ENCLOSURE: I

Agenda Item: 127/14

NHS Bexley Clinical Commissioning Group

Governing Body (public) meeting

DATE: 27 November 2014

Title	End of Life Care Service Development
Recommended action for the Governing Body	That the Governing Body: **Approve** the EOLC business case for the development of services for our patients during their last year of life and at their death to enable more patients to be treated in their own home (normal place of residence) and to plan for their own death.
Executive summary	The main aim of this Business Case is to improve our existing services to provide a quality End of Life Care service (during the last 12 months of life & for an individual's death) which is: • patient centred, • integrated, • delivered by a compassionate, skilled and competent workforce. We aim to enable patients in the last months of life to be well cared for, wherever possible outside of an acute hospital environment, and to enable our population to end their lives in their preferred place of care. Through this improved service we aim to further reduce admissions to hospital, lengths of stay in the last 12 months of life and avoid inappropriate deaths in hospital. This is aligned to our Better Care Fund Plan where we are aiming to avoid a minimum of 199 acute admissions of people aged 65+. In doing this we will also aim to reduce emergency admissions in the last year of life as part of our QIPP. In total between the two schemes our aim is to reduce emergency admissions by 335 per annum (full year effect). To achieve the aims above requires a whole system approach which means that buy in from all stakeholders is as important as investment and service redesign because progress will only be as fast as the slowest participant. We need to therefore "stretch" the whole system to achieve this aim.

The cost of admissions during the last 12 months of life and the cost of deaths in hospital are high. For 2013/14 the estimated annual cost to the CCG for admissions 1 year prior to death and including death in hospital is estimated at £10.049m (this excludes A&E attendances).

The following is an estimate of savings which could be achieved by a reduction in deaths in hospital and admissions prior to death. These are reductions in our acute spend on these services (gross costs) as investment in services outside of hospital is not included in the below.

			At 10% avoided		At 15% avoided		At 20% avoided	
Admissions avoided	Admissions pa	£ pa inc ExBD	Admissions pa	£ pa inc ExBD	Admissions pa	£ pa inc ExBD	Admissions pa	£ pa inc ExBD
Admissions including "death events"	1,162	£5,823,907	116	£582,391	174	£873,586	232	£1,164,781
Admissions in last year of life (excluding above)	1,634	£4,226,007	163	£422,601	245	£633,901	327	£845,201
Totals	2,796	£10,049,914	280	£1,004,991	419	£1,507,487	559	£2,009,983

The above figures exclude any A&E costs associated with an admission.

Our aim through this business case is that in the first full year of operations we will target a 12% reduction in admissions avoided and enable 40%+ of our population to die in their normal place of residence with dignity, compassion and respect.

The costs of re-provision in the community will be less than those shown in the Business Case as a result of successful negotiations since it was drafted. The final price is still subject to agreement on activity levels and risk share.

Which objective does this paper support?	**Patients:** Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders	✓
	People: Empower our staff to make NHS Bexley CCG the most successful CCG in (south) London	✓
	Pounds: Delivering on all of our statutory duties and become an effective, efficient and economical organisation	✓
	Process: Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience	✓

Organisational implications	Key risks (corporate and/or clinical)	The development of the workforce in the community to provide the services to a revised and improved specification within the project timescales.

		Engagement and buy in across the whole system of care.
	Equality and diversity	The proposal is expected to improve services for all patients needing EOLC.
	Patient impact	Positive Impact: To improve services and enable our patients to remain in their normal place of residence in their last 12 months of life, and at their death. To enable patients to plan for their last months.
	Financial	Positive financial impact due to reduced admissions.
	Legal issues	None
	NHS constitution	None
Consultation (public, member or other)	We will also be establishing an End of Life Steering Group, and a Dying Matters focus group with engagement from patients, relatives or carers.	
Audit (considered/approved by other committees/groups)	The business case has been approved by the Quality & Safety Sub-Committee and Finance Sub-Committee.	
Communications plan	A specific plan is being developed as shown within the Business Case.	
Author	Mariette Mason	
	Clinical lead Dr Winnie Kwan	Executive sponsor Sarah Valentine Director of Commissioning
Date	13 November 2014	

NHS Bexley CCG

Business Case (Incorporating PID)	
Name of Proposal	End of Life Care
Version	1.0 Issue
Issue Status	Issue
Date Last Updated	17.10.14
Author(s)	Mariette Mason
Clinical Lead	Dr Winnie Kwan
Executive Champion	Sarah Valentine
Financials Signed off	Name: Julie Witherall
	Date: 3.10.14
FSC Approval Date	Date of Meeting:

Appendices:

1. Equality Impact Assessment in full
2. Quality Impact Assessment in full
3. Privacy Impact Assessment in full

Distribution List

Role	Name	Position	Scope
Director Of Commissioning	Sarah Valentine		
Chief Financial Officer	Theresa Osborne		

Issue/Amendment Record

Status	Version	Release	Issue Date	Reason For Issue/Changes Made
Draft	1.0	1	17.0.10.14	

1. Executive Summary

1.1 Overview & summary

The main aim of this Business Case is to improve our existing services to provide a quality End of Life Care service (during the last 12 months of life, & for an individual's death) which is:

- patient centred,
- integrated,
- delivered by a compassionate, skilled and competent workforce.

How would you answer this question: ***"If you knew you only had a few months to live, what would you do differently, what would your priorities be?"*** The main aim of this scheme is to let patients plan for their death, prioritise and achieve their last wishes.

In 2012 there were 1,864 deaths (Office of National Statistics) within the Bexley population – of these 1,762 deaths population aged 55 years and over (estimated to be 1,682 for the age range of 60 and over).

Data for 2013 is not yet released by the Office of National Statistics, however our GP data returns (for Kitemark) for 2013/14 financial year suggest that there were 1,872 deaths across the population. If the 90% from 2012 is extrapolated then it would suggest that **1,685 of these should be for the population aged 60 and over.**

The analytics team have undertaken significant analysis to try to understand both the deaths in hospital and also the admissions for those individuals in the last 12 months of life, using the SUS data records. However, the data is incomplete within the SUS records. Individuals are not admitted to die (i.e. there is no HRG (coding structure) for a death event), the details of the death must be lodged within the backing data in the SUS data record, and often this is simply not given. We have managed to track 848 patients (out of the expected 1,162) as dying in hospital (and some of these have incomplete data records) – this has resulted in the need to make a series of assumptions when scaling up activity and costs for the untracked population.

We aim to enable patients in the last months of life to be well cared for, wherever possible outside of an acute hospital environment, and to enable our population to end their lives in their preferred place of care.

Through this improved service we aim to further reduce admissions to hospital, lengths of stay in the last 12 months of life and avoid inappropriate deaths in hospital. This is aligned to our Better Care Fund Plan where we are aiming to avoid a minimum of 199 acute admissions of people aged 65+. In doing this we will also aim to reduce emergency admissions in the last year of life as part of our QIPP. In total between the two schemes our aim is to reduce emergency admissions by 335 per annum (full year effect).

To achieve the aims above requires a whole system approach which means that buy in from all stakeholders is as important as investment and service redesign because progress will be only be as fast as the slowest participant. We need to therefore "stretch" the whole system to achieve this aim.

The underlying demographic issues behind the Business Case are:

- Our aging population which without intervention will continue to place increasing pressure on acute services
- The number of older people living alone which is a significant risk factor for admission and death in hospital

The financial issues behind the Business Case are:

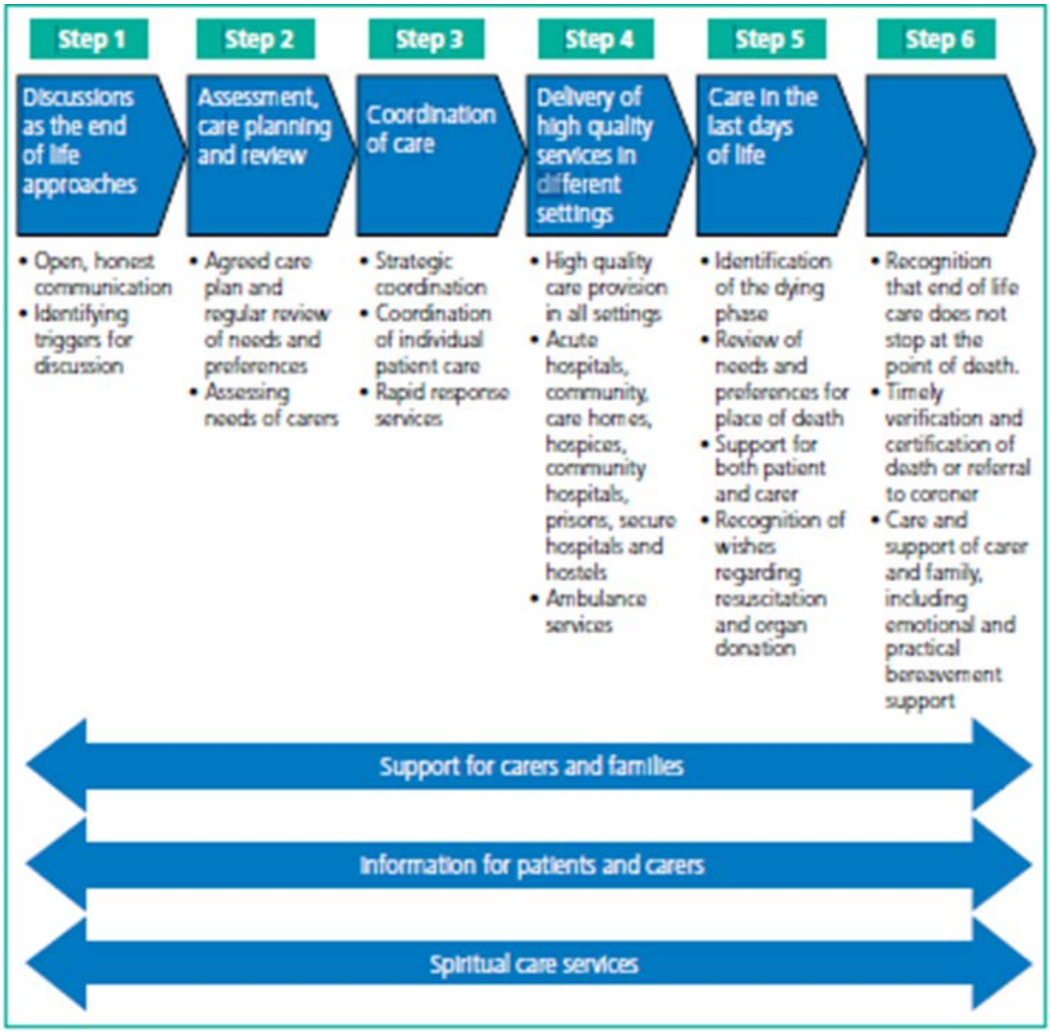
- The costs of deaths in hospital for all ages
- A high rate and cost of excess bed days associated with the above
- The cost of unnecessary and avoidable admissions in the last year of life.

The systems issues locally and nationally behind the Business Case are:

- A high rate of deaths of Bexley people in hospital – an indicator of poor end of life care
- A high number of out of hours admissions
- Negative media coverage

The Business Case sets out proposals to ensure that Bexley adopts an improved and optimal model for End of Life Care (EOLC), thus addressing the problems in the system, which leads to poor outcomes and higher than necessary admissions, lengths of stay and costs.

