NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
27th January 2017

End of Life Review

Summariser:	Dr Simon Williams- Clinical Director
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Executive Lead(s):	James Blythe – Executive Director of Commissioning
Relevant Committees or forums that have already reviewed this issue:	Integration Programme Board Programme Delivery Board Quality Committee End of Life Project Group
Action required:	For discussion / to note
Attached:	Appendix 1- EoL Project Board membership Appendix 2- EoL Project Plan Appendix 3- EoL Presentation
CCG Strategic objectives relevant to this paper:	Core business: Clinical Priority 4: Enhanced support for those patients who require End of Life care
Risk	Risk log managed at Integration Programme Board
Compliance observations:	**Finance:** Aware
	Engagement : Engagement and communication plan on going
	Quality impact: TBC
	Equality impact: TBC
	Privacy impact: TBC
	Legal: NA

EXECUTIVE SUMMARY

In September the End of Life Strategy was presented to the Governing Body with the view that an update should be scheduled for the January meeting.

1. This paper updates the Governing Body on work underway to refresh the CCG End of Life Care Strategy.

2. The refresh of the strategy is being undertaken in the context of a number of drivers which are set out below.

Background:

System alignment and co-ordination

The requirement to align the End of Life Care (EoLC) Strategy to the CCG's wider plans for locality-based health and social care integration, institution of community medical teams and hubs and move towards new models of care set out in the NHS Five Year Forward View. We have specifically recognized that:

a. End of Life Care should form part of the integration agenda as a patient journey should seamlessly include end of life conversations at the right time in line with individual preference. It is understood that the majority of patients within the integration cohort will require end of life support and that the system and individual pathway needs a flexible approach to meet patient need.

b. Within this, EOLC requires a distinctive approach through enablers such as compassionate communities, a workforce that is competent, consistent and confident in providing compassionate care and 24 hour coordinated care supported by strong leadership

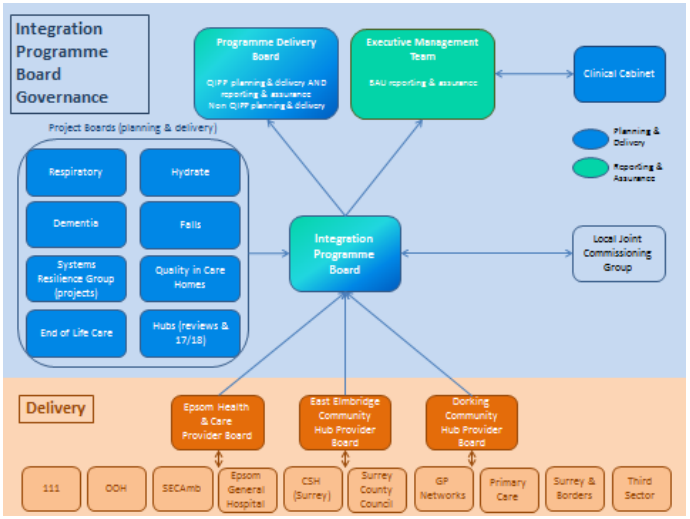
c. There is significant complexity in EOLC with the service user experience being a function of the approach to EOLC in Continuing Healthcare, acute, community, ambulance, GP, GP out of hours, voluntary and social care services. Sometimes provider contracts are wholly or largely oriented around EOLC; more often EOLC provision is a small part of a much wider contract. Therefore transformation needs to recognize the need to influence providers as much as contractually mandate change, and for EOLC requirements to influence provider and contract management in both health and social care

Changes to programme governance and oversight

At the September meeting, the Governing Body discussed the challenges of prioritization across the CCG's portfolio of strategies and programmes, particularly in the context of delivery of the financial recovery plan and related governance. In the context of strong delivery of the FRP in the previous twelve months, changes are now being made to bring the rigor of FRP governance to non-FRP programmes. Specifically:

a. The EOLC programme has been brought under the Urgent Care and Integration Programme Board, reporting to the Programme Delivery Board (PDB) as per the diagram below. PDB is in the process of reviewing its Terms of Reference to include non-FRP programmes, to ensure consistency of treatment and prioritization across all CCG initiatives. Including the end of life portfolio as part of the integration programme facilitates commitment of substantive management resource and maintains focus on progression of the strategy refresh

Integration Programme Governance structure



b. The clinical leadership of the programme has transferred to Dr Simon Williams as Clinical Director for urgent care and integration, following Dr Kate Laws' decision to stand down. Dr Laws' significant contribution to the development of the CCGs' first EOLC strategy and work to put in place developments making a significant different to EOLC are noted.

c. Since the change in approach, the CCG has **refreshed the EOLC Project Board** which has met in November and January membership including Hospices, Community Trust, Social Care and CCG with the addition of voluntary sector organizations and a patient representative. The membership of the Project Board is enclosed at Appendix [1]

d. The CCG has also **Identified and recruited a project resource -** approval was obtained for 1.0 wte band 7 Commissioning Manager to be shared with the CCG Collaborative Programme. An offer has been made with the aim of the post commencing February / March 2017. This post will manage the end of life project plan, project group and communication and engagement plan.

e. In line with the established project governance, the CCG has **compiled a project outline document and project plan**. A Project Outline Document (POD) has been completed in draft with the Project Board and accepted in principle by the Programme Delivery Board with a review date to coincide with the next Integration Board deep dive. A project plan has also been drafted (see high level plan Appendix [2]). This will enable the End of Life Project Board to stay on track and will be managed by the Commissioning Manager and led by the Integration Management Team.

f. Work has been undertaken to **review end of life contracts and grant agreements**. A review of the Better Care Fund contracts and aligned contracts was completed in December 2016. A number of contracts were identified and contract management input will be provided through the new Commissioning Manager post, inputting to the Local Joint Commissioning Group where contracts sit under the Better Care Fund (including some funded from jointly held money under LJCG but contracted by social care)

g. Work is also underway to **scope out other potential dependencies** to understand the complexity of the current contracting environment, and particularly the CCG's £2.5m per annum commitment to fast-track CHC placements for service users expected to be approaching end of life.

