GOOD PRACTICE CASE STUDY

NHS North West

CENTRAL & EASTERN CHESHIRE PCT IN PARTNERSHIP WITH CHESHIRE HOSPICES EDUCATION

CENTRAL AND EASTERN CHESHIRE END OF LIFE CARE SERVICE MODEL

SUMMARY

The Central and Eastern Cheshire End of Life Care (EOLC) Service Model facilitates a seamless, collaborative approach to **leading and facilitating education and best practice in EOLC across Central and Eastern Cheshire**, with the key objective of improving the experience of care for patients, families and care workers. This approach is led by two MacMillan EOLC post holders, a small team of care setting specific co-leads, and clinical champion groups who provide EOLC support to various health and social care settings and work across organisational boundaries.

Prior to the development of this model there were two PCTs which split the area between Eastern and Central Cheshire. This led to the development of two very separate approaches to EOLC facilitation and education. The East locality model was facilitator-focused and headed up by a single post-holder who employed a range of different EOLC tools and worked across all care settings. Central Cheshire however employed an education-focused approach whereby a number of lecturer practitioners worked separately within specific care settings.

Each of these models had its advantages and delivered similar outcomes. However, it became apparent that a collaborative model, which had a strategic, whole-system approach and could attract future funding, would be more beneficial for all concerned. For example, posts tended to be seconded, and once funding ran out work had to stop, resulting in an inconsistent start-stop approach.

The new model on the other hand overcomes limitations and allows the 'best bits' of each approach to be brought together. Work is no longer dependent on one post-holder and can now gather momentum, helping to develop and educate the workforce to deliver a higher quality service for all.

KEY OUTCOMES

Cost Savings

Robust data on cost savings has not yet been collected, as the team is still in the process of hiring a data analyst to support this work. However, it is felt that savings have been made in the following areas:-

- **Bed days –** Development of an Integrated Rapid Discharge Pathway and the adoption of a variety of Advance Care Planning measures has reduced the number of inappropriate admissions and enabled the prompt and safe discharge home for patients identified to be in their last days of life who would prefer to die in their usual place of residence.
- **Pathways –** Increasing the appropriate uptake of evidence based care pathways is helping to facilitate the avoidance of inappropriate and costly treatments and tests.
- **Reduction of waste in resources –** Promoting a collaborative approach to end of life care and sharing best practice across organisations prevents duplication of work, reduces the incidence of conflicting initiatives, and avoids the common issue of 're-inventing the wheel'
- **Potential generator of monetary gains –** The model is supporting individual organisations in their implementation of related cost saving initiative's and through the achievement of monetary incentives such as CQUIN's

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NHS North West

Funding

- **Facilitator funding –** more effective use of funding has allowed consistency and continuity of projects which has led to local credibility of the model thereby creating greater clinical engagement and project sustainability.
- **Better access to funding –** the cost effective model is innovative and attractive to external funding which has opened up new funding routes.

Workforce Training & Communication

- **Equitable access to training –** a more consistent, coordinated approach to EOLC and communication skills training gives everyone access to high quality education, reducing skills gaps and making the whole workforce feel valued
- **Training is more relevant –** by offering bespoke training packages to different groups of staff, training is tailored to their needs
- **Improved communication –** Bringing together lead personnel across different organisations to champion EOLC gives an opportunity for matrix learning, information exchange, sharing of best practice and facilitating continuity and quality of patient care

Service Delivery

- **Improved service delivery –** service delivery is faster and more efficient as all stakeholders are engaged. This allows barriers to be quickly identified and overcome. The service has developed in a way that not only responds to the individual dynamics and needs of the workforce, but that also delivers EOLC in a seamless and coordinated way across the patient pathway. Feedback from the receiving community team and the patients' relatives is being collated as part of audit and so far has included comments such as:

  "thank you for making it possible for dad to come home and enjoy his last week with us' and;

  "my wife achieved her wish to die at home in a pleasant room where she could look out and see the comings and goings of the farm'.

