Commissioning end of life care to improve patient outcomes

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Plan

1. **Welcome and introductions**
   Key issues for you ?

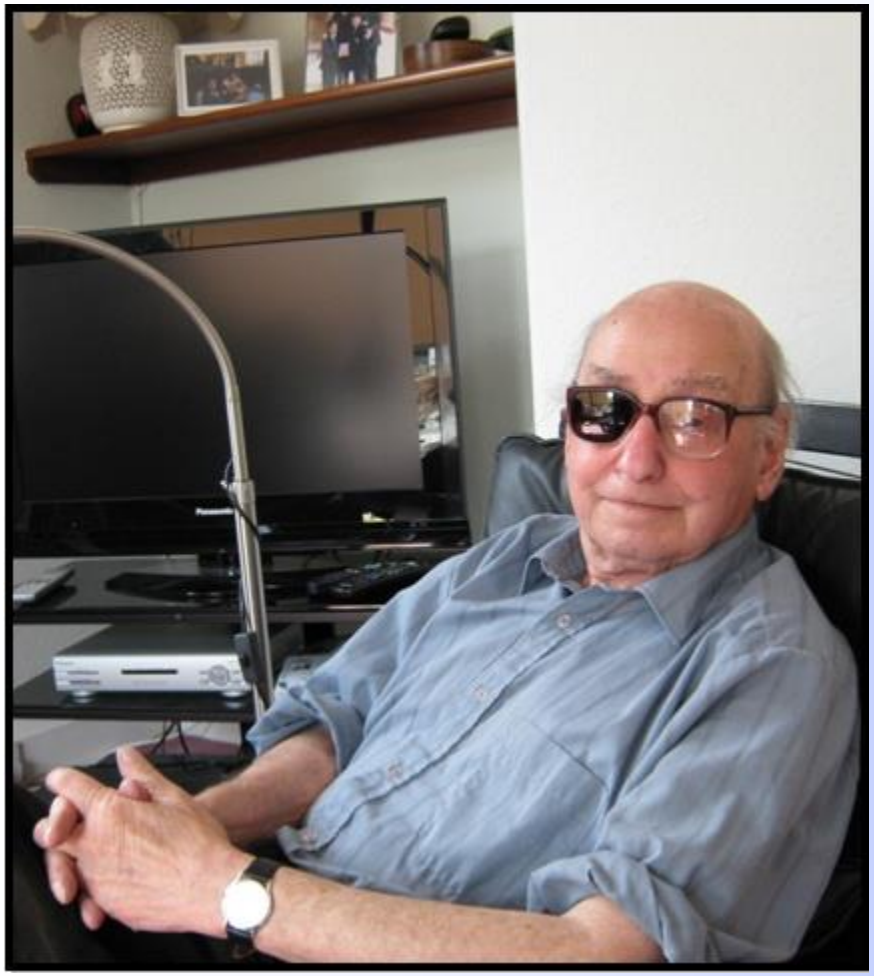
2. **Setting the scene in Clinical Commissioning and End of Life Care, King's Fund recommendations**
3. **RCGP EOLC Commissioning Guidance**
   6 point plan – priorites for commissioning in your area
4. **Partnership working with Marie Curie**

5. **Next steps**
   Action planning, feedback, next steps,

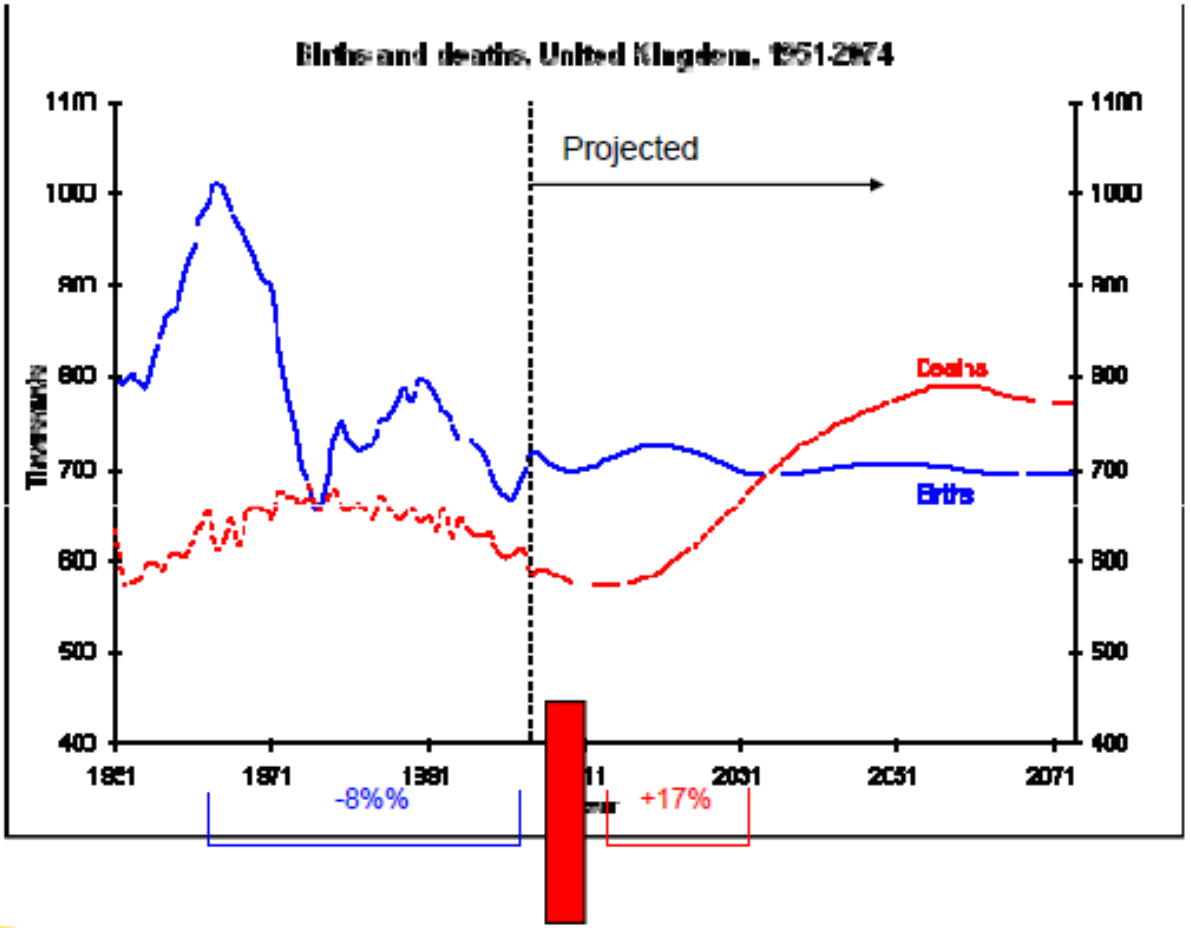
1. Introductions and Question - Key Issues for you and your CCG?

