is not currently accessible for the purpose of carrying out routine analysis.

Proposal: ISD will keep up to date with Scottish Government eHealth and any developments regarding the proposed new KIS system. When the time comes, will seek support from NIAG to

ensure access to KIS is considered a necessary requirement to obtain information for future analytical purposes.

Issues: New KIS system is at early stages in development, so any progress dependent on that. General issue relating to information governance.

Outcomes: Routine access to KIS information which can be used for further analysis of end of life care.

Resource: 10 days, Senior Information Analyst.

3.3. Inpatient hospice data

Although most hospices have submitted some level of inpatient data through SMR01 at one point in time, only eight of the fifteen charitable hospices submitted data during 2015/16. Towards the end of 2016, Scottish Hospice CEOs committed to working towards improving the availability and utilisation of national hospice data.

Proposal: Work with relevant hospices to encourage/obtain regular and complete inpatient data submissions.

Outcomes: Improve outputs as described in, for example, [section 2.2](#).

Resource: 20 days, Senior Information Analyst.

3.4. Hospice at Home data

The recent [Hospice UK report](#) highlights the important role that hospice community care plays as 53% (11,000) of patients seen by Scottish hospices were either through community or hospice at home services. ISD have been working with Strathcarron Hospice to help them assess the effectiveness of their hospice at home service in reducing hospital and emergency admissions (see [Appendix A6](#)). Although not yet complete, the initial analysis is promising.

Proposal: To pilot a national Hospice at Home data collection.

Process and issues: Work with hospices that provide this service to ascertain current level of local data collection. Seek their buy-in and determine the best way forward for the systematic collection and submission of this data e.g. simple excel spreadsheet or SMR01.

Outcomes: Number of people receiving Hospice at Home care, number of hours of care received, additional patient journey information e.g. died at home supported by Hospice at Home service. Establish data collection from at least one site. Develop plan for full national roll out.

Resource: 30 days, Senior Information Analyst to work with Hospices, assess options for data capture/submission and, once approved, follow through with implementation.

3.5. Third sector community care

In addition to hospice at home, a range of community based services are provided by third sector and there is currently a distinct lack of data available around these services. If this data were available it would fill one of the main data gaps that exist.

Proposal: Work with third sector community care to understand the landscape better, explore the possibility for routine data collection(s) and establish a pilot data extract to allow provisional (linked) analysis.

Process and issues: Meet with providers to determine what is possible. For example, what data, if any, do they already collect and how does it vary between different providers. What would be the key data to collect. Establish what the data sharing/information governance requirements would be. Aim to have some pilot data shared from at least one provider.

Outcomes: Learning from pilot. Following pilot, if successful, establish proposal for wider routine data collection.

Resource: 60 days, Senior Information Analyst.

3.6. Quality of care

The quality of care provided to patients nearing the end of their lives and the support their families receive is clearly an area of the utmost importance and is very prominent in the strategic framework. There is, however, no current systematic method for assessing or capturing this information and so resources will be required to develop this area.

Proposal: As recommended by the Scottish Partnership for Palliative Care (SPPC) in their paper to the Independent Review of Targets and Indicators for health and social care, explore the introduction of a Scottish National Survey of Bereaved Informal Carers using the VOICES (View of Informal Carers – Evaluation of Services) tool. Also consider/investigate how the use of Patient Recorded Outcome Measures (PROMs) could be used in specialist palliative care settings to measure the quality of care received.

Process: As mentioned in the SPPC paper, NHS Lothian will soon be piloting this survey, the results of which could inform a national approach. We will seek to collaborate with NHS Lothian to support and learn from the pilot details and in due course the results obtained, offering support where required. Engage with other relevant staff around PROMs.

Outcomes: To determine whether this approach will provide the necessary information around quality of care in a form with potential to be rolled out nationally.

Resource: 30 days, Senior Information Analyst to work alongside NHS Lothian, attending meetings regarding the pilot and potentially assisting with the analysis of the data and developing a specification for a national survey.

