Making Health and Care services for an aging population - End of Life care

Prof Keri Thomas
The National GSF Centre in End of Life Care
Hon Professor End of Life Care Birmingham University

www.goldstandardsframework.org.uk • info@gsfcentre.co.uk
Three Take Home Messages

1. **This is a key time** to improve care in the final year/s of life (EOLC) for the aging population and crucial for our health and care services development – *increased numbers, multi-morbidity, inequity, poor outcomes, poor systems, integrated health+ social care, losing the personal*

2. **There are signs of hope**- some progress and examples of good practice in our experience at the GSF Centre but needs further development and mainstreaming of best practice standards

3. **Hold two aims together to progress** –
   1. Population values based integrated End of life care,
   2. and individual personalised care – right care.
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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 co-existing 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
- life-threatening acute conditions caused by sudden catastrophic events.
Some things don’t go away!
The looming epidemic of need for end of life care
‘Hospitals are very bad places for old, frail people,’

CEO NHS Commissioning Board, David Nicholson,
BMJ News

“People with dementia are going into hospital...staying too long, and coming out worse.”

Mike Dixon, NHS Alliance
RCGP Commissioning Guidance in End of Life Care

A logical six-step framework and overview to support GP commissioners to deliver practical improvements in their Clinical Commissioning Group (CCG), aligned with national policy and quality standards. A collaboration between the RCGP End of Life Care Team of the Clinical Innovation and Research Centre and the RCGP Centre for Commissioning.

February 2013
What is the aim of EOLC Commissioning for your area?

• To provide care in alignment with preferences
• ‘A good death’
• Living well until the end of life
• Reduce hospital admissions
• Improve patient carer feedback
• Meet targets?
Four target areas that overlap with End of Life Care -

- EOLC must be included in these intersecting areas to enable effective improvement
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2. Signs of hope - our GSF experience

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

“Every organisation involved in providing end of life care will be expected to adopt a coordination process, such as the GSF”

DH End of Life Care Strategy July 08

The right care, for the right people, in the right place, at the right time… everytime
GSF Primary Care - 95% Foundation Level (8,500 practices)
1. From 2000- Foundation GSF mainstreamed (QOF)
2. 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 programmes
200/year accredited – recognised quality assurance
Many re-accredited annually – recognised by CQC and commissioners

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

GSF Domiciliary care – 300 care workers
Phase 1-Manchester, West Mids SHA, Rotherham + others
Phase 2- Train the trainers 6 modular distance learning programme

GSF Community Hospitals - 42 community hospitals
Phase 1 - December 2011 - Cornwall & Dorset-14 each
Phase 2 Summer 2013 - Cumbria

GSF Dementia Care- 60 candidates
Phase 1 Pilot programme complete 2013 – evaluations underway
GSF enables a gold standard of care for all people nearing the end of life

1. Spread
GSF Quality Improvement provides full package of support for many different settings

2. Depth
Quality assurance through accreditation eg Primary Care and care homes

Depth also in compassionate or heart care

3. Joined-up
Integrated Cross boundary care GSF can be a common language to help improve coordination of care

Diagram:
- Primary Care
- Care Homes
- Acute Hospitals
- Community Hospitals
- Domiciliary Care
- The Patient
1. First Stage - Foundation Level

Most (95%) GP practices in UK using GSF - QOF
Foundation Level - having a register and a meeting

BUT...National Primary Care Snapshot Audit 09/10
Every death Feb March 09 in 502 practices, 4500 pts

- 25% patient deaths on register only
- 25% non-cancer patients on register
- Of those on a register - better coordinated care

2. Next Stage GSF - ‘Going for Gold’

Practice based Distance Learning - move to Accreditation Level
Over 300 practices - first wave accreditation - Nov 12
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
Case Study - Coastal Medical Group
Morecombe Bay- 33,000 patients

- **Key ratios - Increased early identification** of patients for the register (9%-45%) especially non-cancer (5%-65%) and from care homes (19%-53%)

- **Key ratios - halving hospital deaths** (35%-16.6%),
- almost doubling dying in usual place of register (40.5%-72.9%)
- bereavement support increased (5.4%-76.5%)
- **ACP-** Impressive total offered ACP discussions (83%)
- **Practice protocol** with clinical guidance
- **Impressive coordination** of big numbers in a large practice
- and coordination with care homes and community resources
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
- Almost 50% nursing homes

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
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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<tr>
<td><strong>Percentage of deaths occurring in NHs</strong> [numbers of deaths]</td>
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<tr>
<td>57%</td>
<td>67%</td>
<td>72%</td>
<td>76%</td>
<td>78%</td>
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<td>n=324 deaths across 19 NHs</td>
<td>n=989 deaths across 52 NHs</td>
<td>n=1071 deaths across 53 NHs</td>
<td>n=1375 deaths across 71 NHs</td>
<td>n=1351 deaths across 71 NHs</td>
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“...the response is amazing”
• GSFAH Programme

• Pilot 2010-11 Phase 1 and 2 in 24 hospitals
• Phase 3 in 8 hospitals - several whole hospital
• Phase 4 in 7 hospitals

• Defined Foundation and Enhanced levels –
• Developing the accreditation process for 2014/15
• Improved cross boundary care
Improving quality of care and saving costs
The possible ‘win-win’ in EOLC – our GSF Experience

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 – hospitalisation, ACP alignment
   • Reduced crises, hospital admissions, length of stay e.g. halve hospital deaths
   • Care delivered in alignment with patient and family preferences
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2 areas of outcome measures

Sect A
• 1. Quality Accountability report –
  – Key outcome measures,
  – patient/carer feedback of experience of care
  – and accreditation of organisations

Sect B- individualised-
  1. Right person- People who are approaching the end of life (final year or so) are recognised early.

  2. Right Care People whose care planning has been recorded and care tailored to meet needs.

  3. Right place- People enabled to live and die where they choose.

  4. Right time People who receive timely proactive anticipatory care, including in the final days.

  5. Every time Consistency of care delivery - workforce trained and enabled, family and carers supported.
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 – care in alignment with preferences - 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
- Better assessment + ACP discussions offered
- Proactive planning of care
- Advance care plan – preferred place of care documented

Gold Patients
- GSF patient identified and flagged on system, registered
- EOLC Strategic planning, Locality Register
- Domiciliary care using same coding and planning
- Community hospitals
- Hospices
- GSF patient identified and flagged on system, registered
- Assessment & preferences noted
- Better discharge collaboration with GP using GSF register
- Rapid Discharge

Care Home
- ACP & DNAR noted and recognised
- Care homes staff speak to hospital regularly
- Referral letter recommends discharge back home quickly

Acute Hospital
- Car park free and open visiting
- Readmission - STOP THINK policy and ACP

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

Putting Patients at the Centre of Care

- Collaboration with care home
What does being a GOLD patient mean to you?

- **G**ood communication
- **O**ngoing 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
Case Study - GSF in hospitals - improving cross boundary care
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“When your time comes to die make sure that dying is all you have left to do”

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