- What are the most challenging issues in End of Life Care Commissioning for you ?
- What would you like to get out of today?

Part 2 Ageing and multiple morbidity



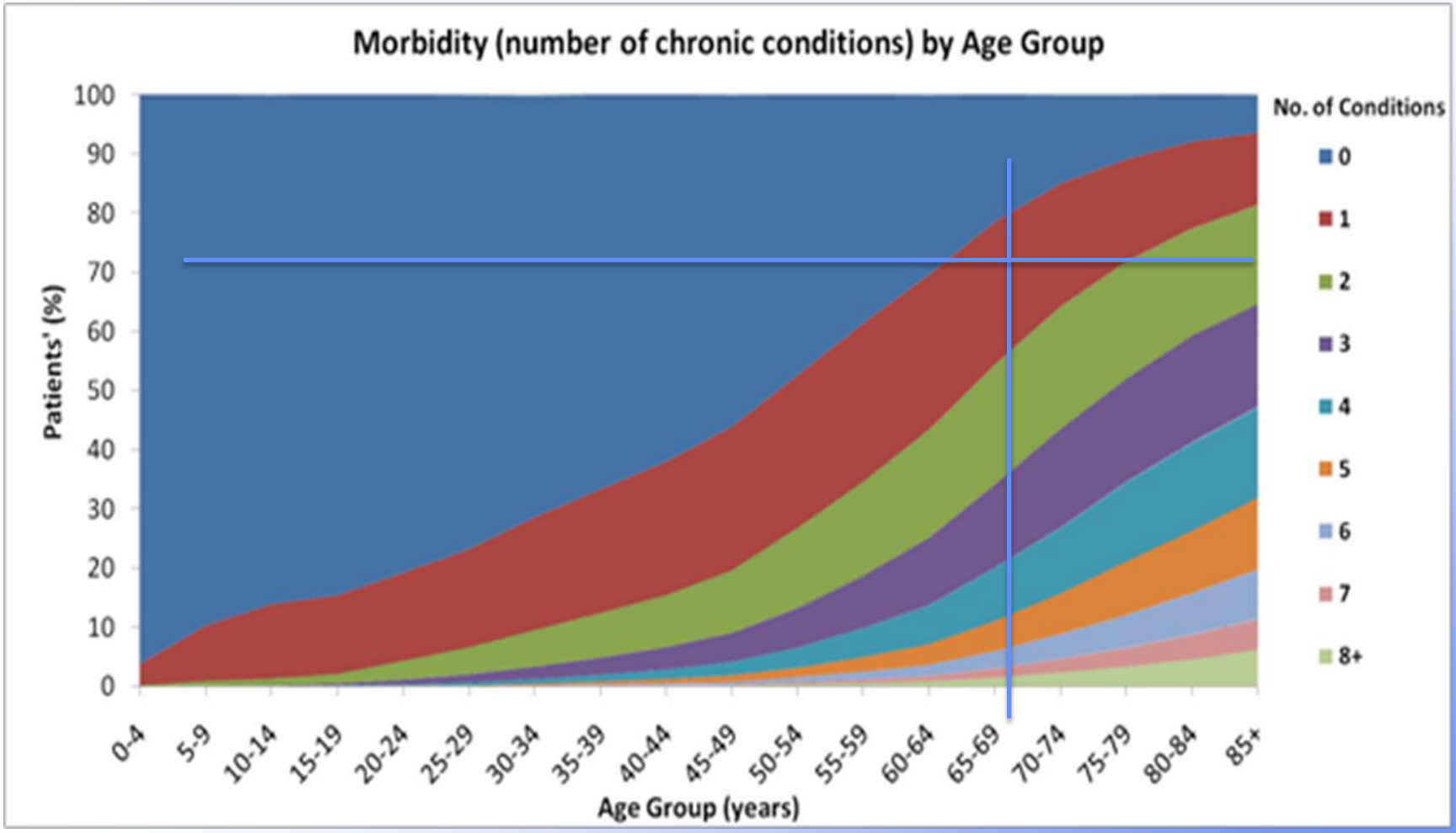
The Future, UK Projections 1951-2071



THE DEMOGRAPHIC TIME BOMB

Source: Government Actuary Department 2004-based Projections for the UK

Multimorbidity and complexity



Ageing and multiple morbidity

Number of people aged over 80 will double between 2010 and 2030

Average consultation rate with GP is 5.5/year

But for over 80s, consultation rate is 14/year (2008)