Patient care/experience

- **Fewer people dying in hospital –** Recent local audit shows that 56% of hospital inpatients and 88% of community patients who were identified to be at end of life achieved their preferred place of care. It is hard to evaluate what impact the model is having on these numbers. However, anecdotal evidence suggests, for example, that care home staff are more confident in looking after patients at the end of their lives, rather than admitting them to hospital
- **Better understanding of patient wishes –** Local community audit for 2010-2011 shows that 76% of all patients identified to be at end of life discussed and expressed their wishes and preferences with a member of staff caring for them. A proportion of patients also chose not to discuss their wishes

Use of EOLC Tools

- There has been a much greater uptake of tools such as the EOLC / Integrated Care Pathway, the Gold Standards Framework and the Community Collection tool. For example, uptake of the EOLC Pathway at one of the local hospitals has risen from 10.1% of all deaths in 2008 to 23.2% in 2010, and 31% in 2011, and to date 43 out of 51 GP practices are engaged/participating in this continuous annual audit of community data, which captured 486 deaths for the period April 2010 to April 2011.

BACKGROUND

Partnership Organisations

When work on this model began in 2009 East Cheshire and Central Cheshire PCTs had recently combined into Central & Eastern Cheshire PCT . Before this time, when EOLC monies were allocated by the Greater Manchester and Cheshire Cancer Network (GMCCN), East Cheshire used the funding for a single post-holder, whilst Central Cheshire commissioned Cheshire Hospices Education (CHE): this organisation is an independent charity, which is a Palliative Care Education and Practice Development Unit.

As well as the PCT there are a large range of stakeholders involved in this collaborative model including; voluntary sector organisations, Mid-Cheshire Hospital Foundation Trust, East Cheshire Trust, East Cheshire Hospice, Crossroads Care, East Cheshire Council, Community Providers, GMCCN as well as MacMillan Cancer Support. Also 103 care homes and extra care housing are involved across the whole patch. Links are also in place with a Compassionate Communities Team, employed by St Luke's Cheshire Hospice, who have a slightly different role, to foster matrix working with public health.

EOLC in Eastern & Central Cheshire

Across East and Central Cheshire there are an average 4,400 deaths per year and it has the fastest growing ageing population in the North West, with 80% of the predicted population increase aged 65 and over, and an above UK average life expectancy. 35,000 people are not in good health with long-term illness, and heart disease and cancer the biggest causes of mortality.

National statistics for EOLC

- **70% would prefer to die at home but only 18% do so**
- **40% people dying in hospital have no medical need to be there**
- **Current trends suggest 20% increase in institutional deaths by 2030**
- **54% Acute hospital complaints relate to end of life care**
- **A proportion of patients dying in hospital receive very poor care without optimal symptom control**

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OBJECTIVES OF THE EOLC MODEL

- Optimise the identification & coordination of end of life care through wider use of **Gold Standards' Framework** across all disease groups and care settings
- Offer all patients approaching the end of life the opportunity to express their **preferences and wishes** for care & in relation to death/dying
- Support the proactive management of patients nearing the end of life through various forms of **advance care planning**
- Ensure communications concerning end of life care planning are effectively shared both within & across organisations including Out Of Hours Services
- **Reduce the % of people dying in hospital** who have expressed a wish to die at home
- Support the patient & their family during the last days & hours of life through use of the **Integrated Care Pathway**, ensuring the delivery of appropriate & holistic care including the **management of any potentially distressing symptoms**
- Provide on-going support for **family members and carers** during the first days after death and into **bereavement**
- Equip the local **health & social workforce with the skills and knowledge** to deliver end of life care competently and professionally including the delivery of communication skills training to support this process

These objectives align with the Trust objectives of:-

- Continuously improve quality, safety and the patient experience
- Supporting and developing staff to enable them to achieve their best
- Achieving financial sustainability
- Working with our partners to provide an integrated health service for our local population
- Encouraging staff to be innovative when delivering and planning services

KEY STAGES OF SET-UP

Initial Funding Allocated – During 2006-2009 funding was allocated to each PCT. East Cheshire seconded an individual post-holder to begin supporting staff in using EOLC care tools, whilst CHE were commissioned to achieve the same objectives for the Central Cheshire locality.

