

Report to the Health Scrutiny Committee
11th March 2014

Report outlining progress of the End of Life Care Strategy and Pathway development within Walsall Healthcare Trust

This is the third update in a series of reports to the Health Scrutiny Committee in relation to the overall plan and strategy to improve Palliative and End of Life Care for all Patients and Carers within the Borough of Walsall.

- Progress report against End of Life Action Plan
- Report on progress with the national TRANSFORM Programme improving End of Life Care in the acute care setting
- Update report on national developments in relation to Liverpool Care Pathway and organisational arrangements to manage the transition

Recommendations:

That: That the committee note and debate the content.

Introduction

The purpose of this report is to provide the Health Scrutiny Committee with an update on the development and progress against the Walsall Healthcare Trust's existing End of Life Action Plan. The key deliverable outcomes referred to in the paper are taken from the existing End of Life Care Action Plan. In addition, report on progress with the national TRANSFORM Programme improving End of Life Care in the acute care setting and an update report on national developments in relation to Liverpool Care Pathway and organisational arrangements to manage the transition.

Our local approach to an effective end of life care pathway incorporates the following components and it is these components that our End of Life action plan is based:-

Local End of Life Care System



Key Deliverable: Care in the Last Few Days of Life

Action: Care at the End of Life and the Liverpool Care Pathway

The national review of Liverpool Care Pathway (LCP) and its use in England was released in July 2013, chaired by Julia Neuberger, titled “more care, less pathway”. This advocated far reaching change in our system for how we manage this very vulnerable group within our population. As a result of this the National Alliance for Dying was formed and have been working together nationally to produce new best practice guidance. Further to the initial immediate recommendations the Alliance released announcements in December 2013 the directive that the LCP must be withdrawn from use by July 2014. Our use of the LCP across the organisation has remained low since the release of the report and transitional arrangements have in place since November to ensure whether the pathway is used or not patients and their families are still receiving good quality care. These are:

- The new process for referral for End of Life Care to the End of Life Specialist Practitioner is now embedded and dashboard monitoring is demonstrating referrals at a similar level to pre LCP National Report
- The new Best Practice Guidance in End of Life Care has been developed and is currently in the consultation and sign off phase. This will replace the organisations Liverpool Care Pathway Policy.
- The new process for auditing care delivered to end of life care patients is now established and is populated within the EOL Dashboard for both Acute and Community Care.
- Data was entered as planned for the Fourth Round of National Care of the Dying Audit in November with results available in the spring 2014. For the fourth round of the National Audit for Dying Patients the submission data was altered considerably, information required for submission was more detailed and included patients not on Liverpool Care Pathway plan of care for the first time. This is a prelude to providing national data that will inform the future recommendations.

More recently in December 2013, there was a clear change in advice and direction from The National Alliance for Dying. Initially it was suggested that they wanted to develop a national replacement/ solution which would possibly be in the form of an individualised end of life care plan and organisations were encouraged not to develop their own plans. More recently, this decision appears to have been reversed and the Alliance will issue guiding best practice principles as a replacement rather than a care plan. We are currently developing our local approach within the End of Life Strategic Development Group by April with an options appraisal to Trust Board in May for final agreement.

Key Deliverable: identification and discussion as end of life approaches.

Action Plan point 3.3 appropriate sharing of information occurs across the pathway with relevant stakeholder and partners in an electronic form.

Review work is on-going in collaboration with the Informatics Team to continue to develop a local Electronic Patient Coordination System (EPACC's) in the form of an End of Life Register within the Fusion System. We have held a number of workshops with Primary Care Gold Standard Framework Facilitators to elicit their views and engaged national pilot sites in relation to their development nationally, there appears no one solution to wider information sharing at this level. We will be taking full advantage of any opportunity within the Lorenzo System to improve our current register; this will be work completed post launch date of March 2014. In addition to the national Information Standard that was released 18 months ago a further amendment to this standard was released in December 2014, we are currently progressing compliance with this within our own template.

Action: 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 Patients.

End of Life Care Mandatory Training is continual throughout this year and numbers have been included within the EOL Dashboard. In addition programmes of education continue for all Nursing and AHP staff through our existing Palliative Care Education Facilitator Programmes.

