Health and Wellbeing Board

25 September 2017

Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 – 2018

Report of David Hand, Macmillan Commissioning and Development Lead, North of England Commissioning Support Unit

1. The purpose of this report is to present the Health and Wellbeing Board with the Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 – 2018 (appendix 2).

2. In 2016 The Palliative and End of Life (EOL) Care Group undertook a refresh of the 2013-2018 EOL Strategy. In June 2016 a stakeholder event was undertaken which brought together a wide range of agencies aimed at improving delivery of service and outcomes for patients and families. The event and refresh identified a number of similar themes and needs which included.

3. A restructure of the End of life steering group to ensure it has the necessary membership, direction and leadership to deliver the strategy:

    - A task and finish group focused on delivering 24/7 Medical Cover
    - A task and finish group focused on delivery of a Single point of Access for EOL.
    - A Hospice group focused on sharing of best practice and resources.
    - A lead on improved co-ordination of delivery in areas such as Electronic Palliative Care Co-ordination Systems (EpaCCs) and paperwork
    - Improving patient engagement and involvement in improving pathway and service delivery
    - Improving the use of data to allow for an improved understanding of current and future delivery of services

4. Accordingly a new work plan has been produced for the EOL group which uses the National Ambitions for EOL 2015-2020 document as the template with which to drive forward local delivery. As the Ambitions 2015-2020 Document had been published and was supported by all the key stakeholders for the Documents 8 foundations and 6 Ambitions formed the basis for the workplan. It was agreed that the group would focus on the 8 Foundations until 2018 and then look at work on the Ambitions.

5. A Task And Finish Group on the Medical model led to delivery of a hospice review which is currently looking at changes to delivery of Consultant delivery

aimed at improving Consultant capacity and delivery through increased flexibility and changes to the delivery model and looking at the use of Nurse Consultants to improve delivery and outcomes. The Group also identified improved pharmacy cover as an issue and work is still ongoing to ensure an improved service for patients.

6. The Task and finish group led to the establishment of a 12 month pilot. This Pilot was agreed by Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups (CCGs) and went live in mid-April 2017. Initial figures suggest a quiet start but efforts to improve access in a number of areas including care homes are underway and the results of the pilot will impact on the configuration of future services across the county.

7. The regional work on EPACCS is still underway and Durham is working with the regional delivery group to look at implementation at a local level. No area has full solution for EPaCCS and still lots of challenges ahead. In many ways the North East is ahead of the rest of the country in that agreed data sets are in place and some intra-operability in place as well. This will provide a major step to improving co-ordination of services for patients.

8. The Palliative and End of Life Care Group look at a wide range of data to improve patient outcomes which includes data on death in usual place of residence, the palliative care register as used by GP practice's and safeguarding and incident reports.

Recommendations and reasons

9. The Health and Wellbeing Board is recommended to:

    a) Note the contents of the report

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Appendix 1: Implications

Finance – No direct Implications

Staffing – No direct implications.

Risk – No direct implications.

Equality and Diversity / Public Sector Equality Duty – Equality impact assessment has been undertaken

Accommodation - No direct implications.

Crime and Disorder – No direct implications

Human Rights - No direct implications.

Consultation – No direct implications on current issues but will be undertaken in line with CCG policies as required.

Procurement – The Health and Social Care Act 2012 outlines that commissioners should take regard of the JSNA and JHWS when exercising their functions in relation to the commissioning of health and social care services.

Disability Issues – Equality impact assessment has been undertaken

Legal Implications - The Health and Social Care Act 2012 places clear duties on local authorities and Clinical Commissioning Groups (CCGs) to prepare a JSNA and JHWS.

Appendix 2

Partners in improving local health

North of England Commissioning Support

Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 – 2018

Purpose of the Report

1 To inform the Board of the current progress of the Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 – 2018.

Background

2 In December 2015 the Palliative and End of Life Care Group (hereinafter to be referred to as the Group) agreed to carry out a stock take or refresh of the Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 – 2018. This stock take was requested as it was recognised that several of the task and finish groups had not progressed and there was sense that whilst there were some positives outcomes to the strategy there had, in recent months, been a loss of focus and direction. Moreover it was recognised that the current financial climate meant that some of the indicative spends in the 2013-2018 strategy were highly unlikely to be achieved. Accordingly the group felt that the refresh should take a pragmatic approach to priorities and assess how some of the strategies key cases for change could be achieved.

