

<p>Yorkshire and the Humber Strategic Health Authority</p> <p>BOARD MEETING</p>	
<p>Date: 6 July 2010</p>	<p>Report Author: Catherine Wardle</p>
<p>Title of paper: Delivering Healthy Ambitions: Update on End of Life Pathway and SHA Work Programme for 2010/11</p>	
<p>Actions Requested:</p> <ul style="list-style-type: none"> Note and comment on progress in delivery of the end of life care pathway. 	
<p>Governance Requirements</p>	
<p>SHA Objectives supported by this paper: Objective 2: Healthy Ambitions</p>	
<p>Risk Management: 2.1 Scale of the challenge and opportunity</p>	
<p>Board Assurances:</p> <ul style="list-style-type: none"> The EoLC Pathway Leadership Board has an agreed workplan with ambitious targets which is monitored on and reassessed on a quarterly basis. 	
<p>Risk Assessment:</p> <ul style="list-style-type: none"> The content of this paper has been subject to a risk assessment. Actions required to mitigate the identified risks are being pursued either through the corporate or operational risk registers as appropriate. 	
<p>Communication (including public and patient involvement): Minutes and workplans are shared through the three end of life sub regional groups and updates to the Healthy Ambition workplans are shared with local NHS and partner organisations.</p>	
<p>Resource Implications Funded through SHA budgets and through the Healthy Ambitions Investment Fund created by PCTs and managed by the SHA.</p>	
<p>Legal Implications: Not Applicable</p>	

Equality and Diversity:

One of the key objectives underpinning all programmes set out in Healthy Ambitions is to tackle unjustifiable variations in care, so that no particular population is disadvantaged. This helps to address the overarching equality and diversity agenda.

NHS Constitution:

This paper meets the principles of the NHS Constitution.

Yorkshire and the Humber Strategic Health Authority

6 July 2010

Delivering Healthy Ambitions: End of Life Pathway

Introduction

1. This paper updates the board on the work of the end of life pathway as part of the overall Healthy Ambitions programme.
2. It sets out:
 - The case for change for end of life care
 - The key features of the Healthy Ambitions end of life care programme
 - Progress to date on key issues

Background

3. Approximately 50,000 people die each year in Yorkshire and the Humber. Many of these people (their carers and families) will need significant support during their last year of life. However the quality of care they can expect is variable across the region.
4. There is still a lack of public awareness about the end of life issues, death and dying are not discussed and health services tend to focus on treatment and cure. This leads to difficulties with health professionals discussing death and dying with individuals, families and carers. Therefore advance care planning for end of life care is not consistently undertaken so that patients preferred place of care and care choices are not always adequately recorded to inform last days of care life. Patient's preferences for place of care are not well met. When Healthy Ambitions was published a majority of patients (60%) indicated that they would wish to die at home and regional data told us that only 19% of patients currently have this wish met.

Case for Change

5. There were 12 key issues identified by the End of Life Pathway Leadership Board that needed to be addressed these were:
 - Lack of public and professional awareness and discussion about dying and death across society as a whole
 - Low priority given to end of life care within the NHS and social care by both commissioners and providers

- Lack of recognition in identifying people who may be approaching the end of life and initiating discussions about people's preferences for end of life care
- Inadequate assessment and review of people's needs and preferences
- Poor coordination of care across the sectors, which leads to delays in setting up packages of care to meet people's needs
- Sub optimal delivery of care in hospitals, care homes and the community
- Poor care in the last days of life
- Problems with the verification and certification of death, viewing the body at the mortuary and with return of the person's property to their family
- Inadequate support for carers
- Inadequate education, training and support
- The lack of robust measures to assess the quality and effectiveness of care
- Inequalities in access to and provision of end of life care within a diverse population

Programme of Change

6. The detailed recommendations are set out in Healthy Ambitions. Key areas of focus are:
- Ensuring that every part of the system makes use of good practice protocols and tools, such as the Gold Standards Framework, the Liverpool Care Pathway and Preferred Priorities for Care
 - Ensuring the correct commissioning of end of life training is implemented across the region
 - Addressing the stigma amongst society at large and amongst the majority of health and social care professionals to help facilitate the difficult conversations about death and dying leading to improvements in planning for a good death

Local Delivery

7. A considerable amount of work is being taken forward at a local level and has been set out in PCTs' strategic plans (appendix A), which the SHA assured through both the Clinical Reference Panel and as part of the world class commissioning assurance process. All fourteen PCTs have initiatives in place to improve end of life care.
8. Once implemented the end of life care pathway should lead to:
- Patients and families to have more involvement in decisions regarding end of life care
 - A better service and experience for patients and carers
 - Wider implementation of integrated care pathways with minimum standards
 - Improved education, training and support
 - Improved coordination of care
 - Improved advanced care planning
 - Improved bereavement care

Healthy Ambitions metrics to be reported to the board as part of integrated performance reporting will show the levels of progress being made.

