**MUNICIPAL YEAR 2011/2012 REPORT NO. 214**

**MEETING TITLE AND DATE:**

Cabinet - 21 March 2012
Council – 28 March 2012

**REPORT OF:**
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| Agenda – Part: 1 | Item: 13 |
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| **Subject: Enfield Joint End of Life Care Strategy 2012 - 2016**<br><br>**Wards: ALL** | |
| **Cabinet Member consulted:**<br><br>**Councillor Don McGowan** | |

## 1. EXECUTIVE SUMMARY

1.1 This report recommends the approval of a 5 year commissioning strategy and costed implementation plan for End of Life Care jointly with NHS Enfield. The full strategy and supporting documents are available online and in the member's library.

1.2 The strategy sets out how Enfield will develop and deliver health and social care services to better meet the needs of people nearing the end of their life over the next 5 years (2012-16). It outlines 11 strategic objectives that were developed in partnership with local stakeholders; each of which is aligned with the National End of Life Care Strategy (2008)[1] and supported by a robust rationale.

1.3 The development of this strategy has been guided by the expert advice of the Enfield End of Life and Palliative Care Steering Group, which includes representation from Public Health, Primary Care, Acute Sector, Adult Social Care, London Ambulance Service, Community Services and the Voluntary and Community Sector.

1.4 Formal public consultation on this strategy was undertaken over a 3 month period ending 7 October 2011. Submissions were reviewed and considered and a number of changes to the strategy were made as a result. A summary document 'Delivering Choice: Enfield's Joint Commissioning Strategy for End of Life Care (2012 – 2016) - A Summary of Submissions received in response to Consultation' has been prepared and is available in the member's library. This document describes the consultation process, summarises the feedback received and sets out the Council and NHS Enfield response to the comments and suggestions that were submitted.

[1] End of Life Care Strategy: Promoting high quality care for all adults at the end of life. Department of Health. 2008.

1.5 A predictive equalities impact assessment has been undertaken and is available in the member's library.

1.6 The strategy was reviewed by Partnership Boards, the Health and Wellbeing Board, the Older Peoples and Vulnerable Adults Scrutiny Panel, and the PCT Professional Executive Committee. A number of helpful comments were received which influenced the final strategy.

1.7 Research suggests that two-thirds of people would prefer to die at home, while in reality only about one-third of individuals actually do[2]. The National End of Life Care Intelligence Network shows that from 2008-2010 the majority of deaths in North Central London occurred in hospital, with Enfield the highest at 67% (Haringey 64%, Barnet 59%, Islington 56% and Camden 56%).

1.8 This strategy aims to ensure that we deliver better quality of care and greater choice in End of Life Care. The primary focus is on increasing the number of people who are able to exercise a positive choice about their place of death. If people are properly supported to exercise choice, evidence suggests that significantly more people will choose to die outside of the hospital setting (home, care home, and hospice) and avoid unnecessary admissions and treatments. In order to achieve this, focussed efforts need to be made to increase identification of patients who are at the end of their life, increase the number of people who are given the opportunity to plan their care in advance, improve co-ordination of care, and further develop community based services.

1.9 This strategy has been developed in the context of an extremely challenging financial environment as well as major changes to the way health services are commissioned. Councils are being asked to reduce their budgets year on year, and NHS organisations are working hard to improve their financial positions and reduce their deficits. PCTs are being abolished and Clinical Commissioning Groups will have a new role in commissioning health services for their population. It will therefore be more important than ever that health and social care commissioners and providers work in partnership to implement this strategy and develop shared solutions to improving quality. Over the longer term, investment will need to shift from the acute sector to the community in order to reduce the number of people dying in hospital. This will be both a more efficient use of limited resources and an improvement in quality, choice and control for people at the end of their life.

1.10 Implementation of the strategy will require a total investment of £415,000: £5,000 in year 1 (2011/12), £155,000 in year 2 (2012/13), £155,000 in year 3 (2013/14) and £100,000 in year 4 (2014/15). As detailed in the attached implementation plan, funding for years 1 – 3 will be met by Enfield Council from the NHS Allocation for Social Care. There is an expectation that from year 4 funding for palliative community support services and ongoing quality improvement activities will be met by health from savings due to reductions in acute activity.