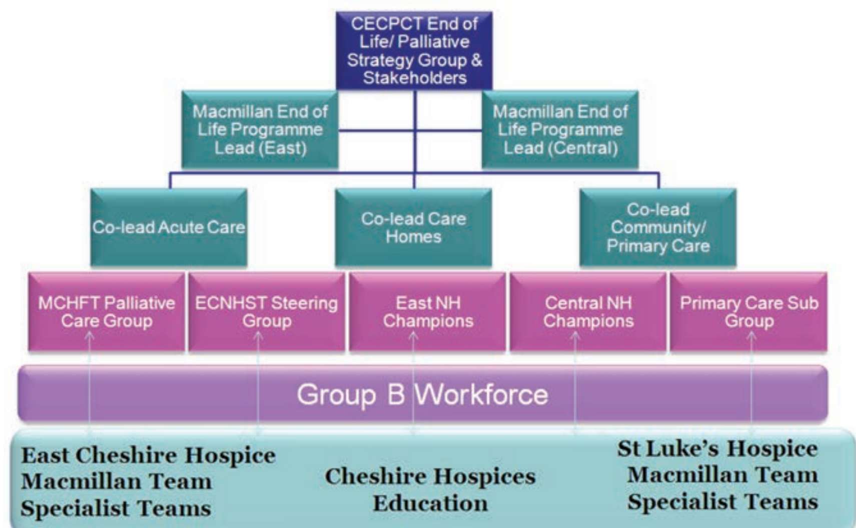
Visualisation of Collaborative Model – With posts only temporarily funded until December 2009, it became imperative to create a more robust model to attract longer-term funding. Therefore, it was decided to bring together key clinical stakeholders, service users, strategic leads and the Commissioner for EOLC, at a Stakeholder Away Day. The main aim of this event was to thrash out key priorities across the patch and to determine what service users wanted. Having such a large group of stakeholders together in one room allowed them to visualise a new model and to grasp the importance of future collaboration. Having both operational and strategic groups represented it was easier to identify current good practice and any differences between existing models and obstacles that had to be overcome.

Model drawn up – Next the model was captured on paper, as a visual representation of how all the organisations could link and work together. This was then compared with the old fragmented approach and the key strengths identified.

STRENGTHS OF THE EOLC MODEL

- MODEL DIAGRAM TO PROVIDE VISUAL CLARITY
- MINDFUL OF LOCALITY BASED ISSUES (EAST & CENTRAL)
- SUPPORTIVE OF A COORDINATED & STREAMLINED APPROACH ACROSS THE PCT
- ENABLE THE SHARING OF BEST PRACTICE
- PROMOTE LOCAL OWNERSHIP/ SUSTAINABILITY
- RESPONSIVE TO TRADITIONAL BOUNDARIES/ BARRIERS
- INCLUSIVE OF ALL CARE SETTINGS/ DISCIPLINES
- LED BY EXPERT CLINICIANS FROM CANCER & NON CANCER SPECIALITIES
- UNDERPINNED BY BESPOKE EDUCATION
- COST EFFECTIVE AND ATTRACTIVE TO INVESTMENT
- A FOUNDATION MODEL WITH FLEXIBILITY TO CHANGE AND EXPANSION

ORIGINAL CHESHIRE & EASTERN CHESHIRE END OF LIFE SERVICES MODEL- 2009



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KEY STAGES OF SET-UP (CONT)

Consultation – Once complete, the model was circulated to different stakeholders for comment, and consultations were held with the two key operational Palliative and EOLC groups. These are composed of matrons from hospices and directors from all involved organisations. This helped gain engagement and provided vital feedback to fine-tune the model.

High Level Sign-up – Tracey Wright, the Commissioner for EOLC in Central and East Cheshire, was on board right from the start. This really helped the model gain impetus and by July 2009 there was full sign up from key Directors across each organisation.

Model Launched – in January 2010 the model was rolled-out across the patch. A launch afternoon event was held at St Luke's Hospice which key stakeholders were then invited to and where the operationalizing of the model was presented in detail.

Project Plan – During the first three months of the new model a project plan that outlined the broad and key objectives of the model was developed with all participating organisations and this clearly linked in to local, regional and national objectives.

