

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

DELIVERING THE END OF LIFE CARE STRATEGY

Report Purpose:
Decision / Approval
Discussion
Information

✓

Brief description of the item and any significant issues:

This paper describes progress with two key initiatives which aim to improve the quality of end of life care and deliver the End of Life Care Strategy.

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DELIVERING THE END OF LIFE CARE STRATEGY

EXECUTIVE SUMMARY

“How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and in particular it is a litmus test for health and social care services”.

Professor Mike Richards, Chair, End of Life Strategy Advisory Board

The end of life care strategy has two main emerging themes:

- Developing a whole systems approach at the end of life
- Improving choice and involvement at the end of life

Newcastle Hospitals are involved in two major pieces of work to address these emerging themes, these are the implementation of the Liverpool Integrated Care Pathway for the dying patient onto wards and departments within the Trust and the Marie Curie Delivering Choice Programme.

RECOMMENDATION

To receive an update on progress with these two key initiatives which aim to improve the quality of end of life care and deliver the End of Life Care Strategy.

Alison Featherstone
Lead Nurse/Manager Cancer Services
8th July 2008

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DELIVERING THE END OF LIFE CARE STRATEGY

1. INTRODUCTION

The end of life care strategy has two main emerging themes:

- Developing a whole systems approach at the end of life
- Improving choice and involvement at the end of life

The preferred choice of the majority of people is to die at home. Research commissioned by Marie Curie Cancer Care shows that 64% of people would choose to die at home however in reality only 25% achieve this. Whilst it is understood that for some people the reality of being able to die at home may not always be possible there is still a need to improve the care and support available for the dying and to allow more people to die in their place of choice.

Newcastle Hospitals is involved in two key initiatives to address the needs of the dying patient. In 2004 the Liverpool Integrated Care Pathway (LICP) for the dying patient was introduced onto 14 wards and is now in place on 32 wards across the Trust. Introduction of the LICP into wards and departments and auditing of its effectiveness continues to be a rolling programme for NUTH palliative care team. In June 2008 the Trust announced its involvement as a partner in the Tyneside project for Marie Curie Delivering Choice which will be the seventh site for this major palliative care programme. The project begins in September 2008 and will cover the entire Tyneside population of 1.5million and will last for a period of three years. The programme aims to double the number of people who are able to die in the comfort and familiarity of their own homes.

2. MARIE CURIE DELIVERING CHOICE PROGRAMME

This Department of Health initiative, being led by Marie Curie Cancer Care, is a series of locality-wide service redesign projects aimed at enabling palliative care patients to die in their preferred place of care. In 2004/5 only 18% of people living in Tyneside were able to die at home. Each project has three phases:

- Understanding the current service provision
- Designing new models of improved service delivery
- Implementing and Monitoring new service models

A comprehensive service review phase will begin in September 2008 and is expected to take approximately 9 months. Working in partnership with all local statutory and voluntary organisations that deliver palliative care this phase identifies the key areas of service re-design to be implemented. Services then work together to implement the re-design and to assess its impact. It is expected that the project will run until December 2011. All the areas participating so far

(Lincolnshire, Tayside, and Leeds) have identified better integration of services as a key component, congruent with Newcastle Hospital's vision of vertical integration of services. Leadership from within all partner organisations will be core to the success of the project.

In Boston, Lincolnshire (population 150k) deaths in hospital have decreased from 63% to 45% with an increase in deaths at home from 17% to 42% and the projects have been effectively revenue neutral with a cost saving trend.

Some examples of service improvements in other projects include:

- Reducing length of stay
- A more robust transport system specially equipped for the needs of palliative care patients (Leeds)
- Discharge Community Link Nurses
- Palliative Care Co-ordination Centre
- Rapid response teams

Newcastle Hospital's involvement in this programme will allow us to make a contribution to the implementation of any service redesigns needed in Tyneside.

3. LIVERPOOL INTEGRATED CARE PATHWAY (LICP) FOR THE DYING PATIENT

There are now thirty -six wards across the Trust trained in the use of The Liverpool Care Pathway for the Dying patient (LICP) and the project is being rolled out to other areas. There is now a facilitator for the LICP who takes a lead on preparing each area for the pathways introduction. This includes doing a base review prior to commencement, staff training, implementation, evaluation and long term support by the palliative care team.

The Newcastle Intensive Care Units (ICUs) have registered with Liverpool National Team, to take part in the National Audit within ICUs and the pathway was introduced into some of these areas at the beginning of July having completed the base reviews and establishing a steering group with representatives from the four ICUs and Palliative Care Team. NUTH palliative care team recently took part in a national audit of the LICP and the results were good.

National Audit

The aim of undertaking the national audit was ultimately to improve the standards of care for patients who die in acute hospitals in England. Specifically enabling participating hospitals to:

1. Identify the quality of their care for dying patients as documented on the LICP
2. Compare their performance with other hospitals across England

Participating hospitals prospectively collected all completed LICPs of patients who died within their hospital between 1st September 2006 and 30th November 2006. Data from a maximum of the most recent 30 consecutive pathways was coded and submitted at the end of this period.

For audit purposes the LICP was organised into five domains:

Domain 1 Physical comfort of the patient: We performed well in this aspect of care.

Domain 2 Psychological and spiritual/religious aspects of care (patients and carers): Includes spiritual assessment and, was not well achieved nationally or locally. This had previously been identified in local audits. This does not involve undertaking an in depth spiritual assessment but, does require healthcare professionals to raise the issue with both patients and carers to ensure that appropriate support can be made available if required. This gap has previously been identified in local audits, and work is in progress to address this which will include training for staff.

Domain 3 Communication (patient, carer and healthcare colleagues): Communication with primary care colleagues, prior to and immediately following a death, occurs in only around one third of cases: compliance with this domain was poor nationally.

Domain 4 Appropriate information (giving and receiving): Nationally there was a wide variation in performance; hospital leaflets are given out relatively inconsistently. The RVI site achieved well above the national average.

Domain 5 Compliance with appropriate policies and procedures: The level of missing data for the goals of care within this domain is relatively high. The RVI site once again achieved well above the national average.

Comparing the Trust with the national picture is extremely favourable, with all three main hospital sites performing well compared to the national benchmark. However, all domains have areas in which improvements could be made and there are some differences between hospital sites.

4. AREAS FOR FURTHER WORK

The National Audit Group made a number of recommendations which need to be considered:

- Hospital audit departments should undertake regular formal audits of care delivered to dying patients and their carers within their organization – ideally ones that incorporate a survey of the views of informal carers. Audit is well established in NUTH but could be developed further.
- Hospitals should ensure that healthcare workers (qualified and non qualified clinical staff) caring for dying patients and their carers have access to appropriate ongoing training in care of the dying.
- Hospitals should ensure that appropriate information leaflets are readily available to support care in the last days of life.
- Several recommendations are made regarding the importance of further education around the LICP, which includes recognition of dying, communication and missing data.

The LICP facilitator and members of the palliative care team are undertaking work to improve on the areas highlighted above.

4. SUMMARY

Continued implementation of the LICP across all appropriate areas within the Trust remains one of the palliative care team's priorities over the next couple of years. Continued education and support is needed in those areas already implementing the pathway to ensure continued quality of service. The Marie Curie Delivering Choice programme offers opportunities for new ways of delivering end of life care.

5. RECOMMENDATION

To receive an update on progress with these two key initiatives which aim to improve the quality of end of life care and deliver the End of Life Care Strategy.

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Lead Nurse/Manager Cancer Services
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