The diagram below from the National Care Strategy shows how services should look, and in the Business Case, in this document we address how we can make progress towards such a model in Bexley.



Despite the existence of foundation blocks such as an electronic palliative care communication systems (Co-ordinate My Care, CMC), care is currently uncoordinated and lacking in advance and anticipatory planning, resulting in poor patient care/ experience with inappropriate admissions and low numbers of deaths in a preferred place of death. Inappropriate admissions and deaths in preferred place (their Normal Place of Residence) can only be impacted by:

- Effective advance and anticipatory planning so that everyone knows the wishes of the patient and their carers
- Adequate skills and capacity in the community to meet needs without acute admission
- A joined up and co-ordinated EOLC system which is known, understood and supported by everyone in the care pathway

This Business Case therefore recommends that Improvement to palliative/end of life care is tackled in two phases:

Phase 1

- Establish effective coordination and partnership working across Community, Primary Care, Secondary Care and voluntary sector.

- Developing the skills, knowledge and competencies required to deliver a quality service.

Phase 2

- Innovation and integration

1.2 Change implications including impact on life expectancy & health inequalities

This business case is not intended to impact on life expectancy or to reduce health inequalities due to the nature of the service. However the changes will enable patients/carers to have increased control over their preferred place of treatment and death and therefore improve patient/care/carers experience.

The major change implications will be in the training and education, and in the role redesign that is required to provide Community, Primary Care and Care Home services.

1.3 Financial and procurement headlines

The cost of admissions during the last 12 months of life and the cost of deaths in hospital are high. For 2013/14 the estimated annual cost to the CCG for admissions 1 year prior to death and including death in hospital is estimated at £10.049m (this excludes A&E attendances).

The following is an estimate of savings which could be achieved by a reduction in deaths in hospital and admissions prior to death. These are reductions in our acute spend on these services (gross costs) as investment in services outside of hospital is not included in the below.

			At 10% avoided		At 15% avoided		At 20% avoided	
Admissions avoided	Admissions pa	£ pa inc ExBD	Admissions pa	£ pa inc ExBD	Admissions pa	£ pa inc ExBD	Admissions pa	£ pa inc ExBD
Admissions including "death events"	1,162	£5,823,907	116	£582,391	174	£873,586	232	£1,164,781
Admissions in last year of life (excluding above)	1,634	£4,226,007	163	£422,601	245	£633,901	327	£845,201
Totals	2,796	£10,049,914	280	£1,004,991	419	£1,507,487	559	£2,009,983

The above figures exclude any A&E costs associated with an admission.

To date there is no evidence based formula to calculate the extra resources to manage the associated increase in demand on primary and community health services. Coordinate My Care commissioned research across London looking at extra community resources used to enable increase of deaths out of hospital.

As a benchmarking exercise the table below represents the range of increased finances to community services required per death at the lower, mid and upper range of the figures quoted by CMC research).

Community investment, for enabling patients to die in their Normal Place of Residence (estimates based on CMC research)	10% avoided	15% avoided	20% avoided
Admissions avoided including death event only	116	174	232
Additional community investment at £365 each	£42,404	£63,606	£84,808
Additional community investment at £674 each (midway)	£78,303	£117,454	£156,605
Additional community investment at £974 each	£113,155	£169,733	£226,311

Note that the above table only focuses on the cost of avoiding a death in hospital, it does not include activity in the last 12 months of life.

The following table summarises, activity, expenditure and potential net savings for reduction of deaths and admissions 1 year prior to death. Our target will be to avoid 12% of admissions in the first full year of operations with a saving of £505k.

Our aim is to enable (as a minimum) 40% of patients to be able to die in their Normal Place of Residence in the first year of operations.

In the chart below we have also risk rated the savings to take into account that extrapolated data has had to be used to arrive at this business case (see section 2.1b).

Event less costs	Full year	10% avoided	12% avoided	15% avoided	20% avoided
Estimated activity admission including death event pa	1,162	116	139	174	232
Estimated £ pa including excess bed days	5,823,907	£582,391	£698,869	£873,586	£1,164,781
Estimated activity 12 months prior to death event pa	1,634	163	196	245	327
Estimated £ pa including excess bed days	4,226,007	£422,601	£507,121	£633,901	£845,201
Avoided admissions pa	activity	280	335	419	559
Avoided admissions spend in acute pa	£	£1,004,991	£1,205,990	£1,507,487	£2,009,983
Less investment (high end) at £974 per avoided admission		£0	£0	£0	£0
Less Co-ordinate My Care with GPs (funded in PCIF)		£0	£0	£0	£0
Training & education Tutor estimated		£69,131	£69,131	£69,131	£69,131
Oxleas Community Resource (see analysis) 24/7 expansion		£441,671	£441,671	£441,671	£441,671
Increase bereavement support (review current contracts 1st)		£5,000	£5,000	£5,000	£5,000
GP event inc. The Hurley Group backup		£6,750	£6,750	£6,750	£6,750
Increased prescribing costs to support patients at home		£8,735	£10,310	£12,963	£17,490
Potential saving post investment		£473,704	£673,128	£971,972	£1,469,940
Risk rate potential saving at 75%		£355,278	£504,846	£728,979	£1,102,455

This Business Case does not require a re-procurement but builds on existing community health services and primary care innovation fund investments.

We may have to seek quotations for the pharmacy services to support the above.

1.4 Recommendation and approval required

It is recommended that improvement to palliative and end of life services is completed in two phases with step change targets.

We already have many of the elements (by building on our existing Integrated Care Service that exists 7 days per week) to provide a quality palliative/ end of life service but our services lacks effective coordination, communication, specialist skills and competencies.

It is therefore proposed to improve service quality and delivery and outcomes in a phased manner:

Phase One	**Phase Two**
This will focus on: • Early identification • Training and education • Skills and competencies • Coordination of care, advance care planning • Communication • Partnership working • Identification of gaps and omissions in service provision • Identification of innovative provision.	• Filling gaps and omissions • Consolidating improvement • Moving to integrated model

The Finance Sub-Committee are asked to support this recommendation (approval and support will also be sought from:

- The Quality & Safety Group and
- The Governing Body

2. Services

2.1a Current service model

Currently services are provided via the following organisations, but they are not fully integrated and are fragmented:

Inpatient care	Day care/respite	Community services	Institutional care	Specialist palliative services	Bereavement Services
Acute Sector – all providers	Greenwich and Bexley Hospice	Oxleas NHS FT	Residential Homes	Greenwich and Bexley Hospice	Greenwich and Bexley Hospice
Greenwich and Bexley Hospice		Greenwich and Bexley Hospice	Nursing Homes	Greenwich and Bexley Hospice; telephone support and advice	Bexley Cruse
		Primary Care	Greenwich and Bexley Hospice care home team		Acute Sector
		Marie Curie night sitting			Funeral Directors
		Nursing and Domicillary care agencies commissioned by Bexley CCG CHC Team			

2.1b Scope & Scale - Statistics: Number of deaths & data issues

Data for this project, is both complex and incomplete – we are having to triangulate many sources of data, and are hampered by our inability to see or access patient level data as a CCG.

Therefore this necessitates making forecasts based on the data available to us, and to arrive at forecast assumptions on costs and savings, based on a subset of the population data.

Office of National Statistics (ONS) reports that **in 2012 there were 1,864 deaths within the Bexley population** – of these 1,762 deaths were in the population aged 55 years and over. ONS group patients into age ranges which means that we then need to estimate of the age range of 55-60 that they report on how many of those would be in the age range of 60 plus (to match to our further analysis). We have presumed a straight line average per age so we estimate that 1,682 of these would be for the 60 years and over. This is displayed in the following chart:

Death data for Bexley Office of National Statistics 2012	Totals	%
Total deaths (all ages, all causes)	1,864	
Under 1 to 54 years	102	5.47%
55 to 64 years	134	7.19%
65 to 74 years	295	15.83%
75 to 84 years	584	31.33%
85 years +	749	40.18%

Extrapolate Over 60s to match to analysis	Total	%
Total deaths (all ages, all causes)	1,864	
55 to 64 years presume straight line (so 60 years + at 40% of total above)	54	3%
65 to 74 years	295	16%
75 to 84 years	584	31%
85 years +	749	40%
Totals deaths in over 60s (inc. estimate on 60s+) 2012	**1,682**	**90%**

Data for 2013 is not yet released by the Office of National Statistics, however our GP data returns to the CCG (for Kitemark) for 2013/14 financial year suggest that there were 1,872 deaths across the population. If the 90% from 2012 ONS figure is extrapolated then it would suggest that **1,685 of these should be for the population aged 60 and over.**

Deaths in Bexley - GP Kitemark Returns for 2013/14	Total
Total deaths	**1,872**
Deaths in the over 60s (estimated at 90% of the total deaths)	1,685

The analytics team have undertaken significant analysis to try to understand both the deaths in hospital and also the admissions for those individuals in the last 12 months of life, using the SUS data records. However, the data is incomplete within the SUS records. Individuals are not admitted to die (i.e. there is no HRG (coding structure) for a death event), the details of the death must be lodged within the backing data in the SUS data record, using a specific data field of the “reason for discharge” and choosing “death” and often this is simply not coded. What we have found is shown in the following and means that any analysis undertaken by the team is on the basis of a limited extract of our population, we therefore need to scale up to reach our total population size.

We know from the GP Kitemark return that 31% of the 1,872 deaths died within their Normal Place of Residence (this includes deaths within hospices and care homes). By extrapolating this we would expect 1,292 to have died in hospital (all ages) and of these using the 90% analysis 1,163 would be 60 years and above.

The analysis of SUS data records tracked that include a data event are 848 individual patients – this falls short of the expected number of patients that we believe died in hospital, therefore in any analysis a “scale up of +37%” for quantum must be used on both activity and costs – this is a crude calculation but necessary:

In addition, within the SUS data records for the 848 on 62 of these records the data was not good enough to enable previous activity (last 12 months) to be tracked (i.e. the full NHS number was missing) – therefore again any analysis of activity in the last 12 months (prior to the admission that included a death) requires a “scale up of +48%” for

quantum must be used on both activity and costs – this is a crude calculation but necessary. The chart below tracks these calculations:

Deaths in Bexley - GP Kitemark Returns for 2013/14	Total	%
Total deaths	**1,872**	
Deaths in Normal Place of Residence (incs hospices)	580	31%
Deaths in Hospital (presumed given above)	1,292	
Deaths in Hospital (presumed given above) for over 60s (at 90% of total)	1,163	
Deaths tracked in Hospital (from SUS data records)	848	
Extrapolation increase on Hospital deaths for population	**315**	**37%**
Admissions for patients in last year of life trackable to patients that died in hospital	786	
Extrapolation increase on admissions in last year of life for population	**377**	**48%**

Throughout this business case we then employ the 37% or the 48% scale up on our activity and cost figures to bring it back to the population size.

2.2 The case for change & recommendations

How would you answer this question: ***"If you knew you only had a few months to live, what would you do differently, what would your priorities be?"*** The main aim of this scheme is to let patients plan for their death and achieve their last wishes. It is to ensure that in the last 12 months of life (& for their death) patients (& their carers) are supported and enabled to remain in their Normal Place of Residence.