The new education programme has been developed to support the introduction of AMBER Care Bundle within Ward 15, 16 and 17 has now progressed to Wards 7, 4 and 10 which is our first Surgical Ward during the months of January and February 2014. Both the Medical and Nursing Team are receiving a training programme prior to beginning to use AMBER Care Bundle but in addition Nursing staff have experienced a number of clinical placements within the palliative care setting in order for them to make positive change and improvement within their clinical areas. The continued development for this will be through on going action-learning sets with nominated AMBER Champions. Discussions are currently progressing in relation to the next clinical areas to begin using AMBER Care Bundle.

Key Deliverable: Assessment Care Planning and Review

Action: Advance Care Planning is embedded within the organisation

The Advanced Care Plan (ACP) for use across the Borough was released in May 2013. The role out programme and training will be continued throughout the year. The numbers of Advanced Care Plans completed (numbers in total) are now being populated within the EOL Dashboard and demonstrating a steady increase month on month.

Key Deliverable: Integrated pathways are developed between hospital and community services in meeting the needs of people at the end of their lives

Action: Develop direct access and diversionary pathways for Palliative & End of Life Care Services into and out of acute care

Over the past four months Specialist Palliative Care Staff have been working with Partners at St Giles Walsall Hospice and the Clinical Commissioning Group (C.C.G) to develop operational plans for five diversionary pathways for Palliative and End of Life Care patients. This will utilise three beds within the in-patient unit as an alternative to hospital admission. This is initially as a pilot scheme but if reviews well may become permanent option for patients in the pathway

Aim of the project

- To divert patients into a Specialist Palliative Care In-Patient bed to offer an alternative treatment pathway for a number of organisationally agreed interventions.
- To relieve Winter Pressures on acute hospital services for agreed treatment pathways.
- To offer patients in the receiving care and support in the end of life pathway (12-18 months) alternative options for sub- acute management of a number of conditions in an alternative place to hospital
- To maximise bed capacity and availability within St Giles Walsall Hospice in-patient unit

Scope of the pilot project

Adults (18+) identified as entering a number of agreed management pathways condition, regardless of diagnosis.

Pathway 1 Hypercalcaemia Treatment Pathway
Pathway 2 Lymphoedema Pathway for Cellulitis
Pathway 3 Blood Transfusion Pathway
Pathway 4 Intravenous Antibiotic Therapy for Exacerbation of Respiratory Conditions Pathway
Pathway 5 Intravenous Furosemide for Patients with Decompensated Heart Failure at End of Life Pathway

1.3 Criteria for access to diversion pathway beds

- Patients can only be admitted to a diversion pathway bed if they require treatment from one of the five cited pathways. All decisions will be made on a case by case decision process and it is acknowledged that alternative pathways may emerge during the course of the pilot.

This will be commenced as from mid- January 2014 once agreement has been reached at CCG level. First Phase is hospital prevention priorities but the working group will continue to develop access pathways for all areas to include acute care.

Key Deliverable: Care after Death

Action Point 3.4.1 Ensure that Families are appropriately supported after death

The new Bereavement Leaflet was introduced into the organisation in December 2013 across all clinical areas alongside a new Care after Death audit form produced by the Heads of Nursing. This was a result of audit results which demonstrated our care after death was poorly documented, monitoring of use will be through monthly audit. This is to ensure that bereaved families are receiving good quality, appropriate information at this difficult time. We also are planning to use an amended National Bereavement VOICES Questionnaire given to bereaved families at the time of hospital death as the next step in our Bereavement Strategy.

The TRANSFORM Programme

The TRANSFORM Programme aims to equip hospitals with robust tools, while leaving them scope to create solutions that work best for their patients and their organisation. Overall, it provides a comprehensive service improvement approach. In March 2013 key programme leads for the Trust attended the first launch day for Phase 2 of the programme. Since this time the implementation group have been focused on the two key enablers, AMBER Care Bundle and Rapid Discharge Pathway Home to Die as these were the two areas where no development work had been undertaken and we had work streams in development for the other three enablers which are; Advanced Care Planning, EPPaC's (electronic patient registers at End of Life) and LCP.

AMBER Care Bundle

The Trust's first used AMBER Care Bundle commenced in October 2013 on Ward 16. Both the Medical and Nursing Staff are both very committed to this development and support for the programme has been good. As previously reported within the paper there is further on-going development currently underway.