3.7. Hospital and community based palliative care nursing

Currently the only method for identifying palliative care in a hospital setting is through examining patients in the palliative care speciality or palliative care unit; this will not cover all patients receiving palliative care. Nurses will also undertake a range of palliative care tasks which are not captured in existing datasets and so large amounts of palliative care specific information is not accounted for. Palliative care specialists will also be involved in training of other staff groups. Additionally, data relating to palliative care provided by Clinical Nurse Specialists (CNS) in the community is not currently captured.

Proposal: Investigate the possibility of routinely capturing information around hospital and community based palliative care nursing activity. Identify whether this is required and achievable. Explore the information governance requirements/issues.

Process: Attend meetings of the Scottish Acute Palliative Care Clinical Nurse Specialist Forum (SAPCF) to discuss the Scotland wide referral form they are developing. Identify whether current proposals would capture the necessary additional information. Explore the potential to routinely record/collect data electronically. Explore information governance requirements. Establish pilot data submission from at least one site. The SAPCF are keen to collaborate and have already explored options, such as pilot locations, for taking this work forward.

Outcomes: Learning from pilot. If pilot successful, develop proposal for the development of a national routine data collection for 2018/19.

Resource: 60 days, Senior Information Analyst.

4. Priorities for 2017/18

Recommended priorities for throughout 2017/18 are divided into sections two and three of this report: developing routine analytical outputs and addressing existing data gaps. Descriptions for each suggested work strand are summarised in the tables below.

Table 1 – Developing Routine Analytical Outputs

Analysis	Release	Issues	Resource	Included in 2017/18 work plan?
<p>1. Location of death – number of annual deaths broken down by area and location e.g. hospital, home, care home or hospice/palliative care unit. Also focus on where patients die if resident at home or a care home, examining the proportion of each which die in hospital. See Appendix A1 for example output.</p>	<p>Management information to partnerships, GPs and policy leads via Source and PCI. Updated annually.</p>	<p>None. Information available now.</p>	<p>Initial 20 days, Senior Information Analyst followed by 4 days/year.</p>	<p>Yes.</p>
<p>2. Ranks days before death for hospice referrals - length of time from hospice admission to patient death, present the average length of inpatient stay by hospice, long term conditions (LTCs) and cause of death. See Appendix A2 for example output.</p>	<p>Management information to partnerships, hospice providers and policy leads via Source and Excel. Updated annually.</p>	<p>Not all hospices submit inpatient data to SMR01, the data is not always up-to-date and it is unclear how complete the data submissions are. Investigation required.</p>	<p>Initial 20 days, Senior Information Analyst followed by 4 days/year.</p>	<p>Yes.</p>

<p>3. Develop last 6 months of life information – develop ISD publication by including breakdown of hospital and community (i.e. time spent in large/community hospital, care home, supported at home or not supported at home). See Appendix A3 for example.</p>	<p>Management information updated annually made available to partnerships, GPs and policy leads via Source and PCI.</p>	<p>Dependent on improvements in data completeness and quality of Source Social Care returns.</p>	<p>Initial 20 days, Senior Information Analyst followed by 4 days/year.</p>	<p>Yes.</p>
<p>4. Last 12 months of life trajectories - ISD currently releases management information to each Partnership showing a variety of breakdowns e.g. LTCs, costs, deprivation. Enhance further by using existing data, such as diagnosis at death, and incorporating Source Social Care and District Nursing activity/costs data.</p>	<p>Management information to partnerships and policy leads via Source. Updated annually. See Appendix A4 for examples.</p>	<p>Dependent on improvements in data completeness and quality of Source Social Care returns.</p>	<p>Initial 30 days, Senior Information Analyst followed by 5 days/year.</p>	<p>Yes.</p>
<p>5. End of life classification matrix and journeys - various patient cohorts and demographics are presented in the patient classification matrix which helps to highlight the service utilisation associated with EoL patients set within the context of the overall population and other</p>	<p>Management information, updated routinely, available to partnerships and GPs via Source and PCI.</p>	<p>Technical and methodological aspects of journey mapping may take some time to finalise.</p>	<p>Already resourced through separate programme.</p>	<p>Yes.</p>

defined groups. The journeys of specific patients or groups of patients (from GP Practice clusters or whole Partnerships) can then be drilled into to examine EoL journeys in more detail. See Appendix A5 for examples.				
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Total resource required to set up analysis: 90 days, Senior Information Analyst.

