Dr Peter Nightingale

GP Rosebank Surgery
Joint RCGP/Marie Curie Clinical Lead for End of life care

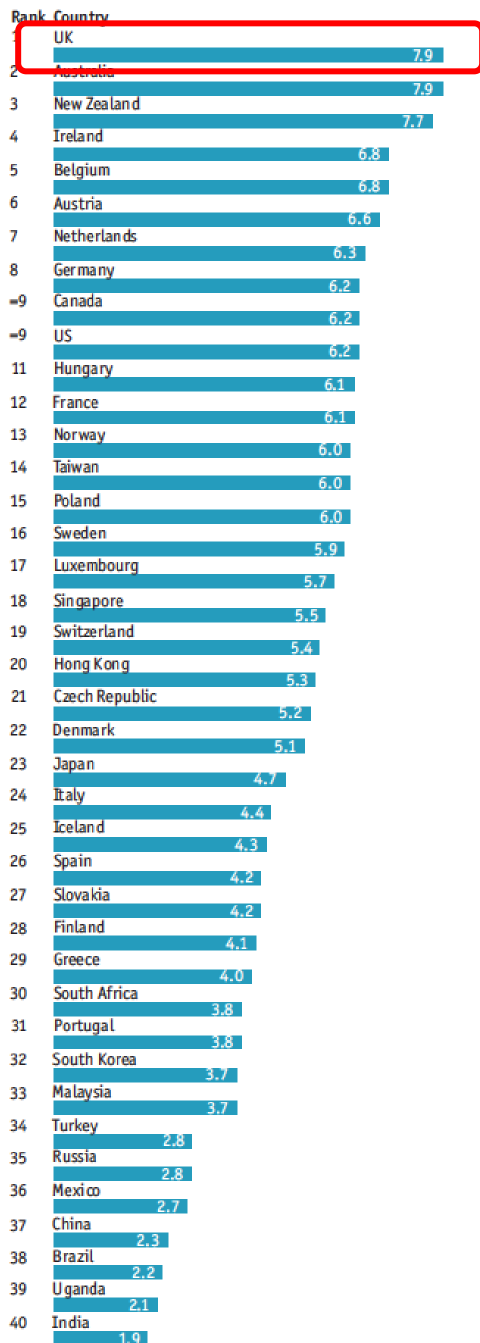
Commissioning to future-proof end of life care

Marie Curie and the Royal College of GPs have entered a three-year partnership to support commissioning GPs in their aim to improve end of life care for their patients.

The programme will prioritise clinical skills, workforce development and commissioning best practice

Royal College of General Practitioners

Marie Curie Cancer Care



Source: Economist Intelligence Unit.

