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| **London Borough of Hammersmith & Fulham**<br><br>**HEALTH AND WELLBEING BOARD**<br><br>**21 March 2016** | |
| **END OF LIFE CARE JSNA** | |
| **Report of the Director of Public Health** | |
| **Open Report** | |
| **Classification - For Decision**<br><br>**Key Decision: No** | |
| **Wards Affected:** All | |
| **Accountable Executive Director:** Liz Bruce, Executive Director for Adult Social Care and Health | |
| **Report Author:** Colin Brodie, Public Health Knowledge Manager | **Contact Details:**<br>Tel: 020 7641 4632<br>E-mail: cbrodie@westminster.gov.uk |

## 1. EXECUTIVE SUMMARY

1.1. This report summarises the work and findings of the JSNA on End of Life Care, including the recommendations for key partners.

1.2. This report requests the Health and Wellbeing Board to formally approve this JSNA for publication, and to take responsibility for monitoring the implementation of the recommendations, holding the relevant partners to account.

## 2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is requested to approve the End of Life Care JSNA for publication, and to note how the JSNA will be used to inform local strategic approaches to end of life care.

2.2. The Health and Wellbeing Board is invited to consider the recommendations arising from the End of Life Care JSNA, in particular Recommendation 3, and provide a steer on how this should be implemented locally:

- **Identify clear strategic leadership for end of life care across social care, health and the independent sector**. A lead organisation should be identified with responsibility for ensuring developments are cohesive and aligned. This is also reflected in the recent Ambitions for Palliative and End of Life Care recommended by the National Palliative and End of Life Care Partnership.

2.3. It is recommended that the Health and Wellbeing Board review progress against recommendations in 1 year from publication

## 3. REASONS FOR DECISION

3.1. A JSNA on End of Life Care was undertaken as part of the approved JSNA Work Programme in order to provide a comprehensive evidence base and information about the local population, to guide a future strategic approach to end of life care and inform commissioning intentions.

3.2. The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB). Local governance arrangements require final approval from the Health and Wellbeing Board prior to publication.

## 4. INTRODUCTION AND BACKGROUND

4.1. People approaching the end of their life experience a range of physical, emotional and spiritual symptoms. To manage these issues effectively requires integrated and multidisciplinary working between teams and across sectors regardless of whether the person is in their home, in hospital, a care home, or hospice.

4.2. Families and carers of people at end of life also experience a range of challenges and will have their own specific needs which must be addressed before, during and after the person's death.

4.3. While some people experience good and excellent quality end of life care, many people do not. To address the variation in end of life care, it is vital that end of life care is seen as 'everyone's business' and not limited to certain specialities such as palliative care services.

4.4. The focus on supporting people to receive care, and be supported to die in their preferred place of care, requires a future shift in culture which can only be achieved by upskilling the workforce in identifying the dying phase, having difficult conversations and managing end of life care needs and preferences.

4.5. Primary care teams in the community can deliver excellent palliative care for their dying patients and enable patients to die well where they choose when complemented by good access to specialist services, support, and expertise. As demand for community care increases, it is important to maximise the potential of primary palliative care and the use of frameworks or protocols with good collaboration with specialists.

4.6. Whole Systems Integrated Care (WSIC) and Shaping a Healthier Future (SaHF) strategies and respective local authority strategies provide opportunities to focus on community based care and enhance end of life care.

## 5. JSNA RECOMMENDATIONS

5.1. There are 5 recommendations, with each recommendation including a range of opportunities for consideration by commissioners for local implementation.

5.2. Recommendation 1 refers to an ambition for the local delivery of high quality, person- centred end of life care designed to improve the experience of the dying person and their families, carers and friends. Recommendations 2 to 5 describe the culture, governance, processes and systems that need to be in place in order to achieve this ambition

5.3. The recommendations are:

| **Recommendation** | **Summary** |
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| **Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination** | Everyone with a life limiting long term condition should have care plans which address their individual needs and preferences, particularly as they approach the last phase of life. Their care must be coordinated, with a clear oversight of the respective roles and responsibilities of all health, social care and third sector service providers. |
| **Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people** | The overall focus of end of life care must be a community model, with input from specialist services when needed. Local leaders, commissioners, professionals and our populations should generate a culture where talking about and planning for the last phase of life is 'normal', and all practitioners are willing and able to give end of life care. |
| **Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector** | A lead organisation should be identified with responsibility for ensuring developments are cohesive. Leadership should reflect a community based model across a range of services, with a clearly articulated end of life care vision and ambitions. |
| **Recommendation 4: Develop a coordinated education and training programme for practitioners, the person** | Formal and informal training and education programs for all frontline practitioners needs to be coordinated, systematic, visible and evaluated, in line with good practice guidelines. |