Total resource required thereafter: 17 days, Senior Information Analyst.

Table 2 – Addressing Existing Data Gaps

Proposal	Process/Issues	Outcomes	Resource	Included in 2017/18 work plan?
<p>1. Routine access to ACPs – gain access to ACP information through the SPIRE project. SPIRE will collect data from GP systems and will be available to practices Scotland wide by the end of 2017.</p>	<p>Work with pilot sites to obtain initial relevant data extracts. Obtain access and navigate any information governance issues, working closely with the ISD Primary Care team and the GPs themselves.</p>	<p>Initial analyses would focus on:</p> <ul style="list-style-type: none"> • Number and rates of people with identified palliative care needs. • Analysis of variation across GP practices, clusters, partnerships and other geographies. • Linkage with death records to identify the number of people who died at their preferred location. • Linkage with Source data to allow cross referencing of outputs in section 2 with record of ACP. 	<p>60 days, Senior Information Analyst to attend relevant meetings, liaise with GPs, overcome potential described issues and create initial outputs.</p>	<p>Yes.</p>
<p>2. Key Information Summary - ISD will keep up to date with Scottish Government eHealth and any developments regarding the proposed new KIS system. When the time</p>	<p>New KIS system is at early stages in development, so any progress dependent on that. General issue relating to information governance.</p>	<p>Routine access to KIS information which can be used for further analysis of end of life care.</p>	<p>10 days, Senior Information Analyst.</p>	<p>Will keep updated on development of system but unlikely to require much resource during 2017/18.</p>