Regional Delivery

9. The main focus for improved end of life care is at local PCT level, (appendix A), six of our PCTs have included end of life as one of their WCC outcomes. As the board will know, the majority of recommendations in Healthy Ambitions are for local implementation. Compared to some pathways, there is relatively little work to be taken forward at a regional level.
10. However, the End of Life Care Pathway Leadership Board has developed a wide ranging workplan (appendix B) to deliver on a number of areas on a 'do once and share' basis. The Pathway Leadership Board has developed a set of regional quality measures, based on the National End of Life Care Markers, for use by commissioners, providers and the SHA to set the standard of provision of end of life care (appendix C). The End of Life Pathway Leadership Board is currently developing an electronic audit processes so that effective monitoring of the regional quality measures can be undertaken at local level.
11. A social marketing project on end of life care has been undertaken to look at the issues surrounding difficulties in discussing end of life, the initial phase has been completed. Phase two is now underway with ongoing support being provided from the End of Life Care Pathway Leadership Board to look at market analysis, information review and development of recommendations.
12. The End of Life Pathway Leadership Board is undertaking a project to look at cost effective and sustainable end of life training with a particular focus on staff working within residential and care homes. The focus on this project is to improve the quality of care and to subsequently reduce the need of admission to secondary care allowing patients to die in their preferred choice. A project plan has been developed and phase 1 is currently being implemented (Appendix D).
13. The End of Life Pathway Leadership Board is also developing a Yorkshire and the Humber e-learning strategy to ensure that the national end of life care e-learning program is available to health and social care staff regardless of their current access to the National Learning Management System.
14. Within the overall End of Life Pathway Leadership Board workplan there are a number of additional areas where work is being progressed at regional level. These include:
 - The implementation of a Yorkshire and Humber DNACPR (do not attempt cardio-pulmonary resuscitation) form and guidance which will ensure patients' wishes at the end of their life can be met in a systematic way across the region.

- Collaborative working with the Long Term Conditions, Mental Health and Learning Disability Pathway Leadership Board to provide recommendations for coordination of care
- The development of service recommendations for bereavement services including a quality measure across the SHA.

Metrics

15. There is a lack of comparable data that highlights the quality of end of life both nationally and regionally. The initial metrics collated for end of life care gave only very basic details, therefore the End of Life Care Pathway Leadership Board have developed three further metrics to provide some benchmarking data for the delivery of good quality end of life care. The five metrics for end of life care are:

- Percentage of patients who die at home or in a care home
- Percentage of all hospital wards where patients may be expected to die in which the LCP (or equivalent) has been introduced
- Percentage of GP practices using the Gold Standards Framework
- Percentage of patients who die having been on an end of life care register
- Access to nurses, medication and equipment:
Is access to district nursing available on a 24/7 basis
is access to end of life care drugs* available on a 24/7 basis in all settings
is access to equipment available within 48hrs of it being requested in all community setting

Risks

16. The key risks identified in taking forward the end of life care pathway have been identified as follows:

- The financial downturn – however this may also present an opportunity to drive higher quality and more efficient pathways and practice.
- Clinical engagement – senior clinical leaders will need to be supported to make an impact on driving forward the recommendations with colleagues across Yorkshire and the Humber
- Establishing and embedding robust metrics and an approach to performance management which is accepted and effective across the region
- NPfIT – speed of roll out of integrated IT solutions

These are all issues which both individual work programmes and the work overall of the SHA seek to address.

Governance

17. Delivery is overseen by the End of Life Care Pathway Leadership Board as per the arrangements outlined in Delivering Healthy Ambitions. This Board reports into the Yorkshire and Humber Chief Executives Forum as well as to the SHA.
18. The chair of the End of Life Care Pathway Leadership Board is jointly held by the clinical leads June Toovey, Nurse Director – Yorkshire Cancer Network and Dr Fiona Hicks, Consultant in Palliative Medicine at The Leeds Teaching Hospitals NHS Trust. The Pathway Leadership Board is also supported by Alan Wittrick, Chief Executive, NHS Wakefield, who acts as sponsor for end of life care developments within the wider chief executive forum and assists the clinical leads.

Summary

19. The End of Life Pathway Leadership Board has completed several pieces of work to support improvements in local systems and have shared these with the national end of life care programme. These include:
- Completion of a set of common quality measures for use across the region
 - Development of electronic audit processes so that effective monitoring of these measures can be undertaken
 - Completion of phase 1 of the social marketing project to understand how we can tackle the stigma around discussing end of life care
 - Development of a project for residential and care home staff to improve quality in end of life care and reduce admissions to secondary care
 - Completion of a locally agreed DNA CPR form with implementation due to start from September 2010

Taken together, these initiatives will lead to an improved quality of patient experience, reduce unnecessary admissions to secondary care and contribute to the overall cost savings in delivering end of life care.