Economist Intelligence Unit | The Economist

The quality of death

Ranking end-of-life care across the world

A report from the Economist Intelligence Unit

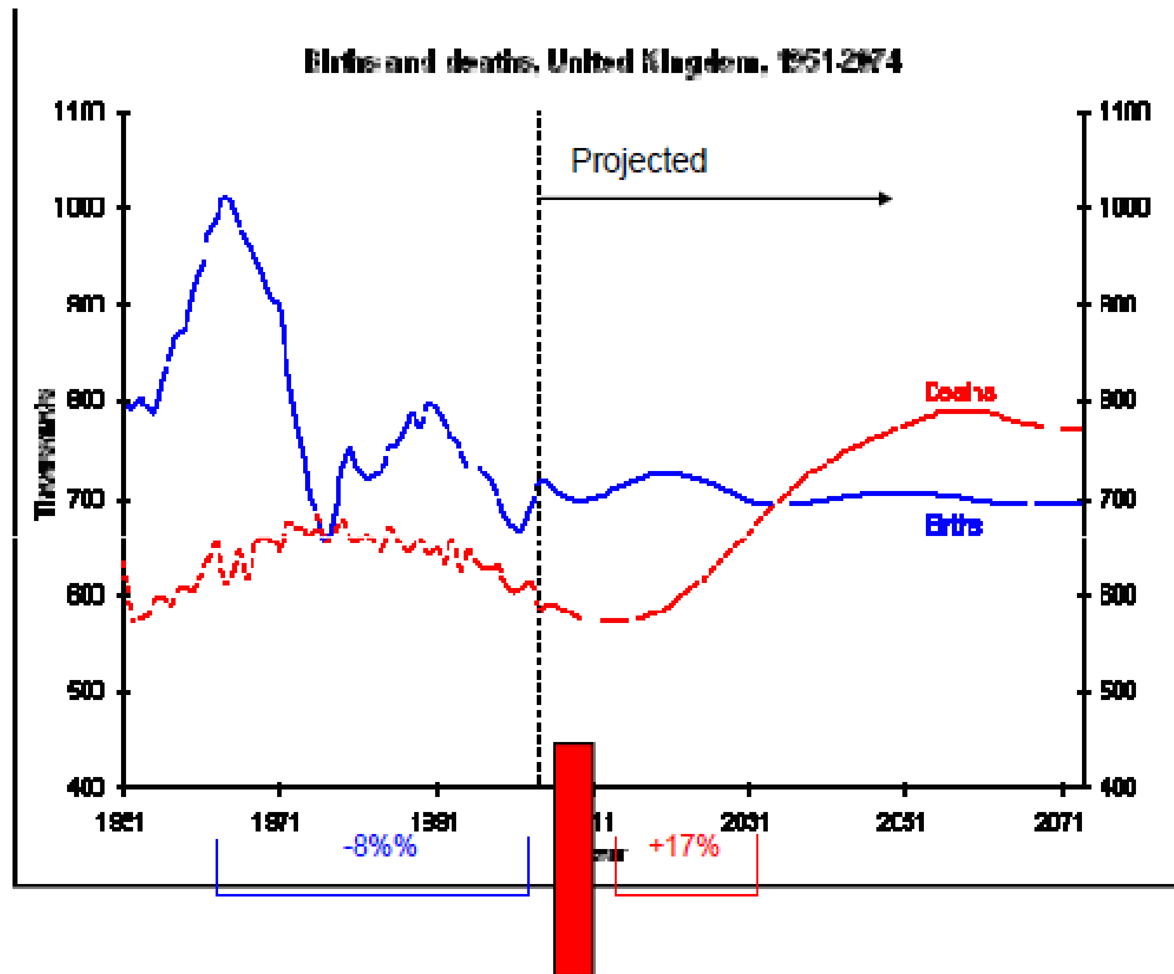
Commissioned by

Strategy to deliver excellent care

- To work with Commissioning Teams to prioritise EOLC and to ensure consistency and sustainability within Primary Care.
- To work to develop an appropriately trained and motivated GP workforce - we could still do better with pain control etc. Apps in development.
- To effectively build relationships with partner organisations - We will not manage by ourselves and will be supporting the concept of health promoting palliative care.

http://www.ncpc.org.uk/communitycharter

The Future, UK Projections 1951-2071



THE DEMOGRAPHIC TIME BOMB

Source: Government Actuary Department 2004-based Projections for the UK

the gold standards framework

The Perfect Storm

- Growing patient demand with static or decreasing supply
- The widespread ‘Potemkin Village’ notion that a high quality, comprehensive health service free at the point of delivery is achievable with limited resources

Ageing and multiple morbidity

- Number of people aged over 80 will double between 2010 and 2030
- Average consultation rate with GP is 5.5/year
- But for over 80s, consultation rate is 14/year (2008)

The capacity of general practice

- In 2000 the RCGP called for a 30% increase in GP
- Between 2001 and 2011 District Nurses numbers fell 34%
- FTE numbers of practice Nurses peaked in 2006 since when we have lost 7%

Doing nothing?
-not a good option

Remember the boiling frogs?

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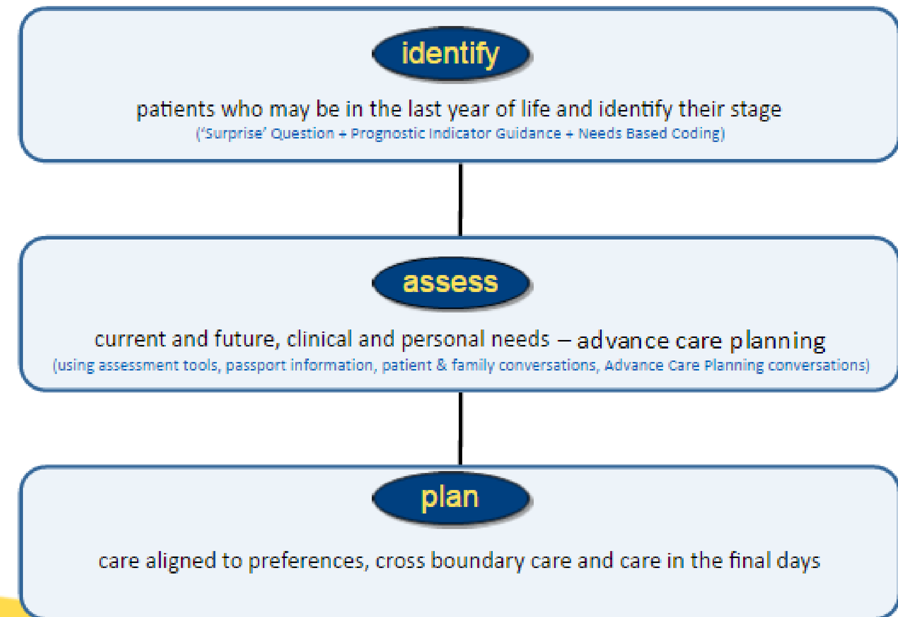
GSF experience