The capacity of general practice

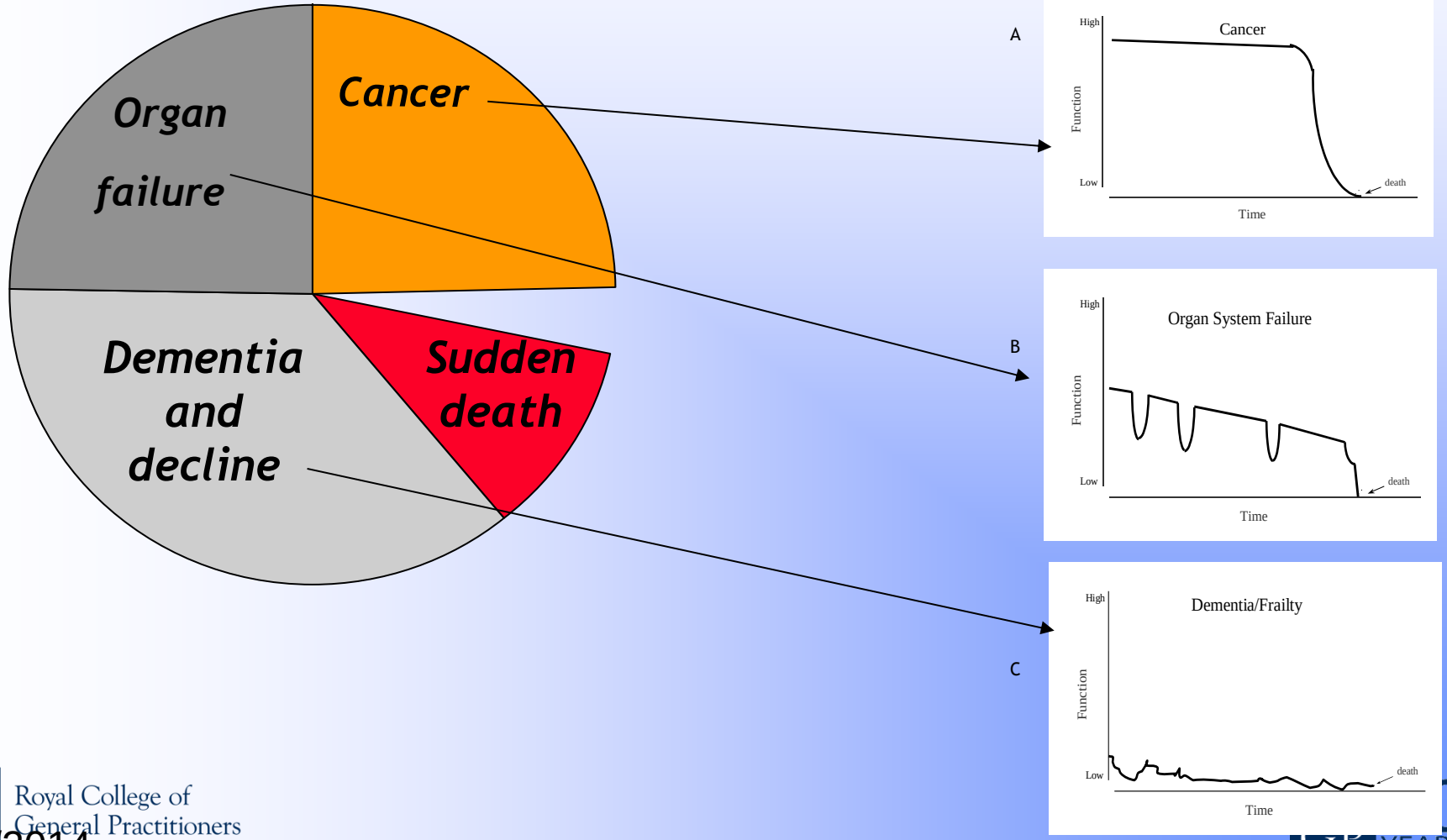
In 2000 the RCGP called for a 30% increase in GP

2001-2011 the FTE number of GPs increased by 2% per year

Between 2001 and 2011 District Nurses numbers fell 34%

FTE numbers of practice Nurses peaked in 2006 since when we have lost 7%

Illness trajectories



EOLC in numbers

1% of the population dies each year in UK

- **75%** of deaths are from non-cancer/long term/frailty conditions
- **85%** of deaths occur in people over 65
- **54%** die in hospital - **35%** at home (18% home, 17% care home)
- **40-50%** of those who died in hospital could have died at home (NAO Report 09)
- **70%** of people do not die where they choose
- **£3,200 – the** cost of every hospital admission - average three in final year

A Paradigm Shift in Management Goals- survival is not the only objective

-As long as it is Ethically and Legally justified

Doing nothing?
-not a good option

Remember the boiling frogs?

Outcomes and Cost

OUTCOMES

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

COST

- Overspending on hospitals and unwanted treatments
- 30% rise in costs if stay same

CONCLUSION

- With better planning and prevention of crises more could be expected to die at home/ where they choose
- Focus on community care and reduction of hospital admissions

Doing nothing is not an option

STRATEGIC OUTCOME PRIORITES

Kings Fund April 2013

- facilitation of discharge from the acute setting
- rapid response services during periods out of hospital
- centralised co-ordination of care provision in the community
- guaranteeing 24/7 nursing care.

The Clinical Commissioning Cycle

Thematic Review - CQC

- Of the deaths in hospital,
  - over a third (36%) occurred within 3 days of admission,
  - over half (56%) occurred within 7 days.
  - 40% occurred between 8-90 days following admission
- Of the total number of people who died in hospital in 2010,
  - 12% were admitted from a care home

Social care and hospital use at the end of life,

The Nuffield Trust, 2010.

- The cost of admissions that end in death increases for those who die after eight days
- and hospital care is estimated to cost twice as much as social care towards the end of life.

End of Life Intelligence- Hospital Deaths- Lancashire North

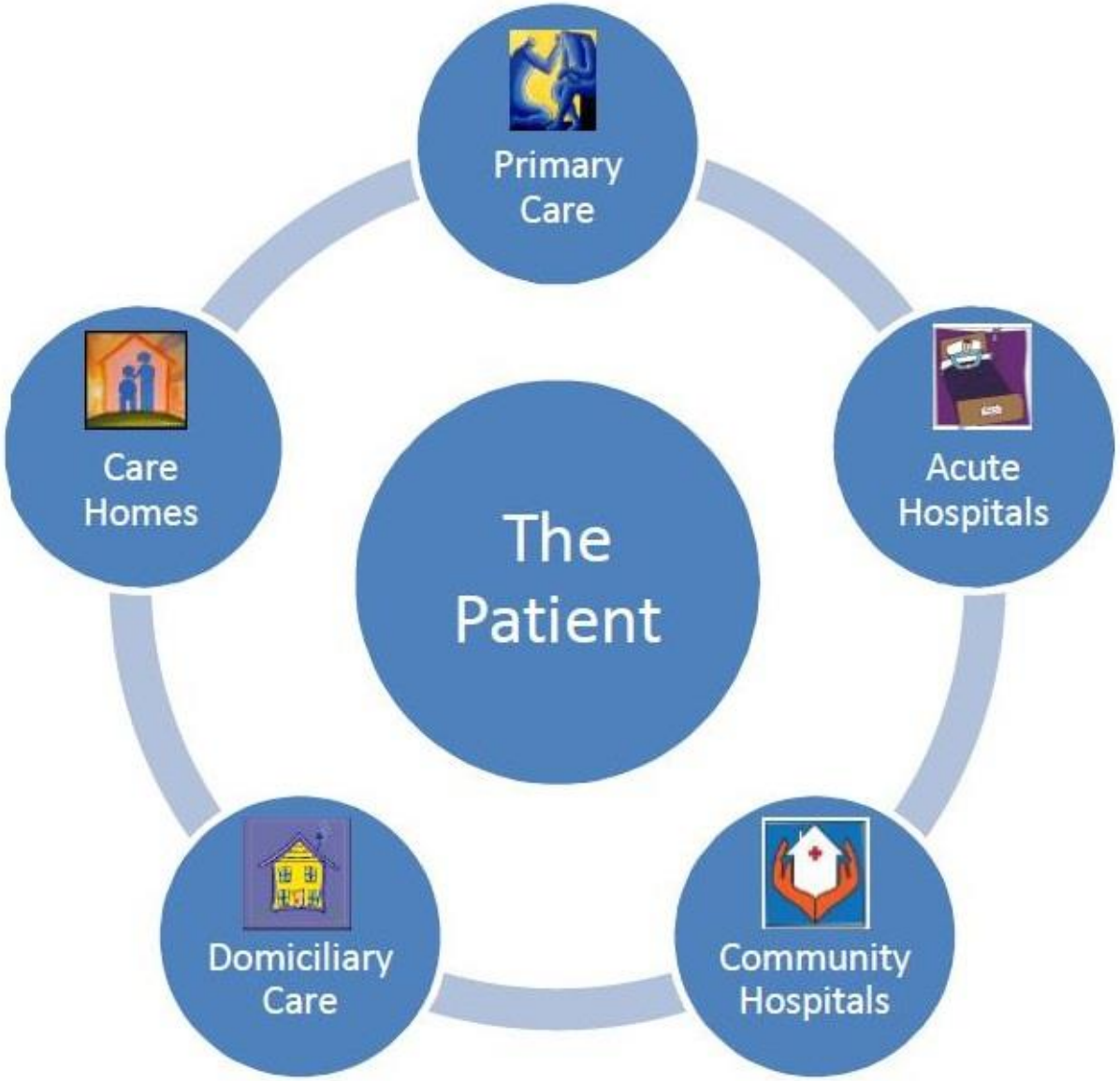
3 Modelling workshops -Types analysed and results

