"You matter because you are you, and you matter until the last moment of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

Dame Cicely Saunders

Change Management when vision is involved: lessons from St. Christopher’s
Professor Rob George MA MD FRCP
Medical Director St Christopher’s Hospice
Consultant Guy’s & St Thomas’ NHSFT
Professor Palliative Care Cicely Saunders Institute, KCL London
Problem:
✓ We’re not as good as we think we are

Solution:
✓ How should & do we change our spots?

MOVING FORWARD
✓ A mixed economy
✓ ‘Part of the NHS’ but (mostly) paid for by charity
✓ Used to setting our own limits

✓ “A bit of heaven for the few”
✓ “Too good to be true, too small to be useful”
Clinical, financial and ethical imperatives:
frailty / multi-morbidity is our problem now, not cancer-plus

✓ People die from lives
✓ Population-based
  • No size will fit all
  • What is the best that you can do?
  • Build capacity
  • Collaborate
  • Co-produce

• Most of our dying popul are old & frail
  • The rest have multi-morbidity
• People with different diseases have different needs
• Palliative care in our communities must double by 2040
• 83% of health spending is in the last year of life.

Rob George 2018
Horizon Scanning is a necessity

“No problem can be solved from the same level of consciousness that created it. We must learn to see the world anew.”

Albert Einstein

From my perspective it looks like ‘frailty’ is the only show in town

Rob George 2018
Where we are going this session

MANAGING TRANSITIONS

Tasks
- respond to our changing population
- be more effective and efficient
- do more for less

Two examples
- Frailty
- Heart Failure

Leading our teams
- Reframing how we think
- Refining our processes

Rob George 2018
Building is essential but always risky

One near collapse  
✓ Frailty  
One success story  
✓ Heart Failure

HEART FAILURE  
We learned our lesson

FRAILTY  
We did it our way ...

Generative curve

Rob George 2018
Managing change = overcoming resistance

- Efficiency
- Change
  - Skills
  - Technology
  - Personnel
- Cost

Driving forces generally already exist

- Frailty
- Multimorbidity

THE CHANGE

DRIVER(S)

RESTRAINTS

VERY STRONG

NO CHANGE

CHANGE

EQUILIBRIUM

- One size fits all
- Everyone can have everything
- People will do almost anything to maintain equilibrium

- We do the very best for you
- We look after you until you die
- That what we’ve always done
- That’s why I work here

Rob George 2018
Looking after the frail ‘in the old way’

**Caseload grew**
- We treated everyone the same and did stuff to them
- We saw people only as ‘in’ or ‘out’
- Patients were discharged & told to ring in. They didn’t
- Ended up dying in hospital

**Cumulative referrals by month in 18/19**

STOOPID! Don’t do the same and expect a different outcome.
Leading people out of Egypt (slavery to the past)

**MANAGING TRANSITIONS**

**SUCCESSFUL TRANSITION**

- Leading our teams
  - Reframing how we think
  - Refining our processes
  - Involving everyone in the new vision

Rob George 2018
Frailty: exploiting our mistakes & back to basics

Academic involvement
Review of data
Conceptualisation
modelling
NIHR Programme Grant:
Defining needs, seeing what is available, developing training programmes

✓ Frail elders, family and friends
✓ GPs, palliative care, mental health and allied health professionals, geriatricians
✓ Social care, social workers, personal care providers
✓ Third sector: Age UK, Ageing Better, Hospice UK
✓ Academic collaborators
✓ St Christopher’s

Rob George 2018
What Age Attuned Hospice Care look like?

Key Principle: **what matters to older people?**

✔ Being me over a life long-lived
  ✔ Maintaining Continuity
  ✔ Maintaining Personhood
  ✔ The continual work of balancing and adaptation to loss
  ✔ The social networks/community “the glue” through which and in which lives are lived

✔ Old age is not a disease (but it does kill you ...)
  “it is strength and survivorship, triumph over all kinds of vicissitudes and disappointments, trials and illnesses”
  *(Maggie Kuhn 1905-1995)*

✔ When the old are sick they stop ringing!
Watchful Waiting:
- Proactive purposeful interventions
- Identify & respond to incremental change

Enablement
- Rehabilitation
- Signposting
- Community engagement

Parallel Planning
- Several options in play according to the problem

Multimorbidity
- MDT working across specialties
Heart Failure = success story

**THE CHANGE**

- Inaccessible expertise
- Barriers between organisations

**DRIVER S**

- Too many unnecessary admissions
- Palliative Care knew little cardiology
- Cardiology struggled with care planning and symptom control
- GPs felt unsupported with CHF

Driving forces generally already exist

**VERY STRONG**

- Drank wine over difficult cases
- Set up a joint decision-making model together
- Persuaded the CCG to fund a pilot
- Made it competitive to be a pilot GP Practice
- Measured our impact

**NO CHANGE**

- Pressures to maintain equilibrium

**CHANGE**

- We have tried a joint clinic & it failed
- We (cardiology) need to see them in outpatients
- The cardiologists need to see patients with us (palliative care) at home

Rob George 2018
Heart Failure Pilot 100 patients for 1 year:

✓ Collaboration with cardiology
✓ Joint decision-making meetings
✓ Joint assessments as needed
✓ One stop shops

Physical Symptoms at referral n=81

- Poor mobility
- Drowsiness
- Sore or dry mouth
- Constipation
- Poor appetite
- Vomiting
- Nausea
- Weakness or lack of energy
- Shortness of Breath
- Pain

Other issues

- Practical Matters Addressed
- Information Given
- Share Feelings
- Felt at peace
- Depressed
- Family Worried or Anxious
- Worried or Anxious

0 - Not at all  1 - Occasionally  2 - Sometimes  
3 - Most of the time  4 - Always  Cannot assess/blank
Patient experience

- Symptoms better (55%)
- Symptoms worse (40%)

over 124 days (1-461) their disease and function was worsening and 44% died
Views on Care: during and afterwards

What's happened to your main problems and concerns?

- I don't know: 16%
- Things have got much better: 61%
- Things have got a little better: 23%
- There has been no change: 16%

Has Palliative Care made a difference? (VoC)

- I don't know: 4%
- Things have got much better: 32%
- Things have got a little better: 5%
- There has been no change: 32%
- Things have got a little worse: 2%
- Things have got much worse: 54%

Is Palliative Care Making a Difference n=57 (Zarit)

- I don't know: 7%
- Things have got much better: 68%
- Things have got a little better: 21%
- There has been no change: 7%
- Things have got a little worse: 4%
Impact on the Hospital:
36% fewer admissions, 51% fewer bed days ie the project paid for itself

A&E Admission per patient 1yr pre-pilot n=72

- non-cardiac n=58
- cardiac n=14

THE YEAR BEFORE the pilot these people with heart failure needed 1700 bed days with a median of 21.5 days ranging from 2-111 per patient.

DURING THE PILOT their need fell, comparatively by 51% with a median of 9 days ranging from 2-64 per patient.

St Christopher’s saved the PRUH 21 admissions totalling 281 bed days with median stay of 11 days ranging from 3-29 days per patient.
The take home message

- Carry on the same way and the system will explode
  - We already know that!
  - We need the courage or recognised necessity to do things differently

- There are no shortcuts to new developments if they are to be effective
  - Draw all the players together

- A clear and underlying process is common to all teams/organisations, but it doesn’t take prisoners.
  - Short-termism should be dead
  - The culture has to change
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