- **Identify the right patients** particularly non-cancer
- **Assess needs** with crucial conversations/ ACP discussions
- **Effective team work** - proactive care, coordinating and collaborating



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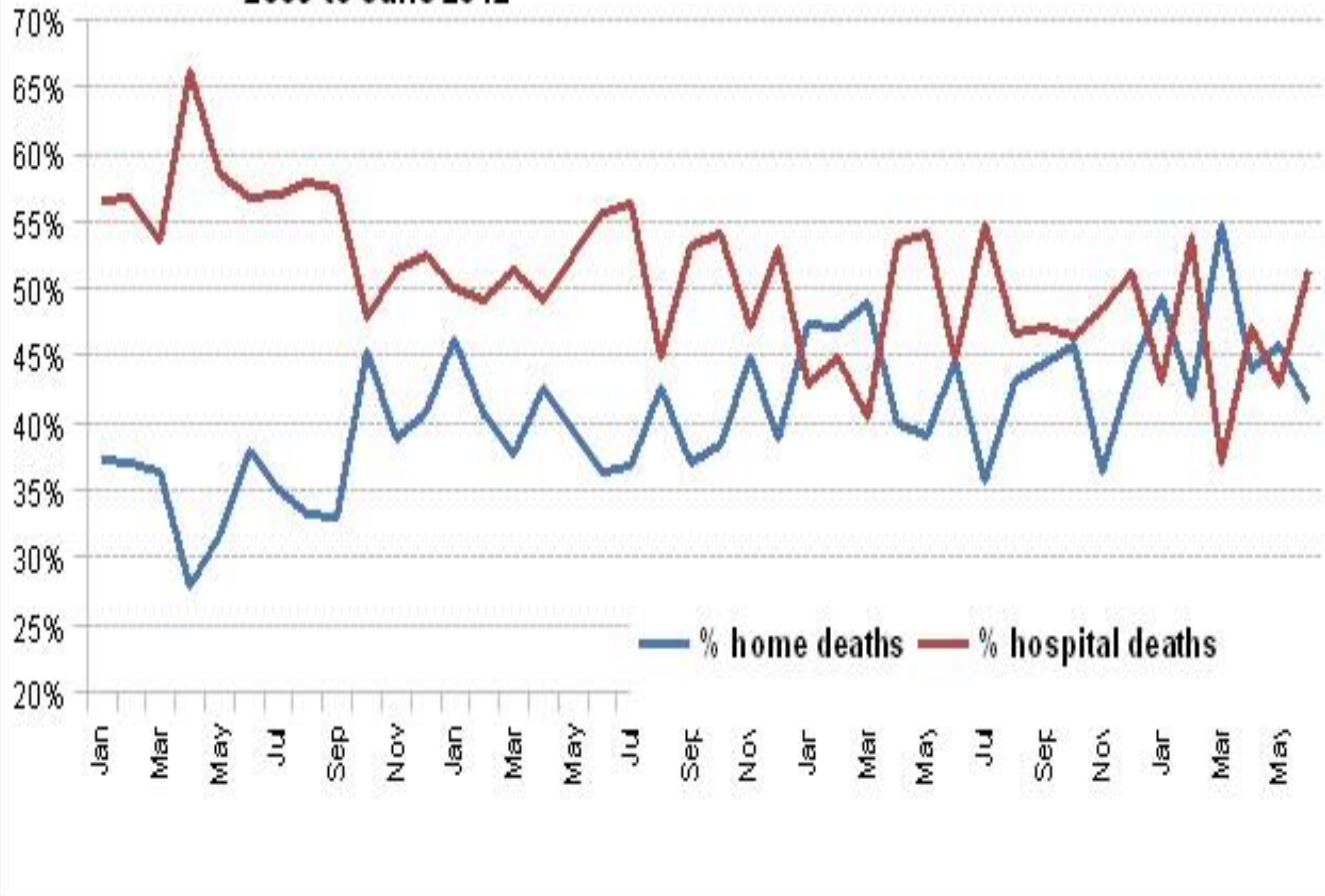
Summary of Results from the LMCG Clinical Commissioning Group

