NHS North Lincolnshire

End of Life Care Commissioning Strategy

NHS North Lincolnshire - Adding Life to Years and Years to Life

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END OF LIFE CARE

1. Background

The 'End of Life Care Strategy – Promoting high quality care for adults at the end of life' was published by the Department of Health in July 2008. This strategy and action plan has been produced by the North Lincolnshire Palliative Care and End of Life Strategy Group, supported by service review undertaken in 2010.

2. Context

Approximately 1650 people die each year in North Lincolnshire, about 1% of the total population. Around 1 in 3 of these deaths occurs amongst people aged 80+. A large majority of those deaths now follow a period of chronic illness such as heart disease, diabetes, cancer, stroke, chronic respiratory disease, neurological disease or dementia. This represents an average 15.6 deaths per GP per year, or just under 80 per practice. National research evidence suggests that most people would prefer to die in their own home, (including their care home) or in a hospice, rather than in a hospital – although this is in fact where most people currently do die. 56% of our deaths are in hospital which is close to the national average of 58%.

End of life services are intended to support those with advanced, progressive, incurable illness to live as well as possible until they die.

This strategy should not be read in isolation and should be considered alongside the

- Joint dementia strategy
- Palliative care strategy
- Unplanned care sections of the Single Integrated Plan for 2011/12 to 2014/15

3. What do we want to achieve?

<u>Outcomes</u>
Our local ambition is to improve the availability and quality of end of life care in North Lincolnshire, reduce unnecessary admissions to hospital and improve choice at end of life.

In refreshing our Strategic Plan for Year 2 (2010/11), we agreed a 10th health outcome recognising our goal to enable more people to die in the setting of their choice:-

10. "Increasing the numbers of people at end of life who die in their place of choice"

An update against this health outcome was attached to our Single Integrated Plan for 2011/12 to 2014/15 and is attached at appendix 1.

We aspire to commission services that meet the individual needs of patients and carers and which deliver the following outcomes:

- Ensuring timely conversations about end of life with patients and carers
- Enabling people to die in the setting of their choice with appropriate care

- Ensuring access to care and support over any 24 hour period for those approaching end of life and their carers.
- Providing age appropriate responses and services
- Reducing avoidable admissions to hospital
- Ensuring practitioners have access to accurate and timely information to support patient care
- Ensuring patients, carers and support services have access to specialist advice if appropriate
- Ensuring practitioners have access to adequate resources including medications and staffing at the times required, supported by appropriate guidelines, policies and procedures
- Ensuring we have a skilled and competent workforce across the health and social care community

4. What will Transforming Community Services mean for people at the End of Life

NHS North Lincolnshire will put in place a clear commissioning framework for end of life care which aims to improve the quality and availability of care which is appropriate and responsive to patients and carers needs. This care will be delivered across all settings, and consistent end of life care pathways. For people at the end of life this will mean:-

- 24/7 access to care for those approaching end of life
- those working with patients at the end of life will have access to specialist advice to support them in providing the best care
- Professionals will hold timely conversations about end of life with patients and carers
- Support for carers throughout the whole pathway including respite, psychological care and providing care support
- Recognition of end of life status, enabling entry onto registers and ensuring robust assessment, care planning and co-ordination of services
- Integrated service delivery across all those who provide care
- patients and carers will receive the support they need in the last days and weeks of life
- Providing support and care after death to carers and families as well as dignified care of the deceased patient and their property
- Adoption of best practice evidence, professional consensus on good practice and experience of service users

5. How will we achieve this?

We will:-

- Review and agree clear pathways for end of life care
- Develop person centred services
- Plan care and services across each of the 5 local areas where appropriate
- Commission services that encourage integrated service delivery
- Commission integrated services with social services to develop a single, joint system of case management with all partners involved in the management of care for the individual and the family or carer
- Adopt a common approach to care planning and case management including implementation of the Liverpool Care Pathway in all settings, for all appropriate patients