The case for change has the following main elements:

- The poorer patient and carer experience and lack of choice of place of death
- The frequency of admissions prior to death (i.e. in the last 12 months of life and for the death event) and the associated stress and disruption for patients and carers
- The causes for these admission which can be managed in the community via:
  - More specialist skills in the community
  - More responsive services out of hours
  - More confident nursing home and residential care
- The demographic position both now and in the future
- The financial waste associated with unnecessary admissions in the last 12 months of life and deaths in hospital

The majority of people with palliative or end of life care needs are elderly and we know that the trend is for a continued increase in the number of people 65 years and over.

In Bexley there has been a significant rise (7.8%) in the number of people aged 65+ between 2001 and 2011 Census (from 34,506 to 37,200 people) The largest increase has been the numbers of people aged 90+ (1,700 in 2011 compared to 1243 in 2001), meaning 1 in every 136 people in Bexley are now aged 90+.

By 2021 it is forecast that there will be 5,329 more people aged 65 and over in Bexley (15% increase). The largest proportional increases will be in the older age band, especially the very elderly, which is predicted to rise by over 46% (source: *Bexley JSNA).*

By 2033 it is projected that there will be 20,000 more people aged over 65 living in Bexley than there are today, of these 10,000 will be over the age of 85 compared to just 5,000 in 2011.

Table 3 Bexley JSNA ;source mid2011 interim population projections

Age Group	2011	2021	% Change
65-69	9,900	10,719	8.27%
70-74	8,800	10,707	21.67%
75-79	7,500	8,302	10.69%
80-84	5,900	6,325	7.20%
85-90	3,400	4,297	26.38%
90+	1,700	2, 484	46.11%
Total	**37,200**	**42,834**	**15.15%**

It is estimated that at present 14,475 Bexley residents aged 65+ live alone (61%) and they will increase to 15,800 by 2020. *(Bexley JSNA).* It has been identified by the Social Care Institute for Excellence (SCIE) that the single most important factor that enables people to die at home is a caregiver who is willing and able to provide care at home. The rise in lone older people will be a challenging issue that will require innovative thinking. Bexley has a lower than national average number of care home beds per head of population (see section 2.2.2) and no extended sheltered housing.

The shift from acute care to community care, combined with increasing needs of an aging population, requires a sustainable quality integrated end of life service, which at the present moment we do not have.

2.2.1 Place of Death:

A high rate of deaths in hospital can be seen as an indicator of poor end of life care:

- Bexley is in the bottom quintile for the percentage of deaths in hospital for people aged 65-84+.
- GP reporting from Kitemark shows that in 2013/14 on 31% of patients appear to have died in their Normal Place of Residence.
- For the year 2013/14 the total number of deaths that could be tracked in acute care for Bexley residents in acute care came to 848 across all of our acute providers (this number is understated due to recording issues (see 2.2.1b above).
- 25% (218) of these patients died within 3 days of admission.
- The total costs for these deaths, including previous admissions in the last year prior to death came to £5,866,493 (for the 848 deaths see 2.2.1b).

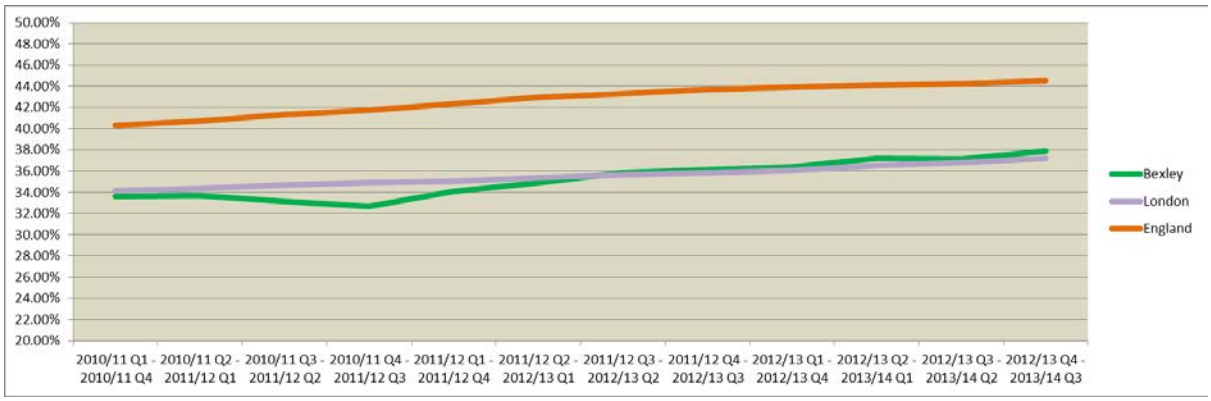
For the 848 tracked patients there was also a high rate of excess bed days for people who subsequently died. Of the 848 patients tracked:

- The number of people who died 11 days or more after admission was 45% (383).
- The number of excess bed days recorded was 3739 at a cost of £688,315

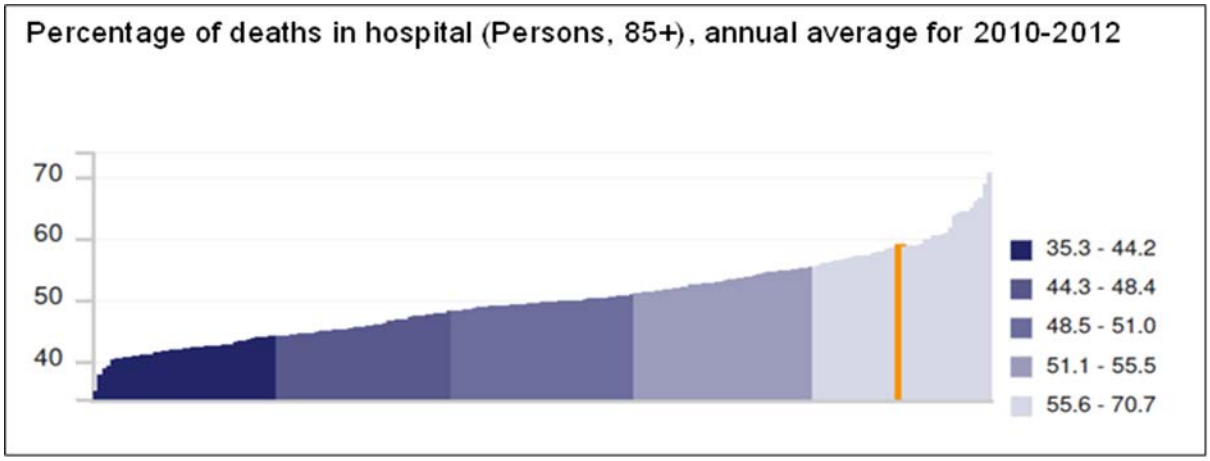
- Of the 848 patients, 118 had a Care Home listed as their Normal Place of Residence (14%).

In Bexley, over the last three years, there has been an increase from 32.1% to 37.9% (this higher figure is the latest released figure from Co-ordinate My Care) in the percentage of people whose death occurs in the normal place of residence. We compare well to the London average, but this does not reflect our population peer group of CCGs (i.e. our more elderly population demographics).

During the same period the England average has increased from 39.7% to 43.6% which demonstrates that further improvement is required urgently.



The National End of Life Intelligence Network provides to each CCG a profile. These profiles draw together a wide range of information to give an overview of variations in cause and place of death, by age and sex, for each clinical commissioning group in England. The Bexley profile below shows that we have above average number of deaths in acute care for people over 85. The chart shows that Bexley is in a poor position for people aged 85+, with our at 58.73 being above the national average of 53.69.



Recommendation Group 1

Improve the percentage of people that are enabled to die in their Normal Place of Residence (in 2013/14 this was 31%, it is currently reported at 38%) suggest increase to 40% minimum in 2015/16 or 45% as a stretch target.

To enable this introduce early identification, advance care planning and increased skills and capacity in the community.

2.2.2 Planning for a "Better Death Experience":

Planning for the last 12 months of life, and for your death, is one of the most important factors that anybody will need to face - there is only one chance to "Get it Right".

If you knew you only had a few months to live, what would you do differently, what would your priorities be?" The main aim of this scheme is to let patients plan for their death and achieve their last wishes. It is to ensure that in the last 12 months of life (& for their death) patients (& their carers) are supported and enabled to remain in their Normal Place of Residence.

Recently there has been sustained media coverage over end of life issues particularly on the use of the Liverpool Care Pathway. Sensationalist headlines have misunderstood both the purpose and intentions over end of life issues such as resuscitation and electronic palliative care communication systems. Death is the last taboo subject that both professional and patient may find hard to discuss, making meaningful and timely communications difficult.

Dying Matters is a national coalition which seeks to raise awareness of death and dying in the general public and remove this last taboo subject.

'One Chance to Get It Right' (June 2014) sets out the approach to care for dying people irrespective of where they are cared for. The approach has been developed by Leadership Alliance for the Care of Dying People in response to the 'More Care Less Pathway' report on the Liverpool Care Pathway which recommended phasing out of the LCP. The paper sets out 5 priorities of care for when it is thought a person may die in the next few hours or days. The document is also accompanied by a separate commitment and call to action paper. It sets out individual commitments to ensure all care given to people in the last days and hours of life:

- is compassionate;
- is based on, and tailored to the needs, wishes and preferences of the dying.

Examples of recommended actions from the “Call to Action” are below:

- Clinical Commissioning Groups should commission services that are co-ordinated and integrated across health and care, to improve quality and choice, as well as reduce emergency admissions. They should ensure adequate provision of specialist palliative care services. CCGs should also commission services in ways that support the development of a well-educated, skilled workforce that engages well with the population they serve.”

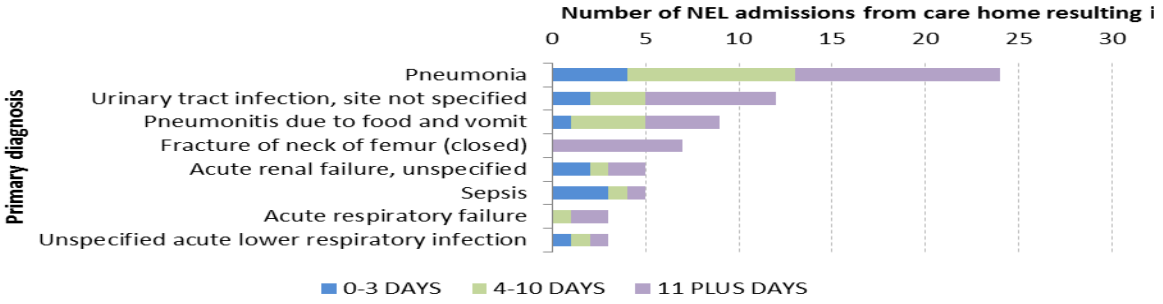
- The alliance calls on members of the public to participate in a national conversation about dying to raise awareness and understanding of this important part of life that we will all experience, and help ensure that we make people’s care and experience of dying as good as it can be.

This report also sets out the duties and responsibilities of health and care staff in achieving the 5 Priorities of Care, when it is thought that a person may die within the next few days or hours:

1. That this possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person’s needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

Given the above we need to focus on not only the End Stage of Life, but also the last 12 months of life.