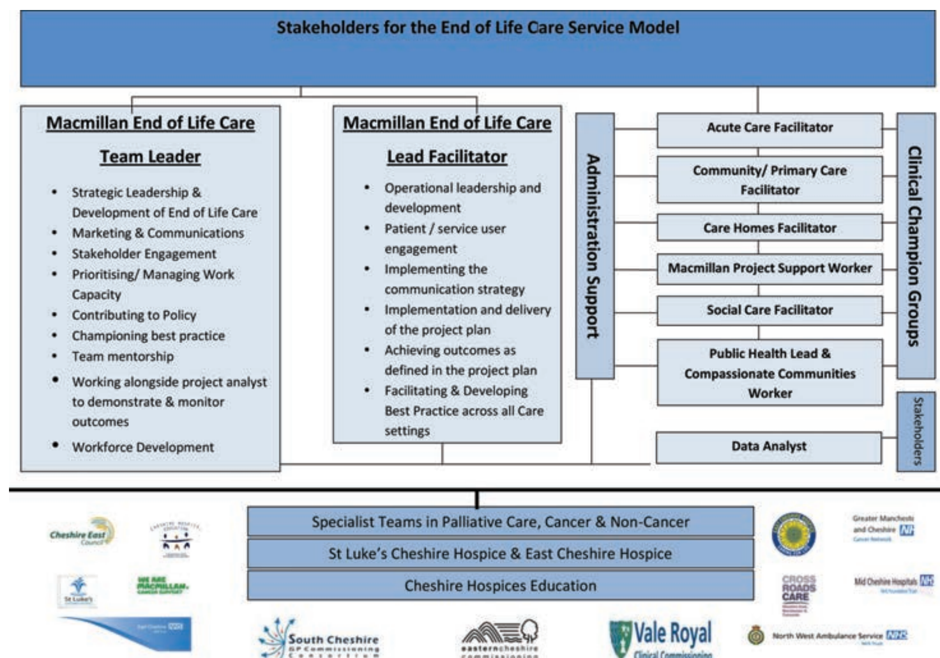
Award won – in 2011 the team won an International Journal of Palliative Nursing and MacMillan Cancer Award for "Multi-Disciplinary Team working. This was a national event. The award helped to raise the profile of the model on both a regional and national level and gave formal recognition to everyone for their commitment to the model approach from the stakeholders down to the clinical champions.

Funding & sustainability – The high level of stakeholder engagement and promotion of a whole system approach to EOLC facilitation and education has to date continued to attract funding primarily from GMCCN and Macmillan Cancer Support. The model also has a dedicated sustainability group who are proactively seeking funding 12 months+ in advance.

Guidance Issued – Members of the EOLC model were invited to present at a National Facilitators Conference a list of 'Top Ten Tips' for securing funding in recognition of the uniqueness of the Central & Eastern Cheshire approach. This guidance was published by the National End of Life Care Programme as an example of a widespread strategy for other facilitators to adopt.

Model Redesigned – Almost two years following full implementation of the original EOLC model the structure has been adapted in response to local need and in order to maximise the working styles of all the key leads working within the model. This review led to the development of a written profile outlining the model's key objectives and functions to give greater clarity and transparency around how it functions. The model redesign is based on experience-to-date and outcomes. Also, the Health and Social Care economy is changing so there is a need to be responsive. What worked two years ago might not be fit for purpose now or five years down the line. So it is important to constantly evaluate the model and to remain flexible

REVISED EOLC MODEL – 2011



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HOW IT WORKS

For an understanding of how the model works in practice, and compares to the old models please see Appendix 1

RESOURCES

Funding from traditional NHS sources became difficult to obtain due to cost savings caused by recent reforms. Between 2010 and 2012 the EOLC model will have attracted £516,000 of funding from the following organisations:

- Macmillan Cancer Support
- Greater Manchester & Cheshire Cancer Network
- Other grant-giving organisations

The average annual running cost of the model is £172,000.

