QAH
QUEEN ALEXANDRA Hospital

Portsmouth Hospitals NHS
NHS Trust

End of Life Care in Portsmouth Hospitals NHS Trust

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Overview of Presentation

- Context
- Compare & Contrast: G5 and EOLC Support Team model
- The engagement process
- Specifics: How the new model works
- Governance & Evaluation: How will we know it's working?
- Early evidence
  - Liverpool Care Pathway Audit
  - Skills, Confidence & Competencies
  - Plaudits & Complaints

A new model of care – the context

- 2009/10: just over 2,100 deaths in Portsmouth Hospitals Trust (PHT)
  - Of those, 1,900 were patients over the age of 65
- In December 2009, the inpatient end of life ward in PHT moved to G5
- In the 8 months to July 2010, 360 patients died on the ward (equivalent to 540 per annum).
- This equates to 28% of deaths in the over 65's - meaning that 72% of patients over the age of 65 received their end of life care on general acute wards.
- **End of life care is a core element of acute hospital care**

End of life care is a core element of acute hospital care…

…and is provided in all of the following clinical services at PHT:

- Medicine for Older People
- Adult Medicine
- Surgery
- Paediatrics
- Renal
- Critical Care
- Neonate Intensive Care Unit
- Trauma & Orthopaedics
- Emergency Department
- Cancer Care

About the inpatient end of life ward

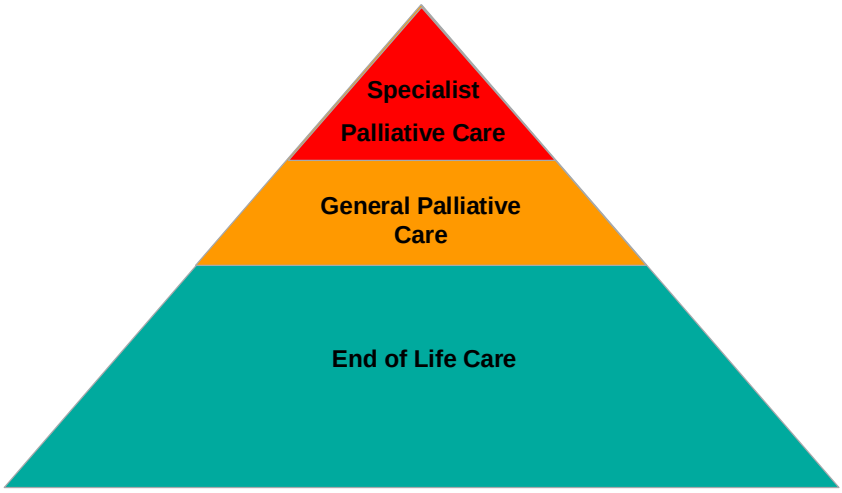
- Set up in 1991 to provide end of life care to older people in the Portsmouth and SE Hampshire area
- Patients transferred from acute wards; or admitted direct from home because, at that time:
  - No local hospice
  - Underdeveloped community palliative care provision
  - Limited / non-existent community night nursing services
- Staffed by general nurses and geriatricians. Not specialists in palliative care
- Ward moved on multiple occasions: Charles, Ashdown 1 (SMH), Charles, F1, G5.
- Environments included Nightingale, 4-bed bay & cubicle and, latterly in G5, an all-cubicle ward

Dying for Change – Demos Report, October 2010

Four development priorities

- Get people to talk about how they want to live while they are dying
- Training in end of life care to be more widespread amongst doctors, nurses, care home staff
- Better linkage between hospices and care homes, so hospice values and ethos can migrate
- Better commissioning of a range of services

End of Life – The Spectrum of In-Hospital Care



The proposal for change

G5

- c25% of patients over 65
- Same medical skills
- Additional patient move
- All patients in side rooms (co-located)
- G5 nursing team (not trained but experienced) but minority of patients benefitted
- Access to specialist palliative care team

New model

- 100% patients
- Same medical skills
- Patients remain on primary ward
- Side rooms in general wards (48 in MOPRS acute)
- End of Life team see vast majority of MOPRS patients at end of life – expanding to other areas in time
- Access to specialist palliative care team

The Decision Making Process

February 2010

- End of Life Steering Group discussed options for improving end of life care, particularly within older people's services. Options developed and stakeholder engagement process agreed

