Health Scrutiny and Performance Panel **Agenda Item No. 5**

24 April 2012

End of Life Care and Liverpool Care Pathway Implementation within Walsall Healthcare NHS Trust

Ward(s) All

Portfolios: Councillor Barbara McCracken – Social Care and Health

Report:
This report has been produced in response to questions raised from the previous presentation at the panel in January 2012.

Focusing on two issues:

1. Practical implementation of the Liverpool Care Pathway (LCP). The Panel want assurances on how the checks and balances of the process are followed in practice.

2. Progress on the recommendations made the last time the issue was considered by the Panel in January, namely:

a. A more detailed action plan for further improving palliative and end of life care services, including improving the way the Liverpool Care Pathway is used, be reported to a future meeting of the Panel

b. The results of the audit conducted with bereaved relatives who have raised concerns about end of life care across health partners and how lessons learnt will be implemented be reported to a future meeting of the Panel

c. A further investigation be undertaken to provide more information regarding the nine patients in the audit who it was not possible to ascertain the date they commenced the Liverpool Care Pathway be undertaken and the findings reported to a future meeting of the Panel.

Recommendations:

That the Panel please note the response to questions raised.

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Introduction

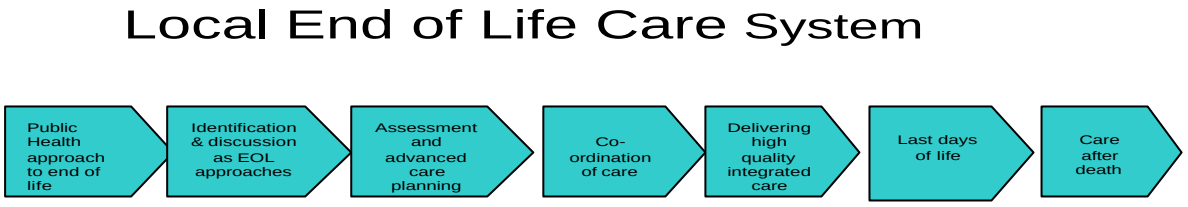
For the purpose of the report and consistency of information the paper will initially detail the vision and existing implementation plan that is in place within the organisation to progress and improve end of life care. Secondly, update the panel on the progress made with plans to conduct an exercise with bereaved relatives and finally the response to the questions raised previously on the results from the Community Audit of Liverpool Care Pathway in August last year.

1. Implementation Plan for Improving End of Life Care Services within Walsall

The Trust Board of Walsall Healthcare NHS Trust formally endorsed the overall approach to Palliative and End of Life Care in September 2011, and subsequently the overall implementation plan in November 2011. Our approach is based upon the following principles;-

- Services should be developed that enable the numbers of patients able to die in the place of their choice "at the end of their life" to be maximised.
- Service provision incorporates and mobilises a range of specialist palliative and end of life care resource in both the hospital and the community.
- Integrated pathways are developed between hospital and community services in meeting the needs of people at the end of their lives.
- Relevant staff whether in the specialist palliative care team or not, have the competencies and tools to provide good quality end of life care for their patients.

The Trust's vision and approach mirrors the national strategy for end of life care in aiming to transform care for people approaching end of life, whatever their diagnosis and wherever they are, including enabling more people to be cared for and to die at home should this be their wish. We acknowledge however that our local approach needs to be underpinned by a cultural shift in attitude towards discussion of death and dying and in encouraging people to feel more comfortable with expressing their wishes and preferences for care at the end of their lives. The diagram below details the key stages and areas of development within the implementation plan which when enabled will result in improved care for patients.



The implementation plan is subject to rigorous internal processes within the organisation internally and progress is presented at Public Board at three monthly intervals.

2. Audit of Bereaved Relatives

Improvement of our existing bereavement services as a whole is one of the key areas of implementation within the End of Life implementation plan. This includes reviewing all elements of our care after death and provision across the organisation. The audit of bereaved relatives is one component of the work stream. This is a particularly sensitive area of exploration and therefore we are planning in detail our approach with this group of relatives. The audit will be conducted using the "For One and All in Your Shoes Approach" if participants agree this is satisfactory for them. The organisation has successfully used this approach with both its staff and public this year. The organisation is happy to share the results of the audit and the resulting action plan once conducted.

3. The Liverpool Care Pathway

Organisationally this year audit has been conducted on the use of the Liverpool Care Pathway in both the Acute and Community setting. The Acute setting submitted data for the third National Audit of Dying Patients in acute care setting and the Community followed a very similar internal process. The actions from both of these audits have been incorporated into the End of Life Implementation plan. This is a continual audit and improvement process within the organisation that is monitored at Board level. There is currently an education programme in progress within the acute setting and Liverpool Care Pathway education is incorporated into all workforce development education plans.

