ENCLOSURE: U

Agenda Item: 45/16

NHS
Bexley
Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 24 March 2016

Title	**End of Life Care Services Update March 2016**	
This paper is for **Information**		
Recommended action for the Governing Body	That the Governing Body: **Note** the report	
Potential areas for Conflicts of interest	None.	
Executive summary	In 2014 NHS Bexley CCG developed a Business Case for improving our End of Life Care services, this was approved by our Governing Body (copy available on request) and the key aims & tenets were: 1. Increasing the ability for our population to be supported to die in their Normal Place of Residence (NPR) 2. Giving our population more control and decision making through better care planning using "Co-ordinate My Care" (CMC) 3. Avoiding unnecessary admissions in the last 12 months of life 4. Increasing bereavement support services 5. Increasing GP and primary care staff's knowledge and skills. This report provides an update for our Governing Body in the significant strides and developments that have been made that have led to real improvements for our population. Key to the above has been our investments in out of hospital services i.e. community, hospice and primary care services. It is for the GB to note (for information) the report. No decision or approval required.	
How does this paper support the CCGs	**Patients:**	Demonstrates progress and improvement in end of life service quality and delivery to enable more people to die in their preferred place of care.

Excellent healthcare – locally delivered

objectives?	**People:**	Demonstrates Bexley as place of excellence in use of Coordinate My care.	
	Pounds:	Demonstrates delivery on some statutory duties, striving towards becoming an effective, efficient and economical organisation.	
	Process:	Demonstrates commissioning safe, sustainable and equitable services in line with the operating framework, National Strategy, Guidance and Standards and improvement in outcomes and patient experience.	
What are the Organisational implications	Key risks	None.	
	Equality	Enabling people to die their preferred place of death.	
	Financial	N/A	
	Data	N/A	
	Legal issues	N/A	
	NHS constitution	N/A	
Engagement	Providers		
Audit trail	N/A		
Comms plan	N/A		
Author:	Clinical lead: Dr Winnie Kwan	Executive sponsor: Sarah Valentine Director of Commissioning	
Date	2 March 2016		

End of Life Care Services Update
March 2016 for NHS Bexley CCG Governing Body

1. Introduction:

In 2014 NHS Bexley CCG developed a Business Case for improving our End of Life Care services, this was approved by our Governing Body (copy available on request) and the key aims & tenets were:

1. Increasing the ability for our population to be supported to die in their Normal Place of Residence (NPR)
2. Giving our population more control and decision making through better care planning using "Co-ordinate My Care" (CMC)
3. Avoiding unnecessary admissions in the last 12 months of life
4. Increasing bereavement support services
5. Increasing GP and primary care staff's knowledge and skills.

This report provides an update for our Governing Body in the significant strides and developments that have been made that have led to real improvements for our population. Key to the above has been our investments in out of hospital services i.e. community, hospice and primary care services.

2. Increasing the ability for our population to be supported to die in their Normal Place of Residence (NPR) and also avoiding unnecessary admissions in the last year of life

The CCG has (in line with the Business case) made a significant range of investments in both community and also our hospice services to deliver on the above. What we have done is:

2.1 Investment in Oxleas Community nursing - £234,589 as follows:

a) A nurse in End of Life Care (EOLC) (Band 7 wte) was recruited in August 2015 to up skill the community nursing workforce. Achievements to date include:
- All qualified staff trained on completing End of Life (EoL) assessments and anticipatory care plans.
- 56 nurses have benefited from 1:1 sessions e.g. difficult conversations, DNAR and advance care planning, CHC checklists/assessments and managing syringe drivers. Feedback has shown increased confidence and competency in the community nursing workforce.
- A training needs analysis has been designed to identify needs and monitor progress
- Support provided to help embed a new process to identify EoL patients on Oxleas patient management system (Rio).
- Regular rotational visits to community nursing teams to provide support and advice
- All Band 7s completed/about to complete, "Train the Trainer" on using T34 syringe driver.

b) Expanded out of hours capacity - the business case highlighted that a large number end of life of patients were admitted out of hours.