We have also sub-analysed the 848 deaths in hospital, to look at how many of these were patients that were admitted from a Care Home (as their Normal Place of Residence) – this was 118/848 or 14%. If this was scaled up it would be equal to 155 deaths in hospital per annum. The table below demonstrates the 7 top causes of admissions linked to length of stay



The following table demonstrates the variation of in number of deaths per bed and the range of length of stay (note that 4 deaths could not be attributed to a particular care home).

Care Homes Deaths in Acute Care 2013/14

Name of Care Home	Type of beds in the care home	Number of beds in the care home	Number of deaths in hospital tracked for the 848 tracked deaths	"Scale up" for difference between 848 and 1372 expected	% of admissions ending in death as % of care home beds	Av age
Abbotsleigh Mews	30 resi 30 EMI -nur 30 nursing 30 EMI – resi	120	17	22	19%	88
Adelaide	20 nurs 25 EMI nurs 31 EMI resi	76	6	8	10%	87.8
Baugh Hse	30 nurs 30 EMI -resi	60	6	8	13%	89.7
Cedar court	47 EMI rersi	47	4	5	11%	81
Groveland Park	37 resid 16 EMI resi	43	3	4	9%	89
Homeleigh	31 resid	47	7	9	20%	89.7
Lyndhurst	16 nursing	16	1	1	8%	84
Maples	18 nurs 9 resi 32 nurs EMI 16 EMI resi	24	1	1	5%	88
Marlborough	21 nurs 29 resi 28 EMI resi	78	1	1	2%	89
Meyer Hse	25 nurs 4 resi	29	4	5	18%	87
Harland		120	13	17	14%	84.8
Old Wells Hse		44	18	24	54%	84.8
Parkview	69 EMI resi	69	7	9	13%	84.2
Riverdale Court	40 resi 40 EMI resi	80	12	16	20%	88
Shaftsbury	38 resi	38	4	5	14%	86
St Aubyns	39 nursing	39	3	4	10%	87
St Margarets	Residential	22	4	5	24%	83.5
St Mary's	Nursing	22	3	4	18%	85.3
Sidcup	30 Resi 71 Nursing	101	6	8	8%	88
Total		**1075**	**114**	**157**	**15%**	**86.5**

The chart shows that there is a wide variation in the number of admissions to hospital that end in a death event, when compared to the number of beds in a home – when the number are considered as a % of the beds (2% to 54%). However, some of the variance could be attributable to the types of beds within a care home – this needs further evaluation and analysis. Further work and analysis is needed with care homes to ensure that all staff are appropriately trained and educated to enable more of their residents to die in their Normal Place of Residence.

Recommendation Group 2

Establish an End of Life Care Steering Group to ensure the implementation of the 5 Priorities of Care above

As a sub-group of the above, establish a “Dying Matters” group in Bexley to engage with the public and encourage conversation about death, dying and the expression of wishes

Increase the use of Co-ordinate My Care (CMC) as a care planning tool across all providers of care (at the earliest point that a patient is identified as being within the last 12 months of life) i.e. acute, community, primary care.

Ensure a co-ordinated approach to training and education of the work force, (incl. care home staff) and ensure advance care planning (and ensuring the use of Co-ordinate my Care consistently through the Primary Care Innovation Fund with our GP practices).

2.2.3 Frequency of Admissions (in the last 12 months of life)

The following table outlines by age group the average number of admissions in the 12 months prior to death and the costs involved.

This is based on the quantum of the 848 patients tracked within the SUS databases, with the 62 patients excluded where (due to lack of patient identifiable specific data see section 2.1b for details) we were unable to find associated records in the last 12 months of their lives. Given this we have used the data sources but then need to “scale up” for the missing quantum of patients.

It is interesting to note the ‘young’ old (i.e. 60-69) have a higher average cost. The reason behind this is they are in the main cancer and Long Term Conditions patients and therefore will need more interventions.

However, the potential for greatest saving is in the ‘oldest’ old (i.e. 80+). The conditions for this age group tend to be more frailty related such as sepsis and UTI. Many of these admissions are for interventions such as IV antibiotics and rehydration which could be undertaken in the community (if the correct skills and competencies are available).

Use of a standardized format for anticipatory planning such as the PEACE document (Proactive Elderly Advance Care Planning) alerts staff as to the appropriate course of action and prevents inappropriate admissions to hospital, particularly the during out of hours periods.

Chart a) Based on 848 deaths less 62.

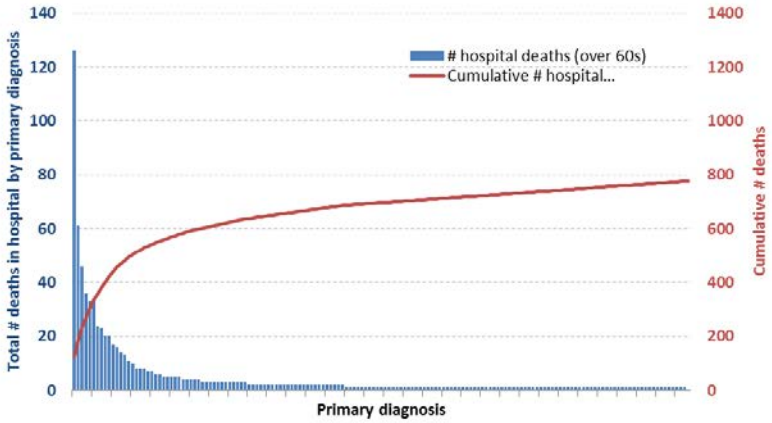
Age band	Previous spells				Total
	Number	Av. per patient	Av. Cost/£	Total cost/£m	Cost/£m
60-69	116	1.5	3,050	0.4	0.7
70-79	262	1.6	2,790	0.7	1.4
80-89	443	1.3	2,970	1.3	2.7
90-99	249	1.3	2,860	0.7	1.4
Grand Total	**1,070**	**1.4**	**2,910**	**3.1**	**6.3**

Chart b) Increased to reflect 1,162 deaths in hospital

Age Band	Admissions tracked	Increase for "Scale Up" + 48%
60-69	116	172
70-79	262	388
80-89	443	656
90-99	249	369
Total	1,070	1,584

The following diagram demonstrates that to increase the number of deaths in normal place of residence (i.e. rather than in a hospital), requires a focus on a small number of conditions that have a high volume of patients.

Distribution of admissions by primary diagnosis for patients over 60 dying in hospital



In the following table we have analysed the top 16 primary causes for over 60s dying in hospital and their lengths of stay (using the 848 records found, we have also increased this to take into account the true likely number).

Diagnosis	Admissions activity (number) in duration of stay				**% of total deaths**
	0-3 days	**4-10 days**	**11+ days**	Total	
Pneumonia	29	44	53	126	14.8%
Malignant neoplasm	7	15	39	61	7.1%
Acute renal failure, unspecified	15	13	18	46	5.4%
Sepsis	14	7	15	36	4.2%
Pneumonitis due to food and vomit	8	13	12	33	3.8%
Urinary tract infection, site not specified	7	7	19	33	3.8%
Congestive heart failure	9	3	12	24	2.8%
Fractures	2	2	19	23	2.7%
Bronchopneumonia, unspecified	8	4	8	20	2.3%
Cerebral infarction	1	3	16	20	2.3%
Unspecified acute lower respiratory infection	5	4	8	17	2.0%
Acute myocardial infarction, unspecified	7	9		16	1.8%
Intracerabral haemorrhage	8	2	4	14	1.6%
Chronic obstructive pulmonary disease with acute lower respiratory infection	1	5	7	13	1.5%
Secondary malignant neoplasm	1	5	4	10	1.1%
Grand Total	**122**	**136**	**234**	**492**	**57.2%**
% of total	25%	28%	47%		
Increase in Grand Total (to reflect scale up to total likely population) + 37%	**167**	**186**	**321**	**674**	

This shows that the top five causes of death are:

1. Pneumonia
2. Malignant neoplasm (tumours that tend to spread to other parts of the body)
3. Acute renal failure unspecified
4. Sepsis
5. Pneumonitis due to food and vomit

We have further analysed the data within the above records to establish the secondary diagnosis for the patients concerned (as these secondary diagnosis fields will often be the indicator of their main disease) – this shows that the top 5 secondary diagnoses are:

1. COPD
2. Nosocomial conditions (a secondary disorder not related to the patient's primary condition).
3. Secondary malignancy of liver and bile
4. Chronic kidney disease
5. Secondary malignancies of bone and bone marrow peritoneum and retro peritoneum.

Chart of secondary diagnoses (note this is based on the 848 & has not been scaled up):

Hospital deaths over 60s	SECONDARY DIAGNOSIS																														
Primary diagnosis	Acidosis	Acute renal failure, unspecified	Acute respiratory failure	Atrial fibrillation and flutter	Cardiac arrest, unspecified	Cellulitis of other parts of limb	Chronic kidney disease, unspecified	Chronic obstructive pulmonary disease with acute lower respiratory infection	Congestive heart failure	Disorientation, unspecified	Escherichia coli [E. coli] as the cause of diseases classified to other chapters	Essential (primary) hypertension	Lobar pneumonia, unspecified	Nosocomial condition	Other and unspecified abnormalities of gait and mobility	Pleural effusion, not elsewhere classified	Pneumonia, unspecified	Pneumonitis due to food and vomit	Secondary malignant neoplasm of bone and bone marrow	Secondary malignant neoplasm of brain and cerebral meninges	Secondary malignant neoplasm of liver and intrahepatic bile duct	Secondary malignant neoplasm of other sites	Secondary malignant neoplasm of retroperitoneum and peritoneum	Sepsis, unspecified	Septic shock	Unspecified dementia	Urinary tract infection, site not specified	Volume depletion	Other	Grand Total
Pneumonia	1	5	8	2		1		27	4	2				32	1	4				1				2	1	1		2	32	126
Malignant neoplasm		3										1					3	1	7	5	11	5	7	1					17	61
Acute renal failure, unspecified	2		1				13								1	1	2	1						3			1	6	15	46
Sepsis		3		1		1			1		1		1				1								3	1	4		19	36
Pneumonitis due to food and vomit	1	3	2	1				3					2	3		1	2									4			11	33
Urinary tract infection, site not specified		6						1			7				1	1									1	1		4	11	33
Congestive heart failure		3	3	1	1			1					2														1		12	24
Fractures		1											1					1											20	23
Bronchopneumonia, unspecified		3	2				1	4	1					1		3											1		4	20
Cerebral infarction		2		3	1												2	1									1		10	20
Unspecified acute lower respiratory infection	1	2	1			1			1	2					1									1		2	2		3	17
Acute myocardial infarction, unspecified		1		1	3				1							1								1					8	16
Intracerebral haemorrhage				2								2						2											8	14
Chronic obstructive pulmonary disease with acute lower respiratory infection			2	1	1	2			1			1																	5	13
Tendency to fall, not elsewhere classified		1		1						1		1			3	1													3	11
Secondary malignant neoplasm																			1			2							7	10
Grand Total	5	33	19	13	6	5	14	36	9	5	8	5	6	36	7	12	10	6	8	6	11	7	7	8	5	9	10	12	185	503

If we aim to reduce the admissions in the last year of life, and the number of people who die in hospital (particularly in the admission for 0-3 days category) we need to further implement a standardised system to:

- Identify patients at an early stage of palliation or end of life
- Ensure advance care planning
- Ensure escalation/anticipatory planning is completed and shared via the universal use of Coordinate my Care (by all care sectors).

