END OF LIFE CARE

CASE STUDY

Derby Hospitals NHS Foundation Trust

A measurable impact for patients whose recovery is uncertain

Introduction
At Derby Hospitals NHS Foundation Trust, the initial driver to improve end of life care came from the 2008 national End of Life Care Strategy. The Trust joined the Transform Programme in June 2013. From 2010 to 2013 the Trust had an active approach to improve end of life care that incorporated elements of the Transform Programme including advance care planning. In October 2012 the Trust had begun implementing the AMBER care bundle, for care of patients whose recovery is uncertain. This is being rolled out Trust wide with an aim to “raise awareness (of good end of life care) across every area.”

Overview
• In its first year of use, 552 patients’ care was supported by the AMBER care bundle. In October 2013 it was in place on 14 medical wards. As at early March 2014 it is in place on all appropriate medical and cancer service wards in the Trust.
• In the first year of use 53% patients whose care was supported by the care bundle recovered and/or were discharged from hospital
• Overall, around 85% of these patients achieved their preference for future care: in 60% of cases, this preference was end of life care at home
• If patients preferred place of care is home and they are discharged home, they may not wish to be readmitted back to hospital. With good communication and planning around their choices, emergency readmission rates may reduce. The emergency readmission rate for patients who received care supported by the AMBER care bundle for the elderly is 7.5%. This can be compared to a 46% readmission rate for patients from a group of six hospitals including Derby.
• There is some evidence that shows identifying patients with an uncertain recovery and following actions required by the AMBER care bundle, such as checking the medical plan is discussed and agreed with nursing staff, leads to a reduced length of stay in hospital. This is because decisions are made more quickly regarding patient care. Information gained from tracking what happens to this group of patients can be used to support decision making around service funding for patients whose deterioration may be rapidly progressive and who would like to die at home.

Patient records review 2012-2013 percentage of patient notes containing information required by AMBER, showing a change in practice following implementation of AMBER

178 patients received care supported by the AMBER care bundle, who were discharged
2Baseline from 6 hospitals, AMBER care bundle design team, 43%, n=40 patients who were assessed as being suitable for the AMBER care bundle retrospectively who were discharged and died within 100 days from 6 hospitals. June 2013
Impact

Individuals and carers
To measure patient experience as part of the wider Transform Programme to improve care at the end of life, three measures of impact are used locally.

1. The Trust has developed a Carer’s diary in last hours/days. Carers use the diary to write any concerns, issues or messages. “Even if people chose to write nothing, its aim is to feel “someone asked me my view, I wasn’t alone.”

2. An adapted version of the VOICES questionnaire is used, with a response rate of 66%. Bereaved relatives can provide contact details if they would like to discuss their experience. When responses are reviewed “if we find there are bereavement issues or somebody needs to come in and talk about part of that experience, the relevant matron will contact the relatives, who are invited in to talk it through.”

3. Any complaints about end of life care are monitored.

Staff
There are signs of changes in behaviour of junior doctors, who have an awareness of the AMBER care bundle because they have used it in the course of their rotational training. “We don’t need to use this for this patient but clinicians will consider and have (advance care) conversations.” Observed by AMBER facilitator

System
The impact goes beyond the hospital, raising the importance of communication between secondary and primary care. With the Clinical Commissioning Group, the team attended locality workshops to meet GPs to explain the AMBER care bundle, and to ask what they believed a patient discharge letter should include. Better discharge letters will support GP practices to continue conversations about uncertainty and Advance Care Planning. Wards get continual feedback on the importance of clear communication to GPs. There is GP representation on Trust discharge groups for ongoing advice.

Challenges and solutions

With any electronic system to record patient preferences for care coordination (EAPCCS) a system needs to work for community and hospital settings. This requires negotiation as well as working across different Information Technology systems.

Firm foundations enabled the new acting lead for the End of Life care team to continue to build on team progress to date.

Across all wards and the community End of Life Care champions had been in place. In 2014 the team plan to revisit the ward champion role with a focus on Transform.

TOP TIPS

• Scope current patient discharge planning processes across the Trust to understand any current challenges. This will allow you to consider whether you can tweak existing systems or will benefit from a dedicated facilitator and redesigning the process
• Aim for Transform to become an overall acute Trust responsibility rather than being driven from palliative care as a palliative care concept
• “Having a dedicated facilitator who is given time to work one to one and face to face with ward staff in order to embed the AMBER care bundle is invaluable” Consultant in Palliative Medicine
• Understanding all the data flows and how clinical coding works from the start can give impact evidence to support improvement more easily
• It makes a difference to have a person in a commissioning role with real understanding of end of life care and to have a long established relationship
• It is not always about do you want to be cared for here or do you want to be cared for there, it’s why the place of care is important to the individual

To find out more about the support available from NHS Improving Quality for End of Life Care visit: www.nhsiq.nhs.uk/endoflifecare
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