NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
30th September 2016

EoLC – Update to the Strategy

Agenda item 9 Paper 5	
Summariser:	Simon Williams, Clinical Director, Integration and Urgent Care
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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 Governing Body May 2016
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

An update to the EoLC Strategy in May 2016 was noted. Since then an emphasis has been placed on the introduction of a commissioned PleurX service and the development of an advanced care plan via PACE. Both of these initiatives support the EoLC key components of:

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

An update was presented to the Governing Body on 27 May 2016 and the attached paper details progress against these aims.

Date of paper	20 September 2016
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End of Life Care Strategy
Update on Progress – 30 September 2016

In September 2015, Dr Kate Laws presented the End of Life Care Strategy to the Governing Body. Dr Laws then gave an update to the Governing Body in May 2016. This paper is a brief outline on progress to date.

The aims & objectives of the EoLC Strategy were 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

Workstream 1: PACE (Proactive or Personalised Anticipatory Care Plan) Development
As an agreed priority, the development of a shared care record was imperative to enable health and social care professionals across multiple organisations to communicate important health information about the patient, together with their patient personal choices around preference for place of death.

PACE within EGH: Epsom Hospital palliative care and CADU teams worked together and received approval from the ESTH Board, to utilise this tool, with the aim of supporting discharges from Buckley Ward into local nursing homes. This began from the end of May 2016. A full evaluation will be put together in early October, however initial findings are:

- CADU GP has developed 10 - 12 PACE documents on Buckley ward
- GPs in Epsom will be notified that this current, paper based version, should be emerging from EGH over the next few months
- If patients and/or informal carers have prior warning and information, the actual completion is much quicker than previously thought (often 20-30 minutes) as many of the issues will have been discussed in previous meetings
- Need for information leaflets to give to patients and carers

PACE within Surrey Downs CCG: Dr Kate Laws worked across the three community hubs to gain feedback on the development of PACE within ePACS (an electronic patient care record that sits within EMIS). This was felt to be the best option as it offers self-population of patient details from EMIS and the ability to create with drop down boxes.

The printed format does not look markedly different from the ESTH version, thus providing us with some standardisation.

Throughout September the ePACS PACE is being piloted in seven practices:

- Eastwick

- Esher Green
- Derby
- Littleton
- Molebridge
- Shadbolt
- Tattenham Corner

Feedback on function will be fed into this workstream and time is allocated at the end of September/beginning of October to make any further changes. PACE will then be rolled out across the CCG. It is important to note that this will be an iterative process and PACE will be subject to change as issues arise.

Workstream 2: PACE Education and Training

To support the launch of the tool the GP lead, Kate Laws, will attend Locality Meetings in East Elmbridge and Epsom, with an additional attendance at an Epsom Educational Day (Dorking is currently using an alternative system but engagement around PACE is due to take place).

Kate will also attend practice meetings as requested to answer any queries. It is often more helpful for training to take place at a practice, where it is easier to demonstrate how to use the ePACS system and show how the system's ability to self-populate can reduce the workload for GPs.

Workstream 3: PACE Stakeholders

Meetings have been held with SECAMB/111 and Care UK/OOH, both of whom are keen to ensure that standardisation exists across the CCG.

SECAMB had a very positive reaction to PACE, viewing it as a helpful tool, that they can hold on IBIS as a Word version. This can be emailed via secure NHS net addresses. The process for this is currently being developed. A SECAMB target is to hold care plans on IBIS and the PACE initiative will help to boost Surrey Downs records, which are currently very low. They were also very pleased with plans for patients and carers to have a printed copy of the PACE that they can keep at home.

The Adastra IT system used by 111/OOH doesn't have the flexibility of IBIS and a Word version cannot be held within it, although technical details are now being checked by the Care UK lead. We have suggested a workaround in which GPs instead of typing patient details on to the GP Patient Notes section within the Adastra portal, can simply state that a PACE document is in place.