- Type 1: the 60% appropriate to admit to hospital
- Type 2: the 24% who could have been managed in the community
- Type 3: the 16% who needed combined community and secondary care (possible turnaround within 4 hours or rapid discharge)

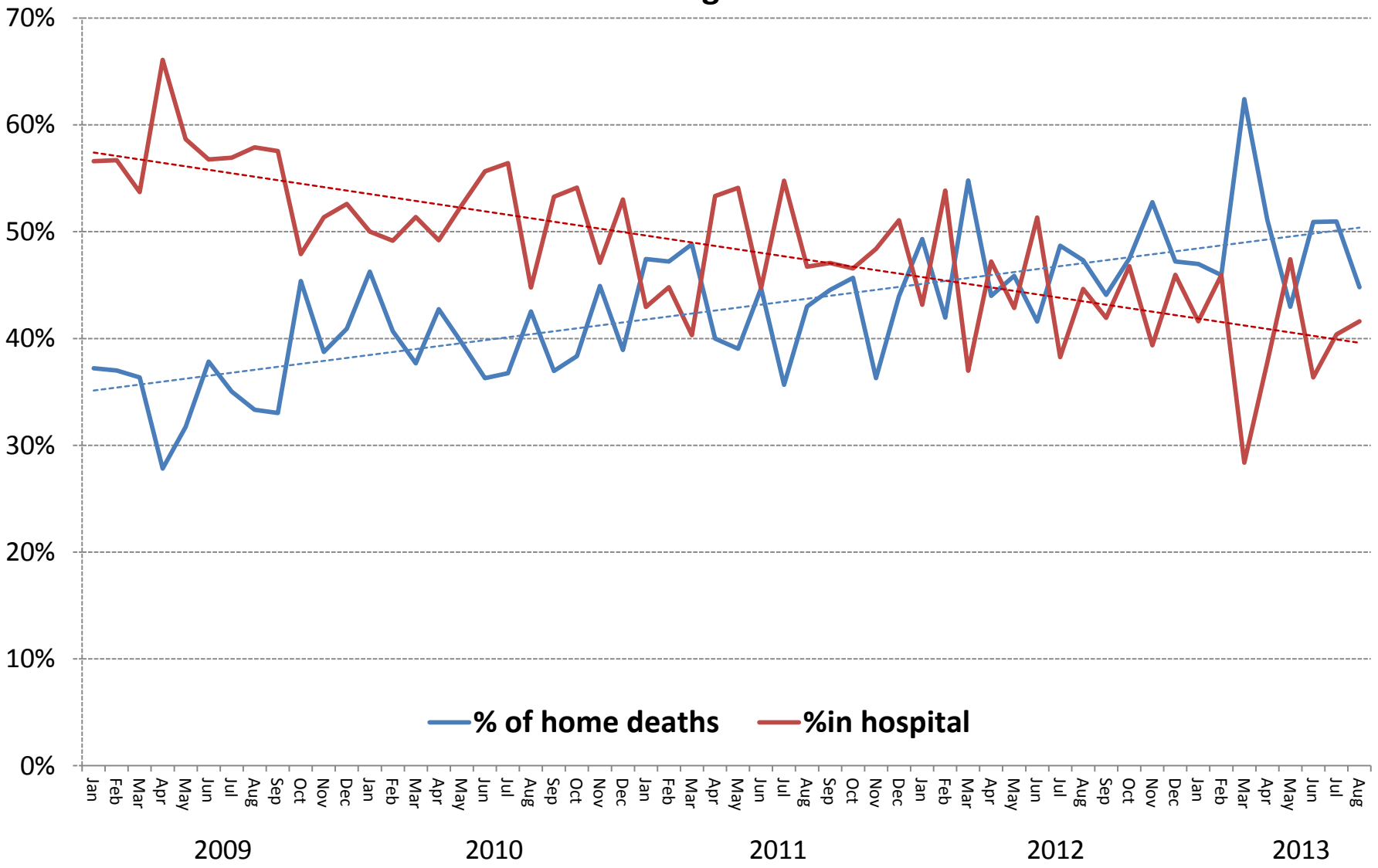
We are not doing nothing!