Decisions required

20. The Board is asked to:
- Note and comment on progress in delivery of the end of life care pathway

Professor Sue Proctor
Director Patient Care & Partnerships
6 July 2010

Strategic Plan Analysis of End of Life Initiatives

PCT	Initiative Covered in Strategic Plan Yes/No	Page Number (s)
NHS Barnsley	Yes. Examples include: <ul style="list-style-type: none"> • Improved choices and more say about end of life care and specifically having the choice and support to die at home 	17
NHS Bradford & Airedale	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Education programmes to implement Liverpool Care Pathway and Advanced Care Planning • Electronic register for pathway and baseline data • Primary and secondary clinically groups – case finding within each specialty • Transition pathway for children to adult services • Primary care led health and social redesign group • Care coordinator role – specialist/generalist • Review of local priorities for EOL care • Review of service specifications and contract management (care homes and domiciliary care) • Establish a health and social care education development group – analysis and monitoring – all groups 	16 & 80
NHS Calderdale	Yes. Examples include: <ul style="list-style-type: none"> • End of Life Programme (particularly for those caring for a dying relative at home) 	90
NHS Doncaster	Yes. Examples include: <ul style="list-style-type: none"> • The promotion of public awareness with regard to issues around death, dying and end of life care. • Undertake a needs assessment to better understand the needs of patients throughout the end of life care pathway. • Develop a Commissioning Plan for End of Life Care covering all terminal diagnoses. • Work with providers to ensure the needs and 	74

	<p>preferences of those approaching end of life are assessed and documented using the nationally recognised tools, such as the Liverpool Care Pathway, Preferred Priorities of Care or the Gold Standards Framework.</p> <ul style="list-style-type: none"> • Work with providers to ensure appropriate information is available on individuals who are approaching the end of life including the care plan, preferred place of care and any Do Not Attempt to Resuscitate status where appropriate. • Work with providers to ensure appropriate information is shared between relevant services such as out of hours, the Emergency Department and ambulance services. • Work with providers to ensure that specialist advice and essential equipment are always available when required. • Develop a directory of local end of life services. • Review and update provider specifications to ensure they meet modern best practice standards. 	
NHS East Riding of Yorkshire	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Promotion of personalised care plans is encompassed in case management initiative (LTCs) • Promotion of the Gold Standard Framework • Promotion of Preferred Priority of Care • Enhancement of Marie Curie Evening Service • Integrated palliative care services • Promotion of Integrated Care Pathways 	87 & 160
NHS Hull	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • A wider cancer strategy has been developed which will cover prevention, detection and early diagnosis, treatment and end of life care. • Understand and commission appropriate rapid response services to meet the demand of people who wish to be discharged home to die day or night • Early Diagnosis at End Of Life • Advanced Care Planning • Family / Carer Support • Provider Resource 	33, 147, 149 - 154
NHS Kirklees	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • The number and percentage of patients who are 	41, 86

	<p>expected to die who have a preferred place of death recorded within an Advanced Care Plan, and the number and percentage of patients who have an Advanced Care Plan with preferred place of death and evidence to demonstrate that they died in their place of choice</p> <ul style="list-style-type: none"> • Monitor, review and link with Community End of Life Services to be developed through the recruitment of a facilitator to reduce hospital admissions and improve EOL care in the home 	
NHS Leeds	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Change attitudes to death • Developing care homes • Hospice Development 	95
NHS North Lincolnshire	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • The Transforming Community Services Commissioning Strategy developed in 2009 identifies end of life services as a priority for review and transformation. As a result end of life services are agreed to be a priority for review and the review is targeted to be complete by the end of 2009/10. • The Board have also supported adding an end of life indicator to the health outcomes for year 2 of World Class Commissioning and the Strategic Plan refresh. The strategy is about delivering appropriate care to people at end of life, supporting a reduction in hospital attendances and deaths in hospital. • We will use the 'proportion of deaths that occur at home' indicator as a proxy for delivery of our strategy, although we are seeking to support patients at the end of their life to die in the place of their choice which for many will be their home, care home or hospice. 	86 - 89
NHS North East Lincolnshire	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Increase the number of people by 3% that feel they are treated with Dignity and Respect 	16
NHS North Yorkshire & York	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Integrated Community Care <ul style="list-style-type: none"> ○ Patient Focused Care & Effective Rehabilitation 	58

	<p>○ The Role of Community Hospitals</p> <p>Providing support for carers</p> <ul style="list-style-type: none"> • To implement the North Yorkshire and the York joint carers strategies in partnership with NYCC and CYC • Early Detection • Better Treatment 	
NHS Rotherham	<p>Yes.</p> <p>Examples include:</p> <p>Improving services and choice for end of life care</p> <ul style="list-style-type: none"> • Implementation of Gold Standard Framework in care homes and GP practices, increased bed capacity at Rotherham hospice. • More people will be able to die in the place of their choosing, which will mean more dying at home and at a hospice, and fewer in hospital • More community palliative care will be available, giving more people the opportunity to be cared for and to die at home • Rotherham’s hospice will have been expanded to provide more beds • Appropriate support will be available for carers 	11 & 33
NHS Sheffield	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Deliver a world class approach to commissioning stroke services across the whole pathway, from prevention and awareness, through to end of life care • Improved end of life care, implementing the Gold Standard pathway and alternative support service in the community 	70 & 77
NHS Wakefield	<p>Yes.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Strategic Review of Palliative and End of Life Care Provision • Palliative Care and End of Life Education Project • Bereavement Services Project 	116

Yorkshire and the Humber End of Life Care Pathway Leadership Board

Work Programme and Progress Reports 2009-2012

Date – 31/03/10

Introduction

The purpose of this report is to describe a 3 year work programme for the Yorkshire and the Humber EoLC Pathway Leadership Board in 2009/ 2012. There will be an annual review of progress against the Work Programme and an annual report prepared for the Yorkshire and the Humber Strategic Commissioning Board.

