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NHS

RM Partners' Palliative Care Stakeholder Event

Remember to check out the London Hospices Choir 'The Living Years' - Xmas No.1???
https://www.youtube.com/watch?v=XBLgZikvM3U

Thursday 15th December 2016
Broadway House Conference Centre

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Welcome & Introductions

Dr Sarah Cox,

Chair of the RM Partners' Palliative Care Group

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RM Partners' palliative care group ongoing work & plans for next year

Maureen McGinn
Senior Project Manager
RM Partners

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Overview of the Cancer Vanguard

The Vanguard covers a total population of 10.7 million – 18% of England's population

One of the recommendations of the National Cancer Strategy was to develop new models of care for cancer. In response to this, the Cancer Vanguard was funded to trial these new models so that the successful elements could be replicated nationally across the other cancer alliances.

The Cancer Vanguard is made up of three systems:

- Greater Manchester (led by the Christie)
- West Essex North Central and North East London (led by UCLH)
- North West and South West London (led by RM Partners)

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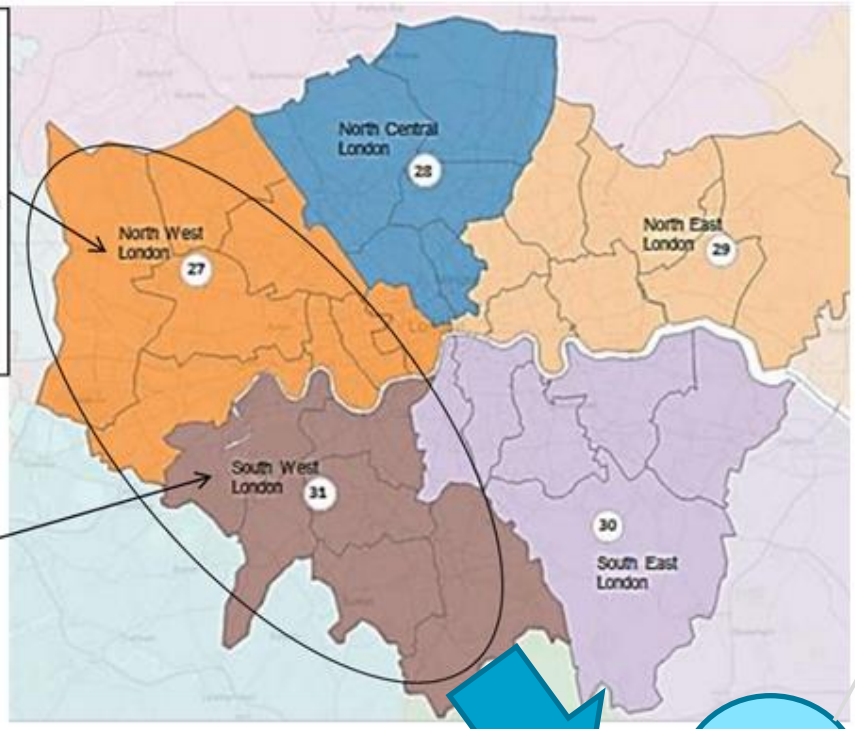
The RM Partners system

8 North West London CCG's....

1. Central London
2. Brent
3. Ealing
4. Hammersmith & Fulham
5. Harrow
6. Hillingdon
7. Hounslow
8. West London

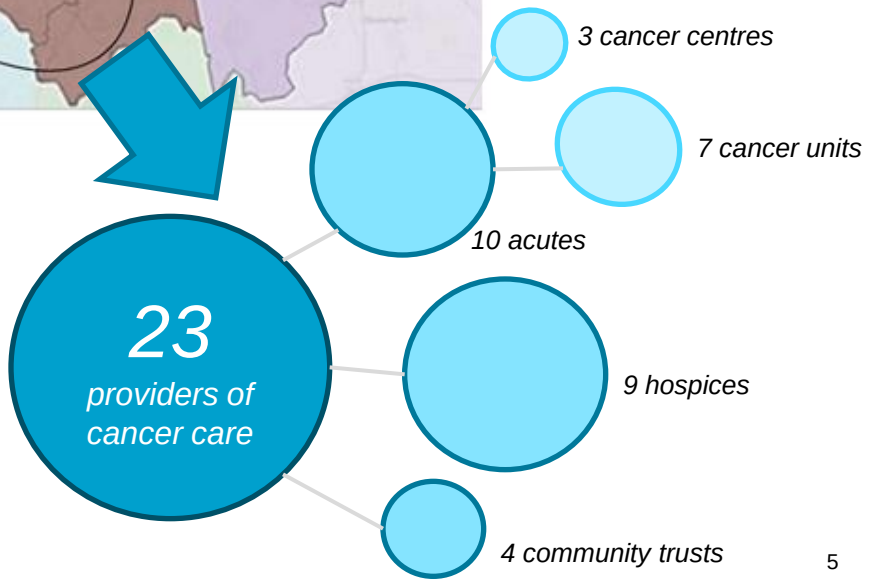
6 South West London CCG's....