We will also need to improve the skills, training and education in the community and primary care (or voluntary) sector to be able to undertake procedures outside of hospital and to better manage caring for people. In particular the following competences will be required:

- Prescribing
- Infusions and IV antibiotics
- Management of specialist lines
- Diagnostics

As holding IV drugs and the associated equipment is not part of Community pharmacist services an Enhanced Community Pharmacy service must be commissioned. Clinical protocols and guidelines will need to be reviewed and possibly established. Although the available data does not lend itself to giving definitive

costings, estimates of costs have been made using the data on deaths and spells focusing on Pneumonia UTI and Sepsis

There is limited data available to us at this point on the number of admissions that are made Out of Hours (i.e. after 18:00 hours and before 08:00 hours Monday to Friday, or over weekends or Bank & Public Holidays).

Further analysis is needed to establish the % that are admitted Out of Hours (OOH) (that could be due to a lack of services) – to those admitted in normal hours.

However, it is recognised that at present there is limited access to OOH support to maintain end of life care patients within a community setting. So in preparing for new services we must consider the needs of those patients that are identified as palliative and end of life patients and their families and carers. We will review current service provision and ensure that a responsive and effective service (with access to the Co-ordinate My Care record) is provided for.

Co-ordinate My Care (CMC) has been developed to give people with chronic health care conditions and/or life-limiting illnesses an opportunity to create a personalised care plan in order that they might express their wishes and preferences for how and where they are treated and cared for.

This care plan can be shared electronically with all legitimate providers of urgent care, especially in the emergency situation. The care plan, which is developed with the patient by a health professional, contains information about them and their diagnosis, key contact details of their regular carers and clinicians, and their wishes and preferences in a range of possible circumstances.

This care plan is uploaded to the CMC system to which only trained professionals involved in their care can have access. These include ambulance control staff, NHS 111 operators, GPs, out of hours GP services, hospitals, nursing and care homes, hospices and community nursing teams. We will also ensure that a printed copy of the patient's CMC plan is located within the patient's Normal Place of Residence, using a "Message in a Bottle" (located in a prominent position in the NPR). This is then available to any healthcare or social care professional responding to the patient.

It is also clear that across Bexley use of Co-ordinate My Care as a planning tool, we need to ensure that all providers (across the whole system) are focused on the need to use this planning tool. The use of CMC has been sporadic and inconsistent due to the lack of operability with other systems. Consequently GPs are involved in double entry of patients to CMC and the Palliative Care Register. The 2013/14 Kitemark data for Bexley demonstrates that GPs will more readily enter patients on the palliative care register.

Kite Mark data 2013/14

Locality	Palliative care register	% of deaths	CMC	% of deaths	Non hosp deaths	% of deaths	Total number
Clocktower	186	32%	132	23%	264	46%	570
Frognal	145	23%	6	0.9%	305	50%	605
Nth Bex	244	35%	126	32%	348	50%	697
Total	575	30.7%	264	14%	917	51%	1,872

Use of CMC has been demonstrated to reduce inappropriate acute care admissions and increase achievement of preferred place of death.

In 2015/16 the Governing Body has agreed through the Primary Care Innovation Fund (PCIF the replacement for Kitemark) that one of the annual focus schemes must be to improve the End of Life Care for patients, through advance care planning. This will help to encourage our GPs to use this tool widely in 2015/16. In 2015/16 through the Primary Care Innovation Fund we intend to use the GP practices as the primary source for completing the CMC with the patient's, and require a 6 monthly update to the plan. The GP practice will also be responsible for giving the patient the printed copy in a "Message in a Bottle" for them to maintain in their Normal Place of Residence.

We will also look at all of the main contracts associated with care of the elderly (e.g. Acute, District Nursing, Integrated Care Services, hospice/ palliative care services etc.) to align these for the use of Co-ordinate My Care CMC via GP practices, but to identify patients entering the last 12 months of their life to our GP practices to enable the above.

Once embedded it is anticipated CMC will reduce inappropriate admissions if supported by quality OOH support and advice. The use of "Message in a Bottle" will also be used to underpin the use of CMC.

Recommendation Group 3

Develop skills and competencies to manage more complex ambulatory conditions in the community (clinical tutors, Primary Care Enhanced Practitioner Role, up-skilling of District Nurses).

Review of 24/7 support needs & services (community, hospice etc.), including Community Pharmacy and commission as appropriate.

To improve the universal adoption of the Co-ordinate my Care planning tool. To ensure 24/7 access to this record for all of the key staff groups responsible for End of Life Care, and urgent or emergency response to crisis situations or exacerbations.

Focus part of the Primary Care Innovation Fund (PCIF) in 2015/16 to improve the use of Co-ordinate my Care in GP practices (this has already been agreed by the Governing Body September 2014 meeting). We will also use PCIF to ensure these are updated 6 monthly, and that the GP practice ensures a copy is maintained in the patient's Normal Place of Residence using "Message in a Bottle".

Case for Change – Summary of Recommendations:

1. Improve the percentage of people that are enabled to die in their Normal Place of Residence (2013/14 was 31% and set a stretch target of improving this to a minimum of 40% in 2015/16 as a first target, or 45% as a stretch target. For 2016/17 60%).

2. Develop skills and competencies to manage more complex conditions in the community (clinical tutors, Primary Care Enhanced Practitioner Role, up-skilling of District Nurses). To treat conditions and avoid admissions in the last year of life, and for the final stages of life.

3. Establish an End of Life Care Steering Group to ensure the implementation of the 5 Priorities of Care. As a sub-group of the above, establish a “Dying Matters” group in Bexley to engage with the public and encourage conversation about death, dying and the expression of wishes

4. Earlier identification of the end stage of life, delivering whole system alignment through incentives. Increasing the use of Co-ordinate My Care (CMC) as a care planning tool by GP practices (at the earliest point that a patient is identified as being within the last 12 months of life) i.e. acute, community, primary care. To ensure 24/7 access to this record for all of the key staff groups responsible for End of Life Care, and urgent or emergency response to crisis situations or exacerbations. With a copy maintained in the patient’s Normal Place of Residence using “Message in a Bottle”.

5. Ensure a co-ordinated approach to training and education of care home staff and ensure advance care planning (and ensuring the use of Co-ordinate my Care consistently).

6. Review of 24/7 support needs & services, including Community Pharmacy and commission as appropriate.

2.3 Proposed Service Model

Our intention is to build on the existing service models of care, and to introduce expansions to the services. In the following chart we look at the recommendations and show how these will be delivered.

No	Summary of Recommendation	How it will be delivered
1 & 2	Improve the percentage of people that are enabled to die in their Normal Place of Residence (2013/14 was 31% and set a stretch target of improving this to a minimum of 40% in 2015/16 as a first target, or 45% as a stretch target). Develop skills and competencies to manage more complex conditions in the community (clinical tutors, Primary Care Enhanced Practitioner Role, up-skilling of District Nurses). To treat conditions and avoid admissions in the last year of life, and for the final stages of life.	We will build on the existing District Nursing Service and also Integrated Care Rapid Response service, to ensure that patients can be supported in the community. In particular we envisage the introduction of a new community role (primary care advanced practitioner B4) that will release skilled nursing time to support end of life and palliative care patients. We will introduce a training tutor to up-skill the existing community nursing workforce. We will ensure resilience and performance within our contract with Greenwich & Bexley Hospice.
3	Establish an End of Life Care Steering Group to ensure the implementation of the 5 Priorities of Care. As a sub-group of the above, establish a "Dying Matters" group in Bexley to engage with the public and encourage conversation about death, dying and the expression of wishes	Our Older People's commissioner will take responsibility for establishing these groups. We will involve patients in these (or their carers). We will also look at the potential for a communications campaign.
4	Earlier identification of the end stage of life. Increasing the use of Co-ordinate My Care (CMC) as a care planning tool across all providers of care (at the earliest point that a patient is identified as being within the last 12 months of life) i.e. acute, community, primary care. To ensure 24/7 access to this record for all of the key staff groups responsible for End of Life Care, and urgent or emergency response to crisis situations or exacerbations.	Work across the Whole System to co-ordinate and encourage earlier identification (e.g. CQUINs or via funding). Primary Care Improvement Fund will encourage GPs to complete Co-ordinate My Care Plans in 2015/16. To update them at 6 monthly intervals, and to ensure a copy is put in the patient's Normal Place of Residence. Ensure that CMC plans are available on-line to all services, and that a copy is kept in the patient's home "message in a bottle" and

		that the patient and their carer ensure this is known when a health professional visits.
5	Ensure a co-ordinated approach to training and education of care home staff and ensure advance care planning (and ensuring the use of Co-ordinate my Care consistently).	Introduce training for Care Homes (targeted particularly at those with the highest % of admissions). Encourage use of CMC across all system touch points (see also above).
6	Review of 24/7 support needs & services, and commission as appropriate.	Discussion initially with Oxleas to include within current agreement. If this fails discussion will take place with another provider (e.g. hospice).

2.3.1 Overview of current to new service model

The summarised aim of the new model which addresses all of the issues in the case for change is to put in place a model of care which enables 60% of people to die in their preferred place of care. The elements of the required improvement are summarised in the diagram below:

Outcome		Primary Drivers
To increase those patients that are enabled to die in their Normal Place of Residence to 40-45% in 2015/16 (targets will then increase yearly). Avoid 12% of avoidable admissions in the last year of life (in 2015/16).		Whole system aligned to earlier identification of a patient that is entering their last 12 months of life
		Co-ordinate My Care usage increased, GP practices to take leadership role in this. Plus to 6 monthly updates
		24/7 co-ordinated community response services
		Training and development of health skills in community services to treat patients in their own home
		Out Of Hours response improvements
		Access to drugs, equipment 24/7
		More care provided in Normal Place of Residence (rather than in hospitals)
		Raising public awareness
		Training and development of health care professionals, with particular emphasis on care homes
		Data and monitoring

2.3.2 Phasing of new service model

This is a two phased approach, the first phase is to consolidate coordinated working and best practice and identify demand and capacity. It is anticipated that out of the first phase more community resources will be required to be commissioned but supported with accurate and timely data.

There will be a need to increase the use of Primary Care Assistant Practitioners to release more time for registered nurses to take on the required nursing duties and responsibilities as outlined in “One Chance to Get It Right across the localities.

We will need to increase in capacity in the twilight and night nursing service. This would be due to all CMC patients have access to the palliative helpline as first point of call. It is anticipated that the help line will utilise the twilight/night service and OOH doctors to provide rapid response if needed.

The completion of the first phase is dependent on the speed of change within providers in particular up skilling of community services and the willingness of primary care to take on the extra workload associated with the increase demand.

The hospice contact is due for renewal in 2016 which gives rise to the opportunity to re-procure if appropriate.

There is a limited access to bereavement services. The CCG has commissioned the Hospice to provide bereavement services but they are for Hospice patients/ carers/ families only. In addition there are some bereavement services within our acute contracts. We will be reviewing all of these bereavement services, but we believe that this work may reveal an unmet need in bereavement support. We have therefore allowed for a small sum in the financial model.