Function

The function of the EoLC Pathway Leadership Board is to co-ordinate and lead the development of the EoLC Pathway across Yorkshire and the Humber following the publications of the Healthy Ambitions document and the national strategy.

Membership

The Board is made up of SHA clinical leaders for EoLC, PCT Chief Exec sponsor, SHA Non-executive board member, SHA Manager, the chairs from the Sub-regional EoLC groups: Yorkshire Cancer Network, Humber and Yorkshire Coast Cancer Network, North Trent Cancer Network and social care representative, SHA and YHPO Data Analysts, Sub Regional EoLC Programme Managers, SHA Education Commissioner.

Frequency of meetings

The EoLC Pathway Leadership Board meet four times a year.

Chair

The Board is co chaired by the SHA Clinical leaders for EoLC

Aim/objective	Ref	Task(s)	Outcome	Progress to Date – 31/03/10	Responsible person	Timescale
1. Terms of Reference and Work Programme	1.1	To agree the role, function of the Board and amend the Terms of Reference and Membership accordingly.	The work programme to be reviewed annually.	TOR Agreed March 2009	June Toovey Fiona Hicks	May 2010 Review annually
	1.2	To ensure that the EoLC Pathway Leadership Board Work Programme is developed to deliver the SHA Healthy Ambitions EoLC pathway and the National EoLC Strategy	The work programme to be reviewed annually.	Work Programme agreed March 2009 Reviewed and updated in line with QIPP in March 2010. To be agreed May 2010	June Toovey Fiona Hicks	May 2010 Review annually
2. Service Planning To coordinate and monitor the work to be taken forward across the SHA	2.1	Develop Quality Measures for EoLC for use across the SHA utilizing and adapting the National Quality Markers	Measures available and agreed by the SHA	Agreed March 2010	Fiona Hicks	Completed March 2010
	2.2	From the Quality Measures support the SHA monitoring of EoLC through the development of <ul style="list-style-type: none"> EoLC Quality Metrics EoLC CQINN for 2010/11 	Metrics developed CQUIN Developed	CQUIN in development for Acute, primary and ambulance. To be agreed end of March Metrics of 5 items submitted to SHA	Fiona Hicks	April 2010 Completed Dec 2009
	2.3	Support the development of data collection and IT systems that enable data for EoLC to be collected as part of service delivery <ul style="list-style-type: none"> Link to the national Intelligence network for EoLC, the SHA quality observatory SHA connecting for health work streams Support the DH funded EoLC Register project in Leeds 	IT systems developed that enable the collection of data required to monitor the agreed quality Metrics	Public health observatory reporting quarterly to EoLC PLB. Some data not yet available. National intelligence network being launched on 18/05/10 Fiona Hicks attends connecting for health and System1 user group for palliative and EoLC. A template is being developed to flag EoLC for patients with Long Term Conditions	Fiona Hicks	Completed March 2010 Review time scale following launch Summer 2011 Spring 2011
	2.4	To design DNA CPR form for use across the SHA including sharing of information with OOHs and ambulance services <ul style="list-style-type: none"> Form designed Form implemented in three PCTs Roll out plan developed and agreed 	Form designed piloted with a roll out plan agreed	DNA CPR Form completed Agreement with 3 PCTs to act as early implementers of the form due to start summer 2010 Regional Innovation funding agreed for project management support	Charlotte Rock	May 2010 Sept 2010

