Title of paper:	End of Life Care Strategy – Surrey Downs CCG
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Exec Lead:	Karen Parsons
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Agenda item & attachment number:	Agenda item 13 Attachment 7
Attachments – please list or state "none"	• EoLC Presentation

Purpose of Paper (tick one only):	
For information only (to note)	
Requires discussion and Feedback	
For decision	✓

Executive Summary:

Key stakeholders in the Surrey Downs area have a shared ambition of providing patients nearing the end of their lives with a better quality of care, and more choice about where to end their lives.

An End of Life Care Steering Group was established to further these aims, Chaired by Dr Kate Laws (Surrey Downs CCG Governing Body Member and EOLC clinical lead). The steering group also has representatives from St Catherine's Hospice, Princess Alice Hospice, CSH Surrey and Epsom Hospital.

The Steering Group has representation on the Epsom and St Helier Steering Group and the strategies from the two groups are in alignment. Both groups in turn link into the wider Kent Surrey Sussex Academic Health Science Network for EoLC.

The key components of the SDCCG EOLC Strategy 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 their last year of life 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 Strategy, together with the Strategic Report were presented at the SDCCG Executive meeting on 21st July, where it was discussed and agreed.

Recommendation

The Governing Body is asked to

- AGREE the End of Life Care Strategy and
- Provide feedback on implementation

Compliance section

Please identify any significant issues relating to the following areas. Do not leave any boxes blank – if there are no compliance issues please state "no known issues".

Risk Register and Assurance Framework	**Risk:** SDCCG will not see an increase in patients achieving their preferred place of death **Mitigation:** work across the health economy to ensure clinicians receive training in Advanced Care Planning (ACP), Mental Health Capacity Act, Dementia and that Nursing Homes are engaged with this process
Patient and Public Engagement	To date the SDCCG EoLC Steering Group has not liaised specifically with patients, however the GP EoLC Lead liaises with patients at her surgery who provide feedback on a number of issues. The ESTH PALS and Complaints service feed into the SDCCG Group via their own Steering Group and the two hospices provide patient feedback into the Group. The Group is keen to include a patient and/or carer but is aware of the sensitivity of this issue and would like to feed patient input into specific workstreams.
Patient Safety & Quality	The SDCCG EoLC Strategy seeks to improve services offered to patients through increased access to palliative care and ACP training, ensuring that patients who are nearing the end of their life are aware of their options around place of death.
Financial implications	There are no known financial implications; budgets for additional staff are held within other projects (Community Hubs) and training will be carried out across the health economy utilising current resource. It will be necessary to appoint a nurse post for education and liaison with nursing and residential care homes as there is currently no one performing this role.
Conflicts of interest	No known issues
Information Governance	No known IG issues – as there are no proposals to change information flows a Privacy Impact Assessment has not been considered necessary.
Equality and Diversity	As this encourages adoption of existing services and best practice, an equality impact assessment is not deemed necessary.
Any other legal or compliance issues not covered above	No known issues

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Executive Summary
EOLC Strategy 2015-2018

Dr. Catharine Laws,
CCG Clinical Lead for EOLC

June 2015

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Video – I Didn’t Want That

End of Life Care Aims & Objectives

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Surrey Downs CCG and the EoLC Steering Group have utilised the *NICE guidelines for EoLC for Adults* (2011, modified 2013) and '*One Chance to Get it Right*', the national recommendations of the Five Priorities for Care of the Dying Person, as a framework to develop their Aims & Objects and introduce service improvement into the current system:

- Ensuring 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
- Workforce training and education that is offered across the whole system
- Identification of frailty 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

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Drivers for Change

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Population

- Population is weighted to over 65s - their percentage is projected to rise from19.7% to 21% (2011 Census) in the next 15 years, with an increasing population of patients with chronic diseases and co-morbidities
- The over 85 population is projected to grow at a similar rate to the national average - between 3.4-3.9% of the local population will be 85 + in 2020
- 2,410 patients in Surrey Downs will require EOLC each year

Dying at Home

- Deaths in the ***home*** in Surrey Downs are one of the lowest in the country, we are currently only achieving 17.70% (age 75+)
- A national survey in 2006 showed 57% of respondents preferred a home death
- Factors influencing hospital deaths – being single, widowed or divorced, aged >75, types of cancer e.g. lung
- Psychological, social and holistic measures suggest patients' wellbeing in last weeks or days of death may be better with a home death

