# Health and Wellbeing Board

## 1. Reference Information

| Paper tracking information | |
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| **Title:** | Health and Wellbeing Strategy Implementation: End of Life Care Partnership Project |
| **Related Health and Wellbeing Priority:** | Those people living with illness and/or disability, including long term conditions, multi-morbidities, people who require support to live independently, and people who require support to die well. |
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| **Related papers** | N/A |

## 2. Executive summary

2.1 The Health and Wellbeing Strategy identified 'helping people in Surrey to lead healthy lives' as one of three interconnected priorities for partners to work together to improve outcomes across the county. An agreed key focus area within this was to help people to live independently for as long as possible and to die well. The Health and Wellbeing Board has asked officers to scope out partnership opportunities to support work around End of Life Care. This paper sets out the current picture of End of Life Care commissioning priorities in Surrey, to enable the Board to scope a partnership project aimed at delivering an equitable, high quality End of Life Care service - to ensure Surrey residents and their families are able to access the care they need, as well as die with dignity in their preferred setting.

## 3. Recommendations

3.1 The Board is asked to:

3.2 Note the initial scoping work that has taken place to map the End of Life commissioning priorities across Surrey.

3.3 Agree to take forward an End of Life Care partnership project and support the next steps listed in the report.

3.4 Work with its Metrics Team to develop improved measures for End of Life Care

## 4. Reason for Recommendations

4.1 There are a range of End of Life Care commissioning priorities across Surrey, varying by geography. During Health and Wellbeing Board business meetings discussions, opportunities for the Health and Wellbeing Board to take a countywide approach to develop consistency of communications and develop a cross-organisational commissioning approach to look at the best use of collective public funds were identified. This approach will have a direct impact on the priorities identified in the new Surrey

Health and Wellbeing Strategy, specifically around helping people who require support to die well.

## 5. Detail

5.1 Death is an inevitable part of life. We will all die and almost all of us will experience the death of someone close to us. Dying well is as important as living well. The care a person receives at the end of their life, and where they receive it, can not only make it easier for them but can have profound impact on their family, friends, loved ones, and the people that deliver the care. It can also leave a lasting impression of the health and care system on all those involved. It is vital that every person who is dying is to be seen as an individual with life yet to live.

5.2 Around half a million people die in England each year. For three-quarters of these people, death does not come suddenly. Instead, it is a process that may take days, weeks or even years, involving a progressive decline in functioning and frequent interactions with health professionals. During this time, many receive some form of end of life care, designed to ease any pain or distress caused by their symptoms, and to maximise their quality of life until the moment of their death. In Surrey, there are approximately 10,000 deaths each year. People nearing the end of their lives often have complex needs, which are predicted to increase as the population is growing and getting older. While improved longevity may be seen as a positive sign, it also means that some people will be living longer but not necessarily healthier. Therefore, the variety of needs to be met will be a serious challenge to health care partners. Cancers, circulatory diseases, respiratory diseases and mental and behavioural disorders are directly responsible for nearly 85% of deaths which are not sudden[1].

5.3 Place of death is an important element to end of life care services. In Surrey, 41% of deaths occur in hospital, followed by 27% in care homes, 20% at home, and 10% in a hospice[2]. The current trend is that the percentage of deaths in hospital and in a hospice is decreasing while the percentage of deaths in care homes and at home are increasing, partly due to a drive to reduce deaths in hospitals. While many would prefer to die at home, it is the quality of care someone receives towards the end of their lives which is essential. It is therefore a priority that commissioners can provide the right care for the individual. This means the right input, from the right people, at the right time, in the right place.

5.4 End of Life Care comes in a variety of different forms, often with health and care organisations working in partnership. Wider partners in Surrey's health and care system, including hospices, play a vital role in delivering these End of Life Care services across Surrey. Hospice care receives around a third of its income through government funding, and the rest from the public through charities, donation, and fundraising[3]. There are opportunities for Surrey Health and Wellbeing Board to support and maximise the benefits of collaborative working in Surrey, and also to work in partnership around the commissioned End of Life services to achieve more for service users to prevent an overreliance on the work being done by hospices.