-Reasons to be optimistic

- Gold Standards Framework for Acute Hospitals
- EPaCCs and ePIG (Electronic Palliative Care Co-ordination and Prognostic Indicator Guidance) coming soon.
- We agreed to co-operatively fund a palliative consultant post to help GP's and consultants lead this process
- 24hr palliative nursing now available in co-operation with hospice services
- Care home training (GSF and six steps) is widespread thanks to EoL network support- with a focus on dementia care
- COPD service available at St John's Hospice and expanding
- IV diuretics at home available from heart failure service
- New Bereavement Office at Royal Lancaster Infirmary


Primary Care
Acute Hospitals
Community Hospitals
Domiciliary Care
Care Homes
The Patient

Percent of Lancashire North CCG deaths at home and in hospital 2009 to August 2013



Source: Primary Care Mortality Database, Public Health, Lancashire County Council
*Provisional data, does not include patients outside LCC boundary

Future State Lancashire North CCG

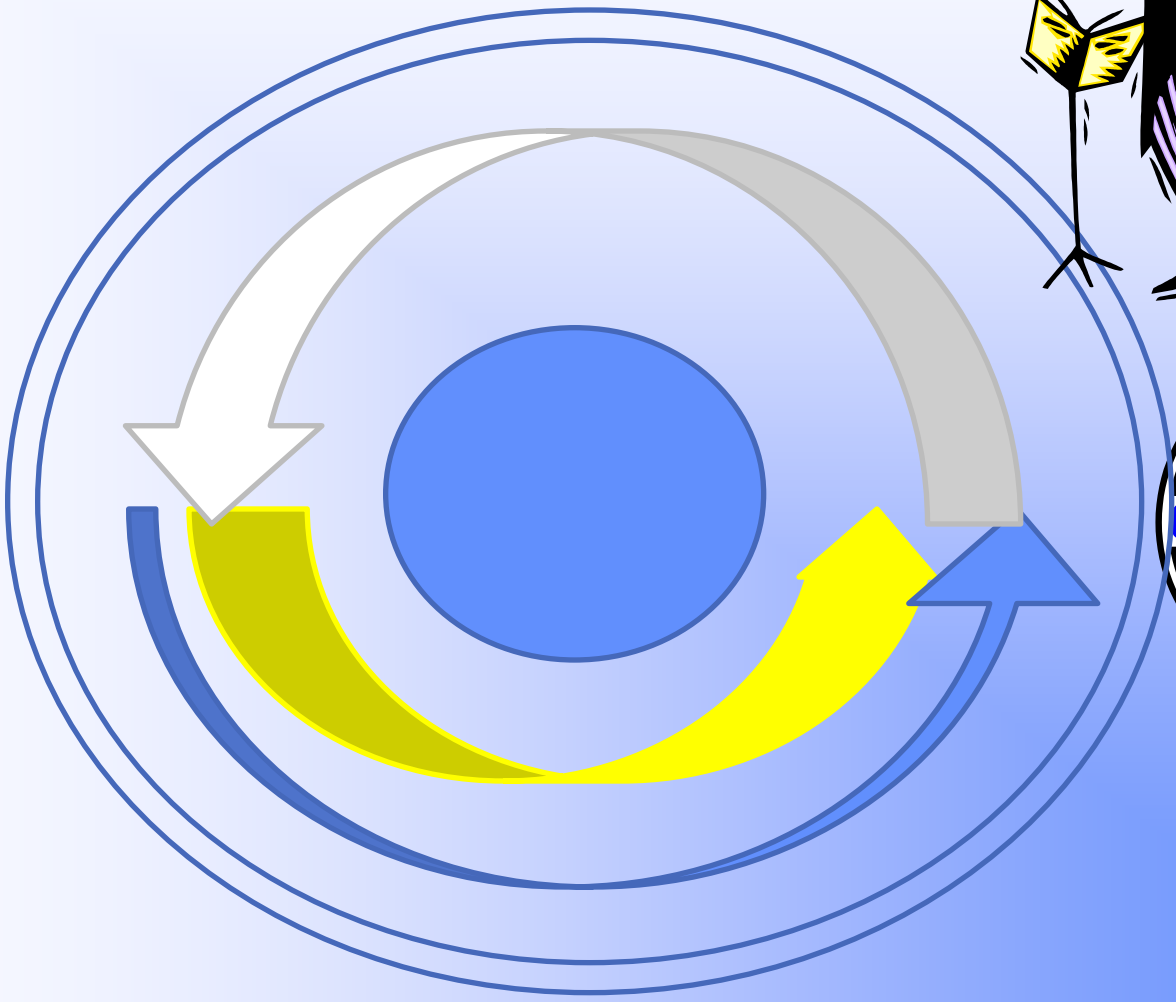
EPaCCs

Core DN & OOH

Hospice at Home

Marie Curie

DN night service



All designed to work in an integrated way with acute hospital services using GSF structures

STRATEGIC OUTCOME PRIORITES

Kings Fund April 2013-Lancashire North Solutions

- facilitation of discharge from the acute setting- Commissioned community palliative care services linking to hospices as the ‘hub’
- rapid response services during periods out of hospital-alternatives to 999- ’GSF Gold cards’
- centralised co-ordination of care provision in the community-EPaCCs
- guaranteeing 24/7 care- overnight nursing - Marie Curie Nurses