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Drivers for Change – Preferred Place of Death

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- During 01/12/2013 - 30/11/2014, sudden deaths accounted for only 2.17% of deaths in Surrey and e.g. over 98% of people dying in this time period therefore could have needed planned end of life care
- Commonest causes of death, accounting for about 75% of deaths = cancers (30% of deaths), circulatory (28% of deaths), respiratory system diseases (15% of deaths)
- For all age groups, the highest percentage of deaths in Surrey Downs CCG take place in hospital, around 49%
- There were fewer deaths in hospices, more at home and in care homes in SDCCG. Deaths in care homes = highest percentage of deaths in people aged over 85
- Based on national survey "Local preferences and place of death in regions within England 2010" the majority of participants in all regions said they would prefer to die at home if circumstances allowed
- Comparing survey data on preferences, with actual data on place of death, suggests most people are unlikely to see their preference met
- There is a major gap between proportion of who prefer to die at home and proportion of actual deaths at home.

Preferred place (based on 2010 national survey) vs actual place of death by age group in Surrey Downs CCG

	45-64		65-74		75+	
Place of deaths	Preferred (2010)	Actual	Preferred (2010)	Actual	Preferred (2010)	Actual
Home	63%	31%	**56%**	**28%**	**45%**	**17%**
Hospice	32%	17%	**37%**	**14%**	**41%**	**4%**
Hospital	1%	47%	**4%**	**51%**	**6%**	**49%**
Care Home	1%	5%	2%	6%	5%	30%

excludes sudden deaths; elsewhere and other communal establishments

Total deaths by place and age range - Surrey Downs CCG 01/12/13 – 30/11/14

Place of death	0-64	%	65-74	%	75-84	%	85+	%	Grand Total	Grand Total %
Care home (Local Authority and Private)	10	4	22	6	105	16	445	36	582	24
Elsewhere	9	4	7	2	5	1	5	0	26	1
Home	68	28	99	28	135	21	176	14	478	19
Hospice – non NHS	43	18	51	14	41	6	37	3	172	7
Hospital – NHS (Acute, Community, not psychiatric)	111	46	180	50	358	56	561	46	1210	49
Grand Total	**241**	**100**	**359**	**100**	**644**	**100**	**1224**	**100**	**2468**	**100**

Primary Care Mortality Database (PCMD). Analysis excludes sudden deaths.

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Service	Achieving Aims & Objectives By:
Palliative Care	• Introducing palliative Care Support Service focussed on nursing homes and care homes • Providing a dedicated palliative care discharge co-ordinator working with Epsom Hospital to facilitate and follow through, timely discharge of appropriate patients and support their preferred place of care/death • Reviewing the service provision currently available within care homes for EoLC • Developing a pathway that supports dementia clinics and frail and elderly services, to identify potential EoLC patients earlier, in order to involve them in their advance care plans and in shared records
Shared care plans	• Introducing a shared care plan that is easy to access and easy to add patients to, for all of the multidisciplinary teams e.g. hospitals, community, ambulance and social services • Promoting the use of advance care planning for patients with conditions related to progressive cognitive decline for example Dementia & Alzheimer's Disease, earlier identification earlier in their disease trajectory, ensuring referral into post diagnosis support services such as dementia clinics while the patient still has capacity
Workforce Training	• Increasing engagement in accredited EoLC standards of training for nursing home and care home staff (eg the Gold Standards Framework Care Homes accreditation scheme) to up-skill staff and empower them to support EoLC for their patients • Offer regular training to all staff involved in the provision of palliative care services • Providing education in advance care planning and 'starting difficult conversations' to GPs, community services, OOH providers and other services and agencies
Patient Education	• Using tools such as the CCG Internet which can provide links into other educational sources e.g. Dying Matters (for use by clinical staff and the general public) and signposting into voluntary sector services as appropriate • Providing resources for peer support for patients, their families and carers • Production of an electronic directory of services, available via the CCG Internet
Bereavement Services	• Providing a coordinated approach to Bereavement Services to overcome the existing inequity of availability • Conducting a postal survey to all bereaved relatives making specific reference to coordination and quality of care, e.g. Voices, to gain an improved understanding via the directory of services, as to current service provision around bereavement • Identify requirements of different faith groups for differing cultural approaches to care of the body following death and bereavement support
Telephone Triage & Support	• Reviewing current EoLC telephone support, including access to urgent care • Working with the Urgent Care Programme to ensure EoLC support is provided and triaged appropriately via 111 • Utilising the electronic directory of services, supporting triage and other services and be easily maintained and available via the CCG Internet • Directing 111 calls in an appropriate way, providing up to date advice and strong liaison with the ambulance service, will avoid unnecessary admissions to acute beds