- Ensuring recognition of end of life status, enabling entry onto registers and ensuring robust assessment, care planning and co-ordination of services
- Ensure all providers work towards the necessary quality metrics, markers and measures
- Develop and implement an integrated Do Not Attempt CPR (DNACPR) Policy
- Increase health and social care support including palliative care available to enable people to remain in their preferred place of care
- Work with North Lincolnshire Council to commission care homes to provide palliative care at end of life
- Ensure appropriate training and development in place for all staff, particularly in care homes
- Provide access to specialist advice for non professionals and a helpline for carers
- Consider the role of bereavement services
- Supporting carers throughout the whole pathway including respite, psychological care and providing care support, including in the last days of the patient's life and after death
- Ensuring patients and carers receive the support they need in the last days and weeks of life
- Providing support and care after death to carers and families as well as dignified care of the deceased patient and their property
- Appraisal and adoption of best practice evidence, professional consensus on good practice and experience of service users
- By reviewing processes including effective audit and evaluation to give assurance that consistent quality of care in the last days of life is provided, in whatever setting an individual is being cared for
- Provide clear and accessible information to patients and carers
- Act on feedback provided by carers, identifying where improvements can be made

6. How will we measure our progress and success?

This strategy is supported by an action plan. This plan is monitored through the Palliative Care and End of Life Strategy Group whilst an implementation group is taking it forward delivery of specific actions with representation from providers of end of life care.

The key areas we measure our progress against are:

- the number of patients achieving their wish to die at home
- Implementation of the Liverpool Care Pathway
- Measuring the proportion of avoidable admissions to the Acute Trust
- feedback from carers, exploring whether they felt supported throughout the pathway

7. Performance Indicators

Performance indicators for end of life care include:-

- Percentage of people who have an identified care plan
- Proportion of people who have an identified care manager/key worker
- Percentage of patients dying on an end of life care pathway
- Percentage of patients dying at home or in a care home
- A method of measuring and interpreting bereaved carer's satisfaction

Appendices

1. Health outcome progress
2. Action plan
3. Vital signs trajectory

This strategy and action plan has been developed with input from

- The Palliative Care and End of Life Strategy Group
- Business MDT

  Including representatives from:
  - NHS North Lincolnshire
  - Northern Lincolnshire & Goole Hospitals – Acute & Community
  - Lindsey Lodge Hospice
  - Patient Involvement Group
  - North Lincolnshire Council Adults Services
  - Care Homes
  - Cancer Network
  - General Practitioner

Appendix 1

Strategic Plan Priority Health Outcomes
End of Life Care

Why chosen?
End of life services are intended to support those with advanced, progressive, incurable illness to live as well as possible until they die. These are services that enable the end of life care needs of both patient and family to be identified and met, throughout the last phase of life and into bereavement.

This includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support. This is not confined to discrete specialist services but includes those services provided as an integral part of health and social care practice which may occur in any setting.

The challenge
Approximately 1650 people die each year in North Lincolnshire, about 1% of the total population. About 1 in 3 of these deaths occurs amongst people aged 80+. Between a quarter and a fifth of people die of cancer, a third from organ failure and another third from frailty or dementia. This represents an average 15.6 deaths per GP per year, or just under 80 per practice. National research evidence suggests that most, although not all, people would prefer to die in their own home, (including their care home) or in a hospice, rather than in a hospital – although this is in fact where most people currently do die.

Local ambition
Our local ambition is to improve the availability and quality of end of life care in North Lincolnshire, reduce unnecessary admissions to hospital and improve choice at end of life. In the short term, the indicator used to monitor the success of these actions is the percentage of people who die in their own homes. However, it is recognised that this is inadequate and so a more appropriate indicator is under development nationally.