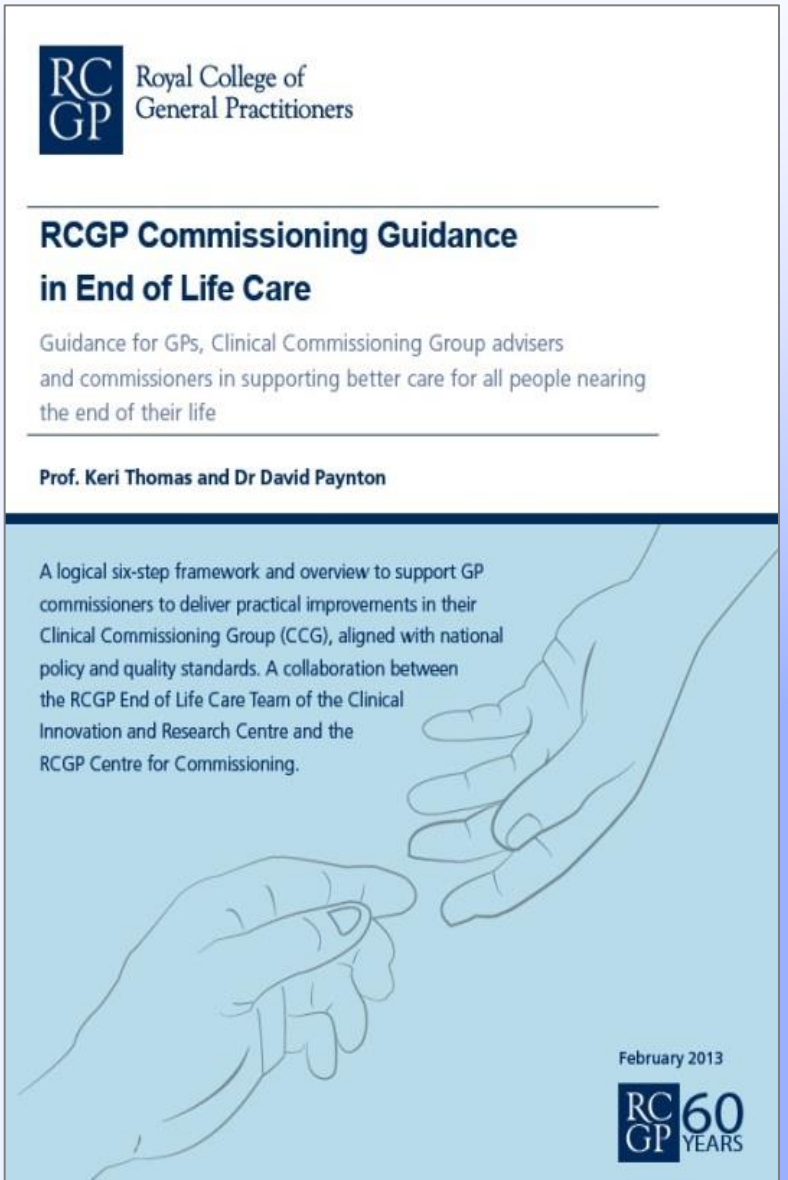
Group work
Questions for your CCG …..

1.What is the main aim of EOLC commissioning in your area?- are they the same as the Kings Fund recommendations?

2. Of the four recommended commissioning priorities, how are you doing?

Part 3

Royal College of General Practitioners

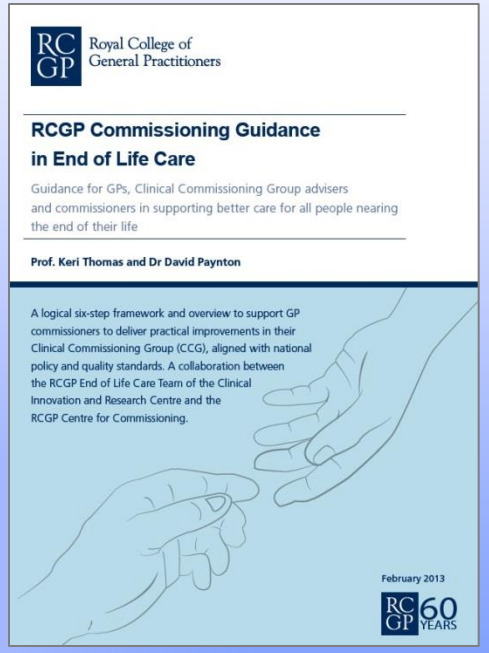


Royal College of General Practitioners

RCGP 60 YEARS

RCGP Commissioning Guidance in EOLC- 6 point plan

1. Aim
2. Goals
3. Sectors
4. Target areas
5. Domains
6. Outcome measures



1. One Aim

RCGP example

"All people approaching the end of life and their carers and family receive well-coordinated high quality care in alignment with their wishes and preferences"

Measured by

- reported satisfactory experience of care by those affected and
- key outcomes measures.

2. Two Goals

- in line with the QIPP agenda
  - delivering **quality** care
  - that is good value and **cost effective**

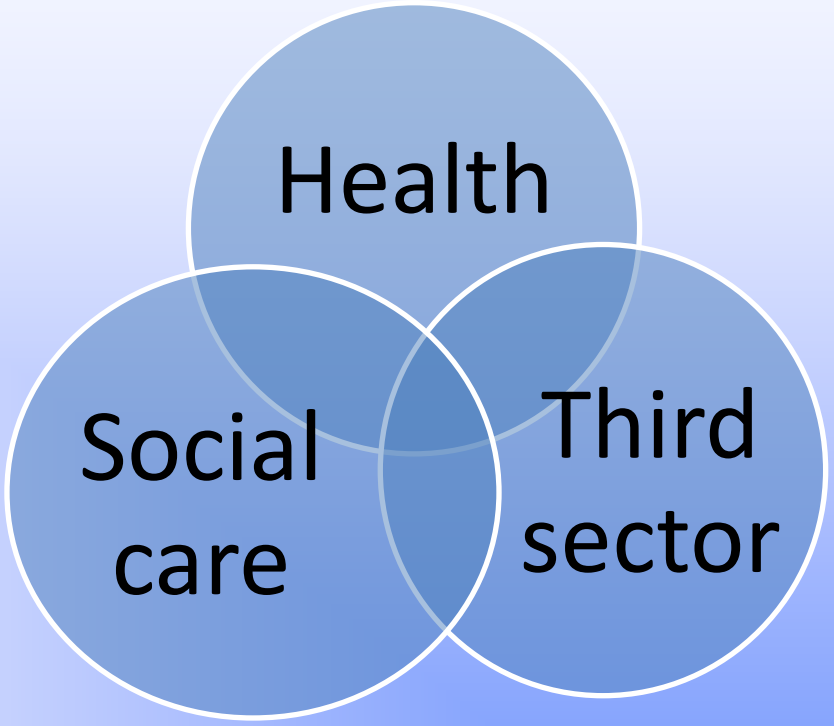
Group work
Questions …..

- Have you commissioned services to support safe rapid discharge of patients to their usual place of residence when correctable conditions have been dealt with?