Scale of vision and ambition in the EOLC strategy

3. The work to refresh the Strategy reflects feedback from previous GB meetings regarding the level of ambition in the CCG's EOLC strategy and alignment with nationally recognized best practice.

4. Data analysis undertaken in support of the strategy refresh, and from NHS RightCare, sets out End of Life data in relation to dementia, circulatory, cancer and respiratory disease and suggests that the CCG needs to focus on patient outcomes and preventing hospital admission in the last year of life. The CCG achieves below average compared to our peers in terms of death in usual place of residence and is above average for number of hospital admissions in the last year of life. Further public health data between 2011-2015 suggests that the majority of deaths take place in hospital, the most in Epsom hospital (62%) with most patients over the age of 85 years. The rate of death is also increasing in line with population growth with more females dying in care homes than males, there has also been a decline in hospice deaths with an increase in deaths at home, in care homes and in hospital

   Key data is summarized in the presentation which is appendix [3].

5. The Strategy refresh will now focus on addressing these specific indicators The work to revise the Strategy now uses as a framework, the Six Ambitions for End of Life Care supported by the National Palliative and End of Life Partnership of:

   - Each Person is seen as an individual
   - Each person gets fair access to care
   - Maximizing comfort and wellbeing
   - Care is coordinated
   - All staff are prepared to care
   - Each community is prepared to help

Conclusion

The Governing Body is asked to note the work undertaken since the last update and discuss:

- The new governance for the EOLC strategy within the CCG
- Its key priorities for the strategy refresh exercise, based on GB members' own experiences and the data presented as enclosed
- The appropriateness of the membership of the EOLC Project Board and whether further organisations should be invited to contribute
- The adoption of the framework of the six ambitions for EOLC set out under (5)

Date of paper	
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Appendix 1 **Membership of the End of Life Project Board**

Job Title	Title	
GP Lead for Integration	Clinical Director Lead (Chair)	Confirmed
Deputy Director of Integration and Urgent Care	Managerial Lead (Deputy Chair)	Confirmed
CSH	Deputy Director	Confirmed
Macmillan	TBC	Confirmed
Brigitte Trust	CEO	Confirmed
CHC	Lead Nurse	TBC- invited
Surrey Care Association	Director/ CEO	TBC
Patient representative	HS	TBC- invited
Public Health	tbc	TBC
SCC	Commissioning Manager, Mid Surrey area	Confirmed
Princess Alice Hospice	Director of Patient Care and Strategic Development	Confirmed
St Catherine's Hospice	Director of Care Services	Confirmed
Quality	Head of Quality / Chief Nurse	Confirmed

Appendix 2 **EoL Q4 Project Plan**

	EoL strategy implementation plan plus stretch					
	Q4 16/17					
		Who	**% complete**	**When**	**Why**	
Vision	'I can make the last stage of my life a good as possible because everyone works together confidently, honestly and consistently to help me and the	NA	NA	NA	0	
1	Review Project Group, ToR and membership	LH	100	Jan-17	project structure	
2	Agree Governance structure	LH	100	Jan- Feb-17	project structure	
3	complete refreash for Governing Body		100	Jan-17	Governace	
4	Review of eol data	LH	80	Dec-16	Supports PiD and Strategy	
5	Agree Project Plan	LH	80	Jan-17	project structure	
6	Complete EoL page for CCG website	PT	70	Jan- Feb-17	Communication	
7	Agree Strategy	LH	60	Jan - Feb 17	Supports Direction	
7	Review and agree anticipatory care plan/ PACE	LH	50	Feb- 17/ March -17	supports integration	
8	Uploading anticipatory care plans on to IBIS/ review DNACPR forms for IBIS	KM	70	Jan - Feb 17	process and integration	
9	Review palliative care community model - and process map	LH/ PM		Feb- 17/ March -17	communication	
10	Complete communication and engagement plan 17/18	PM		Mar-17	Communication	
11	Complete PoD and PiD for EoL QIPP align to integration BC.	PM		Mar-17	Supports integration	
12	Integrate eol pathways into Hubs/ anticipatory care planning	LH		May-17	Enables governance	
13	Align EoL pathway with Quality in Care Home Team	LH/ PM		Mar-17	Enables patient engagement	
14	align to CHC fast track initiatives and explore localised model	PM		March- July 2017	Supports integration	
15	Review the use of Nursing Home CQUINs to include PACE/ anticipatory (advanced care plans and IBIS upload	PM		Mar-17	Supports integration	
16	Review 111 specification	PM/ KM		Mar-17	supports integration	
17	Reviewing carer assessments and health and wellbeing community sign post support including social px	PM		Mar-17	supports integration	
18	implementation of pace / anticipatory care plan documentation into identified wards in Epsom hospital and in hubs- reassess the in-reach	PM		Mar-17	Supports integration	
19	Plan education programme 17/18. Primary care, community care, voluntary and third sector	PM		Apr-17	Supports workforce	
20	agree Q1 17/18 project plan - Check and balance against Strategy	PM		Apr-17	process and integration	

Appendix 3

SDCCG EoLC Exec Summary reviewed g(