

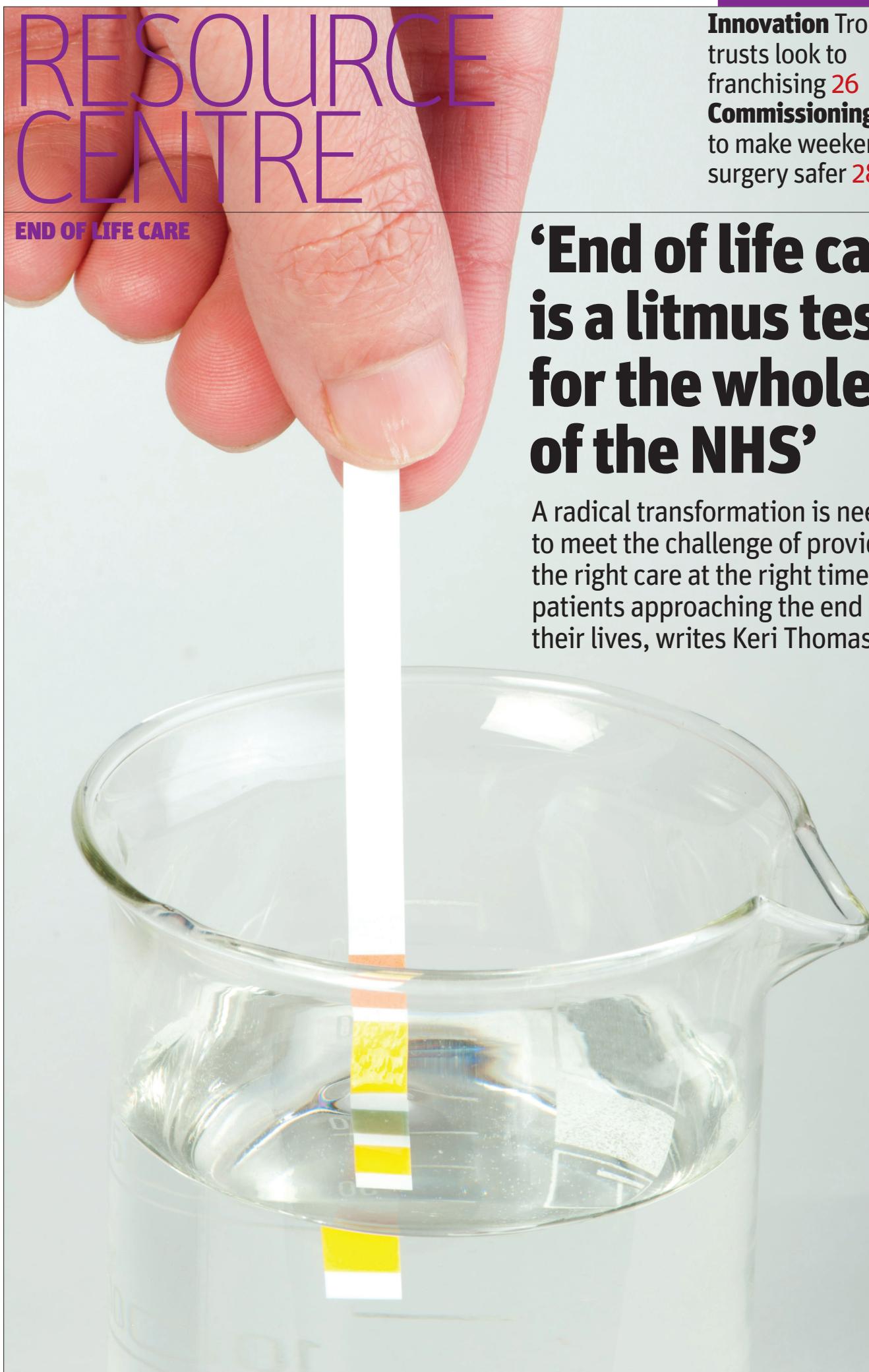
RESOURCE CENTRE

END OF LIFE CARE

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‘End of life care is a litmus test for the whole of the NHS’

A radical transformation is needed to meet the challenge of providing the right care at the right time for patients approaching the end of their lives, writes Keri Thomas



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“End of life care is a litmus test for the whole of the NHS,” said Jeremy Hunt at the King’s Fund conference in November on delivering integrated care for the elderly frail population. The call for a whole system transformation within the NHS has never been more urgent, especially for the frail elderly and those nearing the end of their life.

Avoidable hospital admissions among the elderly are seen as a major contributor to hospital pressures. They rose by 40 per cent in five years, with one in 10 of over 75s and one in five of those over 90 admitted to accident and emergency unnecessarily. Many of those faced the prospect of never returning home, according to the figures released by the Care Quality Commission in November last year.

CQC chief executive David Behan said: “GPs, care homes, home care agencies, community health services and hospitals with local commissioners must plan effectively to make sure our older and more vulnerable people are cared for in the way they deserve.

“Where care can be provided for people outside of hospitals, it is better for them and eases pressures on hospital services.”

And this month, Mark Newbold, chief executive of Heart of England Foundation Trust, wrote in *HSJ*: “With winter pressures a major issue for hospitals again, we should make a resolution to transform the healthcare system for those patients requiring NHS emergency care.”

