London Borough of Hammersmith & Fulham **POLICY & ACCOUNTABILITY COMMITTEE** **26 April 2017**	
END OF LIFE CARE	
Report of the Director of Public Health	
Open Report	
Classification - For Policy and Accountability Review and Comment **Key Decision: No**	
Wards Affected: All	
Accountable Director: Mike Robinson, Director of Public Health	
Report Author: Colin Brodie, Public Health Knowledge Manager Toby Hyde, Head of Strategy, H&F CCG Matthew Mead, Integrated Care Programme Manager, H&F CCG	**Contact Details:** 020 7641 4632 Email: 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. The JSNA was presented for discussion and approved by the Hammersmith and Fulham Health and Wellbeing Board on 21 March 2016.

1.2. The report also summarises the local direction of travel for End of Life Care in Hammersmith and Fulham, and continuing progress made against the JSNA recommendations since publication of the report.

2. RECOMMENDATIONS

2.1. The Policy and Accountability Committee are invited to consider and endorse the End of Life Care JSNA report and recommendations

2.2. The Policy and Accountability Committee are invited to note progress made against the recommendations.

3. END OF LIFE CARE JSNA

Background to the JSNA

3.1. People approaching the end of their life experience a range of physical symptoms, and emotional and spiritual needs. 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.

3.2. 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.

3.3. While some people experience good and excellent quality end of life care, many people do not. In order to address this variation and identify local issues for end of life care a request for a JSNA was submitted and approved by the JSNA Steering Group, a sub-group of the Health and Wellbeing Boards, July 2014.

3.4. The JSNA provides a comprehensive evidence base to inform local strategic and commissioning approaches to end of life care. It draws on a range of information and data, both quantitative and qualitative, including national and local data, policy and strategy, literature, as well as views of patients, service users and the public. It provides an opportunity to understand the whole landscape for people approaching end of life, and their carers' and to highlight areas of improvement to be addressed in joint strategic planning.

JSNA Findings and Recommendations

3.5. The overarching theme emerging from the JSNA is the need for a whole scale 'culture shift', for all practitioners that may come into contact with dying people to consider End of Life care as 'everyone's business', not just a service provided by specialist palliative care.

3.6. The recommendations were drawn from the evidence contained in the JSNA and in development with key stakeholders. Many of the recommendations cut across a number of different themes and service areas, and were presented in a format for commissioners to consider whether they are appropriate for local implementation.

3.7. 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.

3.8. The detailed recommendations are presented in the End of Life Care JSNA Key Themes document but are also summarised below.

Recommendation	Summary
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 dying, carers and for family and friends (if they wish)	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.
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.

4. END OF LIFE CARE IN HAMMERSMITH AND FULHAM/CURRENT WORK PROGRAMMES

4.1. **Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination**.

Hammersmith and Fulham utilise the Co-ordinate My Care (CMC) system along with the other 31 CCGs across London to record the care plan of those identified as being at the end of life. The CMC platform has been updated to facilitate the creation and updating of records and the Three Borough End of Life Care Steering Group regularly review the reports and discuss what additional support can be provided to increase the number of patients whose care information is shared on the system.

Central London Community Healthcare (CLCH) have convened six working groups, closely aligned to the recommendations of the JSNA with three groups looking at:

- High quality, relationship centred, compassionate care
- Advance care planning/risk stratification
- Assessment and care planning

The individual working groups report back on the progress of achievement against each of the outcomes, to the newly formed End of Life Care Operational Group.

Royal Trinity Hospice have sourced 3 years' funding from City Bridges Trust to recruit a Community Dementia Nurse to provide support to dementia patients approaching the end of life and their carers living in Hammersmith and Fulham and Kensington and Chelsea. The nurse was appointed in March 2017 and will address inequalities in end of life care for people with dementia through assessment, providing information and advice, advance care planning, and co-ordination of care.

4.2. **Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people**

Supporting people in the Last Phase of Life (LPOL) has been identified as a priority area in the North West London (NWL) Sustainability and Transformation Plan (STP) submitted in October 2016. The shift to consider people in the last phase of life rather than those at the end of life recognises the more gradual functional decline that characterises the progression of various long term conditions and increasing frailty. This reinforces the need to recognise when people are in the last phase of life and to have discussions at an early stage with them and their families regarding their preferences and what support is required. This will allow a shift from an existing hospital-based model of care, often through emergency services, to a new community and person-focused model of delivering care with input from specialists when needed.