Risks and Assumptions

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Risks Within Current Service (do nothing scenario)

- The two hospice care providers may be unable to cope with the increasing number of patients, as the requirement for EoLC grows alongside an ageing population
- Patients with less traditional hospice conditions e.g. Dementia, won't receive an equitable service, thereby not achieving Parity of Esteem
- Lack of training in nursing homes may lead to unnecessary hospital admissions for the terminally ill
- CMC or its equivalent, may not be utilised putting a co-ordinated approach to EoLC in jeapardy
- PAH and St. C will continue providing an un-commissioned service to SECamb and won't be able to support OOH services
- Bereavement service may remain patchy
- Lack of financial resources may impact on recruitment to vital posts
- Concern that financial pressures places EoLC on a lower priority footing than other planned care priorities

Risks re Integrated Service (new approach)

- Lack of applications or interest in new roles could result in unfilled posts
- Loss of IT infrastructure that supports the use of shared care records, through a technical/internet failure
- Decision by the CCG to appoint a new Electronic Palliative Care Coordination System (EPaCCS) provider that has no inter-operability with all providers, ambulance service and GP systems

Assumptions

- SDCCG has the available funding for the posts required
- A formal nursing home model will be adapted and rolled out for SDCCG
- That the hospices are able to provide support and training for new posts
- Shared care record facilitators are able to provide training to all staff across the Surrey Downs health economy
- GPs continue to take part in GSF meetings
- NHS 111 and the OOH GP service can access the End of Life care plan

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Costs

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Financial Analysis	Comments	Cost Pressure
FTE B7 Nurse - Palliative Care Support	Based within CMDT budget Supports work with nursing homes and practices - educational	£43,750 *CMDT cost pressure*
FTE B7 Palliative Care Discharge Facilitator	Based within CMDT budget; works in the community and liaises with hospitals to facilitate earlier discharge of EoLC patients	£43,750 *CMDT cost pressure*
GP Education – OOH, UC	Commission from hospice providers	to be assessed
Workforce Education: *training and education via HEKSS *training via hospices *Online training Dying Matters	 *to be confirmed *to be confirmed *FOC	to be assessed
Shared Care Record	Current Co-ordinate My Care (CMC) functionality is poor, other options are being explored via the IT Group, however CMC are being funded to upgrade, timelines are as yet unclear	to be assessed
Telephone Triage & Support	Currently provided via HCP Line at £5k pm; potential for this to be provided by PAH	£5,000 pm approx *cost neutral*

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Conclusion

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Adopting the proposed changes could:

- increase the number of patients achieving their preferred place of treatment and death
- decrease crisis admissions and reduce inappropriate acute admissions
- Increase the education offer and take up of advanced care planning across agencies ensuring a higher quality of care
- Understanding our demographic, the prevalence rates for EoLC and establishing interdependencies with LTC, frail & elderly projects, etc., will provide future proofing for the challenges ahead in an integrated, joined up approach

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NEXT STEPS

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- Agree the strategy and high level workstreams

- Produce Project Plan that provides greater detail on project workstreams, timelines and a communications plan

- Produce needs assessment (modelling) that maps 'ageing' growth rates by smallest age group e.g. 54-59, 59-64, enabling drill down into factors such as:
    - Retirement
    - Elderly not moving – impact on SD and housing/home care needs/hospices and hospitals
    - Landscape of retirement, care homes and nursing homes in SD
    - Length of Stay for patients against age groups, looking at potential trim points – understanding how we can unpick spells and episodes to enable discharge co-ordinators to intervene along the patient's admission pathway

- Understand interdependencies with other areas such as Dementia, Frail & Elderly and Falls Teams, LTC projects, ensuring projects don't overlap and that we're sharing and using the same data, pathways and establishing common objectives

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EoLC – Service Delivery Plan