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HEALTH AND WELLBEING BOARD

13 JUNE 2019

SUPPLEMENTARY PAPERS

TO: ALL MEMBERS OF THE HEALTH AND WELLBEING BOARD

The following papers have been added to the agenda for the above meeting.

These were not available for publication with the rest of the agenda.

Kevin Gibbs
Executive Director: Delivery

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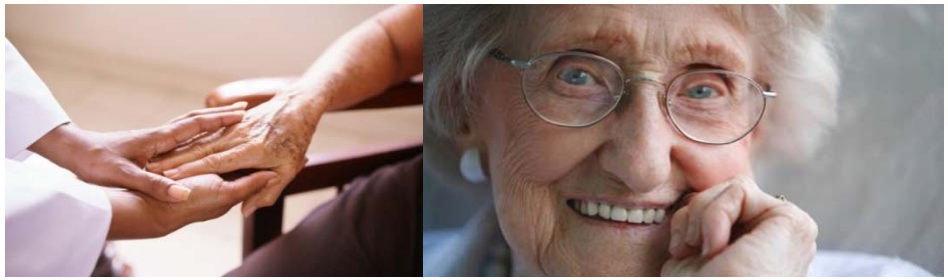

End of Life Care Transformation

Jo Greengrass

Associate Director of Nursing -

Quality & Safety EB CCG

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Background

- CHC Transformation Program underway with 11 work streams including work on FT
- Implementation of EoLC Strategy (July 2018)
- Opportunity to join NHSE project with EoLC & SIP CHC teams (Nov 2018 – Feb 2019)

Work Stream 10
NHSE SIP
CHC Transformation Programme

- Integrated Assessment and Care Management Function
- Delegation of Procurement / Contracting / Placement Function
- End of Life Care Services
- ICS Care & Support for Care Homes (led by SBC)
- Delivery of 180 to 230 PHB's

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CHC Fast Track Data Review

MTH 6 YTD		
Reasons for zero-cost FT approvals	Number of patients	%
Patient died	32	82%
Patient stayed in hospital	2	5%
Patient treated by ITC	2	5%
Patient care already funded by LA	1	3%
Care provider did not supply contract costs to set up POC	2	5%
TOTAL	**39**	**100%**

- FYE = approx. 80 people
- Complexity of patients
- Complexity of the system

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The NHSE Project

- The project aim is to improve the CHC EOL Fast-track process which begins by reviewing our EOLC commissioned services.
- **Working hypothesis:** Through excellent EOL commissioning we can expect to see improved use and efficiency of the fast-track process.
- **Methodology:** 2 locally held multi-agency workshops (Nov 2018 & Dec 2018) to complete the National Ambitions self-assessment tool to benchmark our locality against the 6 Ambitions
- Well attended workshops with good representation from all stakeholders

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Workshop 1 November 2018

	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5
Ambition 1: Each Person Seen as an Individual	0.0%	18.2%	36.4%	45.5%	0.0%	0.0%
Ambition 2: Each person gets fair access to care	0.0%	10.0%	10.0%	60.0%	20.0%	0.0%
Ambition 3: Maximising comfort and wellbeing	0.0%	0.0%	18.8%	18.8%	37.5%	25.0%
Ambition 4: Care is coordinated	4.2%	50.0%	12.5%	8.3%	16.7%	8.3%
Ambition 5: All staff are prepared to care	0.0%	14.3%	14.3%	42.9%	28.6%	0.0%
Ambition 6: Each community is prepared to help	0.0%	75.0%	25.0%	0.0%	0.0%	0.0%

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Areas for improvement in our systems & processes

- CHC not 24/7 = delays
- Unclear which people need FT – even the clinicians don't understand – the system is too complex
- The system is not joined up or supportive
- Incomplete and inappropriate referrals (not 'terminal phase' or 'rapidly deteriorating' – but prognostication is HARD)
- Current Intermediate Care teams operate differently (capacity, referrals, role) = more complexity in the system
- Interplay between CHC and ICT packages = flexibility but complexity
- Not enough capacity in dom care agencies for POC = DTOC, risk of crisis, distressed patients and families

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Areas for improvement in data & information sharing

- Lack of interoperability – current solution is not fit for purpose yet (doesn't include EoL)
- Too many care plans – we need 1 solution (including a digital form)
- Too many DNACPR forms – we need 1 solution
- Need to measure consistent outcomes of care across the system and share data via EoL Steering Group
- Navigating the system is complex for professions and staff - lack of clarity and information