The Hospice currently provides a telephone support service for its own patients and carers. It is anticipated that this service will be extended to all patients registered on CMC and used in particular to cover OOH. The aim of this is that worried patients, carers and professionals call this service first, rather than 999 to gain expert advice and support. This service extension will be phased incrementally and monitored closely to review capacity and demand.

2.3.3 Impact on Workforce

The main impact on workforce will be felt in primary care and community services.

The key workforce impacts are:

- Community Services: a) Expansion of PCAPs (primary care practitioners) at band 4 – this is estimated to be 3 for each locality, to enable nursing staff to be released from routine care duties to provide nursing services, b) additional 2 band 3 healthcare support workers to assist in the above. Total of 11 staff – to be provided via Oxleas.
- Community Services: Nurse tutor to be engaged to assist in training and development of staff across community, primary care and also care homes.

- Hospice Services: Lewisham & Greenwich Hospice have confirmed they will include the 24/7 help line within their existing contract – no work force impact.
- Pharmacy Service: Minor impact on a 24/7 pharmacy provider.
- Acute services: The numbers are too small to have a work force impact on anyone provider of our services.
- Primary Care: Impact is in increased time (clinical and administrative) for completion and co-ordination of Co-ordinate My Care plans (CMC) this is allowed for within the PCIF.

We believe that the above Oxleas staffing will be able to cover more than the first year avoided admissions, and these will be brought on line throughout the year, which will then allow a further expansion of reduced admissions in 2016/17.

A coordinated programme of training and education will be commissioned. The impact on workforce will be the requirement to release staff to attend courses. Discussions have just started with Macmillan over the possibility of using pump priming monies to employ a specialist Macmillan end of life facilitator to provide clinical training and education. This would replace the clinical tutor post shown in the bullet points above.

2.4 Option Appraisal:

In the following we have provided a very brief options appraisal, as we have committed nationally to the Better Care Fund, and to improving End of Life Care services for our population

Option Appraisal for End of Life Care Services		
Option	**Pros**	**Cons**
"Do Nothing"	Less administrative cost to the CCG	1. We do not improve services and outcomes for patients when they need it most 2. We use resources unnecessarily in acute care services 3. We fail to deliver on our Better Care Fund
"Do Something" Re-procure the total service via a Competitive Model	May find some innovation not currently considered	1. Increased administrative costs 2. Standalone service would potentially not see the benefits of the integration of care services, or the quantum of existing services 3. Lack of whole system buy in 4. Time to deliver
"Do Something" – extend existing services	1. Quicker to deliver 2. Services available faster for patients to benefit from 3. Integrated into existing systems 4. Continued service development gives Value for Money 5. Partnership with our whole system 6. Benefits to patients (single point of contact and services) 7. Benefit to patients are achieved faster 8. Wasted resources in acute care are released faster 9. Will enable delivery of Better Care Fund commitments	

We therefore recommend the "Do Something" – extend existing services model.

2.5 Financial Case for Change Summary

In this section we look at the high level summary of costs (extrapolated) for both the death event, and also admissions during the last year of life.

Due to the limitations of the data available we have had to use the “scaling up” methodology shown under 2.1b.

This shows that for the last year of life admissions, and the final admissions that includes the patient’s death, provides an estimate of annual costs to the CCG of £10.049m in 2013/14. The full analysis of these costs is given in Section 8.

Our target will be to reduce admissions by 12% (avoid 335 admissions) in the first full year of running – the costs needed for investments in community services is £534k (this is a maximum cost and is currently subject to downwards negotiation).

Our estimates of savings and costs are shown below, we have also risk rated the bottom line savings at this point to take into account the “scaling up” of data to provide estimated figures.

We believe that the chart above and below therefore provides a maximum cost of investment in the community to release the savings shown. The investment in the community will also allow for growth in the following years.

In the chart below the green highlighted column shows both the savings and the investments to avoid 335 admissions (12%):

Event less costs	Full year	10% avoided	12% avoided	15% avoided	20% avoided
Estimated activity admission including death event pa	1,162	116	139	174	232
Estimated £ pa including excess bed days	5,823,907	£582,391	£698,869	£873,586	£1,164,781
Estimated activity 12 months prior to death event pa	1,634	163	196	245	327
Estimated £ pa including excess bed days	4,226,007	£422,601	£507,121	£633,901	£845,201
Avoided admissions pa	activity	280	335	419	559
Avoided admissions spend in acute pa	£	£1,004,991	£1,205,990	£1,507,487	£2,009,983
Less investment (high end) at £974 per avoided admission		£0	£0	£0	£0
Less Co-ordinate My Care with GPs (funded in PCIF)		£0	£0	£0	£0
Training & education Tutor estimated		£69,131	£69,131	£69,131	£69,131
Oxleas Community Resource (see analysis) 24/7 expansion		£441,671	£441,671	£441,671	£441,671
Increase bereavement support (review current contracts 1st)		£5,000	£5,000	£5,000	£5,000
GP event inc. The Hurley Group backup		£6,750	£6,750	£6,750	£6,750
Increased prescribing costs to support patients at home		£8,735	£10,310	£12,963	£17,490
Potential saving post investment		£473,704	£673,128	£971,972	£1,469,940
Risk rate potential saving at 75%		£355,278	£504,846	£728,979	£1,102,455

A simplified analysis shows the gross and net savings post reinvestment:

Description	At 10%	At 12%	At 15%	At 20%
Av £ per admission	£3,595	£3,595	£3,595	£3,595
Av invest £ per admission avoided	£1,900	£1,591	£1,277	£966
Net saving per admission avoided £s	-£1,694	-£2,004	-£2,318	-£2,629
Net saving per admission avoided %	-47%	-56%	-64%	-73%
The above figures have not been reduced for the risk rating				

Finally, in the above charts we have not taken into account any savings that might also be encountered through avoiding A&E admissions associated with each of these admissions avoided. We believe that each of these patients would encounter a Major

A&E tariff (due to the nature of their admission) the average cost for these across our total acute provider base is £199 per attendance, this would therefore give a further potential saving of up to £67k (risk rated at 75% to £50k) if none of these patients receive an A&E attendance but are diverted away from the acute hospital at source (i.e. by maintaining them in their Normal Place of Residence by the community teams).

2.6 Service specification for new model

The new model will require amendments to the Bexley and Greenwich Hospice and Oxleas Community Serves specifications to reflect the additional requirements.

The Hospice contract must be updated with new specifications on;

- Specialist Palliative care
- Training and education
- Palliative care telephone support and advice line

The Oxleas contract will need to be updated to include:

- Expansion of the 24/7 services (particularly around out of hours nursing services for palliative care)
- The expansion of the staffing (11 WTEs)
- New targets for reducing emergency admissions to reflect these investments
- New standards of care for EOLC
- Response times
- Pharmaceutical providing, and advanced nursing skills (IV, antibiotics, tubes and catheters).

2.7 Service KPIs for new model & monitoring arrangements

At present the KPIs that focus that on end of life are distributed across several contracts. These KPIs will be coordinated and centralised and then reviewed to ensure they reflect the desired outcome. A dashboard for the end of life steering group will be devised to enable monitoring. Examples of the required KPIs are:

- Recording of preferred place of death
- Achieving preferred place of death
- Reduction of care home residents in acute care
- GPs via PCIF leadership on CMC care plans
- Reduction in admissions minimum targets for Oxleas (offset by monitoring of acute to ensure that these are achieved).
- Number and value of admissions avoided against the 335
- Staffing levels for the services (minimum staffing)
- Aligning CQUINs and incentives across the whole system to ensure identification of individuals that are entering (or in) the last year of life as quickly as possible to GP practices (to enable CMC).

2.8 Success criteria for new model

The key criteria are:

- CMC plans (for the relevant population) at 80% (by GP practice)
- Reduction in admissions of 335 (in 2015/16) for those entering or at the end of life stage (with financial reductions)
- 40% minimum of patients enabled to die in their Normal Place of Residence in 2015/16
- Increase of interventions in the Community such as subcut fluids and IV antibiotics to become routine by March 2016
- Whole system approach to identifying patients that are entering the end of life phase earlier in the pathway
- Increased awareness in Bexley population of death and dying.

2.9 Clinical support for new service model

The Clinical Lead for End of life has been involved in the development of this model together with the Clinical Lead for integrated care. Further input from Primary Care will be sought through round table events and Integrated Care Development evenings

2.10 How the new model will be performance monitored in "Business as Usual" mode

Activity and performance will be monitored through the contract monitoring arrangements for the Bexley and Greenwich Hospice and Oxleas Community Services Contracts.

We will also be monitoring the number of non elective and emergency admissions across our acute contracts.

In addition, in order to ensure a whole systems approach to innovation and change an End of Life Steering Group has been established. A KPI dashboard will be created and populated by data from all services to facilitate monitoring of progress towards jointly agreed goals.

This Steering Group will report to the Governing Body, Finance Committee as part of routine contract monitoring for the CCG, and to the Integrated Commissioning Board as part of the Better Care Fund monitoring arrangements.

In addition the Primary Care Innovation Fund will monitor the GP practices performance on CMC. This will also be reported as part of the contract monitoring report on EOLC services quarterly.

3. Consultation & Communications

3.1 Patient council, patient groups engagement and support for new service model

The End of Life Steering Group will have 2 patient council representatives. The Steering Group will strive to have at least one patient/public representative on every work stream. The main focus of patient engagement will be provided by the Dying Matters Group.

3.2 Clinical engagement in primary care

The Clinical Lead for End of Life has been involved in the development of this model together with the Clinical Lead for integrated care. Full engagement of GPs in EOLC is fundamental to the delivery of high quality care and the implementation of CMC will depend on their commitment. Therefore further input from Primary Care will be sought through round table events, Integrated Care Development evenings, and discussions at Locality meetings. We will intend to activate the services on a locality by locality basis, the Clocktower locality will be the first to go live (during 2015 first calendar quarter).

3.3 Clinical Engagement in secondary care / other

Engagement with secondary care, especially paediatricians is crucial to the success of this project as identification of Links with Queen Elizabeth Hospital are being formalised around their large scale Frailty project. Appropriate representatives are being invited to the End of Life Steering Group to ensure a whole system approach. Priorities for joint working will be:

- Early identification and effective communication
- Use of advance care planning
- Joint training and education sessions.

Links are being made with Princess Royal Hospital particularly around the use of the Proactive Elderly Advanced Care Document used for care home residents.

3.4 Consultation with, and notices given to current providers

Consultation with current providers will be carried out via the existing contract mechanisms. Notice has already been given to all acute contracting providers of our plans to reduce end of life and ambulatory care conditions in 2014/15 and also the extension of this into 2015/16.

3.5 Market Engagement

Discussions and engagement is currently limited to existing providers. Should it become necessary to re-procure any of the services engagement with a wider range of providers will be undertaken.

4 Equality Impact Assessment

This is shown at Appendix 1

5 Quality Impact Assessment

This is shown at Appendix 2

6. Privacy Impact Assessment

This has been approved and is shown at Appendix 3

7. Economic, Social, Environmental Considerations (Social Value Act 2012)

7.1 Considerations to be made

High quality end of life care should be rooted in supporting the community to support the individuals within it and as such needs networks which involve statutory providers, the voluntary sector and local faith groups. The current service providers are predominantly locally based healthcare providers and as such, current service provision may be deemed to promote the economic well-being of the local area. It is expected that this will continue and develop as partnerships are expanded.