Aim/objective	Ref	Task(s)	Outcome	Progress to Date – 31/03/10	Responsible person	Timescale
	2.5	Work in collaboration with other PLB (LTC, Mental health for dementia, Primary care and learning disabilities) to provide recommendations for coordination of care	Recommendations available	Initial meetings taken place with LTC and Mental Health and Primary care Leadership Board Chairs	June Toovey Fiona Hicks, Cath Wardle	Spring 2011
	2.6	To develop service recommendations for bereavement services across the SHA and a quality measure to monitor bereavement services	Recommendations and quality measure available	Programme manager appointed in Yorkshire sub regional area. Agreed for the project to be led by this post holder	Penny Kirk	December 2010
	2.7	To develop recommendations for ambulance transport for patients in the last few days of life	Recommendations available	Draft recommendations circulated to sub regional groups for comment Attending ambulance clinical review group to discuss quality improvements possible	Fiona Hicks	September 2010
	2.8	Develop an audit to support the monitoring of the quality of EoLC (this is anticipated to be case note audit of patients who have died)	Audit developed and disseminated	Programme manager appointed in Humber and Yorkshire coast sub regional area. Agreed for the project to be led by this post holder	Laura Wigley	December 2010
	2.9	Work with the SHA Renal network to develop a pathway for delivering palliative renal for patients with end stage renal failure who choose not to dialyse.	Pathway developed and recommendations made	Initial meetings with renal network medical director Data available Support for the work gained from national director for kidney disease	Fiona Hicks	Spring 2011
3. Supporting networking and influencing	3.1	Support the development of innovation in the delivery of EoLC services by <ul style="list-style-type: none"> Publishing regional innovation fund opportunities Reviewing RIF bids for EoLC 	High quality innovation bids submitted	Disseminated information about the process Reviewed bids submitted One bid successful in the first round Bids reviewed for the second round	Fiona Hicks June Toovey	Completed Feb 2010 Further rounds to be announced
	3.2	Support the sharing of good practice across the SHA	Annual Sharing Good Practice event/ conference EoLC Good practice data base developed	Events held in January 2009 and 2010 180 delegates present Launch of the national E Learning for health programmed for EoLC Data base developed to be populated with good practice gathered at the January 2010 event	Cath Wardle June Toovey	Completed Jan 2009 and Jan 2010 repeat annually Summer 2010
	3.3	To make and maintain links with the DH and other EoLC groups to share good practice and inform the work of the group	Links made and sustained	National EoLC meetings with SHA EoLC leads and national EoLC team three times a year	Fiona Hicks June Toovey	Completed March 2009

Aim/objective	Ref	Task(s)	Outcome	Progress to Date – 31/03/10	Responsible person	Timescale
4. Workforce development and education	4.1	To develop a cost-effective model for education and training around EoLC in care homes <ul style="list-style-type: none"> • Proposal developed and agreed • Project plan completed with model tested and recommendations 	Model produced, tested and recommendations made	Education subgroup formed Project proposal agreed by the SHA Education and Training Commissioner	Cath Wardle June Toovey	Completed January 2010 Dec 2011
	4.2	To develop a Yorkshire and the Humber e-learning Strategy	To provide health and social care providers with access to e-learning specific to EoLC	Initial meeting planned for 22 June 2010	Cath Wardle	Sept 2010
5. Research and development	5.1	Monitor the Social marketing work being undertaken in EoLC by the PCT Collaborative. Included in the project are the following aspects <ul style="list-style-type: none"> • Market analysis • Secondary research • Undertaking social marketing research • Report and recommendations 	Recommendations about the EoLC services required to meet the populations needs	Social marketing proposal developed and agreed by the PCT collaborative and funding secured Project management agreed Project group formed Project proposal developed Market analysis work underway with 2 PCTs fully involved and 3 other shadowing the work Funding agreed for project support for financial analysis by Ernst Young secondary research being undertaken	June Toovey Stephanie Ryan Lois Bentley Scott Anderson	May 2010 May 2010 Autumn 2010
6. Annual Work Plan and Report	6.1	To produce an annual report.	Report disseminated to the SCB and sub regional groups		Catherine Wardle	June 2010

YORKSHIRE AND THE HUMBER STRATEGIC HEALTH AUTHORITY (Y&H SHA)

QUALITY MEASURES FOR END OF LIFE CARE (EOLC)

Introduction

The following Quality Measures have been developed for use across Y&H SHA to support the implementation of the EoLC pathway recommendations in Healthy Ambitions and the National End of Life Care (EoLC) Strategy.

The Quality Measures have been adapted from the National EoLC Quality Markers and have identified the measures that would be the most effective to deliver and monitor high quality, cost effective EoLC services (The Quality Measures have been linked to the National Quality Markers referenced by NM followed by the pertinent National Marker number).

The measures have been developed for use in adult services. Although many of the measures will be adaptable and applicable for children, teenage and young adults, further work is required for these groups.

This document sets out the Quality Measures in relation to outcomes with the evidence that can be used to assess levels of achievement. The systems and processes for performance monitoring and management are still to be developed

It is intended that these Quality Measures will be used developmentally to monitor and improve the quality of EoLC services in localities across the Y&H SHA

Additional work

A Quality Measure specific to bereavement care is planned to be developed in 2010/11

Produced by the End of Life Care Pathway Leadership Board - March 2010

Review date – March 2012

COMMISSIONERS

Strategic planning

Strategic Planning

1. Commissioners will have a service specification in place for the delivery of cost effective high quality EoLC services.