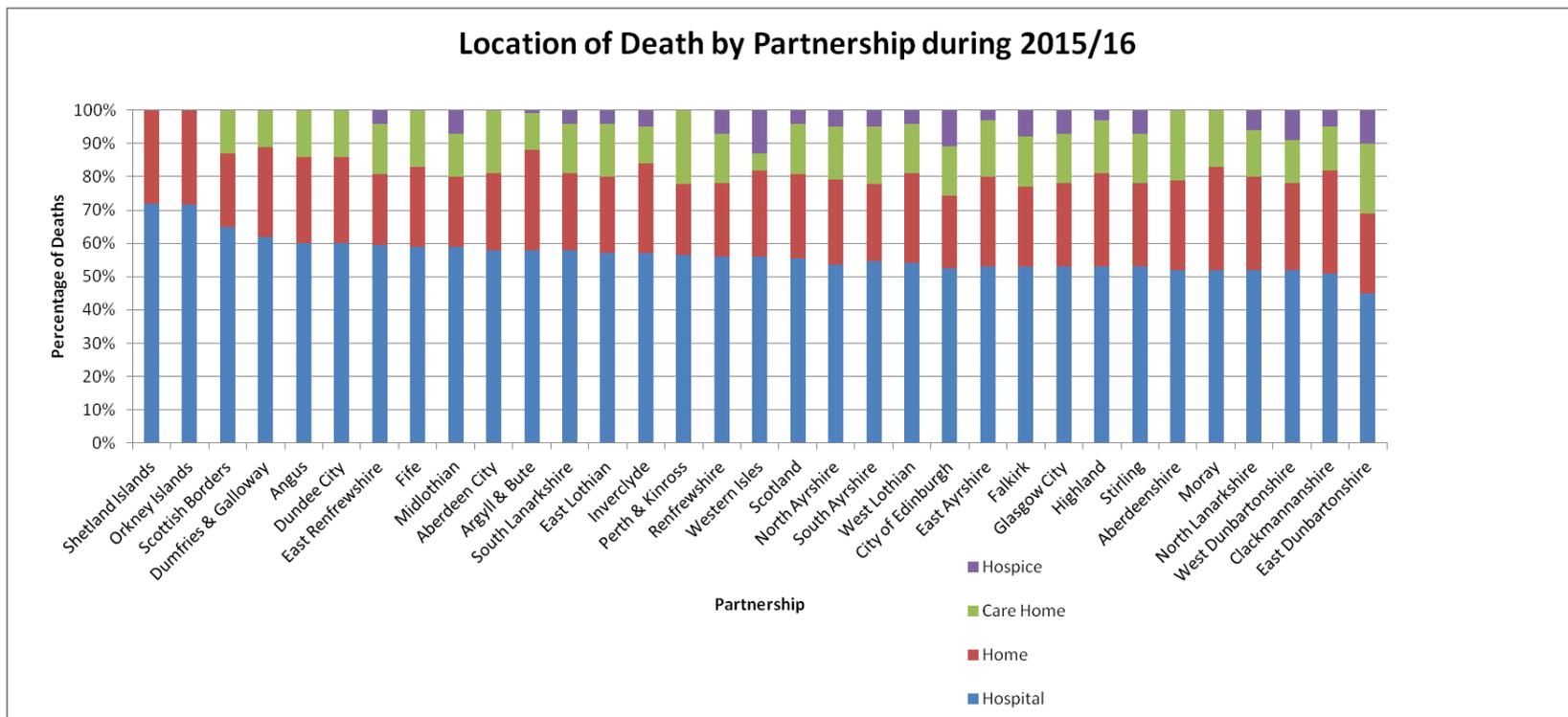
<p>comes, will seek support from NIAG to ensure access to KIS is considered a necessary requirement to obtain information for future analytical purposes.</p>				
<p>3. Inpatient hospice data – work with relevant hospices to encourage/obtain regular and complete inpatient data submissions.</p>	<p>No major issues anticipated.</p>	<p>Improve outputs as described in, for example, section 2.2.</p>	<p>20 days, Senior Information Analyst.</p>	<p>Yes.</p>
<p>4. Hospice at Home data - to pilot a national Hospice at Home data collection.</p>	<p>Work with hospices that provide this service to ascertain current level of local data collection. Seek their buy-in and determine the best way forward for the systematic collection and submission of this data.</p>	<p>Number of people receiving Hospice at Home care, number of hours of care received, additional patient journey information e.g. died at home supported by Hospice at Home service. Establish data collection from at least one site. Develop plan for full national roll out.</p>	<p>30 days, Senior Information Analyst to work with Hospices, assess options for data capture/submission and, once approved, follow through with implementation.</p>	<p>Yes.</p>
<p>5. Third sector community care - work with third sector community care to understand the landscape better, explore the possibility for routine data collection(s) and establish a pilot data extract to allow provisional</p>	<p>Meet with providers to determine what is possible. For example, what data, if any, do they already collect and how does it vary between different providers. What would be the key data to collect. Establish what the</p>	<p>Learning from pilot. Following pilot, if successful, establish proposal for wider routine data collection.</p>	<p>60 days, Senior Information Analyst.</p>	<p>No. Given resource available for this financial year, will be revisited in 2018/19.</p>

(linked) analysis.	data sharing/information governance requirements would be. Aim to have some pilot data shared from at least one provider.			
6. Quality of care - as recommended by the Scottish Partnership for Palliative Care (SPPC), explore the introduction of a Scottish National Survey of Bereaved Informal Carers using the VOICES (View of Informal Carers – Evaluation of Services) tool. Also consider/investigate how the use of Patient Recorded Outcome Measures (PROMs) could be used in specialist palliative care settings to measure the quality of care received.	NHS Lothian will soon be piloting this survey, the results of which could inform a national approach. Collaborate with NHS Lothian to support and learn from the pilot details and in due course the results obtained, offering support where required. Engage with other relevant staff around PROMs.	To determine whether this approach will provide the necessary information around quality of care in a form with potential to be rolled out nationally.	30 days, Senior Information Analyst to work alongside NHS Lothian, attending meetings regarding the pilot and potentially assisting with the analysis of the data and developing a specification for a national survey.	Yes.
7. Hospital and community based palliative care nursing - investigate the possibility of routinely capturing information around hospital and community based palliative care nursing activity. Identify whether this is required and achievable.	Attend meetings of the Scottish Acute Palliative Care Clinical Nurse Specialist Forum (SAPCF) to discuss the Scotland wide referral form they are developing. Identify whether current proposals would capture the necessary additional information.	Learning from pilot. If pilot successful, develop proposal for the development of a national routine data collection for 2018/19.	60 days, Senior Information Analyst.	No. Given resource available for this financial year, will be revisited in 2018/19.