An ageing population

As the population ages and increasingly more people are nearing the end of life, what are the solutions and how can we better plan care to prevent this overdependence on hospitals, soaring costs and too few people dying where they choose?

How can GPs, hospitals, care homes, domiciliary carers and hospitals work together in an integrated way that provides

‘A proactive, integrated, cross boundary approach will make better use of current services for people in their final year of life’

people nearing the end of life with the care they want, where they want it?

A solution is a more proactive, integrated, cross boundary approach which makes far better use of current services for people in their final year of life.

Quality benchmark

One way in which increasing numbers of GP practices, care homes and acute hospitals have been tackling this challenge is by adopting the Gold Standards Framework.

The GSF Centre is the leading national provider for training and quality assurance in end of life care for generalist frontline staff and the various programmes – adapted for use in many settings and subjects (see box, right) – have become benchmarks of quality end of life care, as recognised by the Care Quality Commission and most major providers.

The GSF is a clinically led framework that began in primary care in 2000. Basic level gold standards for GP practices was mainstreamed through the quality and outcomes framework in 2006 and many practices have taken this further through the GSF’s Going for Gold Programme and accreditation through the Royal College of GPs’ quality hallmark award.

The momentum spread to care homes from 2004 and the GSF care homes training and accreditation is now nationally recognised, with more than 2,000 care homes trained and those accredited recognised as



examples of excellence in their care for people nearing the end of life.

The centre developed further training and accreditation programmes for acute hospitals, community hospitals and domiciliary care, with dementia care, hospice support and other programmes in the pipeline.

The GSF is backed by strong evidence, intrinsic evaluations within every programme and years of experience facilitating practical grass roots change.

Individual programmes have already demonstrated significant benefits for patients and, health and social care professionals providing their care.

The GSF Cross Boundary Care Programme provides end of life care training and quality assurance for each of the three main areas where people live and die: in the community (primary and domiciliary care),

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END OF LIFE CARE

Visit *HSJ*'s new end of life care commissioning channel to see the latest news about the services available, as well as resources and videos from providers and commissioners to better understand end of life service delivery. Go to hsj.co.uk/end-of-life-care



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Avoidable hospital admissions among the elderly are a major contributor to hospital pressures

GOLD STANDARDS SET BY BENCHMARK PROGRAMME

Primary care GP practices that have completed Going for Gold training and accreditation showed hospital admissions halved, greater numbers were identified earlier on their register (32-69 per cent) and increasing numbers dying in their usual place of residence (38-50 per cent) in round 1 and 2 of the GSF accredited practices.

Care homes GSF accredited care homes showed a 50 per cent reduction in hospital deaths and crisis admissions, and a third more people dying in care homes. Comparative studies in Somerset confirmed the significant differences between GSF and non-GSF care homes. Hundreds of domiciliary care workers are now

trained across Somerset, leading to better integrated community based end of life care.

Acute hospitals Hospitals that have completed the training reduced the length of stay by an average of six days. Better communication with GPs, better use of registers, more confident staff, quicker discharge and fewer complaints were also found according to the *GSF Acute Hospitals Phase 2 Report*.

Dementia The dementia care programme, a four module distance learning programme supported by the Department of Health's dementia strategy group, focuses on reducing hospitalisation for people with dementia and early results are encouraging.

'For the first time in years, deaths in the usual place of residence outnumber those dying in hospital by 1 per cent'

care homes (nursing and residential care) and hospitals (acute and community care).

The programme provides practitioners with the necessary tools to ensure patients do not fall through the cracks, including help with identification, assessment and planning of patient care such as the GSF Prognostic Indicator Guidance. These require based coding and advance care planning tools, as well as shared outcome measures.

Vehicle for change

Airedale General Hospital works very closely with colleagues in primary care by giving "gold cards" to patients and setting up a dedicated phone line for concerned patients or carers. The Gold Line is a practical alternative to 999 and 111, and is manned by a senior nurse at the hospital, 24 hours a day.

The nurses provide patients and carers with advice and support so that patients can remain at home and will only be admitted to hospital where absolutely necessary.

In Southport, the GSF has been used as a vehicle for change in the whole community. Each of the hospital teams is taught about earlier recognition and coding according to patient needs, encouraged to have open advance care planning discussions and to plan care in alignment with these choices.

More planning ahead means that this most vulnerable elderly population really will have the opportunity to determine the way they wish to be cared for as they approach the end of life.

More often than not this means more focused, but reduced, hospital care. By working cross boundary, with their colleagues in primary care

on a joint register, the number of hospital admissions has decreased. For the first time in years, deaths in the usual place of residence outnumber those dying in hospital by 1 per cent.

It is an exciting time when clinical commissioning groups and clinicians are working with their social care colleagues to use this crisis as an opportunity for radical transformation of care, by commissioning services to truly make a difference to people.

By working together, using a common language and putting patient wishes at the heart of the care, they have shown they can begin to meet the challenge of providing the right care at the right time for patients approaching the end of their lives. ●

Professor Keri Thomas is national clinical lead for the Gold Standards Framework Centre.