The service specification will be based on the needs assessment of the local population (NM 1.3) and their strategic plan, produced in partnership with the Local Authority and voluntary sector, for the delivery and development of EoLC services to meet the needs of their local population (NM 1.5, 1.6). The specification will cover all aspects of EoLC contained in the Healthy Ambitions EoLC pathway, all care settings (NM 1.8 - 1.31, top ten 7) and cover the following:

- 24 hour Nursing services
- Medical services
- Hospital services (Acute and community)
- General Practitioner services
- Out of Hours services
- Care homes – Nursing and Residential
- Voluntary Sector provision
- Prison services
- Personal care services
- Pharmacy services
- Equipment services
- Single point of contact for patients and carers (linked to the key worker)
- Specialist palliative care services (In patient and Teams)
- Workforce development staff competency

Evidenced by:

1a The service specification

1b The strategic plan (to include the organisations involved in the development)

Monitoring service provision

Monitoring service provision

2. Commissioners have effective monitoring systems in place (e.g. identified data to be collected and audits to be undertaken NM top ten 10) to assure them that services commissioned are provided in line with the service specification and that they have the essential services in place and effectively coordinated 24/7 to enable people to live and die in their place of choice (NM1.40, 1.41)

The information gained from the data and audits will be used to improve services and refine the service specification and Service Level Agreements

They will include the need for service user feedback as part of the information required from provider organisations

Evidenced by:

- 2a Service Level Agreements with provider organisations - specifying data to be collected and audits to be undertaken to demonstrate the delivery of care as agreed. (The data collection and audits required, as a minimum, will be in line with the quality measures set out in this document for provider services and include service user feedback)

PROVIDER ORGANISATIONS

Service delivery

<u>EoLC Register</u>	
3. Effective methods are in place to identify patients who are approaching the End of Life (NM top ten 2) and systems in place for entering them onto the local EoLC register (NM 2.5, 3.7). Localities will be working towards the implementation of a locality –wide EoLC register, using the information and learning from the national pilot projects (with due respect to data protection and appropriate sharing)	
Evidenced by:	
3a	Audit of the number of deaths from long term conditions, inc cancer (i.e. those that are predictable) against the number of deaths of patients on the EoLC register
3b	Audit the median and range of the time patients who have died have been on the EoLC register

Individual needs assessment and care planning

<u>Individual Needs Assessment and Care Planning</u>	
4. <i>Patients on the EoLC register have a comprehensive holistic assessment of their needs and a documented, personalised care plan to meet those needs. This will be based on the 5 domains outlined in the Holistic Common Assessment of Supportive and Palliative Care Needs for Adults requiring End of Life Care (2010). These are; background information and assessment preference, physical needs, social and occupational needs, psychological well-being, spiritual well-being. The assessment and care planning will be reviewed 3 monthly as a minimum. Patients will also be assessed for their information needs (NM top ten 3, 4)</i>	
The care plan will also need to include evidence that patients have been offered:	
<ul style="list-style-type: none">• A discussion of their preferences for EoLC (this may be using the Preferred Priorities of Care (PPC) tool), with the preferences recorded when expressed• A discussion about the opportunity to make a formal, witnessed Advance Care Plan, with evidence if this has been undertaken or not.• 24/7 Single point of contact, with a record of the contact details given to the patient	
The Liverpool Care Pathway (LCP) or equivalent is used to assist the assessment, care planning and delivery in the last days of life (NM top ten 9)	

Evidenced by:	
4a	Audit of the % number of patients on the EoLC register that have a care plan
4b	<p>Audit of the content of the patient records of 10% of patients, up to a maximum of 10, who have died on the EoLC register (from GP and Community Providers):</p> <ul style="list-style-type: none"> • Against the content required in the quality measure above, • Evidence of the information offered to patients and what was accepted • Evidence of the use of the LCP, or equivalent, in the last few days of life • Number of patients where a preference was expressed who died in their preferred place
4c	Acute Trusts to be involved in the two yearly National LCP Audit

Carers' needs

<u>Carers needs assessed and planned</u>	
5.	<p>Family and carers of patients on an EoLC register are offered an assessment (including bereavement needs) with a documented assessment and care plan for those accepting the assessment (NM top ten 5). This will include</p> <ul style="list-style-type: none"> • Information needs • Support needs – inc. social, financial, spiritual, practical and psychological • Bereavement needs
Evidenced by:	
5a	Audit of the % number of family and carers of patients on the EoLC register who have been offered an assessment and the % number of them who have had an assessment undertaken.
5 b	Audit of 5 carer assessment and care plans against the content required in the quality measure above including the information offered and what was accepted.

A Quality Measure specific to bereavement care is to be developed in 2010/11

Coordination of care

<u>Coordination of care</u>	
6. Providers will have mechanisms in place to ensure that care for individuals is coordinated across organisational boundaries 24/7 (NM top ten 6). This can be achieved by having	
<ul style="list-style-type: none">• The single point of contact for patients and carers (linked to the key worker role)• Information on individuals on the EoLC register, including; their preferences for care; Advance Care Plan (where present); and DNA CPR Status (where appropriate) shared proactively with other relevant services e.g. Out of Hours (OOHs) services, A&E and ambulance services (with due respect to data protection and appropriate sharing.)• All relevant care providers to have easy access to patients and carers (when available) care plans	
Evidenced by:	
6a	Audit of the % number of patients on the EoLC register who have OOHs forms or equivalent provided for the GP, A&E and ambulance services
6b	Audit of the OOHs forms or equivalent were updated within 4 weeks of death