Rapid Discharge Pathway Home to Die

Process mapping has now been completed; the group is meeting regularly and has a developed work programme to develop the Rapid Discharge Process. The aim is to test the process in real time at the end of March 2014 after developing an agreed Standard Operating Procedure. Progress within the TRANSFORM Programme will be reported to the End of Life Steering Group and other key programmes as required.

National Audit Results of Specialist Palliative Care Services

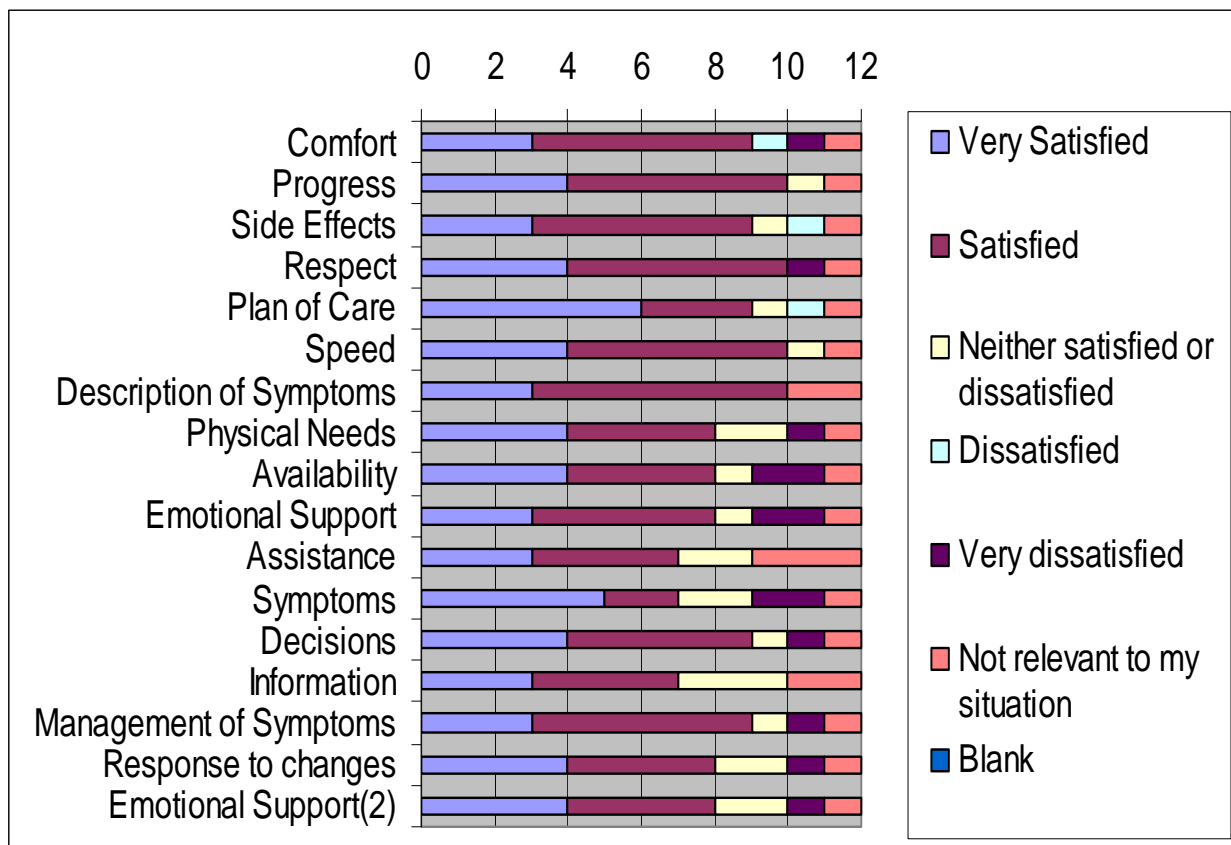
During April – June 2013 the Integrated Specialist Palliative Care Team and St Giles Walsall Hospice participated in the FAMCARE 2 National Audit for Specialist Services conducted by the Association for Palliative Medicine. This was a retrospective audit for all patients that had died within those services between the months of April–June 2013. Each service (hospital, community, IPU) identified patients separately and wrote separate letters, with a questionnaire and space for written feedback. All the letters sent to next of kin with no reminders to complete. The aim of the national audit was to;

- evaluate the services we provide
- benchmark these against evaluations of other similar services across the country