1.11 The strategy aims to reduce deaths in hospital from the current rate of 67% of all deaths to 50% of all deaths[3] by 2014/15. Local modelling suggests that achieving this target will reduce hospital non-elective admission costs by £319,383 in 2012/13, £406,129 in year 2013/14 and £642,709 in 2014/15 – a total of £1.37

[2] Higginson IJ (2003). *Priorities and Preferences for End Of Life Care in England, Scotland and Wales*. London: National Council for Hospice and Specialist Palliative Care.
[3] Commissioning Support for London recommended target

million over 3 years. Taking in to account the investment required to achieve this targets, a net saving to the NHS of £968,221 by 2014/15 is projected.

## 2. RECOMMENDATIONS

2.1 Cabinet is asked to:

i) Approve the Enfield Joint End of Life Care Strategy (2012-16).
ii) Approve the Enfield Joint End of Life Care Strategy (2012-16) implementation plan.

## 3. BACKGROUND

The Joint End of Life Care Strategy (2012 – 2016) has been developed as a local response to the National End of Life Care Strategy (Department of Health, 2008). The strategy addresses a number of shared priorities that are identified in Enfield's Joint Strategic Needs Assessment, including long term conditions and improved access to health and wellbeing information. It also links to a number of other strategies including the Health and Wellbeing Strategy, Local Area Agreement, and other agreed joint commissioning strategies for Dementia and Stroke services.

The strategy aims to ensure that we deliver better quality of care and greater choice in End of Life Care. The primary focus is on increasing the number of people who are able to exercise a positive choice about their place of death. If people are properly supported to exercise choice, evidence suggests that significantly more people will choose to die outside of the hospital setting (home, care home, and hospice) and avoid unnecessary admissions and treatments. In order to achieve this, focussed efforts need to be made to increase identification of patients who are at the end of their life, increase the number of people who are given the opportunity to plan their care in advance, improve co-ordination of care, and further develop community based services.

### 3.1 Consultation

Formal public consultation on the draft End of Life Care Strategy was undertaken over a 3 month period to 7 October 2011.

A summary of submissions received in response to the consultation is available online and in the member's library. This document describes the consultation process, summarises the submissions, and sets out the Council and NHS Enfield response to the comments and suggestions that were received.

The strategy was also reviewed by Partnership Boards, the Health and Wellbeing Board, the Older Peoples and Vulnerable Adults Scrutiny Panel, and the PCT Professional Executive Committee. A number of helpful comments were received which influenced the final strategy.

### 3.2 Funding

Specialist End of Life Care Services are funded by the NHS. Social Care plays an important role in supporting individuals approaching the end of their life and can help ensure their wider needs – including practical day-to-day requirements – are understood and addressed.

An implementation plan detailing resources required to implement this strategy has been developed and is attached. The majority of the commissioning intentions set out in the strategy can be implemented with out additional resources through better use of existing resources and through improving quality, co-ordination, information and access. The need for funding to be invested in years 1-4 of the strategy has been identified in order to:

- Commission a Palliative Care Community Support Service
- Resource an awareness raising campaign to compliment and reinforce national awareness raising activities
- Ensure capacity to co-ordinate the development of End of Life Care Services and support providers to attain the Gold Standard Framework.

It is anticipated that full implementation of the strategy will result in net savings to the NHS of £968,221 due to a reduction in non-elective admissions as summarised in table 1 below.