**End of Life Care commissioning by area**

[1] https://www.surreyi.gov.uk/jsna/end-of-life/
[2] https://www.surreyi.gov.uk/jsna/end-of-life/
[3] http://www.hospiceinfo.org/uk-hospice-facts-and-figures/

5.5 There are a range of health and care commissioning priorities and services in different areas in Surrey. In places, these are starting to become more coordinated around ICS/STP footprints to achieve greater consistency of approach. Further detailed scoping work will be carried out in the next stages section listed at the end of the paper.

East Surrey

5.6 Areas of focus include:

- Better identification of people who may be in their last year of life, and implementation of End of Life Care registers
- Patients known to the community as reaching the end of their life being able to die in their chosen setting by developing End of Life Care Plans and the development of an End of Life Care Team
- A helpline for people and carers to get advice and support
- Tackling the stigma of talking about death, so people can have open, positive conversations about their wishes
- Expanding the teams that care for people in their homes, so they can avoid being taken to hospital in their final days
- Improved care for patients in care homes by commissioning GPs to offer targeted support to community care homes focusing on medications reviews, end of life care planning and treating patients outside of acute care settings
- Health Hubs to assist local nursing and care homes in supporting End of Life Care to improve patient experience as well as reduce unnecessary transports to hospital and resultant admissions

Surrey Heath + North East Hampshire and Farnham

5.7 Surrey Heath and North East Hampshire and Farnham CCGs are now working jointly across the Frimley ICS footprint, with Phyllis Tuckwell Hospice Care and Frimley Park Hospital, and have set up an ICS End of Life Steering Group to address the variation in services around the Frimley system – launched on 28 March 2019. Initial workshops have identified the following potential priorities for work:

- The standardisation of a Frimley directory of services
- The rollout of a 'Patient Passport'
- A development of an End of Life Care training and education strategy
- The offer of 24/7 access to specialist symptom control and advice for patients/carers in Frimley South
- Development of a single, electronic Advance Care Plan

5.8 In addition, the following work is progressing in Surrey Heath[4]:

- Funding is being sought in Surrey Heath for Death Café pilots, to provide guided conversations on End of Life for younger people to think about what they want and to inform the conversations they have with older family members
- Working across the ICS on the implementation of ReSPECT (new extended version of DNACPR forms) and the Future Planning Template (when Summary Care Records are in place)
- Continued encouragement of practices to utilise IBIS notes for improved end of life care

[4] Surrey Heath CCG Cancer and End of Life 2019/20 Plan

- Continuation of the Psychological Debriefing support for community nursing team, which has seen reductions in staff sick leave since implementation
- DNACPR training programme implementation across the Integrated Care Team
- End of Life Care pathway updates and broader circulation with health and social care partners including Continuing Healthcare
- Integration with Frailty Project
- Improving the quality of general practice initial assessments and documentation for patients on admission to nursing homes

Surrey Heartlands

5.9 Consideration is being given to bring together End of Life Care work on a Surrey Heartlands footprint through the creation of a Strategic End of Life group, and linking in with the Surrey Heartlands Academy as a part of the quality improvement redesign work taking place.

5.10 Surrey Heartlands has introduced the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), which is in the early stages of roll-out. Documentation was launched in April 2019 and further development is planned in order to create a platform for an electronic version of the ReSPECT document to enable live, electronic sharing across all providers. This process has been managed through the ReSPECT Steering Group.

5.11 Challenges remain with Acute Providers, most notably Kingston Hospital and Epsom and St Helier Hospital owing to their geography within the South West London Health and Care System which is currently supported by Co-ordinate my Care. Guildford & Waverley CCG has set out key objectives for palliative and end of life care, which it is working to achieve with its partners:

- Identification – Timely identification of people who have palliative or end of life care needs, regardless of diagnosis
- Assessment – All palliative and end of life care needs and preferences are discussed, assessed and recorded for both patients and their carers
- Care Planning – Patients and carers are provided with security and support by effective care planning
- Co-ordination of care – Care is well co-ordinated and there is good communication between all providers of care
- Choice – Patients live and die well in their preferred place of care
- Care delivery – Patients have access to, and receive, responsive high quality palliative and end of life care 24/7, according to need

5.12 Progress has included the introduction of Proactive Anticipatory Care, a comprehensive patient-centred care planning document. PACe is only in place in Guildford & Waverley. In North West Surrey, Locality Hubs have been established in Woking, Ashford, and Walton with a remit to improve care around dementia and End of Life Care. Success has also been had in the past through Coordinated End of Life Service (CoSI) – a community-based end-of-life care service aimed at improving the patient's experience of receiving care at home in the last six to eight weeks of life.