3 The Group agreed that the (Macmillan) Commissioning and Development Lead for End of Life and Palliative Care should lead on the refresh with a rough draft of the report to be delivered in late February 2016.

4 The Group agreed that the refresh should move forward by inviting all the members of the Group to provide feedback on current progress and provide views on how to progress the Strategy via recommendations. It was recognised that the refresh did not supersede the 2013-2018 Strategy and that its original cases for change should remain the standard to which the Group should aspire to where financial circumstances allow delivery to move forward.

5 In order to realise the Group requirements the Commissioning and Development lead agreed to set up meetings with the members of the Group. This included all members of the group included in pages 42-43 of the 2013-2018 Strategy. In order to cover the wide range of discussion points and in an attempt to deliver on key themes for the refresh the approach to discussions focused on the following

areas of the 2013-2018 Strategy (Page 31, Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 – 2018):

Summary of services to support pathway implementation:
The pathway in figure 1, page 27 depicts the journey patients requiring palliative and end of life support may follow. High level case for change documents have been developed to
Support the various elements of the pathway and these have been included in the Appendices. In summary the areas requiring investment are as follows:-

Topic Detail

- Single point of contact
- Consultant led Specialist Palliative Care
- Rapid Palliative Care response
- Palliative Care at Home
- Palliative Care Transport
- Specialist Psychological Support
- Palliative care Rehabilitation
- Lymphedema
- Supporting dementia carers and professionals
- Family Support
- Welfare support
- Workforce Education

6 Meetings were conducted with 23 organisations commencing on the 4th of January with the final meeting taking place on the 22nd of February. In some instances meetings with organisations included more than one individual taking the total number of interviewees in the process to 38.

7 Once the interviews were completed the findings were compiled into recommendations which were as follows:

- A restructure of the End of life steering group to ensure it has the necessary membership, direction and leadership to deliver the strategy.
- A task and finish group focused on delivering 24/7 Medical Cover
- A task and finish group focused on delivery of a Single point of Access for End of Life (EOL).
- A Hospice group focused on sharing of best practice and resources.
- A lead on improved co-ordination of delivery in areas such as Electronic Palliative Care Co-ordination Systems (EpaCCs) and paperwork
- Improving patient engagement and involvement in improving pathway and service delivery
- Improving the use of data to allow for an improved understanding of current and future delivery of services.

8 The Refresh was signed off by the EOL Group membership at the end of May 2016.

EOL Event of 6th June 2016

9 Following on from the Refresh an event on the current state and future delivery of palliative care in North Durham and Durham Dales, Easington and Sedgefield (DDES) was convened on 6th of June 2016. This followed on from Gill Findley (North Durham and DDES Clinical Commissioning Group Director of nursing) meeting with the wife of a man whose experience at end of life had been a failure of everything which the End of life services were meant to address. The event included representation from County Durham and Darlington NHS Foundation Trust (CDDFT), Hospices, Local Authority and Commissioners. The event included a discussion on how the current services were aligned and how providers would like to see some areas continue and others changed or stopped. Individual providers then discussed current delivery and challenges to their services. Finally following on from the refresh work streams from the recommendations were put into three areas, Quality, Co-ordination and work force development. Following these discussions a number of common themes were then identified with actions to be taken forward. These included:

- The Refresh of the End of Life steering group.
- 24/7 Medical cover.
- Single Point of Access. A task and finish group will be convened once the above group has moved sufficiently towards implementation. This is because an SPA cannot function without the above model in place.
- Development of business case for Specialist Pharmacist support. .
- Model of Hospice delivery across county. Palliative care and care home group to continue to deliver standardised EOL training.
- Other issues and action include an Education, Governance and Audit group which will be set up by the CDDFT Palliative Care Consultants and the improved co-ordination on services and upskilling of the workforce.

Legislation and Documentation

10 In the years since the Strategy has been implemented there have been a number of legislative changes, guidance and documents which impact on the End of Life Strategy and delivery of service. What follows is not an exhaustive list but an attempt to outline a number of key drivers which have been introduced.

11 The **Government's mandate to NHS England for 2016-17.** The mandate identifies under <u>OBJECTIVE 2: To help create the safest, highest quality health and care service:</u>

"*NHS England should ensure the NHS meets the needs of each individual with a service where people's experience of their care is seen as an integral part of overall quality. We want people to be empowered to shape and manage their own health and care and make meaningful choices, particularly for maternity services, people with long term conditions* ***and end-of-life care****. Carers should routinely be identified and given access to information and advice about the support available*."