<p>Explore the information governance requirements/issues.</p>	<p>Explore the potential to routinely record/collect data electronically. Explore information governance requirements. Establish pilot data submission from at least one site. The SAPCF are keen to collaborate and have already explored options, such as pilot locations, for taking this work forward.</p>			
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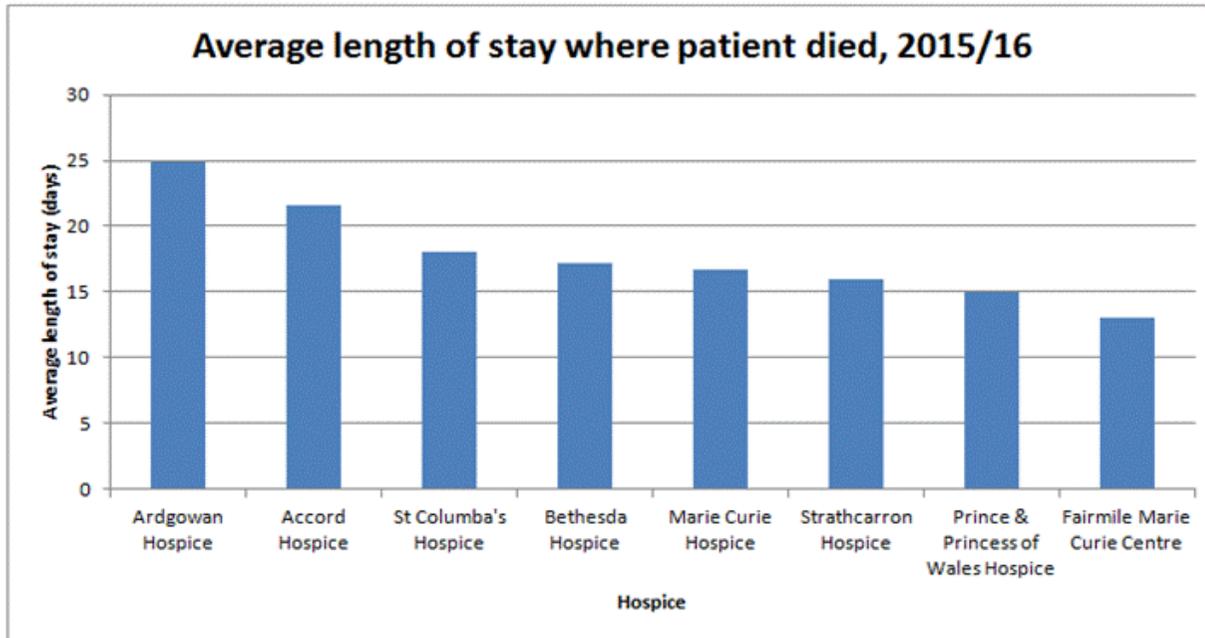
Total resource required to carry out proposed work: 270 days, Senior Information Analyst.