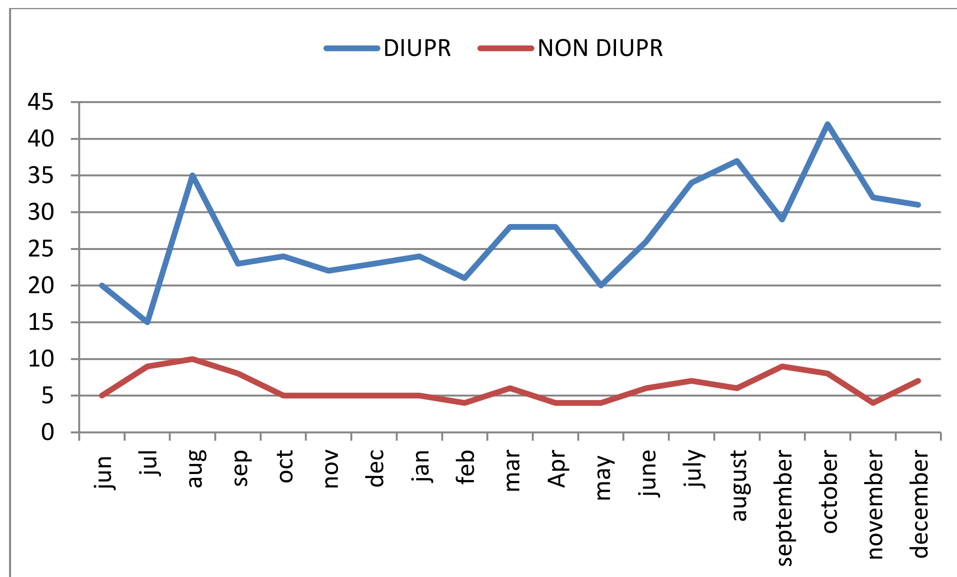
- 2 Band 4 nurses were recruited in June 2015; providing cover from 5-10pm each day including weekends and bank holidays
- Bexley and Greenwich night nursing teams co- located at Bexley and Greenwich Community Hospice to give them more flexibility in responding to demand and immediate access to support and advice from palliative care Consultant and clinical nurse specialists. The co-location required no investment from the CCG.
- From October 2015 the community nursing provide a 24/7 service (filling the hours gap in service that was historically commissioned).

c) EoL administrator was recruited in August 2015 **(**Band 3) to:

- To embed the new electronic EoL record within Rio
- A new monthly report identifying EoL patients by GP practice has been developed for monthly distribution to surgeries from December 2015
- Liaision with Marie Curie to organise night sitting service

From August 2015 - January 2016 the district nurses have responded to 169 calls from palliative patients. The graph below shows community nursing data for people who have died in their usual place of residence (NPR) and those who have not.

Community nursing data June 2015 – Dec 2016



Total number of patients on Community caseload who have died April 2015-December 2015

2015/16	q1	q2	q3
Total number of patients who have died on Community caseload	88	116	124
Total number of patients who have died in their usual place of residence.	74	100	105

Increase in numbers is from Q1 –Q3 is nearly 50%
Increase in deaths in normal place of residence between Q1 and Q3 2015/16 is 38%

Further data on out of hospital deaths (from GP practices) is shown in the following section.

2.2 Greenwich and Bexley Hospice Investment: Access to new personal care £218k

The original business case included the provision of more personal care and support for our end of life patients. The aim was to release time from qualified nurses who could then provide more complex interventions, advance care planning and give support to patient and family/carers.

Oxleas were invited to provide these additional services, but declined. An agreement has recently been made with Bexley and Greenwich Community Hospice to provide community personal care to enable the patient to remain in their place of choice as part of a coordinated service.

3. Co-ordinate My Care (care planning with patients, and their carers/ representatives)

The CCG, with its GP practices, has used a significant investment through its Primary Care Innovation Fund (in 2015 and now rolling forward into 2016) to encourage the use of CMC and ensure that patients (and their carers/ representatives) are involved in the planning of their care and wishes for the last year of their life.