12 **The 2014 Care Act**. The Act places a statutory duty on Local Authorities in respect of areas such as wellbeing, prevention, integration, information advice and advocacy, safeguarding, assessment and eligibility, care and support planning and personal budgets and payments.

13 **Ambitions for Palliative and End of Life Care:** A national framework for local action 2015-2020. This document was produced by the National Palliative and End of Life Care Partnership. The document identifies 6 ambitions for End of Life Care: Ambition One: Each person is seen as an individual, Ambition Two: Each person gets fair access to care, Ambition Three: Maximising comfort and wellbeing, Ambition Four: Care is coordinated, Ambition Five: All staff are prepared to care and Ambition Six: Each community is prepared to help.

14 **Transforming end of life care in acute hospitals (The route to success 'how to' guide) care in acute hospitals**. Produced by NHS England in December 2015. The document provides practical advice and support for front-line clinicians and leaders for the work required to transform end of life care in acute hospitals and is very closely linked to the Ambitions for Palliative and End of Life Care mentioned in 4.4.

15 **What's important to me?** ***A Review of Choice in End of Life Care.*** Published by The Choice in End of Life Care Programme Board. The documents aims are to "*provide advice to Government on improving the quality and experience of care for adults at the end of life, their carers and others who are important to them by expanding choice*".

16 **Actions For End of Life Care: 2014-16**. NHS England

17 **The National Institute for Health and Care Excellence (NICE) Guidelines Care of dying adults in the last days of life**. NICE December 2015.

18 **Getting serious about prevention**: enabling people to stay out of hospital at the end of life. The National Council for Palliative Care 2015. This report identifies steps that commissioners can take with service providers to ensure that people who are approaching the end of life avoid being admitted to hospital when this is possible and appropriate, as well as enabling those who are admitted to make a transition to a community setting quickly.

Updates on Actions

19 In accordance with the key points identified in the refresh and the feedback from the stakeholder event on 6th June 2016 the following actions and updates can be provided. It should be noted that the focus of the updates will be on End of Life and Palliative for adults. In respect of a Children's medical Model work is being undertaken at a regional level by the Northern Children's Palliative Care network and led by a Team at Great North Children's Hospital (GNCH). Once a model has been identified discussions with a regional Clinical Commissioning Groups (CCGs) will begin, this is anticipated in autumn 2017.

Refresh of the Palliative and End of Life Care Group

20 In order to ensure that the group was able to deliver a more focused and coherent approach it was agreed that a new work plan needed to be developed. As the Ambitions 2015-2020 Document had been published and was supported by all key stakeholders the Documents 8 foundations and 6 ambitions formed the basis for the work plan. It was agreed that the group would focus on the 8 Foundations until 2018 and then look at work on the Ambitions. Each of the 8 Foundations has a " Champion " to lead on delivery and the document was agreed to be something which could be owned by the group and "Live" in that examples of progress could be provided and the Red Amber Green (RAG) status moved accordingly (See Appendix 1). Three of the ambitions are focused on at each meeting and progress discussed and practice shared. This work plan will also form the basis of the strategy as it is developed beyond the current 2013-2018 timeframe.

The Foundations are:

- Personalised care planning
- Education and training
- Evidence and information
- Co-design
- Shared records
- 24/7 access
- Involving, supporting and caring for those important to the dying person
- Leadership

In order for the group to become more focused several standing items have been removed from the agenda and the use of Information and data has been enhanced to provide a more strategic understanding of themes and issues. It was agreed that the group would meet quarterly as opposed to the six weekly approach in order to allow time for developments in the work plans to be embedded and feedback to the group

24/7 Medical model

21 Following discussions at the Task and Finish Group between July and December the following key outputs have been identified. It should be noted that discussions on all these points were based on ensuring that delivery within the current financial envelope for the Budgets for CDDFT and Hospices which the Task and Finish group identified at £5,518,709.