8. Finance

8.1 Financial Analysis

In this section we look at the high level summary of costs (extrapolated) for both the death event, and also admissions during the last year of life.

Due to the limitations of the data available we have had to use the “scaling up” methodology shown under 2.1b.

This shows that for the last year of life admissions, and the final admissions that includes the patient’s death, then an estimate of annual costs to the CCG is £10.049m in 2013/14.

Analysis of data from SUS data records (note incomplete data)			
Admissions including "death event"	Number	£	£ average per patient
NEL Admissions tracked including death event	848	£3,562,712	£4,201
Excess bed days associated with the above	3,739	£688,315	£812
Total cost tracked for 848 admisssions including death events		£4,251,027	
Scale up (+37%) for deaths not tracked but believed to be in hospital	1,162	£5,823,907	£5,013
Admissions in last year of life			
NEL admissions 12 months prior to admission including death (848 -62)	1,104	£2,303,782	£2,087
Excess bed days associated with the above	3,984	£551,628	£500
Total cost for 786 patients (1.4 admissions average per patient)		£2,855,410	
Scale up (+ 48%) for deaths not tracked above, less 62 without PID	1,634	£4,226,007	£2,586
Likely forecast cost of admissions in last year of life including death		£10,049,914	
Average cost per patient using 1,162 that are expected to have died in hospital		£8,648.81	

The following is an estimate of savings which could be achieved by a reduction in deaths in hospital and admissions prior to death. These are reductions in our acute spend on these services (gross costs) as investment in services outside of hospital is not included in the below.

Event less costs	**Full year**	**10% avoided**	**12% avoided**	**15% avoided**	**20% avoided**
Estimated activity admission including death event pa	1,162	116	139	174	232
Estimated £ pa including excess bed days	5,823,907	£582,391	£698,869	£873,586	£1,164,781
Estimated activity 12 months prior to death event pa	1,634	163	196	245	327
Estimated £ pa including excess bed days	4,226,007	£422,601	£507,121	£633,901	£845,201
Avoided admissions pa	activity	280	335	419	559

The above costs exclude the costs of A&E attendances

Within our Better Care Fund submission we have estimated a 1% reduction in the total of acute admissions for EOLC new services in 2015/16 – this would be equal to 199 admissions of the total quantum of non elective and emergency admissions. As part of our QIPP plans in 2014/15 we have also presumed an extension of our Integrated Care Services for Older People to reduce admissions by an estimated 132 emergency admissions (£250,000 estimated) To achieve both of these we would need to deliver a reduction of 335 admissions per annum (so 11.8% of the total). In the chart above we have therefore highlighted the 12% reduction of 335 admissions avoided.

To date there is no formula to calculate the extra resources required to manage an increase in demand in primary or community services (inc. hospice care).

Research commissioned by CMC across London, as a guideline to evidence the need for increased expenditure in community services, has shown that for each acute death transferred into the community an extra £365 to £974 is required to cope with the increase of demand in services. This is purely at an end of life stage and may not take into account advanced nursing skills for maintaining patients outside of a hospital environment with significant additional nursing expertise needing to be released.

We have received costs from Oxleas to put in place the necessary additional support costs to release nursing time for these advanced nursing skills in the community (where they are currently being used for more junior care and health duties), together with other costs for pharmaceutical supplies etc. These are shown in the table below.

The costs quoted by Oxleas seem to be high, and we will be undertaking a further negotiation with them to look at these costs and endeavour to reduce them. So the costs shown are the maximum at this point in time. We would also intend to introduce the increased work force with Oxleas on a locality by locality basis so not all of the full costs may be encountered in year 1.

Costs for expanded EOLC services	Full year	10% avoided	12% avoided	15% avoided	20% avoided
Co-ordinate My Care with GPs (funded in PCIF)		£0	£0	£0	£0
Training & education Tutor estimated		£69,131	£69,131	£69,131	£69,131
Oxleas Community Resource (see analysis) 24/7 expansion		£441,671	£441,671	£441,671	£441,671
Increase bereavement support (review current contracts 1st)		£5,000	£5,000	£5,000	£5,000
GP event inc. The Hurley Group backup		£6,750	£6,750	£6,750	£6,750
Increased prescribing costs to support patients at home		£8,735	£10,310	£12,963	£17,490
Total estimated maximum costs		£531,287	£532,862	£535,515	£540,042

Many of the costs quoted above remain static as they include staffing costs that will also cover in excess of the 12% reduction for 2015/16. This will therefore allow a further expansion of the services (and reduction in admissions) in 2016/17 as we grow the services and they mature.

If the above are then correlated to the reduction in hospital admission costs (for admissions that include deaths) then potential savings can occur – however, there is a real paucity of data to compare the existing services, and extrapolation “scale ups” have had to be used on the acute data sources. These should therefore be viewed with caution.

Our estimates of savings and costs are shown below, we have also risk rated the bottom line savings at this point to take into account the “scaling up” of data to provide estimated figures.

We believe that the chart above and below therefore provides a maximum cost of investment in the community to release the savings shown.

Finally, we have shown the 12% avoided column as the target for 2015/16 as this will take into account the Better Care Fund and our QIPP target savings (Ambulatory Care):

Event less costs	Full year	10% avoided	12% avoided	15% avoided	20% avoided
Estimated activity admission including death event pa	1,162	116	139	174	232
Estimated £ pa including excess bed days	5,823,907	£582,391	£698,869	£873,586	£1,164,781
Estimated activity 12 months prior to death event pa	1,634	163	196	245	327
Estimated £ pa including excess bed days	4,226,007	£422,601	£507,121	£633,901	£845,201
Avoided admissions pa	activity	280	335	419	559
Avoided admissions spend in acute pa	£	£1,004,991	£1,205,990	£1,507,487	£2,009,983
Less investment (high end) at £974 per avoided admission		£0	£0	£0	£0
Less Co-ordinate My Care with GPs (funded in PCIF)		£0	£0	£0	£0
Training & education Tutor estimated		£69,131	£69,131	£69,131	£69,131
Oxleas Community Resource (see analysis) 24/7 expansion		£441,671	£441,671	£441,671	£441,671
Increase bereavement support (review current contracts 1st)		£5,000	£5,000	£5,000	£5,000
GP event inc. The Hurley Group backup		£6,750	£6,750	£6,750	£6,750
Increased prescribing costs to support patients at home		£8,735	£10,310	£12,963	£17,490
Potential saving post investment		£473,704	£673,128	£971,972	£1,469,940
Risk rate potential saving at 75%		£355,278	£504,846	£728,979	£1,102,455

A simplified analysis shows the gross and net savings post reinvestment:

Description	At 10%	At 12%	At 15%	At 20%
Av £ per admission	£3,595	£3,595	£3,595	£3,595
Av invest £ per admission avoided	£1,900	£1,591	£1,277	£966
Net saving per admission avoided £s	-£1,694	-£2,004	-£2,318	-£2,629
Net saving per admission avoided %	-47%	-56%	-64%	-73%
The above figures have not been reduced for the risk rating				

Finally, in the above charts we have not taken into account any savings that might also be encountered through avoiding A&E admissions associated with each of these admissions avoided. We believe that each of these patients would encounter a Major A&E tariff (due to the nature of their admission) the average cost for these across our total acute provider base is £199 per attendance, this would therefore give a further potential saving of up to £67k (risk rated at 75% to £50k) if none of these patients receive an A&E attendance but are diverted away from the acute hospital at source (i.e. by maintaining them in their Normal Place of Residence by the community teams).

8.1 Budget requirements

To be completed with, and signed off by the finance department.

9. Sensitivity Growth Analysis

9.1 Details

By 2021 there will be a 15% increase in people aged 65+, the largest increase being in the oldest old age group (80+) which will see a 46% increase.

By 2033 it is projected that there will be 20,000 more people aged 65+living in Bexley and of those 10,000 will be over the age of 85 compared to 5,000 in 2011.

Linked to this increase in older people is an increase in people living alone which is a risk factor for dying in hospital. At present 14,475 older people live alone. This is set to rise by 9% by 2020.

10. Procurement Implications

10.1 Model of service and type of contract recommended

The current proposals are for variations to existing contracts rather re-procurement. We will need to obtain quotations for the additional pharmaceutical services from a 7 day a week pharmacist.

10.2 Details of external procurement(s) required

Not applicable at present

10.3 Timescales for procurement

Not applicable at present

10.4 Market engagement and stimulation

Not applicable

11. Timescale

11.1 Project plan timescales (from approval to go live)

Business Case Milestones		
Action	Begin	Complete
60% of GPs using Coordinate My Care (rising to 80% by end of 2015/16)	November/December 2014	August 2015
Standardised approach to advanced care planning in place for both primary and community health services	November 2014	June 2015
Enhanced Community Services team with additional clinical skills and competencies	November 2014	Ongoing
Acute and community services contracts – align incentives to identify patients nearing the end of life stage earlier to GP practices	April 2015	March 2015
Training of General Practice and Community staffing in respect, dignity and compassionate care of the dying	December 2014	Ongoing
Establish universal access to out of hours end of life advice and support services (Palliative / End of care helpline) .	December 2014	March 2015
Care Home EoL working group to promote best practice in place – working with Health Education South London	September 2014	September 2015
“Dying Matters” Group in place to raise the profile of death and dying with the general public counter act adverse media coverage of End of Life care .	December 2014	ongoing
Clocktower phasing	January 2015	To be confirmed
North Bexley phasing	April 2015 (latest)	
Frognal phasing	July 2015 (latest)	
Clinical end of life tutor	February 2015	Latest
Specification for Enhanced Community Pharmacy		December 2014
Enhanced Community Pharmacy service established		January 2015

11.2 Issues against planned programme timescales

All timescales are dependent on engagement and commitment of required stakeholders.

12. Risks / Constraints / Dependencies / Opportunities

12.1 Risks

Risks Matrix – the following Matrix has been used to assess risks

		Likelihood				
		Rare	Unlikely	Possible	Likely	Almost Certain
Impact		*1*	*2*	*3*	*4*	*5*
5	Catastrophic	**5**	**10**	**15**	**20**	**25**
4	Major	**4**	**8**	**12**	**16**	**20**
3	Moderate	**3**	**6**	**9**	**12**	**15**
2	Minor	**2**	**4**	**6**	**8**	**10**
1	Negligible	**1**	**2**	**3**	**4**	**5**

3.1.1 Risks Identified

Risks	**Impact**	**Likelihood**	**Risks**	**Mitigating Actions**	**Risk after Mitigation**
	Low to High		**I x L**		
Not all GPs using CMC	4	4	16	Community services and Hospice are committed to use as are Hurley group which will compensate	12
May identify need for further funding	4	3	12	Explore options and write business case	8
Dependency on providers to deliver services	3	3	9	Revise specifications and use on contractual levers	6
Recruitment and retention of appropriate staff	3	3	9	Discussions with providers on innovative skill mix/ and recruitment	6
Negative public perception	4	4	16	Use of Dying Matters Group and social media to put out positive message	2
Possibility of unintended	3	3	9	If this appears to be arising the possibility	6

cost shunting to social care				of an additional PCAP/HA per locality should be considered	
Projected savings appear optimistically high	4	3	12	The phased approach will allow for review and adjustment	9
Future viability of Hospice may be uncertain due to notice on contract given by Greenwich CCG	3	4	12	Will work closely with Greenwich to minimise risks and consider possibility of procurement	12
Not able to establish Enhanced Community Pharmacy for IV drugs	2	2	2	Work through the issues with Pharmacists and NHS England	1

12.2 Constraints

This project needs to work within the constraints of the dominance of the 'market' for end of life care by the local hospice. Unless there is an appetite locally for testing the market in this area then all change depends on renegotiation of existing contracts and effective contract monitoring.