**Table 1: Projected Net Savings to NHS Enfield**

| | 2011/12 (baseline) | 2012/13 | 2013/14 | 2014/15 | Total |
|---|---|---|---|---|---|
| Percentage of deaths occurring in hospital | 67% | 63% | 58% | 50% | - |
| Hospital Deaths | 1372 | 1291 | 1188 | 1025 | 4876 |
| Admissions prevented | 0 | 81 | 103 | 163 | 347 |
| Gross savings | £0 | £319,383 | £406,129 | £642,709 | £1,368,221 |
| Investment (GSF) | £0 | £50,000 | £50,000 | £0 | £100,000 |
| Investment (PCSS) | £0 | £100,000 | £100,000 | £100,000 | £300,000 |
| Investment (awareness campaign) | £5,000 | £5,000 | £5,000 | £0 | £15,000 |
| Net savings | £5,000 | £169,383 | £256,129 | £542,709 | £968,221 |

### 3.3 Enfield Joint End of Life Care Strategy (2012-16).

**Our Vision**

**We will improve access to care that meets agreed national standards for all adults approaching the end of their life.**

**We will commission services that provide people with genuine choice about where they are cared for and where they die.**

## Our Commitment

Enfield Council and NHS Enfield are committed to achieving the following for the people of Enfield:

- All people approaching the end of their life will receive high quality care, treatment and support to meet their assessed needs.
- All people approaching the end of life will have the opportunity to make informed decisions about their care and treatment, in partnership with health and social care professionals and with their families and carers.
- Patients and their families will receive support appropriate to their needs to enable them, wherever possible, to die where they wish.
- Care and support will be provided in a way that preserves people's dignity and control.
- People will not suffer from unnecessary pain and suffering.
- Carers and families (including children) of people approaching the end of life will have their own needs assessed and regularly reviewed, and will be offered support appropriate to their needs and preferences.

We will develop an integrated performance management framework across health and social care that enables us to assess how well we are achieving these commitments. This will include strengthening feedback from patients and carers and working with local Dignity Champions to create user-defined measures through which we can define and monitor dignity locally.

**Targets**

Achievement of the following targets will be a key indicator of success:

- By 2015/16 90% of people who have died from advanced, progressive, incurable illness will have been enabled to exercise a positive choice about their place of death.
- By 2015/16 the number of deaths that occur in hospital will be reduced from 67% to 50% of all deaths.
- By 2015/16 90% of Care Homes will have attained Gold Standards Framework accreditation.
- By 2015/16 90% of GP practices will have attained Gold Standards Framework accreditation.
- By 2014 all GP practices will have a complete register available of all patients in need of palliative care/support.
- By 2015/16 90% of people who have been receiving End of Life Care die with the Liverpool Care pathway (or equivalent in place).
- All health and social care staff will receive appropriate training in End of Life Care.

**Strategic Objectives**

## 1. ENCOURAGE PEOPLE TO DISCUSS DEATH AND DYING

***Without communication and understanding, death and terminal illness can be a lonely and stressful experience, both for the person who is dying and for their friends and family. Encouraging people to talk to their family and friends about dying will make it more likely that people will plan for their deaths and die as they wish to.***

Engage with local communities to develop an awareness campaign that aims to break down taboos and encourage people to talk about their wishes towards the end of their lives, including where they want to die and their funeral plans with friends, family and loved ones.

Awareness activities will initially target Enfield Lock and Upper Edmonton, two areas with above average death rates and high levels of deprivation. We will seek advice from community leaders and organisations on the best approaches to raising awareness within their communities.

Engage with potential users of end of life care services who belong to vulnerable, marginalised or socially excluded communities to raise awareness of end of life care services.

## 2. IDENTIFY ALL PEOPLE NEARING THE END OF THEIR LIFE

***Identification of people who are nearing the end of their life is the first step towards ensuring that people's needs and wishes are met. Sharing this information across the various organisations involved in peoples care is crucial for ensuring high quality palliative and end of life care services.***

Identify all patients with end of life care needs through work with primary care on the effective use of GP Palliative care registers to enable proactive service planning and management of patients nearing end of life.

Work with primary care to ensure all GP practices hold regular multidisciplinary case review meetings where all patients on the palliative care register are discussed.

Ensure all GP Practices inform Barndoc, (Enfield's out of hours GP provider) and the ambulance service of any patients who are Palliative care patients or who have any other special health/social needs out of hours.