Table 15
Targets for end of life care % people who die at home or in care homes

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
End of Life	37%	37%	37%	37%		

In 2008, 19% of people died at home and 18% died in care homes. This is slightly above the national average for that year. In 2009 the proportion of people dying in their own homes increased to just under 22%, whilst those dying in care homes increased to 22%. This was above target for that year. Data for the first 6 months of 2010/11 suggest that the proportion dying at home may have fallen back in 2010/11. Although it is too early to say whether this represents a trend, the provision of choice in end of life care is likely to become more challenging as the number of older people dying with multiple complex conditions increases.

Table 16
Place of death, persons, all ages, North Lincolnshire 2009 (calendar year)

	Local position 2009		**National position 2008**
Place of death	No of deaths	% deaths	% deaths
Home	356	22%	17%
Hospital	823	51%	58%
(of which from care home)	*98*	*(6%)*	*N/A*
Care home – residential	222	14%	17% combined
- nursing	123	8%	
Hospice	101	6%	6%
Total	1625	100%	100%

Source: NHS North Lincolnshire

Table 17

	Local position 2010 (Jan – June)		**National position 2008**
Place of death	No of deaths 6 months	% deaths 6 months	% deaths 12 months
Home	132	17%	17%
Hospital	442	58%	58%
(of which from care home)	*54*	*7%*	*N/A*
Care home – residential	85	11%	17% combined
- nursing	55	7%	
Hospice	44	6%	6%
Total		100%	100%

Source: NHS North Lincolnshire

Actions taken in 2010/11

- Local review of end of life care services against national benchmarks completed and Action Plan developed for commissioning high quality end of life services across all care settings.
- Extra funding has been identified for community providers to increase their End of Life health care assistant capacity, with the aim of increasing the number of patients able to die at home where this is their preferred place of death.
- Community providers were successful in a bid for MacMillan money to fund a Macmillan facilitator who will work with staff in community services and nursing homes to develop staff skills in EoL care. This supplements the GP Macmillan Facilitator who works with care home and GP practice staff to develop staff skills and competencies.

Actions planned for End of Life 2011/12

- Implementation of a DNAR process across ambulance, health and social care services to ensure patients are not resuscitated when an order is in place

- Improved education of care homes staff to enable them to manage patients at end of life, reducing hospital admissions and increasing the number of patients dying in their preferred place of care
- Implementation of a patch wide end of life register which details the patients end of life plan, supporting all agencies to manage care according to patient preferences where possible
- Access to 24/7 telephone help line for palliative care advice as part of broader implementation of locality based integrated care teams

Appendix 2

End of Life Care Action Plan

Linked to targets/ guidance	Issue	Milestones	Timescale	Lead
Vital Sign- proportion of all deaths that occur at home	**Increase number of patients dying in preferred place** High number of deaths in hospital, when not most appropriate place to meet needs of patients, and not in line with patient's preferred priorities of care. Meeting patient requirements in relation to preferred priorities of care NHS NL aim to reduce deaths in hospital by 2% per annum. This equates to a reduction in deaths in hospital of 33 patients per annum.(based on 1650 deaths pa)	Marie Curie model to be revised and agreed with MC/NHS NL provider to provider cover 4 nights per week	Mid Nov	KF
		Implementation of Advanced Intermediate Care, to reduce admissions to hospital at end of life		JE
		Work with NHS NL provider service to maximise staff capacity within home healthcare teams	Dec 2010	HD/JE
		Audit of deaths in hospital	Jan 2011	DW
		Single point of access to move to 24/7 service Combine Health Single Point of Access and Local Authority Single Point of Access into single function	Agree way forward by Dec 2010	JE/PS KP/PS
		Education to care homes to ensure appropriate referrals/ admissions Education to GPs and community nursing teams to ensure appropriate referrals/admissions dependent on patient needs Education of all staff to support them in end of life discussions with patients at appropriate times		AD/RA AD/WS All providers
		Development of alternatives to hospital admission e.g management of hypercalcaemia		JE/AM
		Agreement with East Midlands Ambulance Trust to enable transport of patients under PTS and	March 2011	JE/TF