1. Croydon
2. Kingston
3. Merton
4. Richmond
5. Sutton
6. Wandsworth



Also overseeing cancer services locally:

- 2 STPs (one with a Cancer Delivery Group)
- London Cancer Commissioning Board
- Transforming Cancer Services Team
- South London Specialised Commissioning



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RM Partners' vision and aims

Working in partnership, we will achieve world class cancer outcomes for the population we serve

The RM Partners Cancer Vanguard has been tasked with radically restructuring our cancer care systems to place the patient at the heart of service planning and delivery. We believe the three 'gaps' per the FYFV create a very clear case for change in the way cancer is delivered. We aim to enable and drive this change **for the patients of West London**.

The three 'gaps'		Our aims
Health & Wellbeing	1 in 2 people will get cancer in their lifetime**.** Cancer patients are **diagnosed too late, survival rates are lower** than international comparators and **incidence** is increasing.	**Improve survival through early diagnosis & detection, harnessing world class research**
Care & Quality	Patients receive **inconsistent quality of care**, with varying outcomes and experiences.	**Reduce unwanted variation, through use of best practice evidenced-based pathways** **Improve patient/family leadership, engagement and experience** **Prioritising living with and beyond cancer** **Improve access to expert palliative and end of life care**
Funding	The cost of cancer is rising at 9% per year; this is **unsustainable.** The tariff system often creates the **wrong incentives** and is a **barrier** to reallocating resources along the pathway.	**Improve utility / reduce excess costs through implementation of new commissioning models**

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But palliative care is different!

Hosted by RM Partners but reaching out to palliative care providers ***across London.***

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So what are we trying to deliver in this and the coming financial year?

Challenging objectives around 24/7 eolc provision and 7 day specialist palliative care services and…

- ACP work in inpatient & outpatient settings
- Workforce mapping update
- Education/training by SPC and for SPC, including a TNA across eolc providers
- EoLC medicines issues linking with CCGs/NHSE & all relevant providers

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What are we trying to deliver in this and the coming financial year?

- SPC referrals management (criteria, electronic paperwork & processes & response times)
- Syringe pump paperwork spread and format
- Patient / carer experience incl. benchmarking tool
- Monitoring CQC inspection reports for common issues requiring support

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What are we trying to deliver in this and the coming financial year?

- Linking with cancer pathways for common areas of interest (e.g. LWBC) and with CCG / STP / NHSE London EoLC CLG esp. re: eolc priorities
- Revisiting palliative care audit
- Working with RM Partners informatics & finance teams to support providers where possible with outcomes / metrics intelligence in a useful format.

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Objectives re: 24/7 eolc provision and 7 day specialist palliative care services

As part of the palliative care submission for the value proposition in January 2016, five pieces of work were proposed, the first two of which were approved, in July 2016.

In order to address these, a project manager Morag Harvey began work in October 2016.

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Update on Palliative Care Objectives 1 & 2

Morag Harvey

Palliative Care Project Manager

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7 Day Specialist Palliative Care

Objective

Support for specialist palliative care services to develop and deliver seven day face to face services

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24/7 End of Life Care in the community

Objective

Transformational change in the model of community palliative care and end of life care to enable better integration, coordination, responsiveness and effective use of resources

