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Acute Hospitals Community of Practice  
ECHO Knowledge Network  
Series 2  
12 December 2018

Hospice UK  
Project  
**ECHO**

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Today's Agenda  
Topic: Learning from the Emergency Care  
Hospital Improvement Programme

Agenda Item		Duration
Welcome and introductions	Claire Henry	5 minutes
Wirral UTH project, data and QI approach	Anita Hayes on behalf of Dr Catherine Hayle	15 minutes
Feedback from the Leicester ELCHIP project	Dr Julia Grant	30 minutes
Discussion	ALL	30 minutes
AOB	Anita Hayes	10 minutes

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## Wirral UTH project, data and QI approach


Anita Hayes on behalf of Dr Catherine Hayle  
Wirral University Teaching Hospital

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## 'What matters most?' Silver to gold bed days

**12 December 2018**

Anita Hayes on behalf of Dr Catherine Hayle



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A **Red** day is when a patient receives little or no value adding acute care. The following questions should be considered:

- Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
- If I saw this patient in out-patients, would their current 'physiological status' require emergency admission?

If the answers are 1. Yes and 2. No, then this is a 'Red bed day'

Examples of what constitutes a **Red** bed day:

- A planned investigation, clinical assessment, procedure or therapy intervention does not occur.
- The patient is in receipt of care that does not require an acute hospital bed.
- The medical care plan lacks a consultant approved expected date of discharge.
- There are no consultant approved physiological and functional clinical criteria for discharge in the medical care plan.

**A RED day is a day of no value for a patient**

A **Green** day is when a patient receives value adding acute care that progresses their progress towards discharge.

A **Green** day is a day when everything planned or requested gets done.

A **Green** day is a day when the patient receives care that can only be in an acute hospital bed.

**A GREEN day is a day of value for a patient**


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## Silver to gold bed days

- Time is our most precious commodity... especially as we approach the end of life
- Could this concept be translated to suit a palliative care inpatient population?
- Focus felt to be patient **flow**... and leaving hospital is not always the patient's priority as the end of life approaches
- In palliative care, patient **experience** should be the priority

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## Silver to gold bed days

- Focus on patient experience rather than flow.
- Daily positive action to support patients in achieving their preferences and wishes  
*'what matters most today?'*
- All patients on SPC caseload included
- Aim to achieve 'gold' days for all patients on caseload & thematic learning when not achieved.

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## Silver day

*'A day in which the patient experiences safe, high quality, compassionate care in hospital, but no specific actions are taken then to support them in achieving their stated wishes.'*

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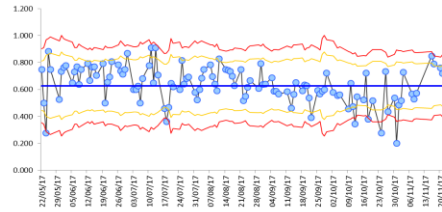
## Gold day

*'A day in which a specific action occurs which enables progress in achieving the patient's expressed wishes'*

Examples have included:

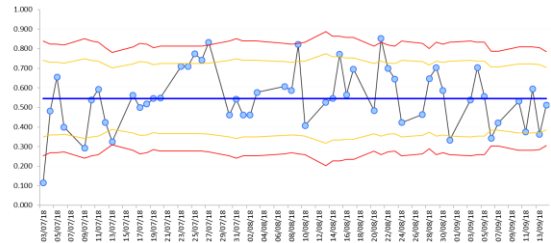
- A wig
- A urinary catheter
- Complex spiritual care
- A wedding ceremony
- Rapid discharge to die
- The Everton Match
- A choir
- Physical symptom control
- A hospice bed
- A good night's sleep

## SPC chart



## Analysis of silver bed days

Source	% Of Total Silver Bed Days	Detailed Analysis
Internal (PEOLT)	39%	23% = symptom control 8% = capacity 8% = other
Internal (WUTH)	22%	Widely spread. Most common = CHC application process 7%
External	37%	16% = lack of availability of package of care 15% = awaiting hospice bed 4% = nursing home bed



## Silver bed days: July 2018

SOURCE	% OF TOTAL SILVER BED DAYS	DETAILED ANALYSIS
INTERNAL (PEOLT)	33.01%	33% Symptom control
INTERNAL (WUTH)	34.9%	Widely spread
EXTERNAL	32.04%	20% Package of care 6.7% Hospice bed

## Silver bed days: Aug 2018

SOURCE	% OF TOTAL SILVER BED DAYS	DETAILED ANALYSIS
INTERNAL (PEOLT)	27.06%	25.56% Symptom control
INTERNAL (WUTH)	25.56%	4.5% Integrated discharge team
EXTERNAL	47.3%	19% Package of care 10% Nursing home 18.1% Hospice bed

## Team Experience

- Increased team cohesiveness, focused on 'what matters most' to the patient and those close to them
- Move away from individual caseloads – shared responsibility and increased peer support (board rounds)
- Sense of achievement with each gold bed day
- Analysis of silver bed days allows increased sense of ownership and control over challenges
- Greater proactivity

## Challenges

- Ensuring 'what matters most' is taken verbatim from the patient themselves.
- Keeping board rounds succinct!
- Capturing the patient experience
- Admin support - ongoing data collection has been challenging
- Clinical capacity/demand
- Ethos embedded. Processes still require 6 to

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## Reflections

- We need to stop advising from the sidelines and get stuck in!!
- The patients should define this – can we cut out the ‘middle man’?
- How can IT help us?
- Data to inform commissioning? Patients' wishes can drive service improvement.
- Your ethos may emerge in other areas...