KEY CHALLENGES

- **Funding –** the biggest challenge was in securing funding, especially with traditional routes having a smaller pot of money to share. Therefore a Sustainability Group was set up by Salli Jeynes from CHE and Tracey Wright from Central Cheshire PCT. This focuses primarily on sustainability, finances and how to secure income. Set up with key stakeholders, it is a great way of getting investment pro-actively, Another important fact is that it works to an agenda twelve months ahead. This allows for less uncertainty now, especially around the EOLC facilitator positions, and funding is in place until the end of March 2013 for this model
- **Multiple stakeholders –** as so many agencies and organisations were involved it was inevitable that there would be challenges arising from their different agendas. For example, sometimes the workload of one organisation can consume the time of the facilitator and it is important that the balance is redressed and equitable service given to all
- **Multiple cultures –** Every organisation has a different set of beliefs and values and a way of working. This is true even within individual wards. Offering the same training to everyone, albeit tailored to different cultures, allows this gap to bridged somewhat
- **Release of staff –** it can be difficult to allow staff time out for training and to attend key meetings, especially when there is increased pressure in the system, as education and workforce development is usually the first thing to be cut. So representation from organisations might dwindle at times, not through lack of interest, but because of the volume of change that the workforce have been exposed to. In tackling this, the EOLC model has become creative in gaining engagement. For example, when communicating with an acute hospital workforce that is already stretched, an EOLC e-bulletin is circulated to staff to keep them informed and updated of current work rather than holding the original two hour steering group meeting. Drop-in sessions are also offered where staff can call in even for ten minutes to give feedback/raise any issues. This encourages clinical engagement around current projects underway, and has proved very successful
- **Profile of EOLC –** with so many vital programmes competing for attention and funding, it was imperative to keep the EOLC profile high and seen as a priority. The EOLC model therefore seeks every opportunity to showcase work to directors and key stakeholders. The team also strive to ensure that EOLC is represented in other work priorities such as reducing admissions, saving bed days, and cost improvement programmes. One key advantage of EOLC is that it links in very well with other key work streams such as those pertaining to Dementia or long term conditions
- **Lack of integration of Health and Social Care Services –** this was overcome by offering training to social care colleagues of all different levels. For example, training to local council staff, responsible for hiring the social care workforce, in order to get buy-in from their workforce development team. A member of the local social workforce team is now represented at the model operational steering group

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KEY LEARNING

- **Marketing important –** marketing for the model could have been slicker. There is a need to present it as a concept, hinged around the fact that it brings together the best of things in one place rather than disparately. Also because of time constraints, it couldn't be published earlier, but this would have been advantageous.
- **Consultation vital –** Must talk to and listen to the views and ideas of key stakeholders early, to engage people and seek feedback. This includes being prepared to be flexible in response. Some people, such as the EOLC Commissioner were crucial to have on board, as well as high-level Director buy-in and key clinical groups e.g. Clinical Care Specialists, Hospices, GP Leads
- **Need to work top-down, and bottom-up –** it is important that strategic links are in place, from Cancer Network level all the way up. Putting yourself out there as leaders allows you to influence policies, and shape what happens nationally, not just locally. However it is just as important to be linked into key clinical groups, who drive things operationally. In a nutshell, you should place yourself in the middle, b eing prepared to reach up whilst not to forgetting what really matters on the ground to the workforce and service users

NEXT STEPS

- **Clinical Commissioning Groups (CCGs) –** it is imperative the new commissioners are engaged with the model, so communication is already under way with lead GPs to gain their interest and support
- **Communication Strategy –** a communication strategy is currently being devised for the model, which will focus on how to fully brand it, in order to market it properly
- **E-Paige Tool –** electronic Prognostic Assessment & Indicator Guide for End of life. This electronic resource is currently under development for use across all care settings within the locality and is due to be piloted in early 2012 to support and signpost clinicians to the most appropriate management of those people at the end of their lives
- **Evaluation –** a new Data Analyst post will soon be created to help evidence outcomes as part of an evaluation of the model. The post has been costed and recruitment will take place over the next few months as funding is already in place. The data analyst will begin the process of enabling a true evaluation of the impact of the model on local services and patient pathways, which will hopefully support the on-going work of the model through the future challenging economic climate

SUPPORTING INFORMATION

- Appendix 1 – How the EOLC Model Works
- Appendix 2 – EOLC Model Presentation
- Appendix 3 – Project Plan

CONTACT FOR FURTHER INFORMATION

- Anna-Marie Challinor - Macmillan End of Life Programme Lead

Email: annamarie.challinor@nhs.net
Telephone: 07920 765269

- Salli Jeynes - Director of Education & Practitioner Cheshire Hospices Education

Email: s-jeynes@che.org.uk
Telephone: 01606 555698

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