Appendix A1 – Location of Death Example Output

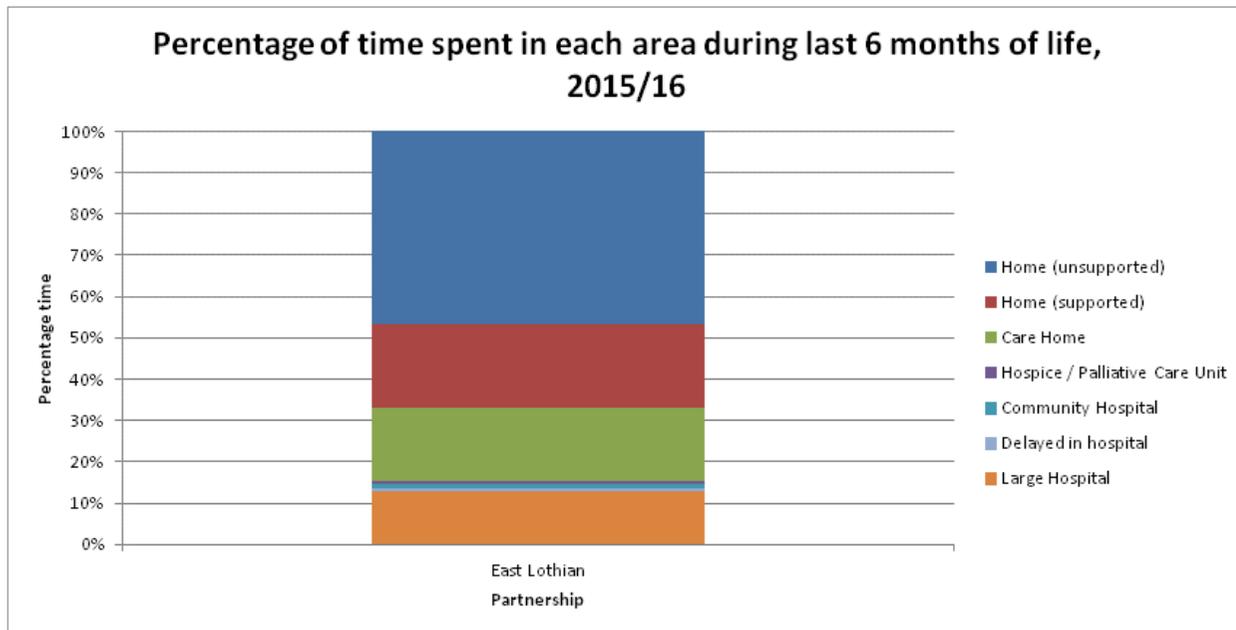


Appendix A2 – Rank Days Before Death for Hospice Referrals Example Output

Look at average length of stay by:

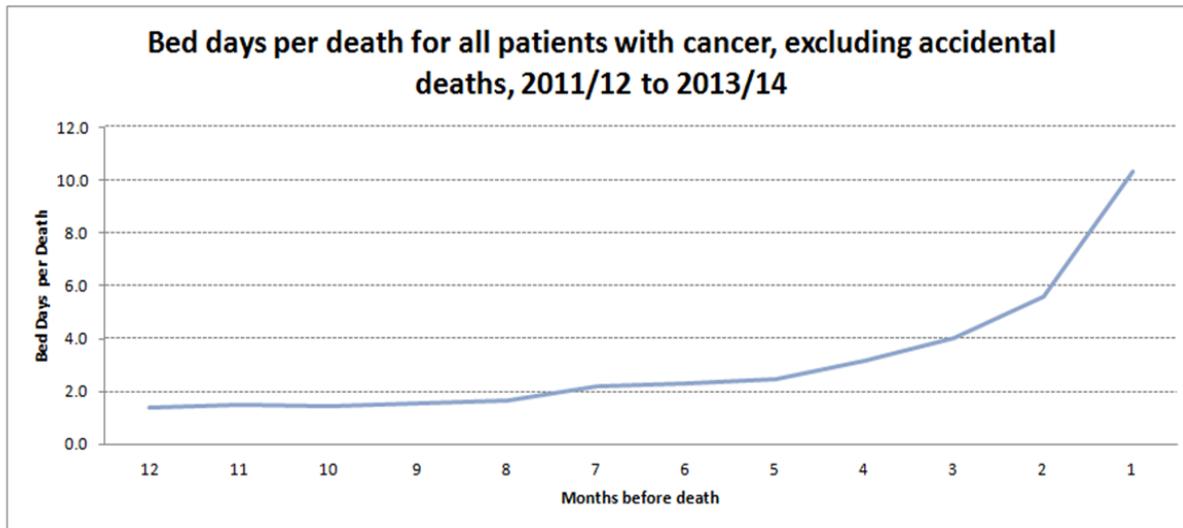


Appendix A3 – Develop Last 6 Months of Life Information Example Output



Appendix A4 – Last 12 Months of Life Trajectories Example Output

Select Service Cost: All
Select Gender: All
Select Age Group: All
Select Type of Death: Excluding Accidental
Select HRI: All
Select Area: East Lothian
Select Condition: Cancer
Select Period: Last 12 months (selected), Last 6 months, Last 3 months, Last 2 months, Last 1 month



Appendix A5 – End of Life Classification Matrix and Journeys Example Output

Level: Partnership | Select Measure: Cost per Head | ic..

Age Band: All | LTC Total: All | Resource Group: All | SIMD: All | Urban Rural: All

Demographic_Cohort	Psychiatry	Geriatric	Maternity	Elective Inpatient	Limited Daycases	Routine Daycase	Single Emergency	Multiple Emergency	A&E	Outpatients	C Pi
End of Life		£5,135		£1,024	£87	£913	£2,112	£6,574	£1	£76	
Frailty	£31	£4,705	£2	£417	£32	£96	£1,602	£2,712	£0	£60	
High Complex Conditions	£95	£3	£17	£919	£183	£523	£467	£707	£2	£236	
Maternity and Healthy Newborns			£3,350		£12		£71	£9			£73
Mental Health	£11,649			£241	£78		£616	£836	£19	£110	
Substance Misuse				£212	£79		£1,401	£3,702	£30	£95	
Medium Complex Conditions		£12		£440	£134	£29	£441	£328	£3	£163	
Low Complex Conditions		£3		£205	£101	£9	£173	£103	£13	£149	
Child Major Conditions				£351	£224	£69	£1,018	£294	£7	£65	
Adult Major Conditions		£3		£317	£443	£12	£380	£103	£1	£143	
Assisted Living in the Community		£30					£16		£5	£63	
Healthy and Low User		£1							£20	£91	
Grand Total	£11,775	£9,892	£3,370	£4,126	£1,373	£1,653	£8,295	£15,369	£102	£1,324	

Navigation to other dashboards
 Select a cell within the matrix to view dashboard options

Appendix A6 – Strathcarron Hospice at Home Service Evaluation Example Output

	People who accessed H@H service (123 people)	Other Forth Valley residents who didn't access H@H service (501 people)
Hospital admissions/emergency attendances	10%	49%
Average number of hospital bed days	0.7	3.8
Average hospital cost	£220	£1,409

Appendix B – Definitions of Palliative and End of Life Care

Palliative Care

Marie Curie describes Palliative Care as “for people living with a terminal illness where a cure is no longer possible”, with the main aim to “treat or manage pain and other physical symptoms” and “to help you and everyone affected by your diagnosis to achieve the best quality of life”.

Palliative care can be provided by a range of professionals, including GPs, community nurses, hospice nurses, consultants in palliative medicine and clinical nurse specialists. The analysis and data capture described in this document as “palliative care” refers to the services provided by such staff to patients where the reason for care is recorded specifically as palliative.

End of Life Care

Marie Curie describes End of Life Care as “for people who are considered to be in the last year of life, but this timeframe can be difficult to predict”. In the context of this paper, End of Life activity refers to information derived from any patient contact with health and social care services within a set period prior to death. For example, this period may cover 3, 6 or 12 months before death.

Appendix C – Acronyms

Acronym	Definition
NIAG	National Implementation Advisory Group
PEoLC	Palliative and End of Life Care
EoL	End of Life
NRS	National Records Scotland
SMR	Scottish Morbidity Records
PCI	Primary Care Information
LTC	Long Term Condition
ACP	Anticipatory Care Plan
SPIRE	Scottish Primary Care Information Resource
KIS	Key Information Summary
SPPC	Scottish Partnership for Palliative Care
VOICES	View of Informal Carers – Evaluation of Services
PROMs	Patient Recorded Outcome Measures