Achieving gold standard care at end of life in care homes

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Context

1% population die/ year, aging population, increasing multi-morbidities, complexity + costs

Frailty and multi-morbidity are the biggest killers

1% population dies / year
“The biggest challenge in the NHS - care for frail older people”

Over 50% of people die in hospital

‘Hospitals are very bad places for old, frail people,’ CEO NHS Commissioning Board, David Nicholson, BMJ News

“we need a paradigm shift in the NHS ... to work towards the point when acute hospitals admissions are regarded as a failure rather than the default position”

Mike Dixon, NHS Alliance

High mortality in hospitals

Keep out of dangerous hospitals, GPs warn

‘Hospitals are very bad places for old, frail people,’ CEO NHS Commissioning Board, David Nicholson, BMJ News
Frailty is the future

- Frailty is an expression of population aging
- Frailty is quantifiable (frailty index)
- The Gait Speed is a good indication of a diagnosis of frailty
- It overlaps is not coincident with co-morbidity or disability
- Frailty is associated with dementia, poor health outcomes and is a predictor of morbidity and mortality
Inequity - At individual Level

Proactive planning - Bill

- 82 year old in care home - COPD, frailty + other conditions
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits - no future plan discussed

- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis worsens at weekend - calls 999 paramedics admit to hospital, A&E - 8 hour wait on trolley - dies on ward alone

- Family given little support in grief - staff feel let family down
- No reflection by teams - no improvement
- Expensive for NHS - inappropriate use of hospital
We are at a new Tipping Point

“Just because we can... doesn’t mean to say we should “

Some are too sick to go to hospital
.....and its hard to stop the domino effect of medical care
A Paradigm Shift in Management Goals—survival is not the only objective

- As long as it is Ethically and Legally justified
Our Experience from the National GSF Centre in End of Life Care

The leading EOLC training centre enabling generalist frontline staff to deliver a ‘gold standard’ of care for all people nearing the end of life

“Half of hospital deaths could be avoided with better community support ”
National Audit Office Report on End of Life Care 2009
1. Quality improvement Training Programmes

**GSF Primary Care - 95% Foundation Level (8,500 practices)**
From 2000 - Foundation GSF mainstreamed (QOF)
From 2009 - Next Stage GSF ‘Going for Gold’ training programme
Round 1 GP practices accredited Nov 2012 , Round 2 2013

**GSF Care Homes - 2300 care homes trained**
From 2004 Comprehensive training and accreditation program
200 / year accredited – recognised quality assurance
Many re-accredited annually – recognised by CQC and com

**GSF Acute Hospitals – 40 acute hospitals**
2008 -Phase 1 pilot 15 hospitals + Improving cross boundary
2011- Phase 2 9 hospitals, 2012- Phase 3 –8 ,Phase 4 -8
Accreditation in development – some whole hospital s,

**GSF Domiciliary care – 300 care workers**
Phase 1 -Manchester, West Mids SHA , Rotherham + others
Phase 2- Train the trainers 6 modular distance learning prog
Phase 3 – Somerset 60 trainers, 1,200 care workers. BHR 2:
agencies
Phase 4 - Manchester

**GSF Community Hospitals - 28 community hospitals**
Phase 1 - December 2011 - Cornwall & Dorset-14 each
Phase 2 Summer 2013 - Cumbria
New Programmes

GSF Integrated Cross Boundary Care
2013 – 3 Demonstrator sites
New sites 2014

GSF Dementia Care
4 module course available on VLZ.
Phase 1 Pilot programme complete – Phase 2 launched

GSF Hospice Support
May 2014 – launch 5 hospices
Day care, hospice at home and some inpatient beds

GSF Clinical Skills
2014 – relaunched Autumn

GSF Spiritual Care
2014 – due autumn – VLZ and workshops roadshow
Measures - Impact + integrity using GSF
Improving quality, coordination and outcomes

1. Quality of care - *Attitude awareness and approach*
   - Better quality patient experience of care perceived
   - Greater confidence, awareness, focus and job satisfaction

2. Coordination/Collaboration - *structure, processes, and patterns*
   - Better organisation, coordination, communication & cross-boundary care