The CCG are also working with the new provider of the Community Independence Service to consider how the service can work alongside local hospices, district and community nursing, primary care practitioners and specialist palliative care teams to provide support to those in the last phase of life.

Trinity have run events in 2016 and 2017 for Dying Matters week. Dying Matters is a coalition of 32,000 members across England and Wales which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life. For Dying Matters Week this year (8-14 May 2017), Trinity have organised a packed schedule of events to encourage people including week-long engagement activities hosted by the Hammersmith and Fulham Trinity charity shops, as in 2016, and other events held at the hospice will be widely promoted in Hammersmith and Fulham.

4.3. **Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector**

In the NWL area, a programme of work is being undertaken as part of the Sustainability and Transformation Plan (STP) to improve the quality of care for people who are in their 'last phase of life'. This includes patients in Hammersmith and Fulham.

Providers working across Hammersmith and Fulham have end of life care strategies with key leaders within the organisations identified and governance mechanisms in place for monitoring progress.

Imperial College Healthcare NHS Trust (ICHT) and Chelsea & Westminster NHS Foundation Trust both have organisational end of life care strategy documents. The CLCH End of Life Care Strategy (2015-2018) was launched in March 2015 and sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

The strategy covers generalist and specialist palliative care, including care given in all settings of CLCH (at home, all community based services, in-patient, specialist in-patient palliative care services, day Hospice, specialist community palliative care services, prison health, nursing and residential care).

The Health and Wellbeing Board approved the End of Life Care JSNA at their meeting on 21 March 2016 and agreed to take on a leadership role for End of Life Care, providing a steer for local implementation.

4.4. **Recommendation 4: A coordinated education and training program for practitioners, the person dying, carers and for family/friends (if they wish)**

The NWL LPOL programme has identified consistent training and education across the NWL Collaboration of CCGs as one of the six key interventions and discussions have been initiated with HEE NWL to agree a funding mechanism.

The CLCH EOLC Strategy includes a working group dedicated to training and education which categorises staff groups and supports the delivery of appropriate training in relation to the end of life care components of their jobs.

ICHT and CLCH have delivered end of life care training to staff including difficult conversations training.

Trinity's Community Dementia Nurse will support other professionals to improve the quality of end of life care for dementia patients more widely, through joint assessments, training, and providing specialist advice over the phone and at multi-disciplinary meetings.

4.5. **Recommendation 5: Everyone should have easy access to evidence and information**

One of the interventions which has been recommended and prioritised by the North West London Last Phase of Life programme is to deliver a **telemedicine clinical support facility**, to help staff in care homes (initially) to be able to access generalist healthcare and end of life care advice and support. The next phase of the programme will then be to focus on the wider cohort of residents, including those people being cared for by district nursing, intermediate care services, and by formal and informal carers.

The service will be staffed by experienced clinical professionals who are capable of providing rapid triage and advice / guidance to both clinical and non-clinical staff. Best practice from elsewhere has shown that this model allows professionals and carers to better facilitate the wishes of patients at the end of their life, and support them to die in their preferred place, and can also reduce inappropriate A&E attendance and hospital admissions.

5. CONSULTATION

5.1. 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).

5.2. 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.

5.3. 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.

5.4. 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.

6. EQUALITY IMPLICATIONS

6.1. 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.

6.2. 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.

6.3. 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).

7. LEGAL IMPLICATIONS

7.1. 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).

7.2. 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.

7.3. 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.

7.4. 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.

7.5. Implications verified by: Kevin Beale, Principal Social Care Lawyer, 020 8753 2740.

8. FINANCIAL IMPLICATIONS

8.1. 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.

8.2. Implications verified/completed by: (Name, title and telephone of Finance Officer).

9. IMPLICATIONS FOR BUSINESS

9.1. None identified.

10. OTHER IMPLICATION PARAGRAPHS

10.1. None identified.

11. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

12. LIST OF APPENDICES:

Appendix 1: CLCH End of Life Care Operational Update August 2016