- As we are presently unable to recruit consultants we agreed that we need to make the current model more attractive and sustainable.
- The lack of a 24/7 Palliative care professionals advice line which is something which NICE identify as a priority for End of Life was agreed to be a priority to be moved forward. A pilot proposal has been drawn up and is detailed in the actions section below.
- Nurse consultants will be utilised to support consultants where possible. (This will include supporting consultants on the 9-5 weekday telephone rota)

- Pharmacy support was identified as a priority and Graeme Kirkpatrick who attended the Task and Finish group has produced a pilot proposal detailed in actions below.
- Using CNS to improve weekend cover. This is an ongoing piece of work and updates on progress will be fed back to the County Durham and Darlington Palliative & End of Life Care Group.
- Work to be done on looking at options to improve advance Nurse prescribing cohort within the sector.

22 As the Task and Finish group is accountable to the County Durham and Darlington Palliative & End of Life Care Group it was agreed that the following two proposals required the approval of the group in order to progress.

Proposal to Establish a Cross-sector Palliative Care Pharmacist Post.

23 Following the aforementioned Event on June 6th 2016 The Task and Finish group identified a number of agreed actions. One of these actions was to understand the potential to recruit a palliative care pharmacist, to support the wider team, and whether this post could be funded by potential savings from medication dispensing and supply.

24 Following meetings between the Chief Pharmacist and representatives from St Theresa's Hospice and St Cuthbert's Hospice it was clear that the hospices fully support the need for a palliative care pharmacist to provide clinical support to hospices and the healthcare professionals they employ. Similarly the CCGs (North Durham & DDES) and the Palliative Care service within the trust are supportive of this post.

25 The hospices were happy with their current supply model for stock medication and for the dispensing of FP10 prescriptions but would consider reviewing this if there was a financial incentive to do so. Initial review of the level of prescribing/supply would suggest that savings could be made but would not be sufficient alone to fund the post. In addition, very initial discussions were had with the hospices about including elements of general procurement and medical gas supply into any contract. It would be in the interests of all parties if the discussions around medication supply, general procurement and estates services were taken forward through Synchronicity Care Ltd as the vehicle for providing all these services.

26 To enable the provision of a Palliative Care Pharmacist, to support palliative care services across County Durham and Darlington, we would like to propose to employ a suitably experienced band 8a pharmacist to work across the county. This would look to achieve the following objectives:

- Provide direct, patient-facing clinical contact to review and optimise prescribed medications
- Support clinical decision making as part of a multi-professional team approach
- Support healthcare professionals working in palliative care with advice and guidance

- Support education & training of healthcare professionals working in palliative care
- Actively produce standardised policies and procedures relating to the use of medicines within palliative care.

27 In addition, during the initial 1 year post, the pharmacist will look to provide audit data to support the funding of a substantive post through savings generated by cost effective supply of medicines and medicines optimisation and through the clinical need for a pharmacist as part of the healthcare team.

28 The post would initially be funded for one year, with the costs split across all parties. The group agreed a cost breakdown of contribution per organisation with a view to a Whole Time Equivalent (WTE) post. However before work could begin on progressing specific role requirements and timeframes one of the Hospices were subsequently unable to deliver their contribution and CCDFT made clear that they may not be able to deliver their contribution. Accordingly talks have recently reconvened and efforts in pharmacy are looking at the following:

- In-house supplies of medicines for the 3 hospices – to see whether the Trust can supply these meds directly to the 3 hospices as a more cost-effective supply route.
- The community pharmacy palliative care scheme. Disseminating clinical resources for staff dealing with palliative care meds in the community.
- Promotion of the Newcastle OOH Marie Curie advice line.

Proposal for Out of Hours Professionals Palliative Care Advice Line.

29 The proposal involved a pilot project from 2017-2018 which would involve a contract variation of the current activity based contract with the Marie Curie Hospice and include the Out of Hours Professionals Palliative Care advice line.

30 The aim of the telephone service is to ensure a seamless provision of advice is given to health care professionals out of hours (OOH), enhancing delivery of palliative care to patients and carers. .The advice line can be accessed between the hours of 17.00 and 09.00 Monday –Friday and 24 hours over the weekend. It is a specialist helpline for support professionals intended to cover North Durham, DDES and Darlington CCGs populations) – this would be manned by staff with specialist knowledge and skills in palliative and end of life care 24/7. This central team will be able to offer direct advice and guidance to patients, carers and/or other professionals. It would also act as a point of triage and offer where required direct contact with other specialist services.

31 This Pilot was agreed (on a 12 month basis) by all three Durham CCGs and went live in mid-April 2017. Initial figures suggest a quiet start but efforts to improve access in a number of areas including care homes are underway and the results of the pilot will impact on the configuration of future services across the county.

