End of Life care - Core Business for Geriatricians?

BGS Conference Brighton 2015

Prof Keri Thomas
National Clinical Lead GSF Centre in End of Life Care, Hon Professor End of Life Care Birmingham University

www.goldstandardsframework.org.uk • info@gsfcentre.co.uk
Plan

1. Context and challenges in End of Life Care
2. Geriatricians and EOLC
3. Our experience from the GSF Centre - in community and hospitals
4. Future challenges and next steps
Your country

A Call to Arm

This is an important time for geriatrics
Key Points

• There has never been a more important time for geriatricians in End of Life Care!

• With our ageing population, broadened definition of EOLC, most dying of frailty/multi-morbidity over 65, over-medicalisation we need a big vision of proactive population-based care

• Practical take-home points – identify, assess, plan at different levels and join us at GSF

• EOLC is core business for geriatricians- call to arms!
1. Context and challenges in EOLC

Things are changing with our ageing population, increasing multi-morbidities, complexity + costs

From pyramid to coffin
Changing age structure of the Australian population, 1925-2045

Over-use of hospitals

Expenditures

Life span

Frailty and multi-morbidity are the biggest killers

Increasing Multi-morbidities

Poor care still happening

Dying without dignity
Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care
UK ranked top of the world in EOLC

“The time for incremental change is over - with the ageing population and the continued growth of chronic illness, the trends are not in our favour - we have to move swiftly!”

Quality of Death Index 2015
Ranking palliative care across the world
‘A new Tipping Point of potential over-medicalisation’

“Just because we can…doesn’t mean to say we should” - potential for over-medicalising

A new paradigm – time for a proactive approach.
GMC Definition of ‘End of Life’

People are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events.
It's about living well until you die!

“a good life to the very end”
**Inequity - Different ways of dying**

Rapid, erratic and slow dying trajectories - After Lynn

- **Rapid e.g. Cancer**
- **Erratic e.g. Organ Failure**
- **Slow e.g. Dementia, frailty**

**GP has about 20 deaths / year**
Goals of care

‘The end of the disease era’

Characteristics of Two Models of Medical Care Tinetti M, Fried T amjmed.2003.09.031

<table>
<thead>
<tr>
<th>Disease – Oriented Model</th>
<th>Integrated, Individually Tailored Model</th>
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<tbody>
<tr>
<td>Clinical decision making: disease focused</td>
<td>Clinical decision making is patient focused</td>
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<tr>
<td>Cause: discrete pathology</td>
<td>Cause: complex interplay of factors</td>
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<tr>
<td>Treatment: disease pathology</td>
<td>Treatment: patient's modifiable factors</td>
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<td>Primary focus: “causative” disease</td>
<td>Primary focus: symptoms and impairments</td>
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<td>Clinical outcomes: determined by the disease</td>
<td>Clinical outcomes: determined by individual patient preference</td>
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<td>Survival: main goal</td>
<td>Survival: not the only goal</td>
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Priorities for Care of the Dying Person

Care in the Final Days of Life

CQC in hospitals assesses care in the
- Final year
- Final days
- After death

GSF Hospital Accreditation process approved by CQC as the only EOLC information source in hospitals

Earlier planning prevents crises in final days - GSF can help
Reactive to proactive ... Bill

**Reactive**
- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits - no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis - worsens at weekend - calls 999 paramedics admit to hospital A&E - 8 hour wait on trolley
- Dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams - no improvement
- Expensive for NHS - inappropriate use of hospital

**Proactive**

Using GSF
- **Identify** and code stage
- **Assess**ment of clinical and personal needs
- Advanced care planning discussion recorded and communicated
- **Planning** - regular support + coordination + out of hours
- Crisis – discussion with family + GP, ACP
- Admission averted
- High quality care provided
- Dies in care home
- Bereavement care for family
- Audit (ADA), reflection
- Continuous Quality Improvement

- Better outcome for patient, family, staff
- Most cost effective + best use of NHS
2. Geriatricians and EOLC
Overlapping areas in caring for ageing population

Ageing
Geriatrics
GPs

Declining
End of life care

Dying
Specialist Palliative care

This is your time!
Enabling generalists in end of life care

1) Specialists

2) Generalists - GSF

3) Lay People - general public

Hospice and Specialist Palliative Care

Workforce 5,500

Enabling Generalists
- Primary Care
- Care Homes
- Hospital
- Domiciliary Care

Workforce - 2.5 m

- Public Awareness
- Community Care
- Carers Support etc
- Population 60m

End of Life care is everybody’s business
Quiz

1. How often do your patients die?
2. How many people who die in the UK are over 65?
3. How many of your patients are likely to die this year?
   a) In community?
   b) In hospital?
   c) In care home?
4. Could you recognise/identify these patients earlier?
5. Do you offer Advance Care planning discussions to all?
6. How many live and die well? How do you know?
7. How many admissions might they have in their final year?
8. How many deaths in hospital could be at home?
9. An 85 year old deprived male admitted -likely 1 year survival?
10. How many of your care homes/wards/practices are GSF Accredited?
3. Our Experience at GSF Centre as a vehicle for change

