Commissioning end of life care to improve patient outcomes

Dr Peter Nightingale
FRCGP, DCH, DRCOG, DTM+H
Cert Med Ed, Cert Pall Care

GP Rosebank Surgery Lancaster, CCG Commissioning Lead, RCGP NW England Education Lead
Hon Senior Lecturer Palliative Care UCLAN
RCGP/Marie Curie Cancer Care Clinical Lead in End of Life Care
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 – priorities 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

Births and deaths, United Kingdom, 1951-2074

Projected

Births

Deaths

-8%

+17%

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

- **Cancer**
- **Organ failure**
- **Dementia and decline**

**Graphs:**
- A: Cancer function over time, showing a high function initially followed by a decline leading to death.
- B: Organ system failure function over time, showing a high function with periodic dips followed by a final decline leading to death.
- C: Dementia/frailty function over time, showing a low function, indicating a decline leading to death.
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 one 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
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

- **Analyze and Plan**
  Analyse population needs
  Assess services and gaps
  Agree outcomes

- **Design Pathways**
  Appraise evidence
  Design services
  Test and refine

- **Specify and Procure**
  Specify provision
  Determine intervention
  Manage contracts

- **Deliver and Improve**
  Manage demand
  Measure performance
  Continually improve

Build partnerships
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

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
The Patient

Primary Care

Care Homes

Acute Hospitals

Domiciliary Care

Community Hospitals
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

Core DN & OOH
Hospice at Home
Marie Curie
DN night service

EPaCCs

All designed to work in an integrated way with acute hospital services using GSF structures.
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
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?
RCGP Commissioning Guidance
in End of Life Care

Guidance for GPs, Clinical Commissioning Group advisers
and commissioners in supporting better care for all people nearing
the end of their life

Prof. Keri Thomas and Dr David Paynton

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
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**
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
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

- Community Nurses
- Marie Curie, Macmillan & Specialist Nurses
- Social Services
- Care Homes & Nursing Homes
- Hospices
- Home
- London CCGs
- GPs
- Out Of Hours GPs
- NHS 111 London
- London Ambulance Service
- Acute Hospitals in-patient wards and outpatient depts + A&E
Outcomes Continued

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

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
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

   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.
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.
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](http://www.palliativecarepsp.org.uk/) to the survey in the next few weeks and would greatly appreciate your responses.

More information is available from the websites above.
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!
"Life isn`t about waiting for the storm to pass, it`s about learning to dance in the rain"
Web Resources 1


http://www.goldstandardsframework.org.uk

http://dyingmatters.org/page/awareness-week-2014-you-only-die-once
Web resources 3

- http://www.rightcare.nhs.uk/index.php/commissioning-for-value/