**Success is not final, failure is not fatal: it is the courage to continue that counts.**

*Winston Churchill*

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## Questions?

**Feedback from Leicester  
NHS Trust ELCHIP Project**

Dr Julia Grant  
Leicester NHS Trust

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**End of Life Care Hospitals Improvement Programme**

Improving care for patients who may be in their last three months of life: the lens of acute hospital admissions

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University Hospitals Leicester NHS Trust  
Hospital Palliative Care Team

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**Our initial project aims.....**

To improve the experience of care for patients attending hospital in Leicester who may be approaching the end of life

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**Driver diagram**

**Outcomes:**

- Care that is compassionate, equitable, reliable, improves the care experience, makes best use of resources.
- Full compliance with national quality markers.
- Reduction of harm.

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### Driver diagram

#### Primary Drivers

- Person centred/family care
- Leadership
- Effective teamwork
- Safe, effective reliable systems
- Measurement

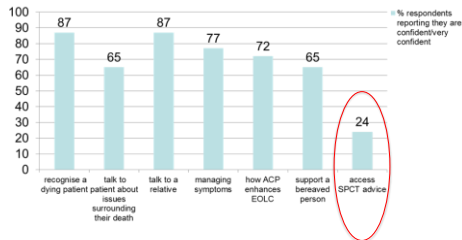
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### Person centred/ family care: Achievements

- Website update for SPC and EOLC
- Dying Matters Week May 2018
- Training needs analysis of staff groups in ED
- Education for emergency floor staff
- Review of patient information (ongoing)
- Funding for resources on Emergency Floor

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### ED TNA



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**Lightning Learning: GREAT Discharge #EM3**

**WHAT?**

- The Best Evidence Framework (BEF) highlights evidence gaps in the care of dying patients in the last 12 months. "Please participate and submit your Practice Self-Reflection".
- Re-evaluation data: Check the workbooks of 20% with the patient and family.
- Check if life care medications and/or medication review. For the top 20% of the patients for each specialty. Medication, education, care-reviews, support, etc. interventions are same for patients. For the last 80% work on why or the other medications could be stopped/reviewed.
- Advance Care Planning: Do not stop. If it has a preference, do not stop. If possible, please consider completing an Integrated Care Plan.
- Treatment, Discharge Plan, Review: Having an admission is not considered an event. It is a process. An Emergency Insurance Plan based on CQD. Educate. Education on a group and/or involvement of patient and family is essential. Review from an ED staff. It is essential. Research if the progress is slow.

**WHY?**

- Around 1% of patients admitted to an emergency will die within 12 months of admission/discharge.
- Patients with the highest frailty score (7 or greater) have the highest risk of dying during an admission.
- Many patients have frequent contact with hospital services in their last year of life.
- Courageous conversations which take place in hospital are infrequently shared with primary care.
- Information included on a GREAT discharge can support the patient, family and staff when a patient is readmitted.

**HOW?**

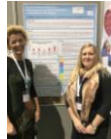
- Remember that the discharge letter goes home with the patient. Involve patients and families with any decisions that are made about them, applying principles of the Mental Capacity Act 2005. Nothing on this letter should be a surprise to the patient or family.
- "People nearing the end of life can benefit from discussing and recording their care preferences in a process known as advance care planning"

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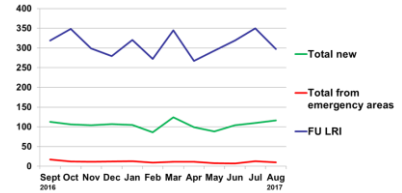
### Leadership: Achievements

- UHL End of Life Care Strategy
- SPCT Operational Policy- pending
- SPCT data collection and reporting, benchmarking against similar trusts
- Poster for Hospice UK conference



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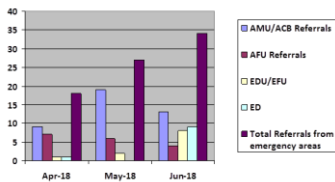
### Referrals to SPC from Emergency areas



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### NHS Improvement

#### Palliative Care CNS input on the emergency floor



Regular CNS input towards the end of May and through June

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**“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).”**

“Every Moment Counts” National Voices, National Council for Palliative Care and NHS England

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### Effective teamwork: Achievements

- Sharing ELCHIP findings with Board, ED, SPCT, AMU, Friday Forum, Frailty Oversight Group, Frailty Summit
- Alignment with Frailty
- Joint working with SPCT and ED- CNS input
- Funding for GREAT discharge cards
- EOLC Champions on emergency floor
- Work on SCR2 and SystmOne access for ED and SPCT staff

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### Safe, effective, reliable systems: Achievements

- Engage with EOLC Board LPT and CCG EOLC Leads
- Working group and pilot re Rapid Discharge home to die

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### Measurement: Achievements

- Dashboard development with IT for EOLC
- NACEL

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### What have been are our challenges.....

Time  
 Clinical workload  
 IT  
 Other strategic priorities  
   Business Case for SPC  
   KPIs  
   CQC  
 Resources  
 NACEL  
 Sickness in team  
 Scale and pace of change  
 Change

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### Our lessons learnt .....

- Early engagement/sharing the message
- Time for QI
- Alignment to Trust priorities
- Involving others in the team

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### What we want next is.....

- QI work with ED around uncertain recovery
- Dying Matters planning 2019
- Simulator training
- Rapid discharge
- Patient information updates
- Operational Policy update for team
- Positive outcome from Macmillan Bid

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### Our next ECHO session...

**Date:** 16 January 2019

**Topic:** Bereavement care after death

**Presenters:** TBC

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