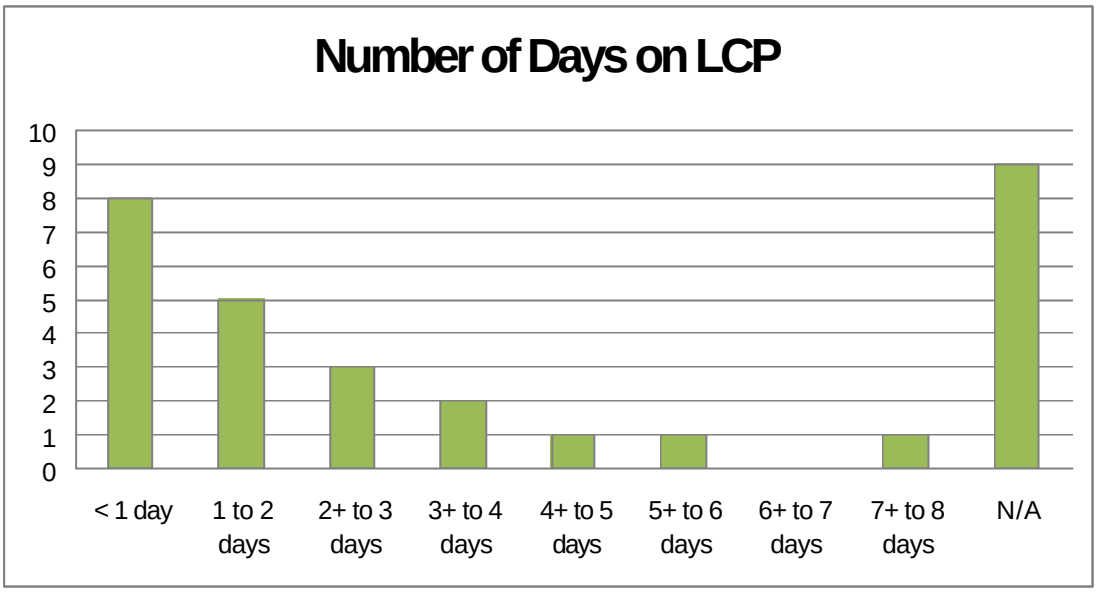
3.1 Further investigation of patient's cases from Community Audit of Liverpool Care Pathway use August 2011

During the month of August 2011 there was an audit conducted of 30 sets of notes. These were patients that had been placed on the Liverpool Care Pathway (LCP) within the Community and Nursing Home setting. Wherever, possible full nursing documentation was reviewed alongside Nursing Home notes and Community Specialist Palliative Care notes. In the previous year there had been a structured roll out programme of education, training and support between April 2010 to April 2011.The purpose of this audit was to establish how the pathways were being completed in practice, give an insight into the level and quality of end of life care being delivered to patients within the community setting and bench mark against the standards within the community policy. So predominantly the additional notes were used for as supporting evidence as all information should be completed within the pathway document.

As demonstrated in Table 1 a majority of patients remained on the pathway for between one and three days seventy–two hours is the target time for the LCP use. But there will always be patients whose dying phase will be shorter of longer. There is also an error in data representation within the original audit results as it was reported that for eight patients it was difficult to establish how long they had been on the pathway from the information available within the document, but in fact it was nine patients and the additional patient has been re-audited for the purpose of this review.

The auditors were seeking to establish the quality of documentation against the standards so therefore if information was not present within the LCP pathway they recorded it as absent. This was due to either the date of commencement or the date of death not being documented within the pathway, but this information may have been detailed within other notes at the patient's home. The aim of this secondary supportive short report is to provide assurance that although there was an inability to identify commencement or completion time within the Liverpool Care Pathway document that patients were monitored appropriately during their end of life care phase in terms of appropriateness for this plan of care.

Table 1



Process

There has been a further review of this group of patients completed by the original authors: Sue Crabtree, Head of Palliative and End of Life Care and Sharon Yates, Palliative Care Education Facilitator, Walsall Healthcare NHS Trust.

