NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
27th May 2016

EoLC – Update to the Strategy

Agenda item 16 Paper 10	
Summariser:	Ray Wagner, Interim Deputy Director of Commissioning
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Executive Lead(s):	James Blythe, Director of Commissioning and Strategy
Relevant Committees or forums that have already reviewed this issue:	Governing Body September 2015
Action required:	To note
Attached:	• Strategy Update
CCG Strategic objectives relevant to this paper:	End of Life Care
Risk	There is no perceived risk to this plan
Compliance observations:	**Finance:** there are no perceived financial risks to this plan
	Engagement : • During the development of the EoLC Strategy engagement was carried out • Princess Alice Hospice carries out continuous engagement • The EoLC Steering Group is actively encouraging patients/carers to be involved in the Group's work • Patients and their families in particular will be engaged around the implementation of the PACE documentation within the CCG
	Quality impact: Quality impact assessments have been carried out against the Strategy and will be repeated to take account of the new PACE work

	Equality impact: Equality impact assessments have been carried out against the Strategy and will be repeated to take account of the new PACE work
	Privacy impact: Privacy impact assessments have been carried out against the Strategy and will be repeated to take account of the new PACE work
	Legal: none applicable

EXECUTIVE SUMMARY

In September 2015, Kate Laws, GP Chair of the EoLC Steering Group, highlighted to the Governing Body, the key components of the SDCCG EOLC Strategy:

- Ensure a higher number of patients achieve their preferred place of death
- Increase the levels of community engagement and education to ensure everyone knows of the services available to support the dying patients
- Ensure workforce training and education that is offered across the whole system
- Identify the frailty and elderly in order to avoid crisis and ensure pro-active management, and improve recognition of the ceiling of care for an individual both in hospital and the community (recognising when someone is dying)
- Encourage active use of advance care planning

The attached paper details progress against these aims.

Date of paper	19th May 2016
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End of Life Care Strategy – Update on Progress

AIMS & OBJECTIVES

1. In September 2015, Dr Kate Laws presented the End of Life Care Strategy to the Governing Body. This paper is a brief update on progress to date, against the aims of the Strategy, which are to:

    - Ensure a higher number of patients achieve their preferred place of death
    - Increase the levels of community engagement and education to ensure everyone knows of the services available to support the dying patients
    - Ensure workforce training and education that is offered across the whole system
    - Identify the frail and elderly in order to avoid crisis and ensure pro-active management, and improve recognition of the ceiling of care for an individual both in hospital and the community (recognising when someone is dying)
    - Encourage active use of advanced care planning

PROGRESS UPDATE

2. A series of workstreams were created to take this work forward (see Appendix 1 for cross reference against the Aims & Objectives and Appendix 2 for timelines).

Workstream 1: PACE Documents – Proactive or Personalised Anticipatory Care Plan

3. As a priority, the development of a shared care record was imperative to enable health professional, across multiple organisations, to communicate important health information, as well as the patient's personal choices around preference for place of death.

4. Attendance at a conference on PACE (a Proactive or Personalised Anticipatory Care Plan) in October 2015 illustrated how this tool supported carers in nursing homes to express their patient's agreed preferences.

5. It was felt that this could be easily adopted in Surrey Downs, beginning at Epsom Hospital and linking with local care homes. PACE does not offer an IT solution but can be used across multiple clinical IT systems. In the context of previous challenges in implementing care planning approaches based on proprietary platforms, this approach was adopted as pragmatic and appropriate to integration with other strategies, in particular integration.

a) **PACE at Epsom Hospital**: a document was developed and approved, within Epsom & St Helier Hospital Trust (ESTH) by April 2016 and is in the process of being launched from May 2016

b) **PACE within Surrey Downs CCG**: the EoLC clinical lead for Surrey Downs CCG, Kate Laws, is working across the three community hubs to establish a document that could be placed on GP systems – the intention is for the document to be self-populating, with drop down boxes. The printed format will be very similar to the ESTH document, thus providing us with some standardisation although harmonisation with Kingston Hospital and East Surrey Hospital documentation will also be required.

6. This work is being undertaken with Dr Sharpe who leads on the GP IT Group. It is vital that the chosen system is fully functional at the time of launch.

Workstream 2: PACE Education and Training

7. To support the launch of the tool, it will be necessary to supply education and training across:
    - Primary care
    - Community health services
    - Care Homes
    - Acute care
    - Ambulance services

8. This training will also incorporate issues around mental capacity and starting difficult conversations. The training events may be divided across two or three events to ensure that they are tailored appropriately for different target audiences.

