End of Life Care Transformation

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Working together to deliver excellent and sustainable healthcare

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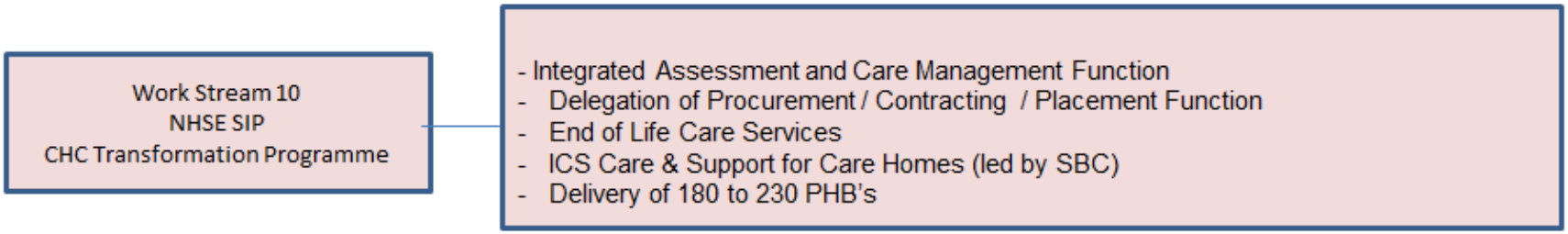
Clinical Commissioning Group

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)



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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!

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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