		emergency ambulance service to alternative destinations including hospice and care homes		
Quality markers *	**Improvement in quality of pathways**			
QM1	**Strategic planning**	Development of a service specification to cover all aspects of EoL care	March 2011	JE/RA/AM
QM 2	**Contract and quality monitoring**	Regular monitoring of all EoL services for quality, with feedback to providers to support service improvement	Ongoing	JE/RA
QM 3	**EoL register** % of patients who die having been on EoL register	Audits of deaths against EoL registers	March 2011	GPs
QM 4 CQUINs	**Individual needs assessment and care planning** Patients at EoL to be cared for utilising LCP or equivalent Health care professionals to discuss options regarding EoL and PPC with patients in a timely and appropriate manner Planning for EoL to reflect patients PPC where possible	Audits :% of appropriate wards who have the LCP (appropriate wards defined as adult wards with 5 or more deaths a year) % people dying on LCP or equivalent on an appropriate ward (CQUINs measure) % patients where evidenced that discussions regarding EoL and PPC have taken place % patients who die in their preferred place Development of action plans to address gaps and opportunities for improvement		GPs/ all providers
QM 5	**Carer needs** All family and carers of patients at EoL to have assessment of their needs – should include information, support and bereavement needs	Audit of % of carers of patients on EoL register who have been offered assessment % of these who have had assessment completed Development of action plans Appraisal of CRUSE business case for provision of bereavement		All providers
QM 6	**Coordination of care** Single point of contact for patients and carers Sharing of information/ care plans between services including emergency and OOHs services	Audit of % patients on EoL register who have OOHs forms Audit of updating of OOHs forms within 4 weeks prior to death Development of one single point of contact for patients and health professionals		Providers SPA/LA/PCT AM/RJF

		Implementation of a DNAR policy in conjunction with EMAS		
	Timely access to equipment for patients to support death in preferred place of care	Input into stakeholder event re equipment provision in conjunction with TCES (Transforming Community Equipment Service) Review of equipment needs against stock		Providers/ commissioners
QM 7 IOG	**Specialist palliative care** Ensure pathways provide timely access to specialist teams for patients with complex needs	Audit of referrals to specialist care team for cancer and non cancer patients % GP practices using GSF level 1 Access indicators- DNs 24/7, end of life drugs 24/7, equipment within 48hrs Commissioning of telephone helpline for healthcare professionals Commissioning of 9-5 specialist palliative care team 7 days per week or agree alternative model Options appraisal for consultant in Palliative Care, working in conjunction with NEL CTP	Jan 2011 Jan 2011	JE/AM JE/AM JE/AM
	Workforce and competencies			
QM 8	Systems and processes to ensure effective workforce development for EoL	Complete work with Y&HSHA re care homes training Develop local plans to ensure all staff receive relevant training (quality markers for care homes, 'Route to Success' for care homes, 'Route to Success' for acute providers) Implementation of e-ELCA for care homes staff Service specification to include workforce development requirements and Key Performance Indicators Work in collaboration with Workforce development	End August End Nov March 2011 March 2011	JE/RA/AM Providers/ RA/ JE/AM RA JE JE Providers

		leads to develop workforce plans		
NICE	Psychological and psychiatric therapies Patients to be assessed for and have access to psychological therapies appropriate to needs	Baseline of current capacity against demand. Development of a costed service delivery model Ensure full implementation across all providers of holistic needs assessment to identify psychological therapies requirements	March 2011	AM/JE/ Network

* Quality markers are based on Yorkshire and the Humber SHA Quality measures for End of Life

Appendix 3

Vital Sign Trajectory

5EF **Name: NORTH LINCOLNSHIRE PCT**

SQU02 **Proportion of deaths in usual home**

Read the definitions in the technical guidance for the 2011/12 Operating Framework before completing the table