9. Funding for training events has been identified through residual Co-ordinate My Care Budget; this budget must be used within this financial year.

Workstream 3: CCG Website – Information and Resources

10. Plans are in place to update the CCG website to include pages on end of life and palliative care resources available across Surrey Downs. This includes a directory of services and updated information on bereavement.

Workstream 4: Supporting patients in their homes

11. In order to support admissions avoidance and to ensure patients have a high quality service during their end of life care, it was decided that SDCCG would agree the use of PleurX, (a fluid drainage system) which allows the drainage process to be carried out in the patient's home.

12. This new system would mean that a patient could:

- attend a hospital for an outpatient procedure
- have a district nurse visit them at home
- some patients and their carers may be able to manage the system themselves once it is implanted and merely have to see the consultant for review

Workstream Timelines

13. Timelines for the implementation of the above actions are set out below.

Workstream Timelines	Actions	Timelines
1. PACE Documentation	PACE Development PACE Pilot PACE Launch	May to July 2016 Aug to Sep 2016 From Oct 2016
2. PACE Events	Events Development Events Implementation	May to Sep 2016 October 2016 to March 2017
3. CCG Website EoLC Pages	Website page development Website launch	April to June 2016 July 2016
4. Supporting patients in their homes	Establish pathways Establish training for DNs Establish costs Ratify via Quality Group/Clinical Cabinet/Other Communications re service availability	May to Sep 2016 May to July 2016 May to July 2016 September 2016 Sept/Oct 2016

PROJECT ENABLERS

14. ***Quality Care Homes Initiative -*** While this initiative sits outside of the EoLC Steering Group remit, it fully supports the aims of the EoLC Strategy by utilising assistive technology that aids risk stratification for patients within residential care homes and aids admissions avoidance. There are also links with the work on Dementia that we are beginning with care homes.

15. ***Community hubs – 2017/18 -*** An initial plan to incorporate two palliative care nurses into the community hubs has been delayed until 2017/18. Community Hubs are being encouraged to include palliative care within their business cases. Palliative care nurses would enable admissions avoidance, provide discharge advice and education across the hubs.

16. **End of Life Care Steering Group -** This group is responsible for the production of the EoLC Strategy and the ongoing direction of EoLC Strategy within Surrey Downs. It now meets every 8 weeks and includes members from the following organisations:

- Surrey Downs CCG
- Epsom & St Helier Palliative Care Team
- Princess Alice Hospice
- St Catherine’s Hospice
- Shooting Star Hospice (children’s)
- Surrey County Council (Care Home Team)
- Central Surrey Health

Appendix 1

EoLC Strategic Aims	Ensure a higher number of patients achieve their preferred place of death	Increase levels of community engagement and education to ensure everyone knows of the services available to support the dying patients	Ensure workforce training and education is offered across the whole system	Identify frail and elderly to avoid crisis and ensure pro-active management, and improve recognition of the ceiling of care for an individual both in hospital and the community (recognising when someone is dying)	Encourage active use of advanced care planning
Workstream 1: PACE Documents – Proactive or Personalised Anticipatory Care Plan	engaging patients, family members and carers in documenting their preferred place of death	engaging carers and other health professionals in recognising a patient's preferred place of death		engaging patients, family members and health professionals in documenting preferred place of death and acknowledging EoL	engaging patients, family members, carers and health professionals in documenting preferred place of death
Workstream 2: PACE Education and Training	training across primary, community, acute and nursing home care	training across primary, community, acute and nursing home care	training across primary, community, acute and nursing home care	training across primary, community, acute and nursing home care	training across primary, community, acute and nursing home care
Workstream 3: CCG Website – directory of services and available resources	communicating to patients, families and carers that this option is available	communicating to patients, families, carers and health that this option is available	Supports health professionals in understanding the resources available to support them		communicating to patients, families and carers that this option is available
Workstream 4: Support patients in their homes	providing health care within the patient's home	providing health care within the patient's home	DNs, carers and other suitable health professionals will receive training	providing health care within the patient's home	providing health care within the patient's home
Enabler 1: Quality Care Homes Initiative		Supports this aim by liaising with community hubs and community services		identifying those at risk	
Enabler 2: Community Hubs		Supports this aim by ensuring by being a repository of information for the dying patient	Supports this aim by ensuring staff are trained at an appropriate level	identifying the frail & elderly, who are often more complex and reaching the end of their lives	