- The increase of patients on palliative care register has almost doubled – with an average range of 26-44
- The average number of non-cancer patients on the palliative care register has almost trebled with an average range of 6-16
- The average number of patients with OOH special notices has increased by 50% with an average range from 23-35
- The Average number of patients with preferred place or priorities care has more than trebled, with an average range of 5-17
- The average number of patients with resuscitation wishes has quadrupled, with an average range of 2-9



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RCGP 60 YEARS

End of Life Intelligence, Yorkshire and Humber Model- 3 Modelling workshops

Types analysed and results

- Type 1: the 60% appropriate to admit to hospital
- Type 2: the 24% who could have been managed in the community
- Type 3: the 16% who needed combined community and secondary care (possible turnaround within 4 hours or rapid discharge)

Results-continued

- The cost associated with the final admission for all patients is £1,614,851 – average cost of £3,589 per patient.
- These are some of the costs we could expect to see reduce with investment in to community services for end of life care.
- For type 2 and 3 patients the cost of final admissions was £563,473.

STRATEGIC OUTCOME PRIORITES
Kings Fund April 2013

- Facilitation of discharge from the acute setting
- Rapid response services during periods out of hospital
- Centralised co-ordination of care provision in the community
- Guaranteeing 24/7 nursing care

Is this a reversible situation?

Have I excluded correctable causes?

- Reversible renal failure (pelvic tumours obstructing ureters, vomiting causing dehydration)
- High calcium
- Spinal cord compression
- Dehydration (poor intake, vomiting, diarrhoea, diuretics)
- Haemorrhage (especially NSAIDS/steroids)
- Hypo or hyperglycaemia
- Severe anaemia
- Medication error
- Infection

Priorities for Care of the Dying Person

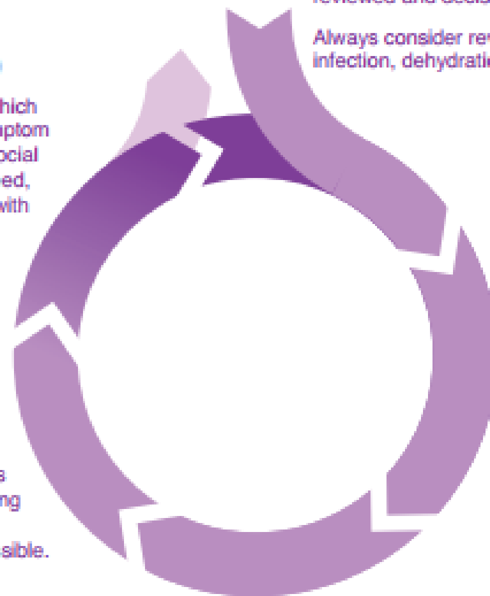
Recognise

The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

Always consider reversible causes, e.g. infection, dehydration, hypercalcaemia, etc.

Plan & Do

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.



Communicate

Sensitive communication takes place between staff and the dying person, and those identified as important to them.