12.3 Dependencies

The project is dependent on cooperation and contribution from a wide range of stakeholders including geriatricians in three acute trusts. It is also dependent on commitment from Bexley GPs to adoption and maintenance of CMC.

12.4 Opportunities

There are wide ranging opportunities to improve care and reduce hospital admissions with limited investment.

13. Approval Required

13.1 Approval required and from whom

The following approvals are sought for this Business Case from:

1. Finance Sub Committee
2. Quality & Safety Group
3. Governing Body

Appendix 1

Equality impact assessment completed details

Equality Impact Assessment	
Does the scheme affect one of the following groups more or less favourably than another?	**If yes, explain impact and any valid legal and/or justifiable exception**
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*	This project is for over 60s only and therefore excludes all those under this age. The focus on this age group is based on clinical and national evidence that many do not die in their preferred place of residence and have inappropriate admissions to hospital resulting in poor patient/carer experience.
Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*	Within the identified cohort there is no discrimination on disability.
Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below)*	Within the identified cohort there is no discrimination on gender. However due to the nature of current mortality rates more women than men will use the end of life services in this age group
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*	Within the identified cohort there is no discrimination on gender reassignment as the central pillar for success is patient centeredness.
Marriage and civil partnership *Consider and detail (including the source of any evidence) on people with different partnerships.*	Within the identified cohort there is no discrimination on marriage and civil partnership as the central pillar for success is patient centeredness
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*	Within the identified cohort there is no discrimination on pregnancy and maternity as the central pillar for success is patient centeredness.
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*	National evidence shows access to palliative care is much lower than the national average, for example, in Black, Asian and Minority Ethnic (BAME) communities. This can be for a number of reasons such as cultural appropriateness, language barriers, geographical isolation or negative perceptions of palliative care. The work will reflect the need to involve these communities in the design of services to ensure that they are able to access the same quality of care. Invitations to BAME reps will be extended to sit on Steering Group and work streams.
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*	It is recognised that religion and spirituality are at the centre of many people's approach to death and dying and as such service delivery needs to take account of the sensitivities and practices of different religions and cultures.
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*	Within the identified cohort there is no discrimination on sexual orientation as the central pillar for success is patient centeredness

Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*	Cares are the single most important factor for a home death. Links have been made with the Carers Partnership Board to share progress. Invitations have been issued to be involved in projects and work streams
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*	None identified as death is universal
Is the impact of the scheme likely to be negative? If so, can this be avoided? Can we reduce the impact by taking different action?	Impact of scheme is intended to be positive, Increasing choice and control for patients/carers and Improving patient/Carer experience. Care will need to be taken to avoid the kind of negative publicity which arose from the use of the Liverpool Care Pathway.

Impact of proposed service on choice, access, equality

In achieving the aims of this service there will be significant impact on choice, access and equality.

With the coordination of services focused on patient centeredness, preferred places of treatment and place of death will be recorded and acted on, giving the patient/care more choice and control

Raising awareness of death and dying in the general public will give people information with which to make informed decisions. This will also enable all to have the “difficult discussions so that people achieve their preference.

Appendix 2

Quality Impact Assessment

5.1 Stage 1 Proforma

Scheme Details:

Scheme Title / Name	Clinical Leads	Management Lead	Sponsor
End of life care	Dr Winnie Kwan Dr Nikki Kanani	Alison Rogers	Sarah Valentine

Answer positive/negative in each area. If **Negative,** score the impact, likelihood and total in the appropriate box. If score ≥10 insert "**Yes"** for full assessment
(Please see 'Quality Impact Assessment Tool Stage 1 final' for guidance on scoring and rag rating).

Area of Quality	Impact question	P/N	Impact	Likelihood	Score	Full Assessment required
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	P				
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care? Does the business case include patient involvement or has it acted on patient/carer experience in its development? Which patient/carer groups have been consulted/ involved in development of this project? Monitoring of complaints to include numbers/themes/whether timeframes are met/whether upheld/action arising. Compliance with 2009 NHS Complaints Regulations +PHSO (Ombudsman) principles. Ensure audit of patient experience + evidence learning from feedback to be included. Proposed access and waiting times.	P				
Patient Safety	Could the proposal impact positively or negatively on any of	P				

	the following – safety, systems in place to safeguard patients to prevent harm, including infections?					
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards? Has reference to up to date relevant national guidance and research been made in the design of this project? Clear demonstration that relevant NICE Quality Standards, Public Health Guidance and Clinical Guidelines are being taken into account / followed.	P				
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	P				
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	P				
Safeguarding Adults and Children **Note** *child safeguarding is also statutory for adult focused services*.	Does the proposal comply with: 1. Policy/Guidance/Procedures • Bexley Safeguarding Children and Adults Boards Guidance and CCG policy. • Pan London Child Protection Procedures (2010). • Working Together to Safeguarding Children (2013). • Pan London Safeguarding Adults Procedures (2011) • CQC Essential Standards of Quality and Safety 2010 2. Open Safeguarding Culture • with 'being open' guidance.- Whistleblowing policy in place. • Procedures for reporting of incident/concerns including feedback to staff and patients of actions taken and outcomes.	P				

	• Safer recruitment arrangements and procedure for dealing with allegations against staff including identification of a Senior Named Officer within their organisation to liaise with the Local Authority Designated Officer or Safeguarding Adult team. • Staff training policy and compliance with this. • Arrangements for staff supervision. 3. Compliance with Equality and Diversity Act 2010. • Monitoring of compliance and reporting. • Equality and Diversity performance indicator identified. ***Note***: Safeguarding children and adults frameworks will need to be embedded within agreed contract and reporting arrangements.					

Please describe your rationale in detail for your assessment of each positive impact here: This proposal is intended to increase and enhance quality of care and across all of these fields

2 Expected Quality Metric Outcomes (success criteria)

Metric – these need to be measurable	**Expected impact (positive/negative and explanation)**
Patients and carers empowered and supported in the community	P
High quality, timely and appropriate referral from primary care	P
Access and waiting times	N/A
Clinical outcomes	P
Patient experience	P
Resilience and sustainability of new model including workforce planning issues	P
Facilitation of inter-professional and inter-organisational working and shared learning	P
Signature:	
Designation:	
Date:	

Stage 2 Proforma

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is equal to or greater than (≥) 10 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring equal to or greater than 10 must go on to a detailed assessment - completion of stage 2 proforma. Stage 2 can be found here: http://www.bexleynet.nhs.uk/Downloads/Business%20Case/Quality%20impact%20assessment%20tool_stage%20two.doc
(Please see 'Quality Impact Assessment Tool Stage 2 final' for guidance on scoring and rag rating).

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 matrix)	
			Impact	Likelihood
DUTY OF QUALITY	What is the impact on our duty to secure continuous improvement in the quality of the healthcare that it provides and commissions? In accordance with Health and Social Care Act 2008Section 139?	P		
	Does it impact on our commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?	P		
	Does it impact on our commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?	P		
	What is the impact on strategic partnerships and shared risk?	P		
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to CCG Equality Delivery Scheme)?	P		
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?	P		
	What is the quality impact of this initiative compared to other options	P		
	Will this impact on our duty to protect children, young people and adults?	P		

PATIENT EXPERIENCE	What impact is it likely to have on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	P		
	What is the likely impact on to the individual patient (in terms of health improvement, patient outcome and life expectancy)	P		
	How will it impact on choice?	P		
	How will it impact on patient access			
	How will it impact on patients' carers	P		
	Does it support the compassionate and personalised care agenda?	P		
PATIENT SAFETY	How will it impact on patient safety?	P		
	How will it impact on preventable harm?	P		
	How will it impact on service quality	P		
	Will it maximise reliability of safety systems?	P		
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	P		
	What is the impact on clinical workforce capability care and skills?	P		
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?			
	How will it impact on clinical leadership?			
	Does it reduce/impact on variations in care?	N/A		

	Are systems for monitoring clinical quality supported by good information?	P		
	Does it impact on clinical engagement?	P		
PREVENTION	Does it support people to stay well?	N/A		
	Does it promote self-care for people with long term conditions?	P		
	Does it tackle health inequalities, focusing resources where they are needed most?	P		
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?	P		
	Does it eliminate inefficiency and waste?	*P*		
	What is the impact on providers	***P***		
	Does it support low carbon pathways?	*Neutral*		
	Will the service innovation achieve large gains in performance?	*P*		
	Does it lead to improvements in care pathway(s)?	P		

Signature:	Designation:

Appendix 3

Privacy Impact Assessment Submitted

PIA SCREENING QUESTIONNAIRE	
Project / Policy Lead:	Mariette Mason
Project Outline - Set out a short summary of the intended project, policy or procedure. This does not need to be complex. If a PID or Terms of Reference for the project already exist please supply these.	The main aim of this Business Case is to provide a quality EOL service which is patient centred and integrated, and delivered by a compassionate, skilled and competent workforce to palliative and end of life patients and their families /carers in their preferred place of care.
Environmental Scan - What is already out there? Do PIA's in this area already exist? Have any consultations (with professional associations or patient groups) already taken place?	Yes PIAs exist with current service providers but consultation has yet to take place
Stakeholder Analysis - Who might be affected?	General public, patients, carers Service providers including GP practices
What is the purpose of this new process or system? Why is it required?	To ensure care is coordinated and person centred
Will the proposed new process or system gather, process or store person identifiable data or corporate sensitive information?	no
Is the proposed new process or system likely to involve a new use or significantly change the way in which existing personal data is handled or processed?	no
Is the proposed new process or system likely to allow personal information to be checked for relevancy, accuracy and validity?	Yes
Is the proposed new process or system likely to incorporate a procedure to ensure that personal information is disposed of through archiving or destruction when it is no longer required?	Yes
Is the proposed new process or system likely to have an adequate level of security to ensure that personal information is protected from unlawful or unauthorised access and from accidental loss, destruction or damage?	yes
Is the proposed new process or system likely to enable the timely location and retrieval of personal information to meet subject access requests?	yes

Is the proposed new process or system dependant on a third party to supply the system, undertake processing or provide support/maintenance?	yes
Is the proposed new process or system likely to create new data flows and will they be internal, external or both?	no
Has this new process or system been added to the CCG's Information Asset Register?	yes
Name: Mariette Mason	Signature: Mariette Mason
Job Role: Head of integrated Commissioning for older people	Department: Integrated Commissioning
Date: 25/09/14	Date submitted to IG Department:
Submit Form to: Information Governance Department, NHS Bexley Clinical Commissioning Group	