Sutton Homes of Care Vanguard Programme

“An Innovative End of Life Care model for care homes”

Kings Fund Conference 6th December 2016

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The Royal Marsden Foundation Trust
Viccie Nelson, Programme Director, Sutton Homes of Care Vanguard Programme
Hosted by Sutton CCG
Overview: The population of Sutton

- 80 Care Homes
- 1213 Care Home Beds

594 residents in NHS Funded Nursing Home placements

203,048 Residents in Sutton
- 14166 aged 75+
- 4450 aged 85+

£1.1M 275 people were eligible to receive Funded Nursing Care

1770 A&E presentations from Care Homes

1034 Emergency Admissions

Health funded home care packages

Fully funded nursing home placements

£10 M

594 residents in NHS Funded Nursing Home placements
Our Partners

Working in collaboration with:
• NHS England
• New Care Model Programme
• SWL Collaborative Commissioning
• Care Quality Commission
• Health Education South London
• Health Innovation Network
• Academic Health Science Networks
• Other Care Home Vanguards

Sponsored by:
The National Institute for Health and Care Excellence (NICE)

... All our Care Homes in Sutton
Our vision is to **have a vibrant, high-quality care home market in Sutton** delivering care that embraces the national nursing values of patient care – Care, Compassion, Competence, Communication, Courage and Commitment (the ‘6Cs’).

The vision is implemented through the three ‘pillars’:

- Integrated Care
- Care Staff Education and Development
- Quality Assurance and Safety
Achievements to date:
Quality Assurance and Safety Pillar

- Joint Intelligence Group
- Quality dashboard
- Policy for medicines management
Achievements to date: Care Staff Education and Training Pillar

Training / Education
- E-learning packages
- Classroom based training
- Bespoke interventions from link staff
- Student nurse mentorship training underway

Summary of resources
- Concerned About A Resident poster
- Priorities ‘For Care of the Dying Person’ poster
- Red bag poster and film
- Quick Guides (reference cards, A3 and A5 posters), posters and film

Care Home Forums
Achievements to date:
Integrated Care Pillar (1/3)

Health and Wellbeing Reviews
- Named care coordinator and link GP
- Weekly review of resident needs

Care Home Support Team
- Link nurses
- Supportive Care Home Team (EOLC)
- Care Home Pharmacist: Medicines Management
- Dementia Support Workers

Dementia Support
- Dementia assessment using DeAR-GP
Achievements to date: Integrated Care Pillar (2/3)

SUTTON Homes of Care

THE JOURNEY OF BETTY AND THE RED BAG

1: Betty has become unwell and so Jenny (the Care Home Lead does an assessment of Betty’s condition, liaises with the appropriate service and a decision is made that Betty needs to go to hospital.

2: While waiting for the ambulance, Jenny packs a Red Bag to go with Betty to the hospital.

3: The Red Bag is given to the ambulance crew as part of the handover.

4: At hospital, Maria (the nurse) receives the Red Bag from the ambulance crew. The Red Bag identifies Betty as a Care Home resident, and the completed paperwork inside helps her understand Betty’s medical background.

5: When Jenny comes to visit, Betty is feeling much better and they discuss her discharge from hospital with Maria and Bina (the doctor).

6: Betty’s Red Bag is packed and ready for her return to the Care Home.

7: When Betty arrives home, Jenny updates their records with the papers and medication received back in the Red Bag.

8: Betty is now back in her favourite chair and enjoying a cup of tea.

What goes into the Red Bag?

Personal belongings:
- Day of discharge clothes
- Toiletries
- Personal aids
- Medication/FTOs

Standardised papers:
- Older Person Assessment Form
- CARES Escalation Record
- MAR Sheet
- Medication leaflet
- Checklist

For more information, go to www.suttonccg.nhs.uk/vanguard

https://www.youtube.com/watch?v=XoYZPXmULHE
Achievements to date: Integrated Care Pillar (3/3)

The Hospital Transfer Pathway

Red bag initiative

- 179 residents of care homes have been tracked through our local hospital in the last nine months

- Average length of stay with a bag was 13.4 days, compared to 17.4 days without a bag

*Residents with a red bag have 4 days less in hospital than those without a red bag*
What we have achieved (1/2)

- **9% reduction** in ambulance call outs and conveyances
- **10% - 18% reduction** in A&E attendances and unplanned admissions
- **4 days reduction** in length of stay in hospital
  (results from preliminary evaluation of Hospital Transfer Pathway)
- **Reduction of £50k** in medicines costs from Nov15 to Mar16 through resident medication reviews
What we have achieved (2/2)

Genuine partnership and collaborative working (across sector) enabling more joined-up services

Enhanced communication across local health and social care

Bi monthly care home forums for care home managers

Joint intelligence sharing across partners

Positive impact on care home staff work roles

Engagement with residents and families

Contribute to Dementia Diagnosis Rates

Collaborative working with other five care home Vanguards: Embedding EHCH Framework into practice
The Supportive Care Home Team