3. Three sectors

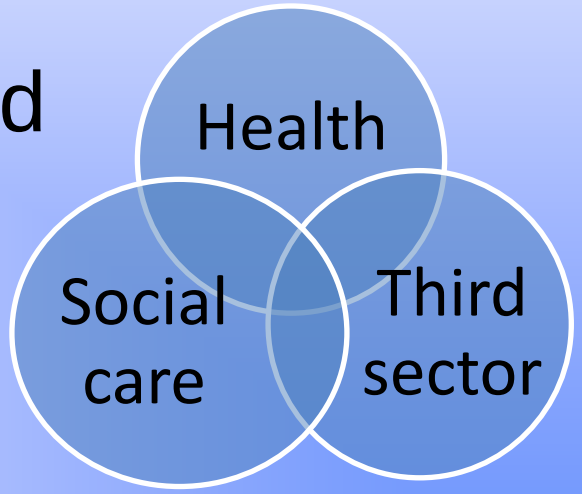
working together in collaboration-

- **Health -** adult child, mental, physical, spiritual
- **Social Care-** Local Authorities and Health and Wellbeing Board
- **Voluntary/Third Sector/ Independent Sector**- hospice, charitable and patient/ users groups



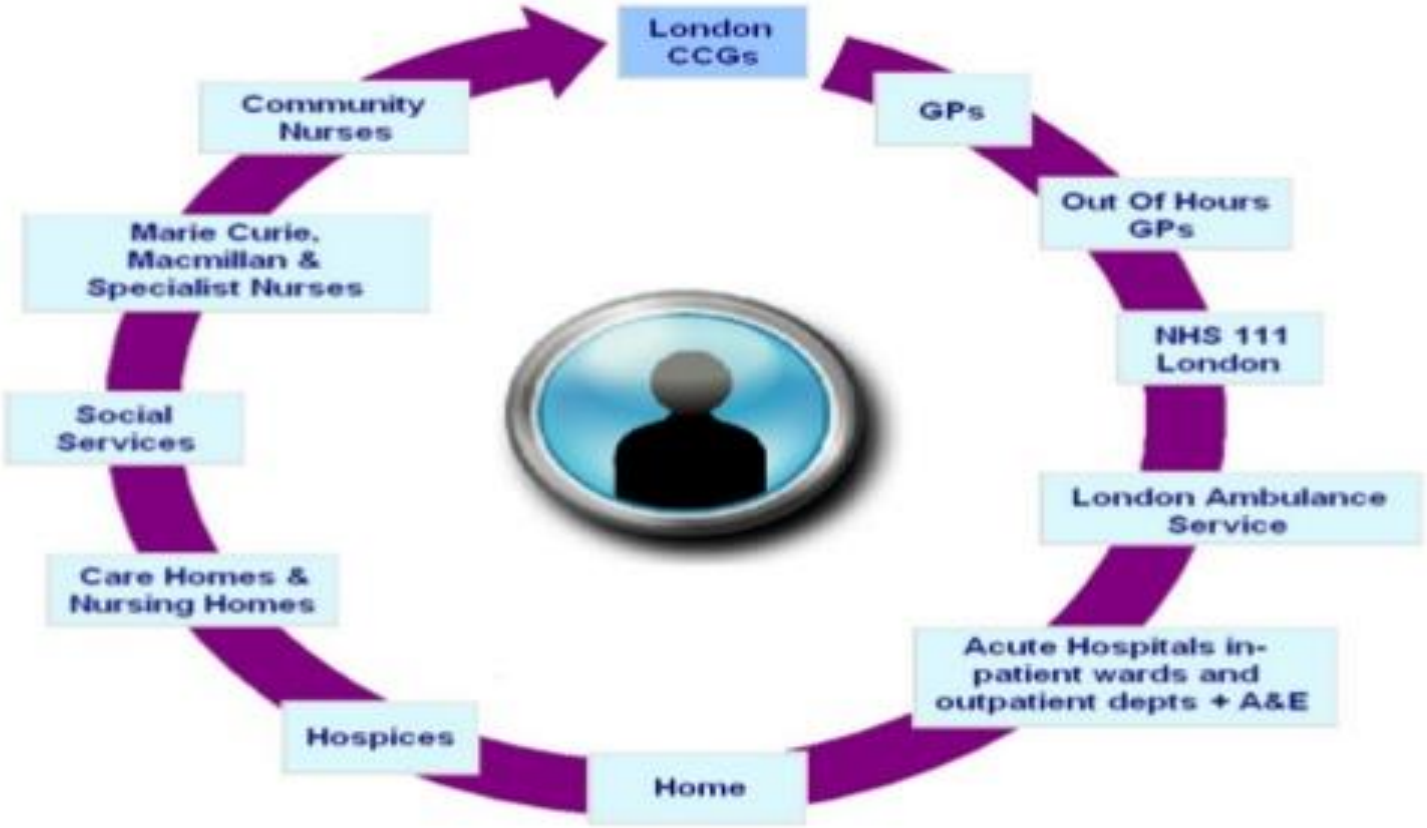
Question …..

- How are you working with your three sectors to provide co-ordinated rapid response services to your identified palliative care patients and avoid unnecessary admission?



Information Across all Care Providers

NHS
Improving Quality



Outcomes Continued

NHS Improving Quality

Evidence from an independent economic evaluation of EPaCCS suggests that -

- **There is a correlation between EPaCCS implementation and the number of people being able to die in the community in line with their wishes with -**
- **An additional 90 deaths occurring in a person's usual place of residence per 200,000 population each year,** over and above the underlying increase in rates being experienced across England.
- **An increase in DIUPR of 15,451 +9.5%.** (N= 24 sites)
- **Can save at least £35,910 per 200,000 population** each year
- **Recurrent savings after four years will be over £100k pa** and **cumulative net benefit over 4 years of c.£270k for a population of 200,000** people

Source: Economic Evaluation of the Electronic Palliative Care Coordination System (EPaCCS) Early Implementer Sites. NHS Improving Quality. May 2013.

NHS
Improving Quality

In the end, care counts

"EPaCCS... is an outstanding example of how a national initiative can be instigated and supported, with high quality evidence in improvement in outcomes.