3. Patient Outcomes - *decreased hospitalisation, dying in preferred place*
   - Reduced crises, hospital admissions, length of stay e.g. halve hospital deaths
   - Care delivered in alignment with patient and family preferences
GSF Accredited GP Practices - case study

“We look after the whole population of our elderly patients much better now - much more proactively”

Karen Chumley
Essex GP

“We’ve changed the culture of how we practice and when we look back on the way we practiced before, it seems very old fashioned and unsatisfactory”

Karen Chumley
Essex GP

Key Ratios
Summary of cumulative results from all practices in key practice ratios before and after GSF training

Before Training

After Training

0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%

Q1 No. on Register/Total no. of Deaths
Q2 ca Cancer/ No. on Register
Q2 nca Non Cancer/ No. on Register
Q3 Care Homes/ No. on Register
Q4 Died in usual place residence
Q5 ACP/ No. on Register
Q6 DNAR/No. on Register
Q7 Carers Assessment/ No. on Register
Q8 Berevement/ No. on Register
GSF Care Homes
Training and Accreditation
“the biggest, most comprehensive end of life care training programme in the UK”

Training
Over 2300 care homes trained
- About 12 projects / year

Accreditation
Up to 200 /year accredited
Externally recognised
- Supported by NCA ECCA etc.
- CQC recognition
- Evidence base showing significant reduction in hospitalisation

Vision of national momentum of best practice
1. Standard Premier GSF CH Programme
   - 6 workshops
   - GSF Centre/ one of 8 Regional Centres
2. Blended Programme
   - 2 workshops + rest distance learning on VLZ
3. Foundation Programme
   - Basic quality improvement
4. Access to filmed programme if completed GSF training
20 Key standards-
Accreditation checklist

1. Leadership + support
2. Team-working
3. Documentation
4. Planning meetings
5. GP Collaboration
6. Advance Care Planning
7. Symptom control
8. Reduce hospitalisation
9. DNAR + VoD policies
10. Out of hours continuity
11. Anticipatory prescribing
12. Reflective practice + audit
13. Education + training
14. Relatives
15. Care in final days
16. Bereavement
17. Dignity
18. Dementia
19. Spiritual care
20. Sustainability
Better team-working and collaboration with GPs and Nursing Homes

- Talking a common language better agreed documentation
- Earlier prediction of needs + preparation eg drugs
- Advance Care Planning - focus on personal needs/ goals
- Better team-working, morale and mutual confidence
Advance Care Planning Discussion

**How?**
- Opportunistic informal conversations
- Formalised systematic

**What?**
- What matters to you?
- What do you wish to happen?
- What do you do not want to happen?

**Who?**
- Named spokesperson (informal)
  - Can tell those who act in best interests what sort of person you are
- Lasting Power of Attorney (formal)
  - Can make legal decisions regarding your health

**Where?**
- Preferred Place of Care
- Carer’s Preferred Place of Care

**Other?**
- Special instructions-Organ/tissue donation
Care closer to home
Reducing hospitalisation

- Advance care planning discussions
- Needs Based Coding
- Needs Support Matrices
- Planning meetings
- Team collaboration
- DNaR/ AND discussions
- Training and education for all staff (including night staff and temp/ bank)
- Policy + guidance on reducing avoidable admissions
- Stop Think policy
- Anticipatory prescribing
- OOH handover form
- Audit/ SEA
- LCP for dying
- Communication with family re ACP
50% of frail care homes residents could have died at home

Where Care Home Residents Died
Grossed up, estimated total deaths = 128

- Died in care home: 61%
- Hospital, no alternative: 20%
- Hospital, with alternative: 19%

Halving hospital death rate after GSF Care Homes

National Audit Office report on End of life Care (Nov 08 www.nao.org.uk)
Fig 1 Findings from GSF After Death Analysis Audits of Phase 4-5 care homes showing reduction on hospital deaths and crisis admissions
- Audit of 5 deaths before, 5 after training and 5 at accreditation. [ii]
Case study - Somerset Study

- Somerset PCT Public Health study
- Over 3 years- 64 care homes GSF trained
- GSF care homes compared with non-GSF homes
- Saved 116 admissions/year - third the number of hospital admissions - 20%- 7%
- Saving almost £500,000

- Work continues to cover all
# Case Study - Comparison of place of death across SE London nursing homes [2007 to 2012]

Care Home Project Team, St Christopher’s Hospice

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<td>67%</td>
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Successes with GSF Care Homes Training Programme

- Open attitude to death and dying
- All residents offered advance care planning discussions
- Improved confidence of staff
- Better working with GPs

“GSF has made my work simple to care for my residents. It has drawn me closer to my residents and relatives, given me confidence in discussing end of life care.”