		2011/12				2011/12
		Q1	Q2	Q3	Q4	Total
SQU02_01	Number of deaths in usual home registered in the respective quarter	137	132	160	155	584
SQU02_02	Number of total deaths (less exclusions) registered in the respective quarter	367	364	428	431	1590
SQU02_03	Proportion of deaths in usual home	37.3%	36.3%	37.4%	36.0%	36.7%

Basis: **Commissioner**

	Cells for organisation to complete.
	Cells not applicable for organisation selected
%	Calculated field. Completed automatically

Validation tests and sign off criteria

Note: If the data entered fails **any** of the **Validation** tests you will not be able to upload the spreadsheet. However this does not apply to the sign off criteria lights**,** they are included for your information only

Validation tests	
0	**Error(s) Remaining**
Whole numbers entered	TRUE
Complete data entered	TRUE
Code_03 does not exceed 100%	TRUE
Data entered where applicable	TRUE
No negative numbers entered	TRUE

Sign off criteria

Footnote to explain validation tests

Whole numbers entered	This traffic light will be green if all numbers entered are whole numbers and red if any numbers are entered with decimal places
Complete data entered	This traffic light will be green if all of the cells contain data and red if some cells contain data and other cells are empty
SQU02_03 does not exceed 100%	This traffic light will be green if the numerator and denominator entered produce a valid percentage and a red if they produce a percentage of over 100%
Data entered where applicable	This traffic light will go red only if a provider enters data for a commissioner based line and vice versa
No negative numbers entered	This traffic light will be green if all data entered are greater than or equal to zero and red otherwise

5EF **Name: NORTH LINCOLNSHIRE PCT**

SQU02 **Proportion of deaths in usual home**

Read the definitions in the technical guidance for the 2011/12 Operating Framework before completing the table

		2011/12				2011/12
		Q1	Q2	Q3	Q4	Total
SQU02_01	Number of deaths in usual place of residence registered in the respective quarter	150	155	165	175	645
SQU02_02	Number of total deaths (less exclusions) registered in the respective quarter	367	364	428	431	1590
SQU02_03	Proportion of deaths in usual place of residence	40.9%	42.6%	38.6%	40.6%	40.6%

Basis: **Commissioner**

	Cells for SHA / PCT / Trust to complete.
	Cells not applicable for trust selected
%	Calculated field. Completed automatically

Validation tests and sign off criteria

Note: If the data entered fails **any** of the **Validation** tests you will not be able to upload the spreadsheet. However this does not apply to the sign off criteria lights**,** they are included for your information only

Validation tests	
0	**Error(s) Remaining**
Whole numbers entered	TRUE
Complete data entered	TRUE
SQU02_03 does not exceed 100%	TRUE
Data entered where applicable	TRUE
No negative numbers entered	TRUE

Sign off criteria	
2009 baseline	40.4%
2011/12 plan greater than 2009 baseline	40.6%

Footnote to explain validation tests

Whole numbers entered	This traffic light will be green if all numbers entered are whole numbers and red if any numbers are entered with decimal places
Complete data entered	This traffic light will be green if all of the cells contain data and red if some cells contain data and other cells are empty
SQU02_03 does not exceed 100%	This traffic light will be green if the numerator and denominator entered produce a valid percentage and a red if they produce a percentage of over 100%
Data entered where applicable	This traffic light will go red only if a provider enters data for a commissioner based line and vice versa
No negative numbers entered	This traffic light will be green if all data entered are greater than or equal to zero and red otherwise

Footnote to explain sign off criteria

The proportion of patients supported to remain in their usual place of residence until the end of their life should show an increase in 2011/12 over the baseline at both PCT and SHA level. This will be assessed by taking the average proportion over the planning period and comparing it to the baseline figure. Note that the baseline used relates to the 2009 calandar year as this is the latest full year for which final ONS data is available.
If the organisation has a baseline for 2009 a green light is generated if the 2011/12 plan is greater than the baseline and a red light if it is less than or equal to the baseline.