We have seen significant increases in the number of CMC plans that have been developed and are then held centrally thereby ensuring that care providers (including LAS) can access and, wherever possible, respect the wishes of the individual and their family/ representatives). The business plan set the following objectives for Primary Care and use of CMC:

Date	Objective	Current situation
Dec 2014	60% of GP practices to be using CMC	Achieved Sept 2014, 70% practices using CMC
March 2016	80% of GP practices to be using CMC	Achieved October 2015, 100% practices using CMC

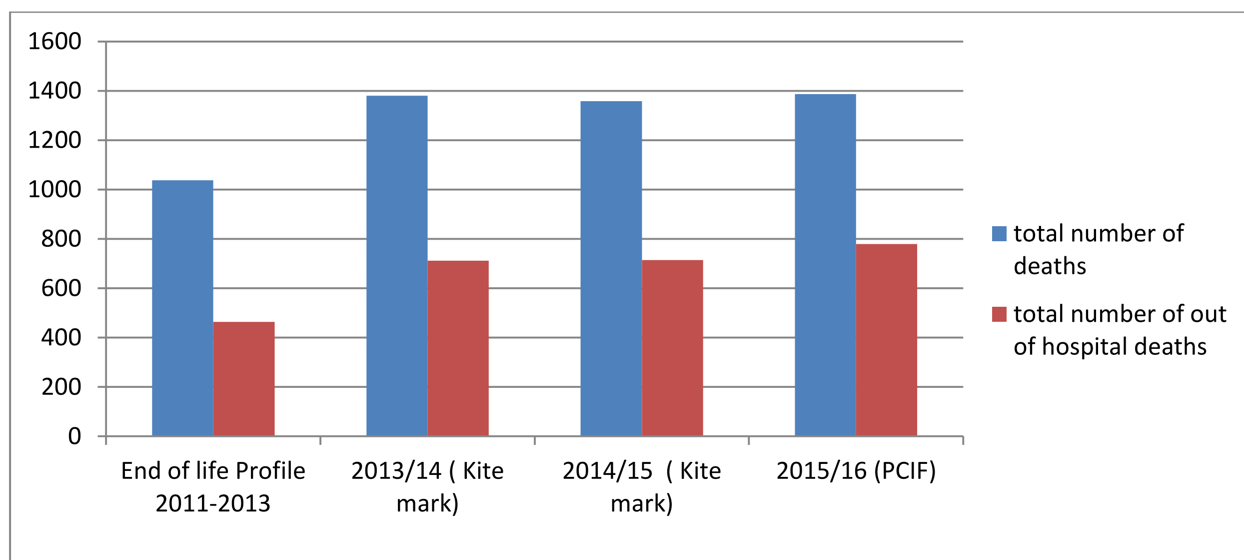
The Table below represents the increase of patient registration on CMC for Bexley – there has been a staggering increase since the introduction of the Primary Care Innovation Fund (PCIF):

	2013/14				2014/15				2015/16		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
CMC care plans	8	107	63	86	62	80	92	266	698	926	1256

Bexley are now being recognised across London as a significant performer in this area. This demonstrates that our investment in PCIF is delivering the desired first outcome of advanced care planning.

4. Enabling our patients to die in their Normal Place of Residence (choice)

Accessing national timely and accurate data to show place of death is difficult. The "End of Life Profile for Bexley CCG 2013" states that the annual average for deaths in hospital, 2011 – 2013, is 55.3%, consequently out of hospital deaths are 44 .7%. The chart below takes the national data but then uses locally reported GP analysis (PCIF now was Kitemark) to provide an interim position on deaths.



The chart above shows that the total number of deaths have increased (population aging) – but it also shows a significant increase in the % of patients that died outside of hospital between 2011-13 (our baseline end of life care profile point) and then the initial results from GP practices for 2015-16. Between the base year and then 2015/16 we have achieved an increase of 10.7%.

While the increase in deaths in normal place of residence has increased and deaths in hospital have decreased a number of issues related to identification have been identified;

- Acute hospitals have no standard process of recognising patients in their last year of life and alerting GPs. Consequently patients do not have the opportunity to participate in advance care planning and, in some cases, patients did not know they were dying . In response to this an end of life 2014/15 CQUIN was agreed with Darent Valley which has resulted in a standardised approach to recognition and more effective communication to GPs. The new approach was commenced in December 2015.

- Primary Care - One of the outcomes of the Clocktower audit[1] was the difficulty in recognising the last year of life and completing advance care planning in a timely way. This has been discussed with guest speakers at the Cancer Round table and Dr Kwan is planning to rollout the Clocktower audit recommendations from April.

---

[1] **A retrospective review of the medical record of the last year of life in the last 10 patients with non-cancer diagnosis who died in hospital**

- Difficult conversations - One of the blocks identified to advance care planning was reluctance of both primary care and acute care to engage with patients and families to have that difficult conversation. Dr Kwan has provided workshops for primary care.