March 2010

- Initial ideas discussed with Local Involvement Network (LINk)
- G5 ward staff briefed on potential options being considered. Options discussed with PCTs, who were supportive of approach
- End of Life Steering Group produced revised options paper

April 2010

- Engagement paper produced and meeting held with Local Involvement Network to discuss

June 2010

- Engagement process concluded
- Presentation of final reconfiguration options to End of Life Steering Group

July 2010

- Proposal and business case presented to PHT Senior Management Team

August/ September 2010

- G5 ward decommissioned and new model of service delivery implemented

This involved significant stakeholder engagement

- Clinical model and proposal developed by End of Life Steering Group. (Note: made up of doctors, nurses, chaplains and doctors and nurses from Rowan's Hospice).
- Presentations of potential new model provided to Patient Experience Council, Council of Governors and Local Involvement Network
- Engagement paper sent via Local Involvement Network inviting feedback on proposals from Portsmouth Pensioners, Community First, Visual Impairment Group, Age Concern, Disability Forum, Learning Disability Partnership Board and Carers Forum
- Individual meetings with patients and relatives held
- HOSP informed of possible closure in June via quarterly report and briefing sheet
- Feedback from all organisations fed back in to options paper

How the model works - access

- Dedicated nursing team on duty 8am-11pm, 7 days per week
- Available by bleep to respond to ward requests for assistance
- Visit wards on a daily basis - joining handover, MDTs, ward rounds
- Leaflets and posters in circulation about the team and contact details – staff and relatives alerted to the service available
- Currently seven wards covered:
  - F2, F4, G3 acute wards, and D1 rehabilitation ward in Medicine for Older People service
  - F3 Acute Stroke Unit and G1 stroke rehabilitation ward
  - D3 Older Person's Hip Fracture ward in Musculoskeletal service
- Next phase of rollout will extend cover to the Emergency Department / Medical Assessment Unit by January 2011

How the model works - practice

- **Record maintained of all 'contacts', including an 'aware list' of patients who may be reaching end of life**
  - 105 patients seen to date
- **Supported learning through practice:**
  - Direct patient care / role modelling
  - Supportive presence when 'doing for the first time'
  - Formal education and competency development
  - Reflective practice and challenge
- **Promoting transfers to preferred place of care**
  - Attendance at Multidisciplinary Team meetings and handovers
  - Supporting teams to identify those nearing end of life earlier in their stay
  - Signposting to discharge support services to enable rapid discharge for those wishing it
- **Link roles**
  - Working with staff to develop enhanced skills in end of life care to promote ongoing improvement

A Day in the Life

- **Pick up team bleep and folder**
- **Join 8am nursing handover**
  - Collect information on new patients who may require assessment or support
- **Visit patients already known to service**
  - Work with staff to provide care
  - Provide advice on symptom control
  - Work with junior staff to support communication
  - Support discharge planning
- **Join hand-over/MDT meetings**
  - Identify patients nearing end of life
  - Support decision making
- **Time with relatives**
  - Support and comfort
  - Answering questions
- **Afternoon training session**
  - Work with 2-3 staff to undertake E-learning modules
  - 1:1 teaching on ward
- **Handover to 'late shift'**

The story so far

- 105 patients seen by the new team
  - 14 patients discharged from hospital
  - 91 patients died in hospital
  - 10 patients who were seen by the team died on the day of referral
- Agreed protocol for transferring patients to single rooms (if they wish)
  - In September, three patients died in bays when cubicles had been requested.
  - A protocol has been developed to guide nursing decision making. None since.
- Significant support given to staff to enhance knowledge, skill and confidence in managing patients at end of life.
- Weekend training sessions on wards

Governance & Monitoring

- LCP Audit, including patients' preferred place of care
- Transfers out of hospital, Fast Track Continuing Healthcare
- Relatives' experience questionnaire re End of Life
  - Including access to single rooms
- Nursing skills and confidence audit
- Close monitoring of plaudits and complaints data

Bereavement Services Experience of Care Questionnaire

End of Life Care

We appreciate this is likely to be a very difficult and distressing time for you and we would like to offer our sincere condolences.