For the purpose of the re-audit the reviewer used additional sources of reliable information, which were the Community Information System (IPM) and Liverpool Care Pathway, fax sheet (between pages 6 and 7 of the LCP booklet) which is completed and sent to the Specialist Community Palliative Care Team when an LCP Pathway is commenced within the Community. To maintain confidentiality of the cohort group they will only be referred to as Patient 1, 2, 3 etc

Results of Re-audit

Of the nine patients reviewed for the second time only one of them was cared for within a Nursing Home Care Setting all other had the pathway commenced whilst at home. Additionally of the eight patients seven of them were being cared for jointly by the Community Nursing Team, General Practitioner and Specialist Palliative Care Nurse and one patient completed their care within an acute hospital setting outside of the Walsall Borough. This gives assurance that this group of patients predominantly were having their care coordinated by Specialist Palliative Care Practitioners. Although the auditors were still unable to determine exact hours of care on the LCP they were able to determine to days.

Patient 1 Commenced LCP ON 17/01/2011, died 21/11/2011- maximum 4 days

Patient 2 Commenced LCP ON 11/03/2011, died 13/03/2011- maximum 3 days

Patient 3 Commenced on LCP 10/09/2010, died 11/09/2010 –maximum 24 hours

Patient 4 Commenced on LCP 25/10/2010, died 25/10/2010 – maximum 24 hours

Patient 5 Commenced on the LCP 17/09/2010 by General Practitioner, referred for Specialist Palliative Care Nurse advice the same day. The patient was seen at home as an emergency that day, there were concerns that deterioration in patient's condition may have correctable cause. Liaison with Oncology Service at Sandwell Hospital where previously treated and decision made to admit for acute management. LCP plan of care discontinued and alternative pathway effected Patient did not return home died in hospital 08/10/2010.

Patient 6 Commenced on LCP 04/10/2010, died 04/10/2010- pathway implemented for no more than 24 hours. This patient was care for within a Nursing Home

Patient 7 Commenced on LCP 26/10/2010, died 27/10/2010- maximum 24 hours

Patient 8 Commenced on LCP 19/03/2011. This patient's palliative and end of life care phase was extremely complex and complicated, with an extended and protracted dying phase. The patient died on the 15/04/2011which means that she was receiving LCP care for potentially 27 days. The care pathway was discontinued and suspended during this period at least once. Also during this time there were multiple Specialist Palliative Care reassessments and a domiciliary visit conducted by Consultant in Palliative Medicine to review the plan of care.

Patient 9 Commenced on LCP 26/11/2010, DIED 26/11 2010-less than 24 hours

Conclusion

It is anticipated that the results of this re-audit of this cohort of patients will give reassurance to the Health Scrutiny and Performance Panel that although the initial audit was unable to identify beginning and end points for the plan of care that none of these patients were not inappropriately placed and continued on this plan of care for long periods without review. Furthermore, within at least two of the patient cases there is demonstration of highly complex care delivery with ongoing assessment by Specialist Palliative Care Services and discontinuation of the LCP Pathway when it is not appropriate, It is also worth noting here that the practice of using LCP at this time within the Community setting was a new implementation.

Walsall Healthcare NHS
NHS Trust

End of Life Care Implementation Plan

Lead Director: Sue Hartley- Director of Nursing

Date: April 2012

Ref 1.	Detail recommendation made	**Services should be developed that enable the numbers of patients able to die in the place of their choice and "at the end of their lives" to be maximised**	**Risk rating : S x L 9**

Ref:	Action	Lead	Completion deadline	Progress update	Evidence	Monitoring Arrangements	Date completed
1.1 **1.1.1**	**Adoption of End of Life delivery tools/models across the organisation:-** Preferred place of care (PPC)	Sue Crabtree	March 2012	Ward 4 of modular block and community specialist palliative care team are implementing preferred place of care. Scope of recording PPC will be extended within the Palliative & End of Life Pathway with the transfer from District Nursing and pathway development PPC is recorded within the GSF	Specialist palliative care team audit October 2011 reveals 66% of caseload supported to remain/die in their own home. **Reference: Quality standard No:1**	End of Life Steering Committee Launching new GSF Template within the Fusion system April 2012	

				Registers within primary care GSF is well established in primary and community services. Ward 4 of the modular block has also implemented GSF. GSF roll out plan in the modular block.		This is monitored by the QoF for Primary Care. Additional payments can be claimed through a locally enhanced service for GSF.	
1.1.2	The Gold Standards Framework	Sue Crabtree/ Chris Davies/ Divisional Head of Nursing	Maintain Community Practice and develop acute Trust progress. Three more ward adopted practice by 2012.		GP Practices across the borough holding a Register TWICC 94% West 100% North 94% South East 95% GP Practices holding an MDT Meeting TWICC 61% West 71% North 94% South East 79% Early discussion as to next wards to adopt GSF Acute Practice	End of Life Steering Committee	