32 In relation to the 2013-2018 strategy the key proposals include a single point of access for patients, families and carers. It is important to note that the OOH line

does not replace this aim and the statistics and experiences gained from its use will allow us to understand themes and demand in relation to a future single point of access. There are a number of regional initiatives aimed at delivering points of access and the EOL group will monitor these to ensure that once these initiatives are clarified we identify the most appropriate solution for family's patients and carers.

Hospice Review

33 During the work carried out by the Task and Finish Group and further to the recommendations from the refresh and the EOL event of 6th June it was agreed that an independent clinical review of Hospices in North Durham would be undertaken to ensure that In-patient, outpatient and associated services were delivering quality and value for money for patients and their families and carers. This Review took place between January to April 2017 and was undertaken by Michelle Muir who is the Lead Nurse/Manager for Palliative care services at Newcastle upon Tyne Hospitals NHS Foundation Trust. The report's recommendations were as follows:

- Consolidate the inpatient beds onto one site.
- Review alternative options for increasing the consultants in post across the patch.
- If an alternative consultant model cannot be achieved, the complexity of the patients admitted to the hospices should be reviewed and more patients should be offered out of county placements in appropriately staffed units.
- Explore options for recruiting a nurse consultant.
- Review the service specifications for the hospices.

34 In respect of the recommendations the North Durham and DDES CCGs have agreed to undertake the following actions:

- Set up an urgent task and finish group to look at options for consultant cover to the whole of County Durham, with a view to providing specialist palliative care in the region. The preferred option being removing monies from CDDFT intended for consultants and placing this with a Hospice. This work is being closely aligned to ongoing work including Team around the Patients and care closer to home.
- Explore options for using existing funding for a nurse consultant post.
- Review the service specifications for the hospices
- Given the difference in cost between the inpatient beds options, continue to commission beds at St Cuthbert's and Willowburn and use them for Community Health Centre (CHC) fast track and CHC cases where appropriate.

35 The recommendation to consolidate inpatient beds onto one site was not taken forward since the CCG became aware during the Review process of an offer from a Local business to "Gift" a purpose built 6 bed inpatient unit at the Willowburn Hospice site. Given this development it was felt appropriate to have inpatient provision across the two Hospices.

EPACCS

36 EPaCCS take various forms of web-based electronic registers, systems based on sharing care summaries and plans alongside patients' electronic records, patient portals, real-time extractions from the records of participating organisations, etc. They aim to provide up-to-date key information about patients believed to be in the last year of their life in GP practices, emergency telephone services (111 and 999), GP out of hours services, accident and emergency departments, ambulance services, hospitals, community nursing teams, specialist palliative care services, hospices and care homes. In the UK, each of these settings has their own (electronic or paper) patient record. EPaCCS aim to improve communication and coordination and ensure that all those involved in a patient's care are aware of their wishes, preferences and advance care plan. They are expected, and to an extent have been demonstrated, to enable more patients to die at their preferred place and reduce unnecessary hospital admissions and ambulance journeys, inappropriate interventions, use of unscheduled care and repeated 'difficult conversations'. Provided that they have well-developed reporting functions, EPaCCS also supply detailed outcome metrics and enable continuous quality improvement in local end of life care services.

37 No area has full solution for EPaCCS and still lots of challenges ahead. In many ways the North East is ahead of the rest of the country in that agreed data sets are in place and some intra-operability in place as well. Within the North East EPacCCS is being progressed by a regional group being chaired by Kath Hall (GP from North Tyneside with representatives from across the Region. Dr David Oxenham and David Hand are attending for County Durham).

38 Key themes and potential solutions identified by the national programme were:

- Important aspects of patients care are flagged (underlining diagnosis; carer needs and support network)
- Information access and sharing (including alerts) across all settings e.g. social care
- Digital solutions which have read/write facilities
- Apps to support system management and assessment
- Systems to help manage and organise appointments
- Access to test results
- Systems to facilitate carer roles e.g. handover information
- Systems to support self-care and management

39 The group discussed the opportunity to work with CHC and put a bid in to further the work regarding EPaCCS within the region. This was regardless of the inter-operability tool that was used. The group felt it was important that any bid followed the overarching essential specifications for an EPaCCS that the regional group felt was important eg the 6 points proposed by Mark Lee (Group member and Palliative care Consultant based at St Benedict's Hospice in Sunderland), i.e.:

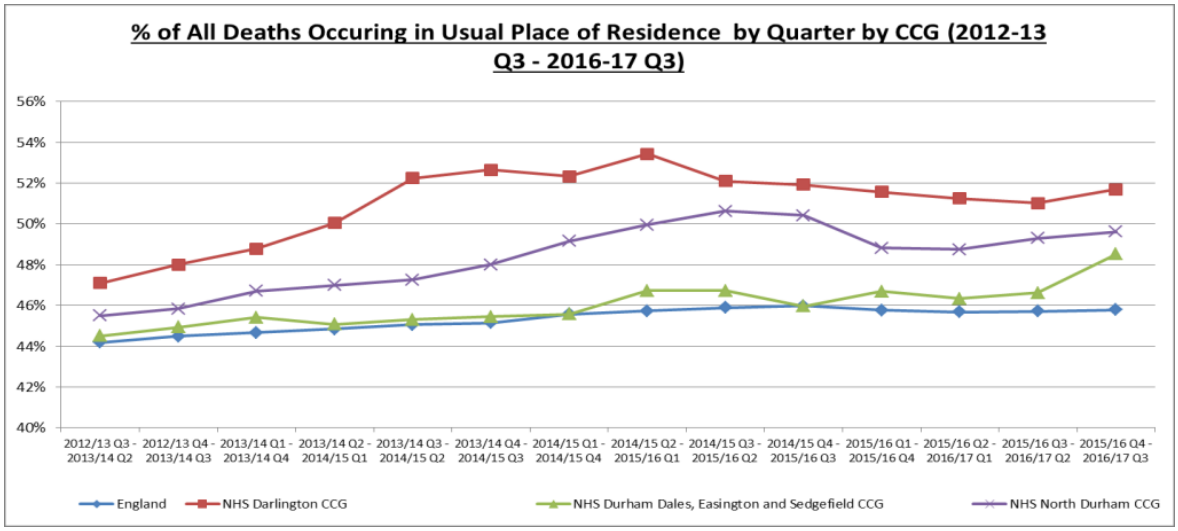
- Can be accessed (to read and to input) by any professional 24/7
- Can be accessed (to read and to input) by patients

- Must have a flagging system to alert professionals when the plan has been changed.
- That can generate reports for individuals, organisations, or as a whole. These reports must be able to look at different groups of patients as well as analyse individual patient journeys to see how future care planning evolves.
- Any changes made to a record would need to be instantly available.
- No 'double data entry' for any professional.

40 The preferred IT system for delivering EPACCS (Black Pear) is currently being piloted over 3 months in North Tyneside with the review due to be complete at the end of August 2017. Following this the pilot will be reviewed and options for roll lout across the Northern CCGs will be assessed. The EOL Group have invited the Pilot leads to attend a future meeting to discuss Durham's state of readiness for implementation in 2018.

Improved use of Evidence and Information

41 The EOL Steering group meetings involve a standing agenda item on information. This includes feedback on a number of key areas including death in usual place of residence. The most recent report is illustrated below.



It illustrates that whilst all three CCGS are above the England average there is still work to be done. The group takes the opportunity to discuss new initiatives within CCGs and how this impacts on figures. Most recently in both DDES and North Durham CCGs End of Life leads have visited practices to improve take up on the 1% register and these efforts will be reviewed at the next meeting on October.

42 The group have also recently begun to consider incidents via the Safeguard Incident and Risk Management System (SIRMS). Themes and trends are identified and actions raised as a result of the incident reporting item. It is hoped that sharing this information will improve practice through appropriate escalation and identification of best practice.

43 In respect of Patient/Carer involvement in the end of |life pathway there are a number of initiatives across the sector which are very good examples of co-design of services. At both St Cuthbert's and St Teresa's Hospices patients and carers were involved in the co-design of the new day patient units. There will be a new Voices Survey with results to be published next year and there are efforts to look at a pilot "Carers Diary" (based on a project started at North Tees) which are focused on delivering real time patient feedback to deliver improvements to services.

Conclusions

44 The updates discussed above have illustrated solid progress across a number of key delivery areas and show the value the Palliative and End of Life Care Group and its membership provide. It is recognised that these actions require continued time and effort to embed and there are a number of areas which still need to be addressed. Recent initiatives aimed at more collaborative working between DDES and North Durham CCGs (As well as other more regional initiatives)

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