Explore the practicalities of sharing the palliative care register information with the London Ambulance Service through a new CQUIN[4] that will build upon successful pilots during 2010/11.

[4] CQUIN (Commissioning for Quality and Innovation) is a payment framework that enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.

## 3. EFFECTIVE CARE PLANNING

***All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan. Care plans should be available to out of hours and emergency services.***

Commission training on advance care planning for health professionals in primary care, community services and the acute sector.

Ensure that each person receiving end of life care has an opportunity to make an advanced care plan.

Develop a system to ensure that out of hours and emergency/urgent care services are able to access patients care plans.

Support primary care to fully implement the Gold Standard Framework[5].

## 4. COORDINATED CARE ACROSS ORGANISATIONS

***Co-ordination of care across different organisations is vital to enable the effective use of capacity and scarce resources to ensure the patient has timely access to high quality services.***

Ensure that everyone approaching the end of their life receives coordinated care, in accordance with their care plan, across sectors and at all times of day and night.

Develop and implement an effective local model to support the co-ordination of patient care, which includes the development of a single point of access.

Support care homes to implement the Liverpool Care Pathway.

Further develop out of hour's service provision for end of life care.

Out of Hours providers will have full access to all the standard Palliative Care drugs from April 2011.

## 5. DEVELOP RAPID ACCESS TO CARE

***As the condition of a person may change rapidly, it is essential that services are organised without delay. Provision of 24/7 community services can avoid unnecessary emergency admissions to hospital and can enable more people at the end of their life to live and die in the place of their choice.***

Develop and implement an agreed pathway for rapid access to services.

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[5] The Gold Standards Framework (GSF) is a systematic evidence based approach to optimising the care for patients nearing the end of life. It is concerned with helping people to live well until the end of life and includes care in the final year of life for people with any end stage illness in the community.

Ensure that funding mechanisms for rapid response services do not create barriers to rapid provision of services to meet identified needs.

Commission palliative care community support services that achieve the following outcomes:

- avoid crisis situations such as a breakdown in carer support
- enable a patient to remain in their preferred place of care
- avoid inappropriate hospice or hospital admissions
- allow rapid discharge home from hospital / hospice to support preferred place of care/death.

## 6. ENSURE ALL SERVICES ARE PROVIDING A HIGH QUALITY OF END OF LIFE CARE

***The Gold Standards Framework (GSF) is a systematic evidence based approach to optimising the care for patients nearing the end of life and reducing the number of death that occur in hospital.***

Support implementation of good practice models, such as the Gold Standards Framework and Liverpool Care Pathway, across primary care, care homes, district nurses, and local authority services.

Improve the quality of care provided in acute hospitals through implementation of guidance set out in 'The route to success in end of life care – achieving quality in acute hospitals' (NHS National End of Life Care Programme).

Develop integrated support services that avoid hospital admission and support care at home.

Introduce quarterly collection and analysis of complaints data related to End of Life Care and use to continuously improve service provision.

Include agreed standards for safeguarding and dignity in all specifications for End of Life Care services.

## 7. ENSURE GOOD CARE IN THE LAST DAYS OF LIFE AND AFTER DEATH

***A point comes in the care pathway when the person enters the dying phase. It is vital that those caring for them should recognise that such a person is dying and that appropriate action is taken.***

***Good end of life care does not stop at the point of death. When a person dies, all staff need to be familiar with good practice for the care and viewing of the body and be responsive to carer and family wishes and cultural or religious and spiritual needs.***

***The manner in which professionals and volunteers respond to those who are bereaved can have a long term impact on how they grieve, their health and their memories of the individual who has died.***

Ensure that the Liverpool Care Pathway[6] is adopted and its use audited in all locations where people are likely to die.

Ensure all services dealing with people at the end of life have agreed resuscitation policies in place to support people's preferences about care.

Ensure organisations caring for people at the end of life have policies in place to ensure that care after death is sensitive and responsive to the cultural and spiritual needs of the deceased and their families.

Improve access to information on bereavement services, including developing a local directory of services.