1.1.3	Liverpool Care Pathway	Sue Crabtree/ Chris Kelly	Acute Trust Programme Oct 2011 to March 2012	Community pathway has been adapted for use across the organisation. Acute Trust roll out plan for LCP Education: Oct- Dec 2011 – Wards 1, 3,4 Nov 2011-Jan 2012 Wards 14-17 Dec 2011-Feb2012 Wards 5, 6, 7, 10, 11, 12 Wards ITU, HDU and A&E Alongside EOL Champion Programme.	**Reference: Quality standard No:1** Version 12 available within acute setting Mortality review group audit (quarterly) Policy ratified November 2011 Community CQIN outcome Achieved 100% of payment in March 2011 80% of total staff trained 87 district Nurses 13 Matrons 33 Specialist Nurses 49 Intermediate Care Team Staff	Version control audit planned for December 2011. Evidence of Training foe acute Trust Feb 2012 43 acute Trust trained ..\LCP\Acute Trust Care of the Dying Pathway Training Feb 2012.xls	

					12 Community Nursing Children's Staff Additionally training given to three key Nursing Homes with GSF status.		
1.2	**Discussion and recording of patient preferred place of care (including an advanced care plan) is well embedded in the organisation.**	Sindy Dhallu	Initial training completed by March 2012	a. Four two day sessions which we have had 29 staff attend from acute and community. b. For staff with existing Advanced Communication skill competency 3 half day sessions, to which we have had 30 staff attend acute & Community c. As part of the e-ECLA training, 23 ward champions received educational sessions on the ACP module. d. Awareness sessions of ACP have been carried out for GP's all clusters, Support groups – ICD	Audit of care plans 6 monthly Complaints, PALS analysis. In your Shoes feedback **Reference: Quality standard No:2**	Advanced Care Planning Sub-Group. End of Life Steering Group.	

				group; Nursing & care homes – 62 staff so far and BADGER Urgent Care Centre staff e. Further awareness training in April with Heart Failure patients and Day hospice attendees in March approx 50. f. The ACP document is to be adopted by St. Giles at Walsall & Whittington as part of their standard practice. The longer term plan is to incorporate the programme into the educational provision and planning already provided within the Trust.			
1.3	**Produce an action plan in response to the third national audit of dying in**	Pat Bennett	Provisional date for release end of	Results released in December by National Team	Report Produced in January 2012 presented to End of Life Steering		Jan 2012

	acute care.		December 2011.		Group Recommendation integrated into existing plan		

Ref 2		**Service provision incorporates and mobilises a range of specialist palliative and end of life care resource in both the hospital and the community.**	**Risk rating : S x L** **6**

Ref:	Action	Lead	Completion deadline	Progress update	Evidence	Monitoring Arrangements	Date completed
2.1	**Access to specialist palliative care advice and support is maximised.**						
2.1.1	Equity of access to specialist palliative care across the 7 day period is achieved.	Pat Bennet/ Mike Goodwin	February 2012	Hospital Palliative Care commenced seven day working for a trial period as from 10th March 2012 Divisional directorate structures under review by COO.	Protocol and rota in place in the community Transitional arrangements in place to manage initial	End of Life Steering Group	
2.1.2	Specialist palliative care operates as a single managed integrated	Jayne Tunstall	March 2012	Some initial discussions have		End of Life Steering Group	

	service.			taken place	issues. Resources maximised. **Reference: Quality standard No:10**		
2.1.3	**Develop and Integrated Multi-disciplinary Team approach within acute care**	Sue Crabtree Jane Tunstall Sue Hartley	Business Case April 2012	Initial recommendations produced from Organisational Review February	Formation either by realignment of existing service or new investment within a range of posts Shorter lengths of stay for Palliative and EOL Care Patients Reduction in HMSR **Reference: Quality standard**	Integration and Improvement Board	

					No:10		
2.2	**The provision of End of Life Care for Dementia Patients**	Sue Hartley	April 2013	Scope current deaths in Hospital with Patients with dementia. Consider how this care may be delivered differently outside of normal acute care provision	Evidence of planning within Dementia Strategy for the organisation	Healthcare Group for Older Adults Dementia Care Strategy	

Ref 3		**Integrated pathways are developed between hospital and community services in meeting the needs of people at the end of their lives**	**Risk rating : S x L** **6**