5.13 In Surrey Downs, a 2016 review indicated a low number of palliative care patients were 'dying in their preferred place of death' and were experiencing, on average, three unscheduled hospital admissions during their last year of life. Many of these admissions were deemed unnecessary and caused significant impact to the 'dying' patient, their

families and their carers. In response, Surrey Downs developed an End of Life Care strategy with the following workstreams:

- End of Life Care Collaborative
- Equality and experience
- Volunteer action
- Medicines Management
- Train & Education
- Fast-track & Personal Health Budgets

5.14 Project progress has stalled, although there has been the agreed recruitment of four Community Matrons to the Quality Care Home Team to provide reactive care, support and provide education to Care Homes for patients nearing their end of their lives, assist in the implementation and completion of the ReSPECT documentation, reduce the number of unscheduled admissions in the last year of life, and support the individual's preferred place of death.

**Role of the Health and Wellbeing Board**

5.15 The Health and Wellbeing discussed the current provision of commissioned services at a business meeting on 09 May 2019. The prevailing opinion was that operational programmes, such as delivering consistency of Proactive Anticipatory Care plans, and the rollout of ReSPECT should rest locally with commissioning organisations – but that the Health and Wellbeing Board should facilitate system-wide discussions to support these as required. The Board outlined that there were two main opportunities for intervention:

- Undertake an effort to raise the profile of End of Life Care and support a collective engagement campaign to initiate a public debate on dying well. The exact scope is yet to be defined, but could include aligning End of Life Care information and training to existing workforce training programmes within Surrey's health and care system, as well as a communications campaign including the wider public.
- Support and facilitate member organisations to undertake a system-wide financial evaluation of End of Life commissioning to look at delivering best value for public money and identify opportunities to join up.

## 6. Challenges

6.1 The variety and complexity of service delivery across the geography of Surrey presents challenges in terms of delivering a consistent approach. However, the membership and remit of the Board allows the opportunity for a county-wide, system-wide approach. There will be interdependencies with the local End of Life care work that is being carried out at a local CCG level, as well as at a wider STP/ICS footprint.

## 7. Timescale and delivery plan

7.1 The timescales are set out in Section 9. The exact content of the work is to be scoped by the Board, in partnership with wider stakeholders. It is recommended that the Health and Wellbeing Board Metrics team continue to work to develop improved End of Life Care metrics, and continue to bring in learning of effective measures being taken across the country. These metrics should reflect that the effective management of an individual's

symptoms is the focus of work, and that preferred place of death be used a proxy measure, rather than targeting a specific setting.

## 8. How is this being communicated?

8.1 Initial conversations have taken place with CCG representatives to understand current areas of work. Further engagement will be required to shape the content of the Health and Wellbeing Board's work. Wider communications will be needed with a range of health and care organisations, voluntary sector organisations, care providers, service users, and families. There may be a role for the Board in a wider communications campaign regarding End of Life Care to increase public awareness. This will be developed in consultation with the Health and Wellbeing Board Communication Group.

## 9. Next steps

**Stage one: Develop the End of Life Care partnership project proposal (June-July)**

- We will use the self-assessments carried out by areas in Surrey as a part of the Ambitions for Palliative and End of Life Care National Framework to identify opportunities for system improvement
- We will engage with key stakeholders to develop a consistent End of Life communications approach, working with the Health and Wellbeing Board Communication Group
- We will work as a system, with commissioning organisations and wider stakeholders, to identify opportunities for joined-up commissioning using shared resources where possible
- The Health and Wellbeing Board Metrics Team will work to develop, benchmark, and monitor robust End of Life Care metrics

**Stage two: Test with stakeholders (August)**

- We will test our proposals with partner organisations, providers, Surrey residents and our workforce to develop the proposal further and test out the different levels of engagement.

**Stage three: End of Life Care partnership project implementation (TBC)**

- We will implement the final proposals, as developed and tested with partners
- We will monitor the progress of the established End of Life Care metrics to measure improvement