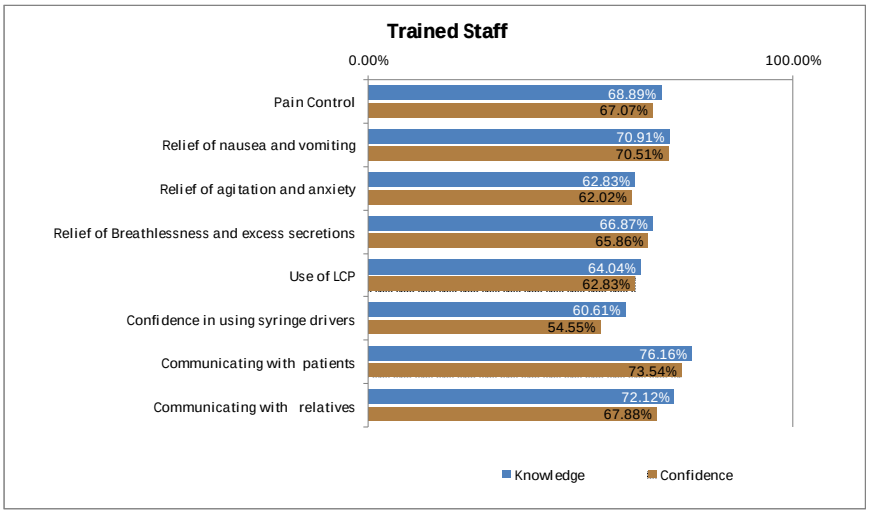
As we continue to develop and improve the care we provide for those who are dying, it is important for us to hear of your experience. This information helps us to develop the service and care for patients who sadly die in our hospital. It also enables us to improve our care of family and friends.

We have distributed some copies of the full questionnaire for your interest

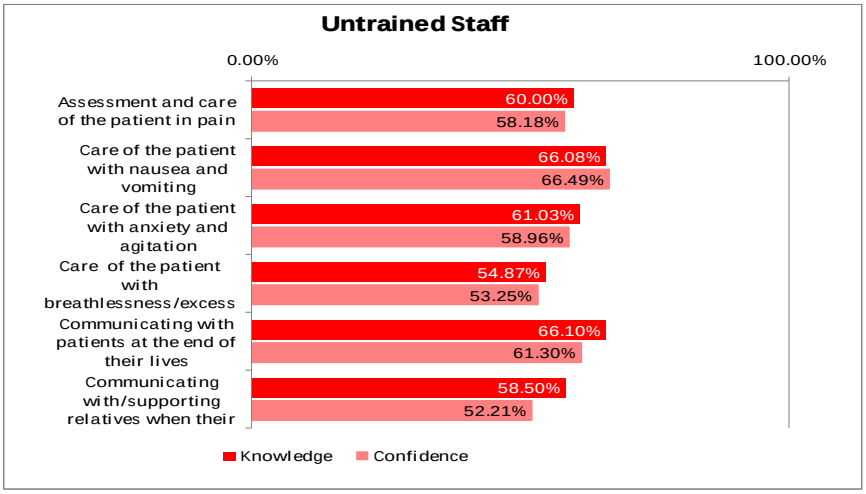
Audit of Liverpool Care Pathway use

- We've been capturing proportion of deaths on LCP since the beginning of August
- 48% of patients who die in an inpatient ward were on the LCP
- Improvement from 21% quoted in the last National Care of the Dying (LCP) Audit
- Exceeding the CQuINS target of 25% which was set for this year.

Staff skills & confidence audit – trained staff



Staff skills & confidence audit – untrained staff



Plaudits

- "…he received the utmost kindness, attention and care. He was given a single room which at all times was spotless and comfortable, which I am sure helped him in his discomfort. I was allowed to stay with him overnight, for which I will always be grateful."

  (F4 ward)

- "Thank you for all the care you took of [him] recently in F3 ward after his stroke. My daughter and I also really appreciated the help and support we received, knowing that [he] would not live."

  (F3 Acute Stroke Unit: note, 20% of patients who died on G5 transferred from F3)

But we're still learning

- Single rooms protocol
- Flexibility within ward visiting times policy
- Improved environments and amenities for relatives
- Opportunity for relatives to discuss questions and concerns about clinical matters following their bereavement
- Improving links with, and transition of patients to, community care providers

Any Questions?