(Nursing Home RN Accreditation Round 3)
Jan Elliott, Oakfield Nursing Home
Lancashire

“We would previously document patients’ wishes but nothing was formalized. Now we sit down with the patient and their family as soon as possible after they come in and it is reviewed every month.’

‘It’s very helpful to know what people want, making it easier for patients, staff and families and helping to avoid crises.”
“He died peacefully in his bed surrounded by his family a few minutes later. Before we did GSF we probably wouldn’t have had the confidence to do that and the patient would have died in the ambulance.”

“GSF has really pulled us all together as a team, both in the home and with our health and social care colleagues.”
4. Developing an integrated approach to cross boundary end of life care

- Integrated approach - Pioneers
- Better Care Fund £3.4b from 2015
Integrated Cross Boundary Care

HOME
GSF Primary Care and Domiciliary Care

CARE HOME
GSF Care Homes

HOSPITAL
GSF Acute Hospitals

Phase 1 Demonstrator Sites – 2013
Vision of Integrated Cross Boundary Care

| Gold patients and GSF ‘Heart of Gold’ projects |

**Primary Care**
- Earlier identification of patients in final year of life
- Better provision + access to GPs and nurses
- Prioritised support for patient and carers + easier prescribing

**Gold Patients**
- Better assessment + ACP discussions offered
- Proactive planning of care
- Advance care plan – preferred place of care documented

**Care Home**
- ACP & DNAR noted and recognised
- Care homes staff speak to hospital regularly

**Care Home**
- Referral letter recommends discharge back home quickly

**Others**
- Urgent care - Ambulance + out of hours care – flagged and prioritised
- Domiciliary care using same coding and planning
- Community hospitals

**Acute Hospital**
- GSF patient identified and flagged on system, registered
- Better discharge collaboration with GP using GSF register
- Car park free and open visiting
- Readmission - STOP THINK policy and ACP

**Better discharge collaboration with care home**

**EOLC Strategic planning, Locality Register**

**Hospices**
- GSF patient identified and flagged on system, registered
- Assessment & preferences noted

**Rapid Discharge**

**Putting Patients at the Centre of Care**
What does being a GOLD patient mean to you?

- **G**ood communication
- **O**n-going assessment of needs
- **L**iving well
- **D**ying with dignity in the place of choice

- Helps everyone communicate better
- Improved team-working and collaboration with colleagues in different settings
- Better listening to preferences e.g. Preferred place of care discussed and noted
- Advance care planning discussion offered
- Resuscitation (DNACPR) discussed and noted
- GP records on their register – quicker access and response
- OOH’s information sent by GP, so quicker response
- Helps keep at home + out of hospital where possible
- Better support for carers and family
- GSF Alert Flag on hospital system (PAS) if readmitted
- Quicker access to medication at home / hospital
- Open visiting / free parking
What if … Bill

Current

• In care home – condition worsening
• Poor quality of life and crisis admissions to hospital
• Ad hoc visits - no future plan discussed
• Staff and family struggling to cope
• No advance care planning, no life closure discussion
• Crisis - worsens at weekend - calls 999 paramedics admit to hospital - A&E - 8 hour wait on trolley - dies on ward alone
• Family given little support in grief - staff feel let family down
• No reflection by teams - no improvement
• Expensive for NHS - inappropriate use of hospital

Ideal

Using GSF Care Homes

• Identify and code stage
• Assessment of clinical and personal needs
• Advanced care planning
• Planning - regular support + coordination within primary care
• Handover form out of hours
• Crisis – discussion with family + GP
• Admission averted
• High quality care provided
• Dies in care home
• Bereavement care for family
• Audit (ADA), reflection
• Continuous Quality Improvement

• Better outcome for patient, family, staff
• Most cost effective + best use of NHS
A matter of life and death
We are all involved …