Part of The Palliative Care Service at The Royal Marsden

4 Clinical Nurse Specialists
Matron and Nurse Consultant

*Commissioned to Improve End of Life Care in Care Homes in Sutton*
Sutton Homes of Care Vanguard Model

NEW MODEL OF CARE

Integrated Care

Care Staff Education and Development

Quality Assurance and Safety

Supportive Care Home Team
End of life care model for care homes

Education

Clinical Rounds

GP – Palliative Care Meetings

Specialist Palliative Care
Monthly Education and Training Sessions

Theory – based around the EOLC process

• Recognition of Dying
• Communication & Advance Care Planning
• Last days of life – adapted Individualised care plan from local Hospice
• Pain
• Bereavement
• Multiple learning methods – case studies, scenarios, role play and reflections

• Development of Signposting tool -
Priorities for Care Of the Dying Person
Clinical round by CNS in Palliative Care

- Role modelling at every opportunity
- Complex cases liaison and referral to local hospice
- Advance Care Planning discussions with residents and families
- Symptom management
- Pain assessments – using validated pain assessment tools

- Sometimes with GP
GP – Palliative Care Meetings

Attendance by CNS at GP Palliative care meetings

- Ensuring care residents on the agenda
- End of life care plans in place
- Coordinate my Care records completed
## Key Performance Indicators (KPI’s)

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<th>Key performance indicators (KPI’s)</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>% of residents dying in PPD</td>
<td>No data</td>
<td><strong>80%</strong></td>
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<tr>
<td>% of residents being offered Advance Care Plans</td>
<td>43.8% (n=196)</td>
<td><strong>70.8% (n=300)</strong></td>
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<tr>
<td>% of residents with CMC record</td>
<td>23.9% (n=258)</td>
<td><strong>50% (n=501)</strong></td>
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**204 teaching sessions - 703 attendees to these sessions**
Key Performance Indicators (KPI’s)

Key performance indicators (KPI’s) - 2015

204 teaching sessions - 703 attendees to these sessions

“Patients do have choice”

“Communication — How to talk to resident and family, how to bring the subject up of ACP and how to listen”

“Awareness of signs of dying”

“More clinical examples needed”
LAS Ambulance Conveyancing in Sutton

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<th>15/16</th>
<th># Diff</th>
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<tr>
<td>Mar</td>
<td>88</td>
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<td>Grand Total</td>
<td>958</td>
<td>880</td>
<td>-78</td>
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Care Home EOLC Programme in Sutton

44 – Learning disability homes

17 Nursing homes

13 Residential homes

Recently commissioned to pilot in 11 LD homes

Close working with Community Services
Recent CQC report – Inequalities in EOLC

People with a learning disability

A DIFFERENT ENDING: ADDRESSING INEQUALITIES IN END OF LIFE CARE

Life expectancy for people with a learning disability is significantly lower than the UK average, and there is also a high incidence of premature and avoidable death. In addition, people with a learning disability are more likely to have unidentified health needs, which can make recognising the end of life phase difficult. This means that people are likely to be identified as approaching the end of life late, which affects their ability to plan and make choices. It can also lead to problems in coordinating end of life care and providing support to the person and their family.

We asked a group of people with a learning disability about what was important to them for good end of life care. They told us that it was important to have family and friends nearby, to have privacy, peace and quiet, preferably not to be in hospital, to be able to go outside, and to have the support of a care coordinator when needed. They thought that services should talk more to people who have a learning disability to get their views and check that they are improving and inclusive.

Lack of knowledge

The health and care staff we spoke to felt that a lack of knowledge around learning disabilities could result in late diagnosis of illness, which could have an impact on the likely success of treatment. In addition, symptoms may not be investigated because they are thought to be related to the person’s learning disability.

Staff also said they sometimes had to fight to get the right care for a person with a learning disability, and that it could be difficult to organise best interests decision meetings because other professionals did not understand the Mental Capacity Act 2005.

Communication

Communication was identified as a significant barrier to good care, with health and care staff sometimes making assumptions about an individual, for example, that they may not be able to ‘cope’ with discussions about end of life. In addition, not being able to communicate verbally or needing specific support to communicate, presented challenges for some people. For example, health and care professionals told us that it was difficult to assess the person’s pain when they have limited verbal communication. This was also a concern for people with a learning disability, who said that being able to explain or use picture cards with a nurse when they were in pain was important. Knowing the person well helped staff to understand non-verbal communication, as did using assessment tools for pain or distress, for example, Distress, the Disability Distress Assessment Tool.

- People with a learning disability are likely to be identified as approaching the end of life late
- This can lead to problems in coordinating end of life care and providing support to the person and family
- Palliative care staff have a lack of knowledge around learning disabilities
- Communication was identified as a significant barrier to good care.
- Difficulty in assessing pain
CQQ - What is important for good end of life care for people with learning disabilities

• “Important to have friends and family nearby
• Have privacy, peace and quiet, preferably not in hospital
• To be able to go outside
• Have support of a care co coordinator”

*NHS England Steering Group for Learning Disability and Palliative Care*
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Great care is a partnership

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