## 8. INVOLVE AND SUPPORT FRIENDS AND FAMILIES

***The family, including children, close friends and informal carers of people approaching the end of life, have a vital role in the provision of care. They need to be closely involved in decision making, with the recognition that they also have their own needs.***

Ensure health and social care professionals involve family and carers in decision making and advance planning.

Ensure that the rights of carers to an assessment of needs are upheld.

Ensure that information is readily available on all local services, which will support those approaching the end of life and the bereaved, including: community support, funeral directors, social and health services, and the voluntary sector.

## 9. DEVELOP THE COMPETENCIES OF THE WORKFORCE

***Ensuring that health and social care staff at all levels have the necessary knowledge, skills, behaviours and attitudes related to care for the dying will be critical to the success of improving end of life care.***

Undertake a competency gap analysis across health, social care and the community sector.

Develop a comprehensive workforce plan that specifies how health and social care staff, and the voluntary and community sector will achieve the necessary competencies.

[6] The Liverpool Care Pathway (LCP) framework is a clinical pathway that provides guidance to clinicians on how to improve care of the dying in the last hours/days of a patient's life. It provides guidance on indications for comfort measures, prescribing, and discontinuation of inappropriate interventions and meeting personal wishes for the last days of life.

Continue to raise awareness of the Mental Capacity Act (2005) among health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the capacity to do so.

Ensure all contracts specify the competences required to deliver quality end of life care.

Ensure the workforce know how to access specialist advice.

| 10. DEVELOP A ROBUST MONITORING AND PERFORMANCE FRAMEWORK |
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| ***End of life care is a very difficult area to measure and an even more difficult area in which to assess progress. Commissioners increasingly need to identify those factors which influence key clinical outcomes so that commissioning meets local strategic targets.*** |
| Develop a robust integrated performance management system across health and social care that enables us to monitor quality, outcomes and expenditure. |
| Strengthen feedback from patients and carers and develop mechanisms to enable involvement in the design, development and delivery of services. |
| Work with local Dignity Champions to create user-defined measures through which we can define and monitor dignity locally. |

| Strategic Objective 11: ENSURE VALUE FOR MONEY AND SUSTAINABILITY OF HOSPICE SERVICES | |
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| **Rationale** | **Commissioning Intentions** |
| Currently PCTs across North Central London meet approximately 36% of the inpatient hospice costs through grant funding. Contributions per bed day range from £110 to £870 with variation both across the sector and within individual PCTs.<br><br>Funding for Hospice services in Enfield has not been reviewed for many years and we want to ensure that we are commissioning in a way that meets the needs of the people of Enfield and ensures value for money. | Vary the payment mechanism for in-patient hospice care commissioned from St Josephs and Marie Curie from a grant based payment to a cost per bed day basis.<br><br>Review funding to North London Hospice to ensure service viability and sustainability. |

## 4. ALTERNATIVE OPTIONS CONSIDERED

4.1 The Strategy sets out the case for change and the rationale for the priorities chosen and supported by local stakeholders. It proposes an approach to commissioning End of Life Care Services that is consistent with national policy drivers and is in line with existing Council and NHS Enfield strategies.

## 5. REASONS FOR RECOMMENDATIONS

**5.1** Prioritising End of Life Care and commissioning effective community interventions at the end of life can offer a real opportunity to both improve the quality of care experienced by patients and their families and reduce costs to the system. As some 1% of the population dies

each year, and the majority of these deaths take place in hospital, there is a significant opportunity for improvement.

**5.2** The strategy is intended to meet local and national objectives for improving the experience of people approaching the end of their life and increasing patient choice.

## 6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

### 6.1 Financial Implications

The End of Life Care Strategy will be funded from NHS Social Care funding resources awarded to the authority through the Finance settlement 2011. The authority was allocated £3.48m for 2011/12 and a further £3.32m for 2012/13.

An initial delegated authority report has been authorised which cascades the full NHS social care funding across the identified priority areas which link to the NHS collection categories.