GSF is the leading Training Provider in End of Life Care in the UK

enabling generalist frontline care providers to deliver a ‘gold standard’ of care for all people nearing the end of life

“Every organisation involved in providing end of life care will be expected to adopt a coordination process, such as GSF”

DH End of Life Care Strategy July 08
British Geriatric Society endorses GSF AH Training and Accreditation

“The BGS are delighted to work with the GSF Team to help drive up standards of care across the country by supporting the GSF accreditation process and Quality Hallmark Award for End of Life care in Acute Hospitals. In working together, we think this will help raise the profile of end of life care in hospitals, and support geriatricians and others to provide more proactive quality care for the 30% of hospital patients considered to be the final year of life.”

Martin Vernon BGS EOLC Lead
GSF enables a gold standard of care for all people nearing the end of life

1. Spread

2. Depth
Accreditation – Quality assurance
6 Quality Hallmark Awards
BGS co-badges our hospital programme

3. Joined-up
Integrated Cross boundary care
GSF can be a common language

GSF Quality Improvement provides full package of support for all settings
GSF website videos
www.goldstandardsframework.org.uk

- ‘GSF in a Nutshell’
- ‘Hospitals Nutshell’
- ‘Your ideal care home’

- Prognostic Indicator Guidance
- ACP guidance
- Accreditation
- Evidence and evaluations
Identify
the right population

GSF Prognostic Indicator Guidance
identifying patients with advanced progressive decline/disease who may be in the final year of life

- 1% of the general population
- 30% hospital population
- 80% care homes population

Three triggers:
1. The surprise question
   ‘Would you be surprised if this person was to die within the next year?’
2. General Indicators for decline + comfort care/need
3. Clinical indicators

Suggested that all patients on register are offered an ACP discussion
Identify Needs Based Coding

Surprise question
Used of Needs based coding
Use of Needs Support Matrices

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<tr>
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<th>Patient and family needs at different stages</th>
<th>Support from GP/practice team</th>
<th>Support from others-SPC/hospital</th>
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<td><strong>Years</strong></td>
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- **A** - All – stable from diagnosis years
- **B** – Unstable, advanced disease months
- **C** – Deteriorating, exacerbations weeks
- **D** - Last days of life pathway- days

**Right care at the right time**

A - Blue ‘All’ from diagnosis Stable Year plus prognosis
B - Green ‘Benefits’ - DS1500 Unstable / Advanced disease Months prognosis
C - Yellow ‘Continuing Care’ Deteriorating Weeks prognosis
D - Red ‘Days’ Final days / Terminal care Days prognosis
Navy ‘After Care’

BGS Autumn Conference 2015
Identifying ‘Gold Patients’

GSF registered or ‘Gold patients’
• identified from any area, included on electronic register
• Given Gold card, information sheet
• can access help-line or ‘Gold Line’ to coordinate their care
• Treated as special
30% of hospital patients are in the last year of life
Clarke et al

They (30%) can be recognised early eg using GSF PIG
Milnes et al,
Can we predict which hospitalised patients are in their last year of life? A prospective cross-sectional study of the Gold Standards Framework Prognostic Indicator Guidance as a screening tool in the acute hospital setting.

O'Callaghan A¹, Laking G², Frey R³, Robinson J⁴, Gott M³.

“The sensitivity, specificity and predictive values of the GSF Prognostic Indicator Guidance in this study are comparable to, or better than, results of studies identifying patients with a limited life expectancy in particular disease states (e.g. heart failure and renal failure).

Screening utilising the Gold Standards Framework Prognostic Indicator Guidance in the acute setting could be the first step towards implementing a more systematic way of addressing patient need – both current unrecognised and future anticipated – thereby improving outcomes for this population”
Assess Clinical and personal needs

Advance Care Planning Discussion

Advance Statement to include

• What is important to you?
• What do you want to happen?
• What do you not want to happen?
• Who would speak for you?
GSF Summary Statement on ACP

‘Every appropriate person should be offered ACP discussions’ (mainly Advance Statements) by their usual healthcare provider which then becomes an action plan against which quality of care is measured’.
Living well, ageing well, dying well

Living well
at any age
Life planning

Ageing well
with long-term conditions, frailty or decline
ACP/CSP

Dying well
Last stage of life - final years, months, weeks, days
ACP - AS for all, ADRT for some

Life planning
ACP for all eg decade birthdays, pensions, retirement, events

Ageing well ACP or Care and Support Planning for people with Long Term conditions

Advance Care Planning
for all nearing the end of life (final year)
Advance Statement for all
Advance Decision to Refuse Treatment
ADRT for some
Plan Living Well and Dying Well

- Living well
- Enabling more to live well at home + reducing hospitalisation
- Dying Well
- More dying at home or where they choose

GSF Accredited care homes - 1st, 2nd and 3rd time
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
Culture change - better listening to patients and relatives.