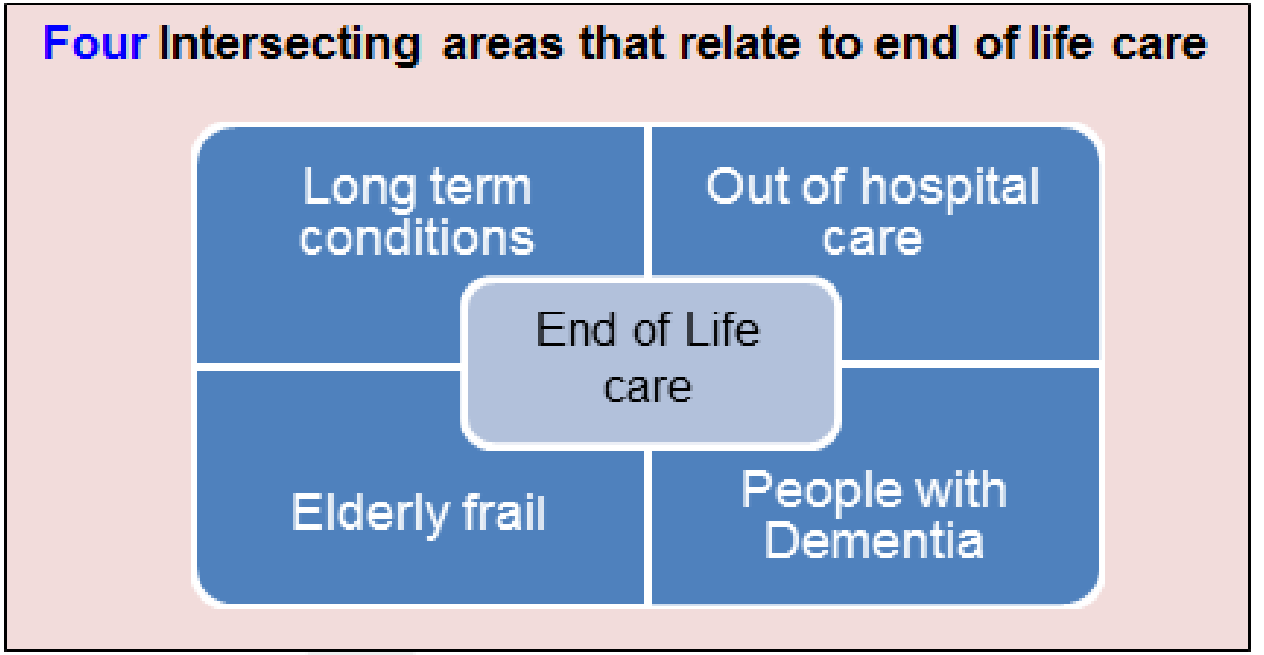
Having run a large EPaCCS programme across the south west, with many thousands of people currently registered on EPaCCS..... (t)here is much satisfaction to be had in putting effort into supporting people to have as good an experience as possible at end of life, and EPaCCS is a critical part of this."

Dr Julian Abel - Consultant Palliative care

4. Four target areas

that overlap with End of Life Care-

- **EOLC must be included in these intersecting areas to enable effective improvement**



How does EOLC connect with…

- Out of hospital care- reducing hospitalisation
  - *30% people in hospital are in their final year of life*
- Dementia
  - *'looming epidemic' -people with dementia are twice as likely to die on admission to hospital*
- Long term conditions / multi-morbidity
  - *Joined up thinking - what proportion are in their final year of life?*
- Frail elderly
  - *Living longer but not sicker- recent international comparisons UK fairs poorly*

5. Five domains of care

1. **Right person**
   - Identifying people nearing the end of life earlier and their carers
   - Use of GP Registers
   - Early alerting/ use of EPaCCS
2. **Right care**
   - Clinical care, provision of services,
   - Personal- shared decision making , advance care plan discussions, spiritual care
3. **Right place**
   - Reducing hospitalisation, improving integrated cross boundary care,
   - improving community services to enable more home deaths,
   - reducing urgent care and out-of-hours crises

5. Five domains of care

4. Right time

- Proactive care, care at each anticipated stage, care for the dying in the final days, and care for the body after death

5. Every time- for carers and family- for workforce, for organisations

- Identifying and proactively supporting carers and family, and after death in bereavement
- Enabling the generalist workforce to work optimally and ensuring training and support - knowledge, skills and attitudes
- Strategic planning and resourcing leading to consistency of care, embedding in structures e.g. Operating Framework, organisational quality assurance and accreditation, quality accounts and accountability

Question for your CCG …..

Are you commissioning services that are available 24hrs a day for your patients to have high quality care in their usual place of residence?

RCGP EOLC Commissioning Guidance-
2 areas of outcome measures

Sect A

- 1**. Population Quality Accountability report** **POPULATION BASED – 'Right Care' agenda**
  - Key outcome measures,
  - patient/carer feedback of experience of care
  - and accreditation of organisations

Sect B- individualised- **PERSON BASED**

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.

James Lind Alliance
Priority Setting Partnerships

Marie Curie Cancer Care

RCGP Royal College of General Practitioners

Palliative and end of life care Priority Setting Partnership

About the partnership

What are the aims of the partnership?

The partnership is bringing together organisations interested in palliative and end of life care. The aim is to consult people likely to be in the last years of life, current and bereaved carers and families, and healthcare professionals about what questions they believe need answering through research.

Together we will prioritise these research needs to ensure that future research improves the care and support that can be provided for those in the last years of life, their carers and families.

http://www.palliativecarepsp.org.uk/

Follow us on twitter @PeolcPSP

- A short survey is currently being distributed to identify research gaps in EOLC.
- The research needs of commissioners working in EOLC are important.
- We would like to send you an email link to the survey in the next few weeks and would greatly appreciate your responses.
- More information is available from the websites above.

SUPPORTED AND GUIDED BY

James Lind Alliance
Priority Setting Partnerships

SUPPORTING PARTNERS

Marie Curie Cancer Care

CHIEF SCIENTIST OFFICE

NHS National Institute for Health Research

mnda motor neurone disease association

NISCHR Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd | National Institute for Social Care and Health Research

AIIHPC All Ireland Institute of Hospice and Palliative Care

WE ARE MACMILLAN. CANCER SUPPORT

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

MRC Medical Research Council

CANCER RESEARCH UK

Marie Curie Cancer Care

Partnership working in end of life care

Part 4- Next Steps

- Questions +discussion
- Action plans
- Feedback from use of guidance
- Dying Matters week 12th May 2014

- THANK YOU !

Tattooed on a Care Worker's Leg during recent EOLC Training

"Life isn`t about waiting for the storm to pass, it`s about learning to dance in the rain"

Web Resources 1

http://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners

http://www.goldstandardsframework.org.uk/

Web resources 2

http://www.mariecurie.org.uk/en-GB/Commissioners-and-referrers/Commissioning-our-services/

http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions/epaccs/epaccs-resource-library.aspx

http://dyingmatters.org/page/awareness-week-2014-you-only-die-once

Web resources 3

- http://www.rcgp.org.uk/news/~/media/Files/CIRC/EOLC/RCGP-EOLC-Guidelines-Apr-2013.ashx
- http://www.rightcare.nhs.uk/index.php/commissioning-for-value/
- http://www.endoflifecare-intelligence.org.uk/resources/publications/what_we_know_now_2013