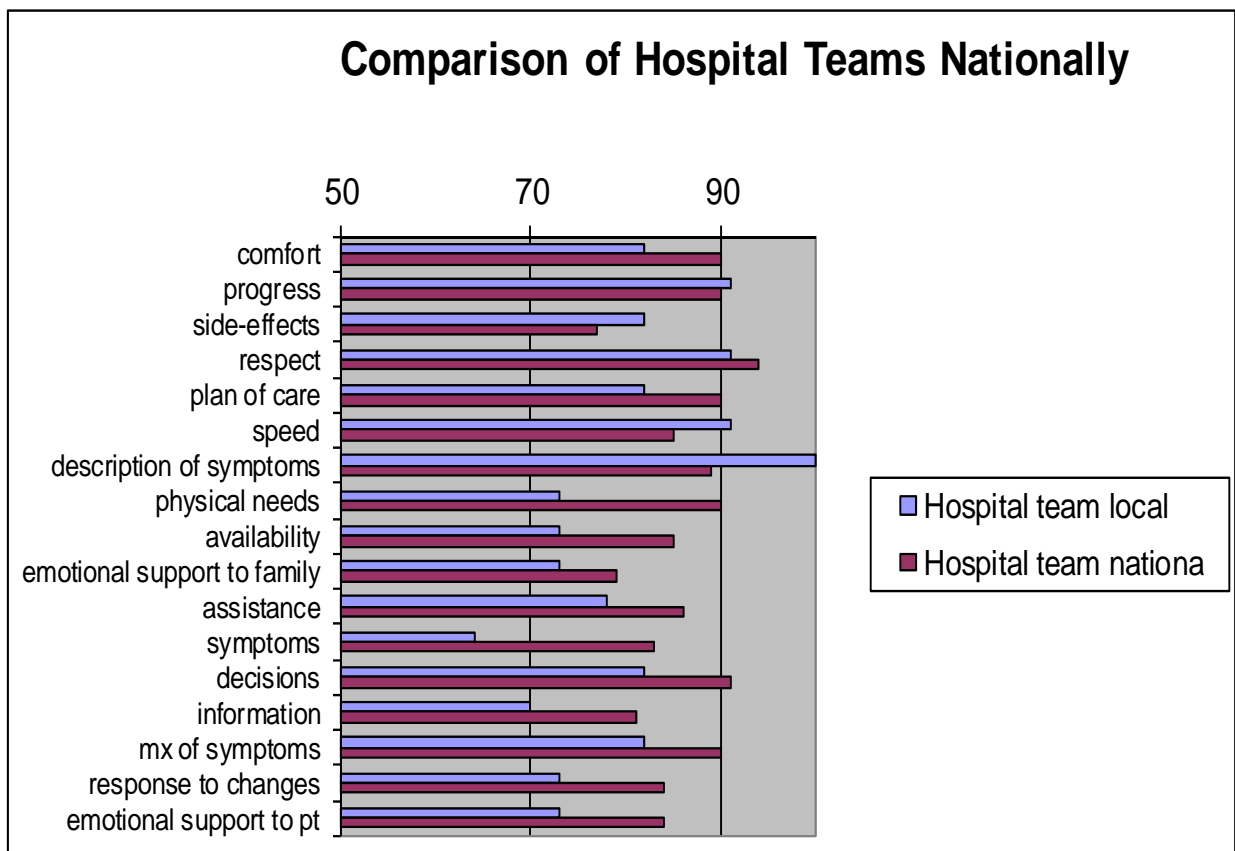
Hospital Specialist Palliative Care

During the audit period there were 113 deaths locally on the acute site, where more than one services auditing was involved with the same patient the decision to whom would send the questionnaire was made by MDT discussion amongst the services to avoid duplication. The hospital site service sent out 41 questionnaires sent out to family members three months following death, only 12 were returned, (29% response rate). Nationally, 11 Teams responded and 127 Questionnaires received a small group. Results for individual areas of questioning are contained in Graph 1 below.

Graph 1: Results for individual areas of questioning Hospital



Graph 2, demonstrates our results as compared with those nationally submitted data for Hospital care.