“GSF has given us the framework to engage with relatives and put things in place to ensure the outcome they want for their relative......

I think the biggest change has been the culture change –...GSF is the framework that allows us to make that happen. The best bit is making sure that patients receive the care they want, where they want it, when and how they want it and the satisfaction they and we get from that.”

Dr Kumar Consultant Geriatrician Stroke Ward Royal Lancaster Infirmary GSF Accredited ward
GSF Hospitals

GSF Accredited Acute Hospital wards

- **Identify** over 30% on average
- **Assess**- Initiating Advance Care Planning discussions - 3 ACP levels
- **Plan** – enabling preferred place of care – length of stay and death rate decreasing
- Improving communication with GP

![Graph showing percentage identified over 30% for different wards](image)

- **Identifying over 30%**
- **All Offered ACP**
Accredited Community hospitals

Identifying patients early
• 31% to 66% patients identified

Advance Care Planning
• Offered to over 90% patients

Offering ACP discussions

Identifying over 30%

Cornwall Community Hospitals

AVERAGE 2 4 6 8 10 12

Tarrant Falmouth Lanyon Willow

Snap shot of Accreditation of the four wards. All patients offered at least initial advance care planning discussions at the full ACP completion

Initial discussion PPC, DNACPR, Proxy Full ACP discussion
GSF Care Homes

“the biggest, most comprehensive end of life care training programme in the UK”

- About 2700 trained
- About 200/year accredited / reaccredited
- 25% of all Nursing Homes

Place of Death

Hospital death decreasing

Care Homes of The Year 2014
# Achievements of GSF Accredited teams

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<td></td>
<td>Early recognition - aim 1% primary care  30% hospital 80% care homes</td>
<td>Advance Care Planning discussion offered to every person</td>
<td>Decreased hospitalisation + improved carers support</td>
<td>Dying where they choose using personalised care plan in final days</td>
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<tr>
<td>GP practices</td>
<td>70% (0.7%)</td>
<td>75%</td>
<td>Halving hospital deaths, 65% carers support</td>
<td>63% die where choose 75% using 5P plan final days</td>
</tr>
<tr>
<td>Acute Hospitals</td>
<td>35% identified</td>
<td>85% offered ACP</td>
<td>Length of stay reduced carers support improved</td>
<td>More discharged home, 80% 5Ps care final days plan</td>
</tr>
<tr>
<td>Community Hospitals</td>
<td>45% identified</td>
<td>98% offered ACP</td>
<td>carers support improved</td>
<td>More discharged home 97% 5Ps care final days plan</td>
</tr>
<tr>
<td>Care Homes accredited</td>
<td>100% identified, 81% identified in dying stages</td>
<td>100% offered 95% uptake</td>
<td>Halving hospital deaths + admissions 97% carer support</td>
<td>84% die where choose, 90% using 5Ps plan</td>
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Integrated Cross Boundary Care

HOME
GSF Primary Care and Domiciliary Care

CARE HOME
GSF Care Homes

HOSPITAL
GSF Acute Hospitals
4. Next Steps - population based care approach

What would you want for your mother?
Public Awareness

Dying Matters

Living Well and Dying Well

Good planning to reduce the risk of a bad death

Muir Gray, Noel Thomas, Mark Thomas
Population based approach
Seven Aims of this approach

1. Inclusive- all conditions, all settings
2. Broad-based- all populations not just those known to a service - whole systems (1,30,80%)
3. Everyone is involved – enabling all
4. Consistent+ reliable – poor care is exceptional
5. Value-based - values for health service, aligning with values of people
6. Recognises different levels - people, providers, places + populations
7. Quality and outcome measurement eg PREMS
Ideas for Action at different Levels of change

1. **Individual** - person, family, workforce staff
2. **Organisation** - team, practices, care home, ward
3. **Community** - local area/region, CCG, LA
4. **National** - regulation, quality, standards + policy

**Suggested Actions**

- ACP with you and your family
- Identify your patients, ACP, GSF
- Consider EOLC Measures, Accredited organisations
- EOLC outcomes quality standards, NICE, Vanguards
Key Points

• There has never been a more important time for geriatricians in End of Life Care!

• With our ageing population, broadened definition of EOLC, most dying of frailty/multi-morbidity over 65, over-medicalisation we need a big vision, with reactive to proactive population-based care

• Practical take-home points – identify, assess, plan at different levels

• EOLC is core business for geriatricians - call to arms!
Companions on the Journey

Gold Standards Framework

www.goldstandardsframework.org.uk   info@gsfcentre.co.uk