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| **dying, carers and for family and friends (if they wish)** | |
| **Recommendation 5: Everyone should have easy access to evidence and information** | More information needs to be easily available. Accessibility in terms of language, style, culture and ability should be reviewed. Evidence and information must be available to commissioners and providers and used to actively improve services. |

## 6. CONSULTATION

6.1. A workshop was held at the BME Health Forum in June 2015. Feedback from the workshop was incorporated into the findings, particularly the Policy and Evidence Review (Supplement 2)

6.2. A workshop was held at the End of Life Care Steering Group in September 2015 to inform the development of the recommendations. The End of Life Care Steering Group consists of CCG and GP End of Life Care leads as well as community and secondary care providers

6.3. The JSNA was presented to the Hammersmith and Fulham CCG Governing Body Seminar on 03/11/2015. In addition, CCG and GP End of Life Care leads were interviewed for the JSNA.

6.4. The draft JSNA was disseminated to key stakeholders in November 2015, including colleagues in Local Authority, Adult Social Care, CCGs, Central London Community Healthcare, Hospices, Specialist Palliative Care Teams, Healthwatch, and Community and Voluntary organisations. Feedback was collated and reviewed by the Task and Finish Group and informed the final report..

## 7. EQUALITY IMPLICATIONS

7.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life.

7.2. The “local area” is that of the borough, and the population living in or accessing services within the area, and those people residing out of the area for whom CCGs and the local authority are responsible for commissioning services

7.3. The “whole local population” includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs etc.)

## 8. LEGAL IMPLICATIONS

8.1. The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

8.2. Section 2 Care Act 2014 imposes a duty on LAs to provide or arrange for the provision of services that contribute towards preventing, delaying or reducing care needs.

8.3. Section 3 Care Act 2014 imposed a duty on LAs to exercise its Care Act functions with a view to ensuring the integration of care and support provision with health provision to promote well-being, contribute to the prevention or delay of care needs and improve the quality of care and support.

8.4. JSNAs are a key means whereby LAs work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of LA s2 and s3 Care Act duties.

8.5. Implications verified/completed by: Kevin Beale, Principal Social Care Lawyer, 020 8753 2740.

## 9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.

9.2. Implications verified/completed by: Safia Khan, Lead Business Partner Adults, 020 7641 1060

## 10. IMPLICATIONS FOR BUSINESS

10.1 None identified

## 11. RISK MANAGEMENT

11.1. Public Health risks are integrated into the Council's Strategic Risk Management framework and are noted on the Shared Services risk register, risk number 5. Market Testing risks, achieving high quality commissioned services at lowest possible cost to the local taxpayer is also acknowledged, risk number 4. Statutory duties are referred to in the register under risk 8, compliance with laws and regulations. Risks are regularly reviewed at Business Board and are referenced to in the periodic report to Audit, Pensions and Standards Committee.

11.2. Risk Management implications verified by Michael Sloniowski, Shared Services Risk Manager, telephone 020 8753 2587.

## 12. PROCUREMENT IMPLICATIONS

12.1. Any future contractual arrangements and procurement proposals identified as a result of the JSNA and re-commissioning projects will be cleared by the relevant Procurement Officer.

12.2. Implications verified/completed by: (name, title and telephone of Procurement Officer).

## 13. IT STRATEGY IMPLICATIONS

13.1. Any future IT proposals identified as a result of the JSNA will be cleared by the relevant IT Officer.

13.2 Implications verified/completed by: (name, title and telephone of IT Officer).

**LOCAL GOVERNMENT ACT 2000**
**LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT**

| No. | Description of Background Papers | Name/Ext of holder of file/copy | Department/ Location |
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| 1. | End of Life Care Key Themes Report http://www.jsna.info/endoflifecare | Colin Brodie, Public Health Knowledge Manager Tel: 02076414632 | Public Health |
| 2. | End of Life Care JSNA Supplement 1 – Technical Document http://www.jsna.info/endoflifecare | Colin Brodie, Public Health Knowledge Manager Tel: 02076414632 | Public Health |
| 3. | End of Life Care JSNA Supplement 2 – Policy and Evidence Review http://www.jsna.info/endoflifecare | Colin Brodie, Public Health Knowledge Manager Tel: 02076414632 | Public Health |