Introducing Advance care planning into the hospital culture improves the care of frail elderly and end of life care patients and is cost effective.

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Background

Frail elderly patients with multiple co-morbidities and those patients in the last year of life can present a significant challenge to healthcare. 43% of emergency admissions are in those aged over 65 and account for; 53% of all bed days; 80% of hospital stays of >2 weeks, delayed discharge and high risk of unscheduled early readmissions. A recent Scottish cohort study found that 31% of all patients in hospital had died within 1 year. 15% of avoidable 30-day re-admissions relate to end-of-life-care (EOLC), yet older people with frailty and dementia are less likely to have advance care planning.

This is not a good patient experience and furthermore hospital readmissions cost Acute Trusts £600m in PBR penalties.

Aims

To reduce avoidable 30-day re-admissions to an acute NHS Trust, we piloted 2 services:

i) A Frail Elderly Transitional Care Intervention (FETCI) to work with carers to plan discharge better and ‘hand-over’ patients discharged from the hospital directly to GPs and community teams, and

ii) The use of Advance Care Planning (ACP) to address EOLC needs in identified patients within the last year of life.

Methods

By identifying medical patients at high risk of re-admission, we used our findings to develop a 5-point referral criterion. Patients were then screened in six areas and formally assessed for depression, dementia and EOLC needs.
Kings Fund Abstract

Non-EOLC patients benefitted from FETCI. A doctor and carers review the cause of admission, symptoms, medications, and alongside the discharge plan addressed alternative plans for responding to recurrent problems. This plan was shared directly with the GP with subsequent follow-up on days 2 and 5 post-discharge.

EOLC patients and relatives were offered discussions exploring their future care preferences and management of deterioration in the community. This was shared widely with GP and community team and on the coordinate my care register.

**Result**

The 30-day readmission rate for the FETCI pilot group was 21.7% vs 29.17% for the comparison group (pilot group n=23, control group n=48). A relative reduction of 25% in the 30-day readmission rate compared to baseline.

The 30-day re-admission rate of the first 60 ACPs was 5% in the pilot group vs the national average of 15%. All deaths occurring within 30-days of discharge with an ACP were in the patients’ preferred place of death, with none in hospital. 3 patients re-admitted within 30-days. 2 had requested re-hospitalisation and 1 patient had been re-admitted contrary to their ACP preference.

**Conclusion**

Reductions in re-admission rates in both pilots translate to a better patient experience and potential cost savings over £1.6m. Our findings support the call for a culture change, where secondary care services embrace the opportunity to work within the whole system, delivering a more effective transition into the community, handover to primary care and wider dissemination of the practice of Advance Care Planning for high risk and EOLC patients.