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Areas for Improvement - Other

- Not optimising voluntary sector organisations at present – night sits, peer support, education, companions
- Bereavement should start at recognition – pathway and services need expanding
- Support for care home residents is non-equitable
- No cross system training offer – need cross system strategy & consistent offer

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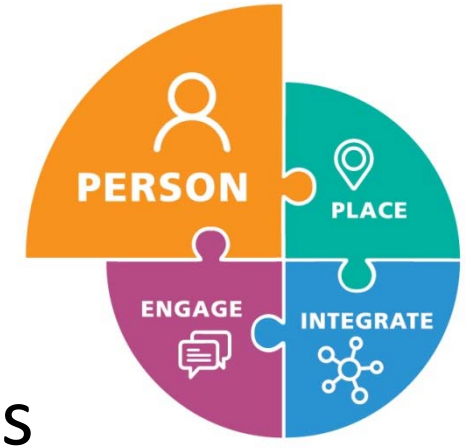
What is working well?



- A real desire to do this better
- Expertise & skill in our EoL teams
- ICT for rapid discharges can be organised in a phone call (where there is capacity)
- 24/7 advice line & RR service
- Joint working with hospice RR team & DNs

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The Vision

A new EoL Care Pathway that produces a flexible, agile service which meets the needs of our patients

- Putting the patient at the centre of the Care Pathway
- One multi-agency assessment/referral form
- Utilise a trusted assessor model
- Create an equitable service for all (including in care homes, people with frailty and dementia)
- Pooled funding between health and social care
- One multi-agency 24/7 team for regular reviews for timely step-up & step-down
- One care plan – paper copy at the patient's home; digital version on Connected Care

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- Utilise a process for using PHBs for EoLC
- Usage of our local adult hospice as the preferred provider of bed-based EoLC (new hospice site due to open in 2020)
- Develop the offer from our Intermediate Care Teams
- Consider a joint domiciliary care specification to meet local need with a preferred provider network that meets regularly to raise standards and maintain quality
- Supported by voluntary sector & family/carers
- Cross-system training offer to develop, recruit and retain staff
- Supported by better information for HCPs – create a Directory of Services (DOS)
- Supported by better information for patients/families – create a patient passport
- One care plan (paper and digital)
- One DNACPR form (paper and digital)
- D2A model for early supported discharge from hospital (with re-ablement, symptom control, access to nursing & medical care) – consider a specific D2A placement for a set amount of time of funded assessment

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Challenge to us from NHSE

- Consider CHC FT spend as a pot of money that the system can use differently
- CHC FT is an assessment function for eligibility to access funding. If services are not there; that's not a CHC problem; that's a system problem.
- Use the funding to get the right services in place so that people can access them earlier
- Do not accept the norm – disrupt!

Frimley Health and Care

Frimley ICS Combined Self Assessment Tool

	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5
Ambition 1: Each Person Seen as an Individual	0.0%	9.1%	27.3%	36.4%	27.3%	0.0%
Ambition 2: Each person gets fair access to care	0.0%	10.0%	40.0%	40.0%	10.0%	0.0%
Ambition 3: Maximising comfort and wellbeing	0.0%	0.0%	12.5%	25.0%	56.3%	6.3%
Ambition 4: Care is coordinated	50.0%	8.3%	8.3%	12.5%	20.8%	0.0%
Ambition 5: All staff are prepared to care	0.0%	0.0%	14.3%	42.9%	42.9%	0.0%
Ambition 6: Each community is prepared to help	0.0%	0.0%	75.0%	25.0%	0.0%	0.0%

Key

0% 37.5% 75%

Level 0 – Not at all ready to achieve/ anticipate barriers to achievement
Level 1 – Desire to achieve this ambition but there are currently no plans in place
Level 2 – Plans are in place towards achieving this ambition
Level 3 – Limited achievement across one or two organisations only
Level 4 – Partially achieving
Level 5 – Fully achieving

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ICS EOLC Priorities

- SHORT-TERM: Development of a Frimley ICS DOS and an online presence
- ‘Patient passport’
- Training & Education Strategy
- Access to 24/7 specialist symptom control and advice for patients/carers in Frimley South
- Development of a single, electronic Advance Care Plan