SPECIALIST PALLIATIVE CARE

7. Specialist Palliative Care Multi Disciplinary Teams are properly constituted (as outlined in the Cancer Peer Review Measures and S&P Guidance) and available for all patients with complex needs, in all care settings, based on the local service specification	
Evidenced by:	
7a	Outcomes from the Peer Review internal and external validation process
7b	Audit of SPC teams referrals for % number of cancer and non cancer patients

WORKFORCE DEVELOPMENT, EDUCATION AND TRAINING

<p>8. Systems and processes are in place to ensure effective workforce development for EoLC with responsibilities shared across the system (NM top ten 8)</p> <p>The competencies for the EoLC workforce will be based on the National EoLC competencies identified – assessment symptom management, communication and advance care planning</p> <p>Y&H SHA – use intelligence from provider workforce development plans/training needs analyses to ensure appropriate accredited programmes are commissioned to meet the EoLC workforce needs (NM 1.32- 1.35)</p> <p>Commissioners - include workforce development in the service specification and Service Level Agreements, to ensure that the workforce is competent to meet the needs of their local population (quality marker 1)</p> <p>Providers – have a workforce plan for EoLC that works towards ensuring that all staff have the appropriate skills, knowledge and competency to deliver high quality EoLC services</p>
<p>Evidenced by:</p>
<p>8a SHA - EoLC education to meet the national EoLC competencies is included in pre registration programmes</p>
<p>8b A range of EoLC programmes and/or accredited courses are available that meet the national EoLC competencies covering all levels and available to all appropriate staff.</p>
<p>8c Providers – Workforce plan available with agreed milestones</p>
<p>8d Evidence of competencies for staff delivering EoLC are identified in line with those set out in the quality measure</p>
<p>8e Evidence of the use of the competencies as part of staff appraisals and professional development plans</p>
<p>8f Commissioners Workforce development is included in service specifications and Service Level Agreements</p>

Evidence Required to Support Compliance with the Quality Measures for Each Type of Organisation

Quality marker	Service Commissioners	PCT provider arm	GP practices	Care homes	Community hospitals	Hospices	Acute hospitals	SHA
1	x							
2	x							
3a			x					
3b			x					
4a		x	x					
4b		x	x					
4c							x	
5a		x						
5b		x						
6a			x					
6b			x					
7		If appropriate			If appropriate	x	x	
8a								x
8b								x
8c		x	x	x	x	x	x	
8d		x	x	x	x	x	x	
8e		x	x	x	x	x	x	
8f	x							

Note

When EoLC registers become available in acute hospitals and community hospitals, measures 3, 4 and 5 will apply to them.

REFERENCE DOCUMENTS

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World Class Commissioning. Department of Health

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Care Quality Commission Standards <http://www.cqc.org.uk/>

Core Competencies for End of Life Care. July 2009

http://www.endoflifecare.nhs.uk/eolc/files/NHS-EoLC_Core_competences-Guide-Jul2009.pdf

Holistic Common Assessment of Supportive and Palliative Care Needs for Adults requiring End of Life Care, National End of Life Care Programme 2010

<http://www.endoflifecare.nhs.uk/eolc/files/NHS-EoLC-HCA-Guide-Mar2010.pdf>

GLOSSARY

See End of Life Care Strategy – Quality Markers and measures for end of life care. Department of Health June 2009

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101681

ABBREVIATIONS

A&E	Accident and Emergency
CQC	Care Quality Commission
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
EoL	End of Life
EoLC	End of Life Care
LCP	Liverpool Care Pathway for the Dying
NM	National Marker
NHS	National Health Service
PCT	Primary Care Trust
PPC	Preferred Priorities of Care
Y&H SHA	Yorkshire and the Humber Strategic Health Authority

Appendix D

Providing Sustainable Education and Training on End of Life Care (EoLC) to Care Homes across the Yorkshire and the Humber Strategic Health Authority (Y&H SHA)

This proposal is put forward on behalf of the Y&H SHA EoLC Pathway delivery board

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The EoLC Pathway Delivery Board was established 2 years ago by the Y&H SHA following the Darzi NHS review and the publication of the Healthy Ambitions recommendations. The remit of the group is to undertake work that can be co-ordinated once and shared across the SHA.

The group has established working relationships with three sub-regional EoLC groups which in turn have established relationships with the PCT locality EoLC groups. The group also has established links with the EoLC Commissioners across the SHA and EoLC Education providers. An Education Steering group is being established to coordinate and manage the Education and Training work being undertaken on behalf of the EoLC Pathway Delivery Board.

Introduction to the Project

EoLC was an identified pathway group for the Darzi NHS Review, with recommendations for the Y&H SHA being made in the Healthy Ambitions Report. One of those recommendations was the delivery of sustainable EoLC education and training across the SHA. This requirement is also included in the National EoLC Strategy published in July 2008.