This has highlighted the issue of multiple organisations creating PACE documents, some of which may not be electronic e.g. within nursing homes. The Integration Team/EoLC Steering Group will need to look at process and work with external organisations to ensure that practices are notified when a PACE document is generated.

Further work continues to seek the adoption of a single PACE document, with future inbuilt interoperability.

Workstream 4: Supporting patients in their homes

In order to support unnecessary and unwanted admissions 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 system allowing fluid drainage from body cavities) which allows the drainage process to be carried out in the patient's home.

This new system has now been implemented with a full set of KPIs for monitoring purposes. Patients can now attend a hospital for an outpatient procedure but receive draining treatment at home via a district nurse and 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 5: CCG Website – Information and Resources

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.

Project Timelines

The timelines below show how the EoLC Strategy has progressed over the last few months, with PACE having a major role to play. Further workstreams will be added to cover additional identified actions:

End of Life Care	Subject	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Workstream 1: PACE Development	GP PACE initial development	end July				
	Work with SC, Locality Leads, etc, to further develop		Complete			
	Roll out to Pilot Practices: - Derby - Esher Green - Littleton - Shadbolt - Tattenham Corner - Eastwick - Molebridge		End Aug	Mid Sept		
	PACE Launch				From Oct	
Workstream 2: PACE Training Events	Via locality meetings EE & Epsom and training sessions within member practices					
Workstream 3: PACE Stakeholders	SECAMB/111/ OOH		24/8	15/9		
Dorking	Establish extent of work with Dorking Locality					
Workstream 4: Supporting Patients at Home	Roll out of PleurX draining via CSH		Complete			
Workstream 5: Communications	development of website pages with Communications Team					

Project Enablers/Interdependencies

A number of projects have been/are being launched across SDCCG and these have direct links into the CCG's EoLC strategy and the development of PACE (there are also strong links to dementia diagnosis and frailty):

Project	Description
Quality Care Homes Initiative	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. PACE is incorporated within the business case
Falls	There are two main elements to the Integrated Community Falls Service. The first is a general, non-specialist service provided by front-line staff working across primary and community care and available for all patients, via the community hub. The second element is a more specialised falls service, intended for those patients who require specialist input exceeding that available from the first-line care staff. Service mapping against the current model and the new NICE guidelines.
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 improved responsiveness and quality of care, whilst providing discharge advice and education across the hubs. PACE is being launched across SDCCG (East Elmbridge and Epsom) this will include Community Hubs.
Care Home Dementia initiative	Short project in which a GP lead liaises with practices that are not achieving a strong dementia diagnosis rate and who have known links to nursing homes. Utilising the NHSE recommended DeAR GP and the DIADEM tool, the GP lead will visit the nursing home, see and collect data on residents who don't currently have a dementia diagnosis but have shown recent symptoms; take this information to the identified practice and download information. This work will be mainstreamed within the Primary Care Standards project; a PACE document can be generated following this visit.
Care Home CQUINs	This CQUIN is based on dementia care planning to which PACE will be integral. There are also links here to the use of the DeAR GP and DIADEM identification tools

Conclusion and next steps

The work on PACE has been developing well. As this work has progressed a number of other considerations have emerged and will require action:

- Admissions avoidance DES – we are hopeful that utilisation of the PACE document can replace the current admissions avoidance care planning template. SDCCG is investigating this possibility
- Dorking CCG currently has its own Advanced Care Plan. Following the launch of PACE across East Elmbridge and Epsom localities, it will be important to work with Dorking to ensure that SystmOne can be adapted to incorporate the same document. It is intended to pick this work up from October 2016, allowing PACE to be established across the EMIS based localities in the first instance
- Information/guidance will be needed for carers and care/nursing homes to feel confident using PACE – we will need this to be standardised across the health economy
- Mechanisms for reporting and incorporating newly generated PACE plans outside of practices need to be considered
- Need to establish timelines for ESTH evaluation and ongoing reporting mechanisms