The GSF Vision of Integrated Cross Boundary Care

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Plan

1. Context and the need for big thinking

2. Our experience+ update from GSF Centre

3. Developing integrated cross-boundary care.

4. A shared vision- Population-based End of Life Care
1. Context

1% population die/year, aging population, increasing multi-morbidities, complexity + costs

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

Frailty and multi-morbidity are the biggest killers

1% population dies/year

Increasing Multi-morbidities

Diagnostic Apartheid

Life span

Expenditures

Gray area under the curve equals 100% of all health care expenditures over a life span
"The biggest challenge in the NHS - care for frail older people"

‘Hospitals are very bad places for old, frail people,’ CEO NHS Commissioning Board, David Nicholson, BMJ News

30% of people in hospital are in the last year of life

"we need a paradigm shift in the NHS … to work towards the point when acute hospitals admissions are regarded as a failure rather than the default position"

Mike Dixon, NHS Alliance
We are at a new Tipping Point

“Just because we can... doesn’t mean to say we should “

Some are too sick to go to hospital
.....and its hard to stop the domino effect of medical care
Frailty is the future

• Frailty is an expression of population ageing
• Frailty is associated with dementia, poor health outcomes and is a predictor of morbidity and mortality
• Frailty is quantifiable (frailty index/Gait Speed)
We need Big Thinking – Population based end of life care

Reframe our thinking- a matter of life and death

Everyone is involved
We all have patients in the last year of life..

….how can we make the best of this last year?

• 1% - general population
• 30% -hospital patients
• 80% -care homes residents

“Its about living well until you die”
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
2. Our Experience from the National GSF Centre in End of Life Care

The leading EOLC training centre enabling generalist frontline staff to deliver a ‘gold standard’ of care for all people nearing the end of life.

“Half of hospital deaths could be avoided with better community support.”
National Audit Office Report on End of Life Care 2009
GSF Centre- Not for Profit Social Enterprise CIC

8 GSF Regional Centres

1. St Christopher's Hospice
2. South East Coast
3. Dorset
4. Locala, Huddersfield
5. St Frances Hospice Romford
6. Princess Alice Hospice Esher
7. North London Hospice
8. Worcester

Call for new Regional centres 2014

GSF International Collaborating Centres

China, Canada, South Africa
? Australia, New Zealand, Brazil, Belgium, Holland, Germany etc
What do we aim to do?

1. Improve **quality** of care
2. Improve **coordination**
3. Improve **outcomes**
   more dying where they choose + decreasing hospitalisation

How do we do this?

By providing

1. Training
2. Tools
3. Measures
4. Support
1. Quality improvement Training Programmes

**GSF Primary Care** - 95% Foundation Level (8,500 practices)
From 2000 - Foundation GSF mainstreamed (QOF)
From 2009 - Next Stage GSF ‘Going for Gold’ training programme
Round 1 GP practices accredited Nov 2012, Round 2 2013

**GSF Care Homes** - 3000 care homes trained
From 2004 Comprehensive training and accreditation programme
200 / year accredited – recognised quality assurance
Many re-accredited annually – recognised by CQC and commissioners

**GSF Acute Hospitals** – 40 acute hospitals
2008 - Phase 1 pilot 15 hospitals + Improving cross boundary
2011 - Phase 2 9 hospitals, 2012 - Phase 3 – 8, Phase 4 - 8
Accreditation in development – some whole hospitals,

**GSF Domiciliary care** – almost 2000 care workers
Phase 1 - Manchester, West Mids SHA, Rotherham + others
Phase 2 - Train the trainers 6 modular distance learning programme
Phase 3 – Somerset 60 trainers, 1,200 care workers.
BHR 27 agencies Phase 4 - Manchester

**GSF Community Hospitals** - 28 community hospitals
Phase 1 - December 2011 - Cornwall & Dorset-14 each
Phase 2 - Summer 2013 - Cumbria
New GSF Programmes

**GSF Integrated Cross Boundary Care**
2013 – Demonstrator sites- Airedale, Dorset, Nottingham- New sites 2015

**GSF Dementia Care**
4 module course available on VLZ.
Phase 1 Pilot programme complete – Phase 2 launched

**GSF Hospice Support**
May 2014 – launch 5 hospices
Day care, hospice at home and some inpatient beds

**GSF Clinical Skills**
2014 – relaunched Autumn

**GSF Spiritual Care**
2014 – due autumn – VLZ and workshops roadshow

**International Collaborating Centres**
China, Canada, Australia, Belgium, Holland, South Africa etc
2. Tools

GSF
Identify  Assess  Plan

RIGHT PEOPLE
- Identify patients early—add to register (EPoC/ES)
- Discus—team proactive MDT discussion
- Code: Needs-based coding + Triggers

RIGHT CARE
- Assess clinical needs e.g., tools/AMBER
- Assess personal needs + Advance care planning

RIGHT PLACE
- Communication
  - with GP, Discharge letter
- Cross boundary care to attain preferred place of care + reduced length of stay

RIGHT TIME
- Anticipatory care in community to prevent crises
- bereavement care + patient/carer needs etc.