One of the potential quick wins for action within the Healthy Ambitions recommendations was to provide education, training and support to care homes with the aim of reducing inappropriate admissions to the acute sector in the last few days of life

As part of the delivery of the EoLC Strategy ring fenced Multi Professional Education and Training funding has been identified for each SHA with an agreement reached with the education and training commissioners that the Y&H SHA funding allocation would be agreed by the EoLC Pathway Delivery Board

During this year the EoLC Pathway Delivery Board has been establishing the recommendations for spending the EoLC education and training money. The aim is to establish sustainable EoLC education and training for EoLC that enables the delivery of high quality care and meets the SHA requirements against the QIPP and 'Better for Less' agendas

Education and training for care homes across the SHA is being delivered currently across the SHA using the national Gold Standards Framework (GSF) for care homes model, education for the implementation

of the Liverpool care pathway (LCP) and a variety of other locally developed models. An example of one of the local models is Care Home End of Life Supportive Services (CHESS) developed in Leeds as part of the Marie Curie Delivering Choice Project.

The main draw backs of using the GSF model is that the training is delivered by national facilitators and there is a cost of (£1300) for every care home involved. The material for the programme is copyrighted to the GSF team.

In contrast the local model materials are freely available to be shared, local facilitators can be trained in the model and there are no additional costs for the care homes involved.

The aim of this project is to evaluate the effectiveness of the GSF and other established locally developed models against care homes where the importance of EoLC has been raised with no formal education input and care homes with no input around EoLC. This will establish the need for EoLC education in care homes and identify the most cost effective and sustainable model for delivery if education and training is required.

A baseline for the longevity of effectiveness of education will be established using a baseline from care homes that have undergone either GSF or CHESS education and training 6 months to 1 year previously.

The outcomes to be measured are: -

- The number of acute admissions to secondary care in the last days of life (?how many)
- The number of care home residents who are on the locality EoLC register
- The number of care home residents that have a care plan that includes discussions about EoLC and plans for EoLC.
- Utilise the relevant CQC quality criteria to assess homes against
- Number of deaths in the care home where the LCP was used

Description of the project

The project will be undertaken in several phases as follows

Phase one (3 Months) – This phase will be an important phase and will be used to robustly scope and further develop the project plan including

- Current education and training being undertaken in care homes - number of homes where training has been undertaken across the SHA and type of training delivered
- the data that is currently available to support the project outcomes and identify the extra data required including published GSF evaluations
- Identify the number of care homes required to be involved in the project from different PCT areas across the SHA

- Identify the variation in acute admission that end in death from care homes to secondary care across the SHA and estimate potential cost savings if the care homes with high numbers reduced admissions to the level of the current least 20%
- Establish working relationships with the GSF team who deliver the education and training to care homes and other local teams delivering locally developed programmes.
- Establish links with other SHAs undertaking similar work to share learning and prevent duplication
- Establish the outcomes and evaluation for the project
- Establish the capacity required to deliver a sustainable model

30 days project management time

Phase two – (1 month) this phase of the project will

- Engage with the PCTs and care homes to identify the appropriate number required to be involved from each area. The identification of homes with a mixture of needs would be based on those with the most number of acute admissions to secondary care in the last few days of life.
- For the PCTs delivering locally developed models to identify staff to undertake the education and training for care homes
- Collect the base line data from care homes involved in the project

5 days project management time

Phase 3 – (12 Months) this phase of the project will

- Deliver the input to the care homes, education, raise awareness of the importance of EoLC

Cost average of £40,000 per PCT = £560,000

120 – 180 days project management time

Phase 4 – (3 months) this phase of the project will

- collect the post education data
- evaluate and analyse the results
- Make recommendations for the most cost effective education and training method of delivery sustained high quality care in care homes.
- Make recommendations on embedding the education and training within PCT and LA budgets including potential cost savings

30 – 60 days project management time

The Project is anticipated to last 18 months and will require project management throughout.

Funding

The remainder of the MPET EoLC Education and training funding for 2009/10 will be used to fund this project and is anticipated to cover all the cost associated with the project.

Consultation

The need for education and training in care homes has been identified during the consultation phase of the NHS Darzi review. Following this in consultation with the EoLC Pathway Delivery Board, EoLC Commissioners and EoLC education workshop members (Clinicians, commissioners and education providers)

Working with others

The project will require collaborative working across the SHA between PCTs, care homes, EoLC education providers, Hospices and Local Authorities, patients and the public.

The project will be managed by a project lead and part of the role will be ensuring the identified stakeholders and involved in the delivery of the project

SHA Priorities

The project has been developed to deliver against the EoLC Healthy Ambitions recommendations for education and training and to support the delivery of the identified quick win of improving EoLC in care Homes

The project will support the delivery of better for less by identifying cost effective sustainable education and training for care homes with the aim to reduce the number of acute admissions to secondary care from care homes in the last few days of life. This links into the QIPP and 'better for less' priorities.

Evaluation

The project has a built in evaluation phase where the benefits will be identified and the project aims demonstrated as achieved

Timescale

It is anticipated as identified earlier that the project will take 18 months. See the earlier section for the breakdown in the timelines for the phases of the project.

Other sources of funding

No other sources of funding have been identified. It is anticipated that some PCTs will have professionals already engaged in work with care homes and they may be available to support the project at no extra cost.