Ref:	**Action**	**Lead**	**Completion deadline**	**Progress update**	**Evidence**	**Monitoring Arrangements**	**Date completed**
3.1	**Demonstrable outcomes measured and delivered as a result of the implementation of the End of Life Pioneer Pathway:-** • **National End of Life Care Modelling Tool developed and**	Trish Skitt	January 2012	Core group developed. Baseline SUS	Model produces a report of assumptions	Sub group of the End of Life Steering	January 2012

	implemented.			data for one year analysed for retrospective review of end of life management 2009/10. Key Findings: 1. Approximately 270 people for whom care could have been delivered out of hospital in a year. 2. The highest disease prevalence includes respiratory and heart disease.	for percentage of people who can be supported “out of hospital” to inform workforce and financial assumptions. Reduced length of stay assumptions produced.	Committee Pioneer Pathway Group/End of Life Steering Committee	
3.2	**Role of named key worker for palliative/end of life care patients is systematically implemented.**	Sue Hartley	Needs to be extended across all services and acute wards by	Community protocol developed.	Alignment of Specialist Community Palliative Care Team to GPs localities and	Sub-roup reports to End of Life Steering Group.	

			September 2012		specific named patients. Reference: Quality standard No:2		
3.3	**Appropriate sharing of information occurs across the pathway including relevant stakeholders and partner agencies. The organisational vision is that data will be shared in electronic form**	Trish Skitt	End of March 2012	Patient alerts in place for vulnerable patients who enter hospital during the winter for response by community teams. Communication and Education roll out programme from April 2012 Begin reporting on dashboard June 2012	Electronic template and register in Fusion developed. **Reference: Quality standard No:1**	GSF Template available from April 2012 Presentation to LMC March 2012	

3.4	**Ensure that families are supported appropriately after death:-** • **Develop integrated bereavement service between community and the hospital.** • **Collate baseline of organisational complaints surrounding end of life care.** • **Conduct an In Your Shoes with volunteer bereaved relatives to explore their experience/ organisational areas for implementation.** • **Develop supportive family provision including Bereavement Facilities that is**	John Hayes Dawn Kenny John Hayes John Hayes Sue Hartley	March 2012 December 2011 January 2012	Sub-group established.	Meeting minutes, agreed work plan for group. Three key priorities from action plan and benefits realisation plan. **Reference: Quality standards No:2,12,13,14**	Progress reported through the EOL Sub-Group structure. Pioneering Pathway Programme Group Some delays in obtaining complaints information from the acute Trust	

	culturally sensitive						
3.5	**Develop closer working relationships between Accident and Emergency front end services and Community Services for the diversion of End of Life Patients**	Sue Crabtree	October 2012	Through Accident and Emergency Services redesign programme develop diversion protocols that include all Community Services	Reduction in unplanned End Of Life admissions Maximised capacity in Arboretum Nursing Home Diversion beds	Integration and Improvement Board	
3.6	**Develop Pathways for End of Life Patients with Cardiac and Respiratory Conditions**	Sue Crabtree Dr Gupta/ Tina Fletcher Dr Nadeem/ Nicky Humphries	December 2012	Maximise potential of using Palliative Care Centre to deliver care closer to home Improve flow and patient pathways between Respiratory and Heart Failure Services with Specialist Palliative Care Services	Reduction in numbers of patients dying in acute care with Respiratory and Cardiac Disease	Pioneering Pathways Programme Group Integration and Improvement Board	

Ref 4		**Relevant staff, whether in the specialist palliative care team or not, have the competencies and tools to provide good quality end of life care for their patients.**	**Risk rating : S x L** **12**

Ref:	Action	Lead	Completion deadline	Progress update	Evidence	Monitoring Arrangements	Date completed
4.1	**Education and workforce competency plan in place across the partnership.**	Sharon Yates/ Kathryn Halford	November 2011	EOL care competencies have been developed for all grades of staff and adapted. Discussion progressing with ESR department re core palliative care education that ensures benchmarking against number of staff trained in four key areas.	Competency Document Will be able to track progress and competency of staff through ESR system when achieved.	End of Life Care Steering Group. National End of Life Care early adopter evaluation.	

				Ambulatory 1.Syringe Driver knowledge and Competence 2.Communication skills and Advanced Care Planning 3.EOL Tool Training 4.Symptom Control at the End of Life	**Reference: Quality standard No: 15, 16**	Evidence of achieved competencies	
			Jan 2011	Dr Senthil to begin to develop educational training programme for medical staff	Consistent Medical Education programme being delivered		

End of Life Action Plan within Walsall Healthcare NHS Trust
Version 6 April 2012