



BRITISH GERIATRICS SOCIETY
SPECIALIST MEDICAL SOCIETY FOR HEALTH IN OLD AGE

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Submission by the British Geriatrics Society to the Department of Health on:

THE END OF LIFE CARE STRATEGY: QUALITY MARKERS CONSULTATION

The Society is delighted to be given the opportunity to contribute to this debate.

There are many markers suggested and they provide comprehensive assessment of end of life care. A small number of the markers may perhaps be refined.

1. Quality Markers for PCT's

A huge number of measures are suggested and there is a danger that measurement could over shadow provision. Perhaps some key markers should be identified as mandatory- for example, time to "urgent" discharge (from hospital (acute or community), time for equipment provision, time to first contact with palliative care.

1.2: Strategic Planning

(and later in section on care homes). Currently collected statistics do not differentiate care home admissions or deaths from other forms of residence. Thus in order to use such data in quality markers this will need to be changed so that care home residents are recognised as such. For hospital admissions they are currently coded as "usual place of residence"

1.5 Availability of Services

Provision of Specialist Palliative care: clearly absolutely appropriate that such services should be available to all those who need them whether in acute hospitals, community hospitals, care homes or their own homes. In order for this to be achievable a massive expansion in current services would be required; out of hours care would be especially problematic without dramatic growth in current services. However, many patients with advanced progressive incurable disease will be frail older people with multiple comorbidities. The evidence base for enabling such patients to "live well until they die" is that multidisciplinary assessment including specialist medical assessment by a geriatrician is effective. The markers should reflect this.

2. Quality Markers for Primary Care

3. Quality Markers for Acute hospitals.

Perhaps the measure of staff training should be numbers and proportions of staff (rather than numbers alone) The measures for community hospitals are very similar to those for care homes. The use of an end of life care pathway is a marker of good care.

Availability and accessibility of specialist teams to support end of life in hospital (e.g. Pain control team; hospital palliative care team; bereavement services and chaplaincy) should also be included as a quality marker for acute care.

4. Quality Markers for Community Hospitals

5. Quality Markers for Care Homes

Community hospitals should also be expected to enter patients whom they are discharging onto the local register if appropriate. Care homes may also discharge patients (e.g. those who have had an episode of respite care or for whom intermediate care has been provided). If decisions about end of life care have been made during such an episode the care home should be expected to communicate (with appropriate permission from the patient and their relatives) with the usual formal carers.

Retention of staff and some measure of staffing levels should be a quality marker for care homes.

6. Quality Markers for specialist palliative care in patient facilities i.e. hospices

Hospices should be expected to offer services regardless of age or disease process on the basis of need for specialist palliative care. The quality markers should include a measure of this.

7. Quality Markers for specialist end of life care services in the community

The provision of equipment and medication is listed as a responsibility of several groups e.g. PCT, primary care, specialist palliative care services. The responsibility needs to be allocated to one group or may fall between stools.

8. Quality markers for ambulance services

The ambulance service should be expected to inform the GP practice about any call out to a patient on the End of Life register and to let them know whether the patient has been conveyed (e.g. to hospital) or not, enabling the GP, community matron etc to take appropriate action

9. Quality Markers for out of hour's medical services.

It is not the role of the out of hours service to ensure that all patients approaching the end of their life are on the end of life register- this is the responsibility of the usual GP or other attending doctor. Rarely it may be that the out of hours doctor is involved in end of life decisions and in this circumstance they have a responsibility to ensure that relevant information is communicated effectively.

10. Additional comments

“Mainstream” services are currently not available 24/7- GP's, therapists, are unavailable, district nursing services are much reduced, social services are uncontactable. Thus the implementation of the strategy requires a huge change in the way health and social care is currently delivered. If such change can be delivered it will undoubtedly improve the quality of care not just for those who are identified as dying but also for those for those who are approaching death slowly and therefore difficult to identify as clearly in the dying phase.

Frail older people, especially if they suffer from dementia may need advocacy at the time of end of life discussions.

Current IT provision is inadequate to allow a register of those who are dying to be held and be available to all services that may need access to such information, especially out of hours.

Services must meet the needs of all ethnic groups

Dr Peter Belfield
Chair, Policy Committee
For and on behalf of British Geriatrics Society
6th February 2009

The British Geriatrics Society

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,500 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, nurses, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

Geriatric Medicine

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.