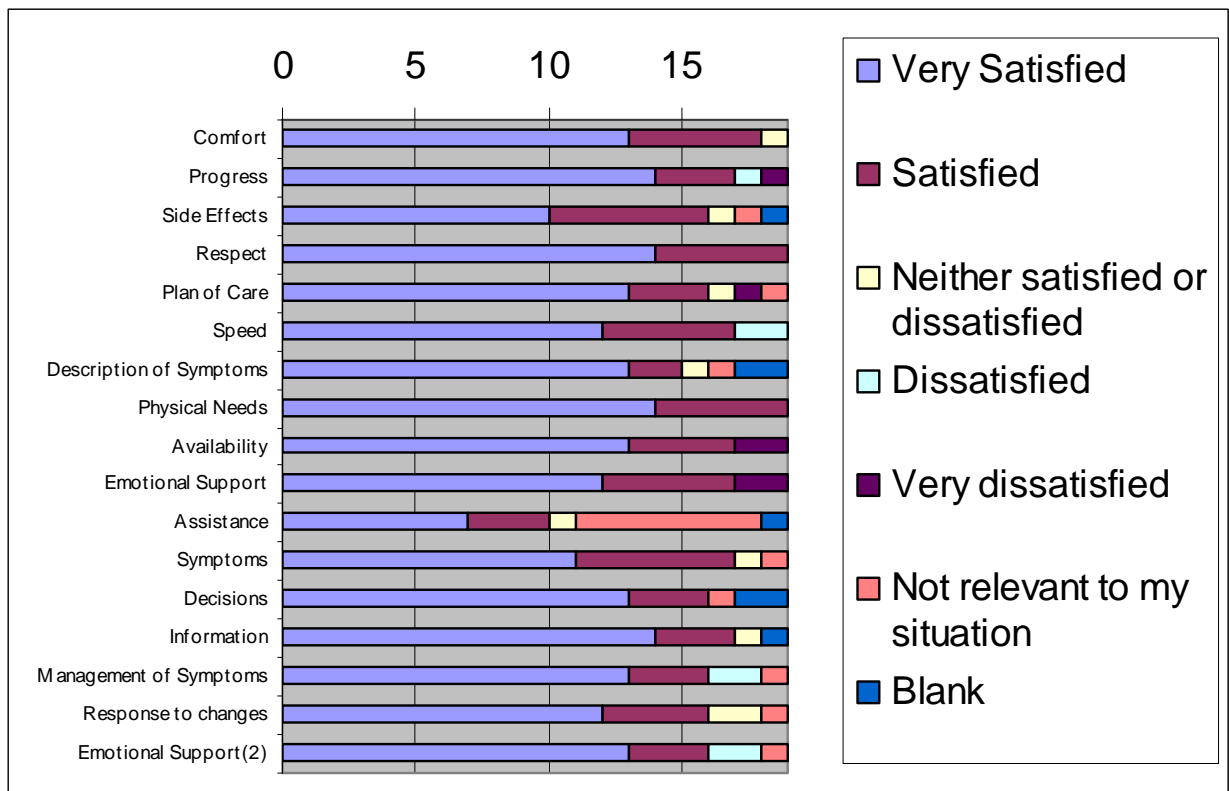


Community Specialist Palliative Care

The community had 124 deaths during the audit period, 41 questionnaires were sent out and 19 returned which resulted in a 46% response rate. Listed below are the reasons why questionnaires were not sent to all family members for community care.

- 32 – team had ‘limited’ or no contact
- 12 (10% of deaths) – it was thought sending a letter would cause distress
- 2 – no family
- 5 – no contact details for NOK
- 1 – died before being seen
- 1 - no contact with family
- 11 sent by hospice
- 18 or more sent by hospital team