The NHS Social Care Funding DAR identifies a contribution towards the End of Life Care program (Crisis Response) of £70k in year 1 (2011/12), £120k in year 2 (2012/13) and £120k in year 3 (2013/14). A total contribution of £310k has been earmarked over the three year NHS Social care funding plan.

The spending profile contained within the End of Life Care implementation plan is £5k in year 1 (2011/12) £155k in year 2 (2012/13), £155k in year 3 (2013/14) and a further £100k in year 4 (2014/15). A total anticipated spend of £415k over the four year plan. However funding for the fourth year of the plan will be met from NHS resources as a result of savings made over the first three years.

There is an estimated shortfall between the NHS Social care funding and the End of Life care plan of £5k. It is anticipated that the service will fund this via bids made against the corporate communication resources. In the event that the communication bid is unsuccessful then the shortfall will be funded from with existing resources

### 6.2 Legal Implications

The Governments aim in publishing this strategy is to improve the provision of care for all adults at the end of their life and their carers. The strategy requires local authorities and PCTs to work in partnership to consider how best to engage with the community to raise the profile of end of life and provide an integrated approach to commissioning.

The current Health and Social Care Bill plans to increase the Local Authority role in health improvement by abolishing PCTs and making the Local Authority responsible for pulling together the work of the NHS, social care, housing, environmental health, leisure and transport .The Bill creates a new role for the local Authority to join up local services and for health improvement to be driven via Health and Well Being Boards. Implementation of the strategy will form part of the enhanced Local Authority role in Health Improvement

## 7. KEY RISKS

**7.1** There are no significant risks identified as a result of this strategy.

**7.2** Implementation of service changes will be managed and considered in the context of proper risk management arrangements.

## 8. IMPACT ON COUNCIL PRIORITIES

### 8.1 Fairness for All

- The strategy commits to engaging with people who belong to vulnerable, marginalised or socially excluded communities to raise awareness of the importance of planning for death and enabling more people to die as they wish to.

### 8.2 Growth and Sustainability

- The voluntary and community sector will be key partners in implementation of the strategy.

### 8.3 Strong Communities

- The strategy is intended to enhance services for the whole community.
- The strategy has been informed by the views of local residents who responded to the consultation.
- We will engage local communities and community leaders to gain advice on the best way to raise awareness and encourage people to talk about their wishes towards the end of their lives.

## 9. PERFORMANCE MANAGEMENT IMPLICATIONS

**9.1** As part of the strategy implementation, an integrated performance management system across health and social care will be developed to enable us to monitor quality, outcomes and expenditure. An annual progress report on implementation of the strategy will be published and will report on progress towards implementing agreed commissioning intentions as well as key performance metrics, such as percentage of deaths occurring in hospital

**9.2** The Quality Outcomes Framework (QOF) provides a framework for measuring primary care performance.

**9.3** NICE have recently published a new quality standard for end of life care which we will use to inform the development of our local performance management framework.

**9.4** There are a number of indicators within the New Local Area Agreement relevant to Health and Adult Social Care. In particular the following are most significant:

- Carers receiving needs assessment or review and a specific carer's service, or advice and information.

- Number of Delayed Discharges from Acute Hospitals.

**9.5** We will review the implementation of the strategy in January 2013 and thereafter produce and publish an annual report on implementation which will include performance on agreed outcome measurements.

## 10. HEALTH AND SAFETY IMPLICATIONS

No Health and Safety Implications arising directly from this report.

## 11. EQUALITIES IMPACT IMPLICATIONS

The strategy is intended to enhance access and quality of services for the whole community. A predictive equalities impact assessment has been undertaken and is available in the members' library.

## Background Papers

The following background papers are available online and in the member's library:

- Enfield Joint End of Life Care Strategy (2012 -2016)
- Enfield Joint End of Life Care Strategy (2012 -2016): Summary of Submissions to Consultation
- Enfield Joint End of Life Care Strategy (2012 -2016): Predictive Equalities Impact Assessment
- Enfield Joint End of Life Care Strategy (2012 -2016): Implementation Plan
- National End of Life Care Strategy (Department of Health, 2008)