EVERY TIME
- Compassionate care/empathy
- Care in final days e.g., LCP
- Consistency, audit and sustainability
- Ongoing learning + Hospital protocol/strategy

Rapid discharge plans
3. Measures - Impact + integrity using GSF
Improving quality, coordination and outcomes

1. Quality of care - *Attitude awareness and approach*
   - Better quality patient experience of care perceived
   - Greater *confidence*, awareness, focus and job satisfaction

2. Coordination/Collaboration - *structure, processes, and patterns*
   - Better organisation, coordination, communication & cross-boundary care

3. Patient Outcomes - *decreased hospitalisation, dying in preferred place*
   - Reduced crises, *hospital admissions*, length of stay e.g. halve hospital deaths
   - Care delivered in alignment with patient and family preferences
4. Support - enabling a gold standard of care for all people nearing the end of life

1. Spread

GSF Quality Improvement provides full package of support for all settings

2. Depth

Quality assurance
Foundation Level to QR Accreditation
eg Primary Care and care homes

3. Joined-up

Integrated Cross boundary care
GSF can be a common language
GSF Accredited GP Practices - case study

“We've changed the culture of how we practice and .. when we look back on the way we practiced before, it seems very old fashioned and unsatisfactory”

Karen Chumley
Essex GP

“We look after the whole population of our elderly patients much better now - much more proactively”

Key Ratios
Summary of cumulative results from all practices in key practice ratios before and after GSF training

![Graph showing key ratios before and after training](image-url)
Case Study - Coastal Medical Group
33,000 patients

- Key ratios - Increased early identification of patients for the register (9%-45%)

Key ratios - halving hospital deaths (35%-16.6%)
- almost doubling dying in usual place of register (40.5%-72.9%)
- bereavement support increased (5.4%-76.5%)
- ACP - Impressive total offered ACP discussions (83%)
- Practice protocol with clinical guidance
- Impressive coordination of big numbers in a large practice
- and coordination with care homes and community resources

Morecombe Bay -

and from care homes (19%-53%)

“It...has changed how we care for people approaching the end of their life unrecognisably

[Bar charts showing before and after training programme results]
GSF Care Homes
Training and Accreditation

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

Training
Over 2300 care homes trained
- About 12 projects / year

Accreditation
Up to 200 /year accredited
Externally recognised
- Supported by NCA ECCA etc.
- CQC recognition
- Evidence base showing significant reduction in hospitalisation

Vision of national momentum of best practice
GSF Hospitals

GSF Acute Hospital

- Earlier identification by staff
- More patient views sought (ACP)
- Decrease length of stay 6 days
- Better communication with GPs
- Better integration with community
- Greater staff confidence
- Some whole hospital

GSF Community Hospitals

Accreditation in 14 hospitals

- Identifying over 30%
- Use of coding
- GSF Core Care Plan- coding triggering activity
- ACP for all
- Length of stay decreasing
- In line with CQC Guidance

The first 10 wards going for GSF BGS Accreditation 2015

The first 12 Community Hospitals being GSF BGS Accreditation Sept 2015

GSFAH - Phase 2 Evaluation
3. Integrated Cross Boundary Care

GSF Primary Care and Domiciliary Care

HOME

CARE HOME
GSF Care Homes

HOSPITAL
GSF Acute Hospitals

The Patient

Phase 1 Demonstrator Sites – 2013
Vision of Integrated Cross Boundary Care

Gold patients and GSF ‘Heart of Gold’ projects

- Earlier identification of patients in final year of life
- Better provision + access to GPs and nurses
- Prioritised support for patient and carers + easier prescribing

Primary Care

- Better assessment + ACP discussions offered
- Proactive planning of care

Gold Patients

- Advance care plan – preferred place of care documented
- Urgent care - Ambulance + out of hours care – flagged and prioritised

Others

- EOLC Strategic planning, Locality Register
- Domiciliary care using same coding and planning

Community hospitals

- Hospices

Acute Hospital

- GSF patient identified and flagged on system, registered
- Assessment & preferences noted
- Better discharge collaboration with GP using GSF register

Care Home

- ACP & DNAR noted and recognised
- Referral letter recommends discharge back home quickly

Putting Patients at the Centre of Care

- Care homes staff speak to hospital regularly
- Car park free and open visiting
- Readmission - STOP THINK policy and ACP
- Rapid Discharge
Its good to be gold!

What does being a GOLD patient mean to you?

- **G**ood communication
- **O**n-going assessment of needs
- **L**iving well
- **D**ying with dignity in the place of choice

- Helps everyone communicate better
- Improved team-working and collaboration with colleagues in different settings
- Better listening to preferences e.g. Preferred place of care discussed and noted
- Advance care planning discussion offered
- Resuscitation (DNACPR) discussed and noted
- GP records on their register – quicker access and response
- OOH’s information sent by GP, so quicker response
- Helps keep at home + out of hospital where possible
- Better support for carers and family
- GSF Alert Flag on hospital system (PAS) if readmitted
- Quicker access to medication at home / hospital
- Open visiting / free parking
Population based End of Life Care to meet the challenges of the ageing population

Why we need this?
The World is changing

• Demographic changes - frailty and multi-morbidity is the future.

• Current inequity causes problems, ‘diagnostic apartheid’, most don’t die where they choose, over-medicalization.

• Doing nothing is not an option – current system is buckling under demands, severe consequences if we don’t change, too expensive, poor levels of care - we cannot afford to fail.

What can we do?
Reframe, new vision

• Join the dots – strategic integrated cross boundary care for all people in their last years of life

• Build workforce – numbers, skill-mix, enabled, motivated, transformational change culture

• Prioritise – Focus on right person, right care right time right place, every-time - Best care for our sickest patients

How can we do this?
Develop collective vision,

• Education and training to enable workforce – eg GSF Quality Improvement programmes in all settings to improve quality of care, coordination and outcomes.

• Aspire – ‘Carrot’ - build national momentum of best practice – aspire to high standards + accreditation eg GSF Going for Gold!

• Regulation – ‘Stick’ – CQC, BMA, GMC setting high standards, lever for change, raise the bar.
Living well until you die

Gold Standards Framework

Companion on the Journey

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