Support

The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

Involve

The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

A Paradigm Shift in Management Goals

survival is not the only objective

-As long as it is Ethically and Legally justified

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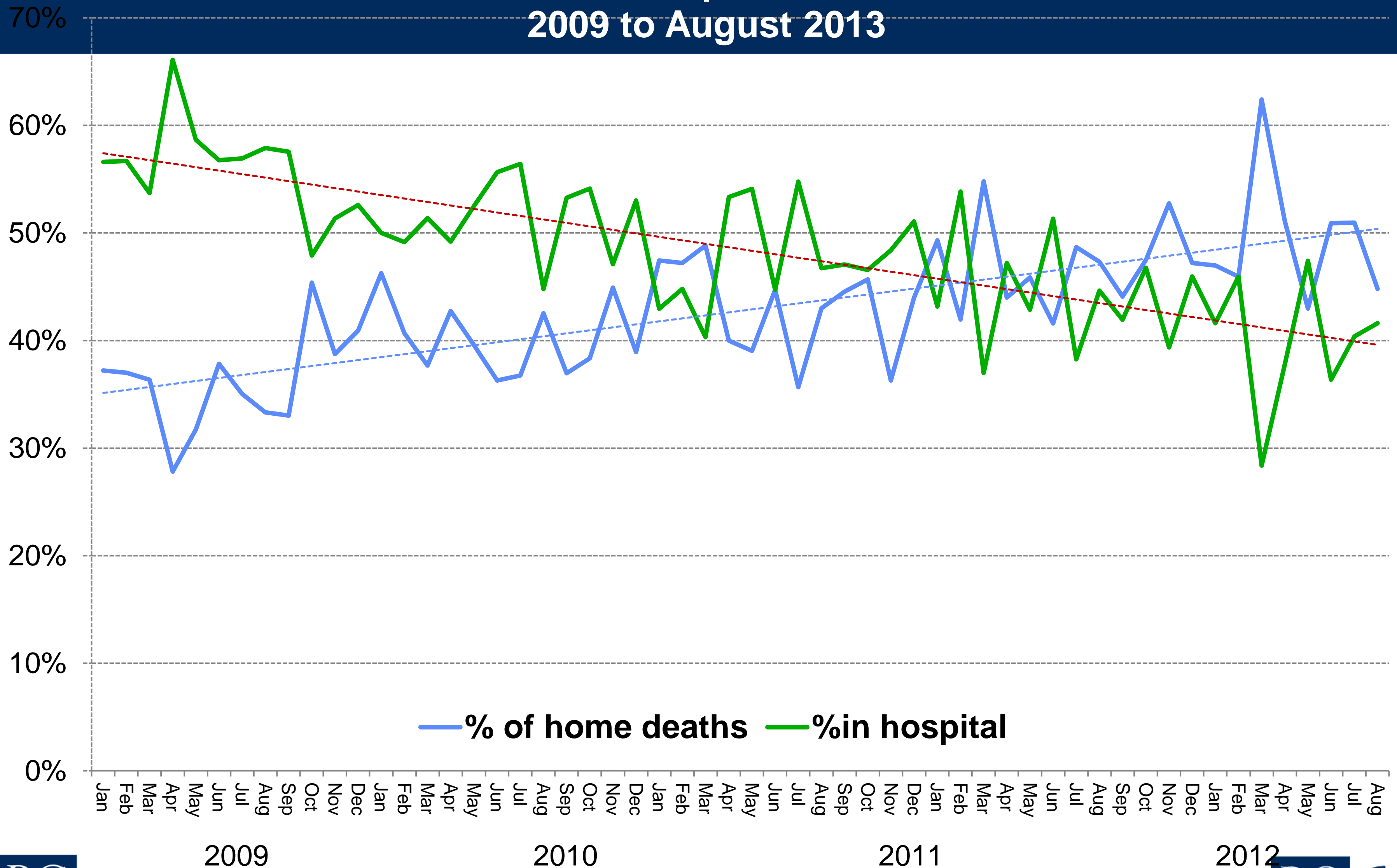

Source: Primary Care Mortality Database, Public Health, Lancashire County Council
*Provisional data, does not include patients outside LCC boundary

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RCGP 60 YEARS

What will help us to deliver the best care possible?

- Effectively sharing the care appropriately with others- EPaCCs
- Making the Unplanned Admissions DES work, so that we don't hit targets but miss the point
- Working with the hospice effectively- you helped to commission this service!
- Should we aim to make Lancaster England's first 'Compassionate City'?

HEALTH PROMOTING PALLIATIVE CARE

Based on the view that:

- Healthcare should be participatory and involve the wider community
- That the focus of palliative care on clinical bedside care needs to be challenged- supportive care in the last ***years*** of life is required
- There is a need for education, information and policy making for health and dying that captures the idea of promoting health in the face of death

Severn Hospice Project

- Project Outcomes

1. Reduced GP appointments.	44%
2. Reduced A&E attendance.	30%
3. Reduce hospital admissions.	60%
4. Reduced Shropdoc calls.	30%
5. Reduced the cost associated with dependency.	unquantified
6. Improved health and well-being for patients and carers.	initial evaluation 120%

These are the results of the Church Stretton evaluation in 2012. At the level of an individual activity before and after the volunteer was measured. This evaluation will be repeated across a much wider cohort of practices in Jan 2014.

THE COMPASSIONATE CITY

- CHARTER -

Compassionate Cities are communities that recognize that all natural cycles of sickness and health, birth and death, and love and loss occur everyday within the orbits of its institutions and regular activities. A compassionate city is a community that recognizes that care for one another at times of crisis and loss is not simply a task solely for health and social services but is everyone's responsibility.

Next Steps

- Commission EoLC services
- Please support Dying Matters/NCPC
- Look after yourselves, you are a spectacular resource
- A BIG THANK YOU !

RCGP Royal College of General Practitioners

Marie Curie Cancer Care

Dr Peter Nightingale
Joint Marie Curie and the Royal College of GPs National Clinical Lead for End of life care

For more information:
Visit mariecurie.org.uk/rcgp
Follow @MarieCurieEOLC
Email rcgp@mariecurie.org.uk

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