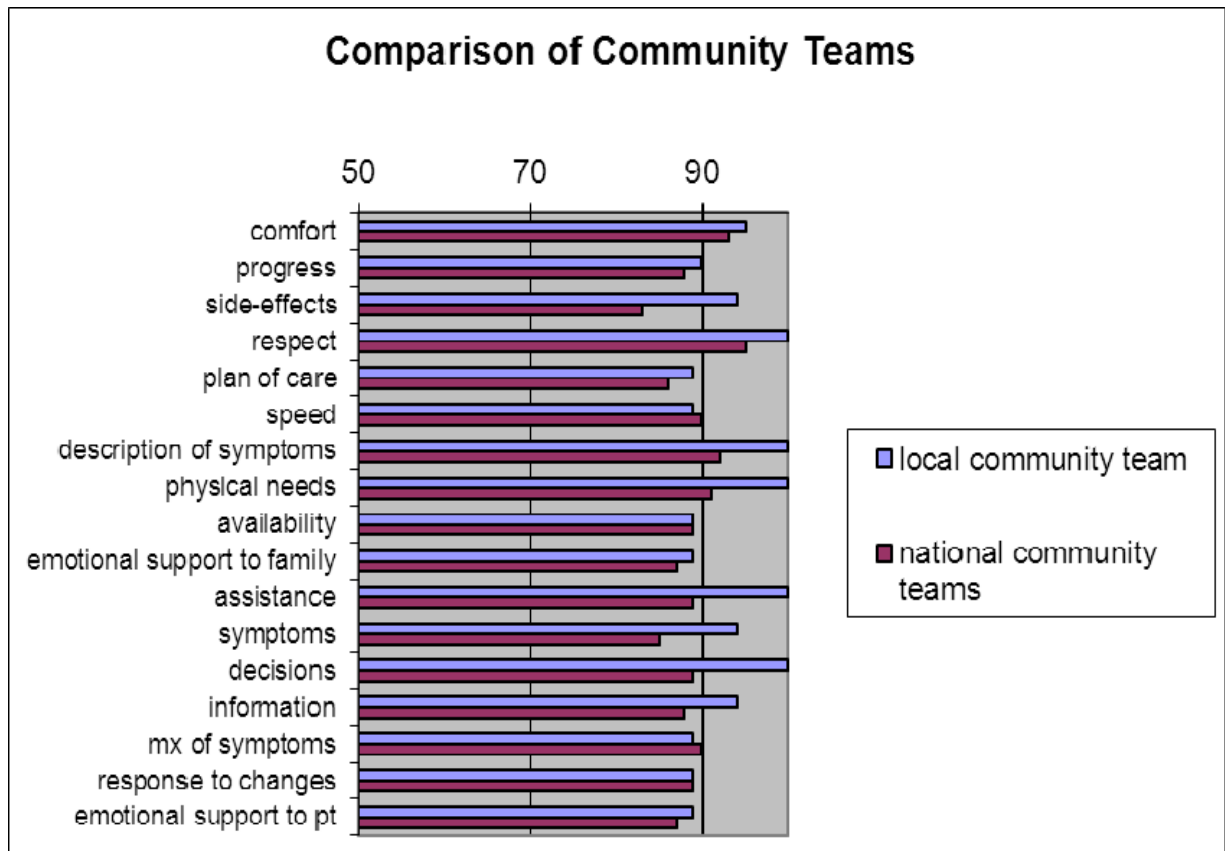
Graph 3: Results for individual areas of questioning Community



Families were also able to provide some free text comments and there was praise, what did we do well;

- ‘caring supportive team ... that was family’
- ‘comfort dignity and pain control were the priorities and were met on all occasions’
- xxx was with you only a few days but I was very satisfied with the treatment and emotional support we received’
- ‘[we] received most loving care and consideration. It is impossible on a tick sheet to amply show the superb level of care we received from all sections of staff’

Graph 4; Local and national comparison for Community Teams



There was also some constructive criticism forwarded from our families, although they did tend to comment on all services involved with care pathway, rather than focus on Specialist Services. Some of the areas of comments were; comments on unmet expectation, amount of equipment and how it invaded the house. Feeling frightened and short bursts of support rather than long periods meant coping alone for long intervals. Additionally, lack of discussion with family in hospital and decision making were still commented on. This has provided a useful insight into how family members perceive our care although it was difficult to conduct so soon after bereavement and as a result difficult to interpret results. But, it has provided us with a useful benchmark against other Teams nationally.

Summary and Conclusion

This is the third paper presented to the Scrutiny and Performance panel at their request this year and is provided to inform the committee of Walsall Healthcare NHS Trust's continued commitment to improving the very important area of care. Development work has been constant and sustained in developing our workforce knowledge and competence and the use of the best practice End of Life Care Tools across the health and social care

interface. The priorities for the last year have been to improve our End of Life Care in the acute setting with obvious benefits to Primary and Community Care through our engagement with the national TRANSFORM programme. In the last year we have realised the Business Case investment into our Specialist Hospital Palliative Care Service and patients are now benefiting from their advice and support to a greater extent.