- CMC- Sharing of information, patient preferences and coordination are central to good end of life care and the increase in out of hospital deaths is closely linked to the use of CMC in particular with Primary Care. Due to a system upgrade for CMC and post change problems GPs have temporarily had difficulties using the system. CMC are currently working with GPs to rectify the system.

5. GP and Primary Care Education, engagement and awareness;

Part of the business case was clear on the need for training, education and awareness. Dr Winnie Kwan has led the way in this area. The following events have taken place in the past year:

- Clinical Roundtable for Palliative Care & Cancer - In the last year this met quarterly and included presentations on Frailty and EOL, the Advanced Dementia Service, Greenwich & Bexley Community Hospice services, Co-ordinate My Care web upgrade, and Continuing Health Care and Mental Capacity Act etc.
- EOLC Steering Group – multi-agency meeting every 6 weeks to discuss EOLC issues. This forum helps to foster integration of services including those of the third sector.
- EOLC Partnership Event was held at Queen Elizabeth Hospital on 30th September 2015
- A workshop on the PEACE/ AMP for the GPs and their Care Home staff is being arranged for April 2016
- “Difficult Conversations” workshops were held to improve health professional’s skills and confidence in initiating the EOL discussion on 29th September for GPs and Nurses and 4th November for GP Registrars
- Clocktower Locality: Each of 9 practices reviewed the last 10 patients with non-cancer diagnoses who died in hospital as a peer reviewed learning process which examined local issues and training needs
- We are part of the London End of Life Care Clinical Network currently focussing on the development of the Emergency Treatment Care Plan which will replace the Do Not Attempt Cardio Pulmonary Resuscitation form (DNACPR). Bexley GPs will be consulted at the Clinical Roundtable in June 2016.

Dr Kwan “In order to enable people to have good EOLC, their needs have to be identified and their wishes be known to the health professionals such that shared care planning can be made to achieve those aims.”

We are grateful to Dr Kwan for her dedication and enthusiasm to this worthy initiative.

6. Bereavement Support Service

The business case identified the need for investment in community bereavement support. In response to this a recurrent £5,000 funding (in the form of a grant) was awarded to CRUSE to provide a bereavement service in Bexley from 1st April 2015.

Between April– December 2015 there have been 311 clients referred to this service. CRUSE offer both 1:1 and group sessions.

The following table sets out the outcomes from April-December 2015

Outcomes	**Q1**	**Q2**	**Q3**
Evidence of reduced prescribing of medication ,i.e. anti-depressants	80%	84%	86%
Evidence of improved health and wellbeing for clients contacting the service	96%	96%	95%
Reduced visits to GPs for clients following a bereavement	90%	90%	89%
Improved mental, physical health and general wellbeing	96%	90%	93%
Clients being able to return to work sooner with bereavement support	95%	97%	89%
Clients further integrating into the community with CRUSE support and less isolation	94%	97%	92%
Comments ; All the outcomes defined above are determined by the client competing an evaluation questionnaire at the end of support.			

CRUSE provided volunteers to work beside the Patient Experience Team during the "Dying Matters Week" in May 2015 and have completed (or nearly completed) the following projects:

- Preparing for death training
- Establishing Older people – bereavement group – friendship group
- Children's suicide and support for schools programme
- Faith groups – joint working
- Bereavement in the workplace programme
- Leaflets available:

Below are some comments from CRUSE service users:

Feedback from one client who had lost her partner and was having 1:1 support:

"Having my first Mother's Day with a new baby without my husband was really difficult for me, after chatting to my Cruse Volunteer about this, I gained the confidence to then speak with other family members and friends about how difficult this was for me, to my surprise I found they some of them sent me a card and flowers as if from my baby son, knowing that I had no husband to do this for me ! I was really delighted!'

Feedback from one client who bereaved by suicide

"'1-1 support felt a bit too scary and I wasn't sure I was ready for that, it was great to attend a group and see some other faces - I knew I wasn't alone".

7. Conclusion:

What we can see is that our strategy to improve the End of Life Care services, and the investments that we have made has had real impetus and resonance in Bexley with our GPs and providers of services.

The ability to die in your Normal Place of Residence and also to be able to plan for your own death and have your wishes respected (wherever possible) has real improved patient and population outcomes for the residents of Bexley. This is year 1 of our on-going strategy, but the change and improvements can already be seen.

Lindsey Coeur-Belle and Mariette Mason

2nd March 2016