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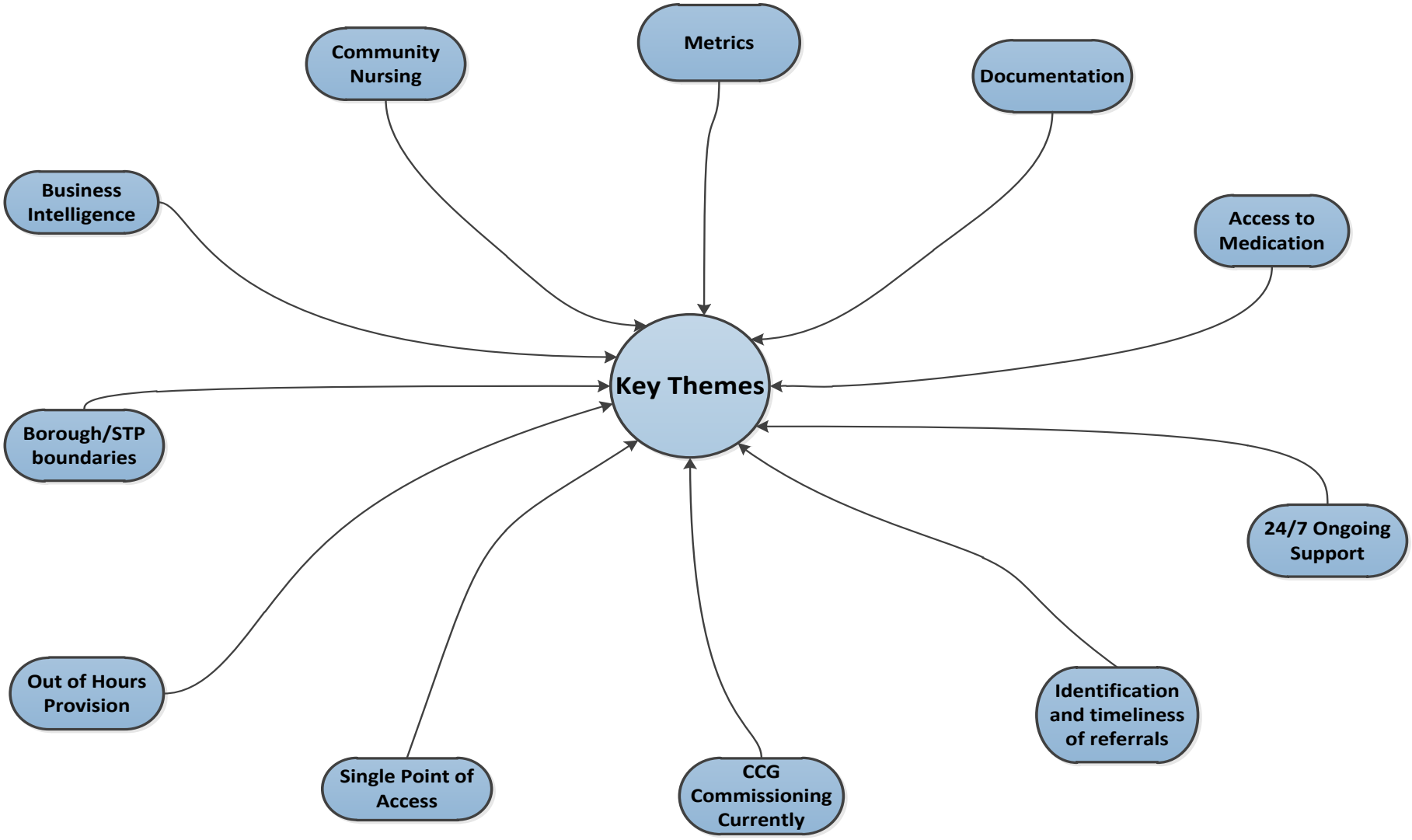
Progress so far

- Currently scoping 7 day Specialist Palliative Care across North West, South West and South East London
- Currently scoping 24/7 End of Life Care Commissioning and provision in the community across North West, South West and South East London
- Identifying Models of Best Practice in London and elsewhere in the country

Key Themes


Key Themes
Community Nursing
Metrics
Documentation
Business Intelligence
Access to Medication
Borough/STP boundaries
24/7 Ongoing Support
Out of Hours Provision
Identification and timeliness of referrals
Single Point of Access
CCG Commissioning Currently

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Identification

- Identifying patients
- Appropriate management
- Timescales: reactive instead of proactive
- Education and Training

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Documentation

- Access to Patient Records
- Coordinate My Care
- DNA CPR

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Community Nursing

- Resources
- Skills
- Training
- Ownership
- Empowerment

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Metrics

Where's your evidence?

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Next Steps

- Continue with scoping of both pieces of work
- To evaluate the findings and establish common principles for service delivery
- To deliver a recommended service specification for 7 day Specialist Palliative Care and 24/7 End of Life Care provision =/- piloting dependent on funding

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Q & A

MCCT
Service for Luton

Presented by Sarah Myford and Elaine Tolliday

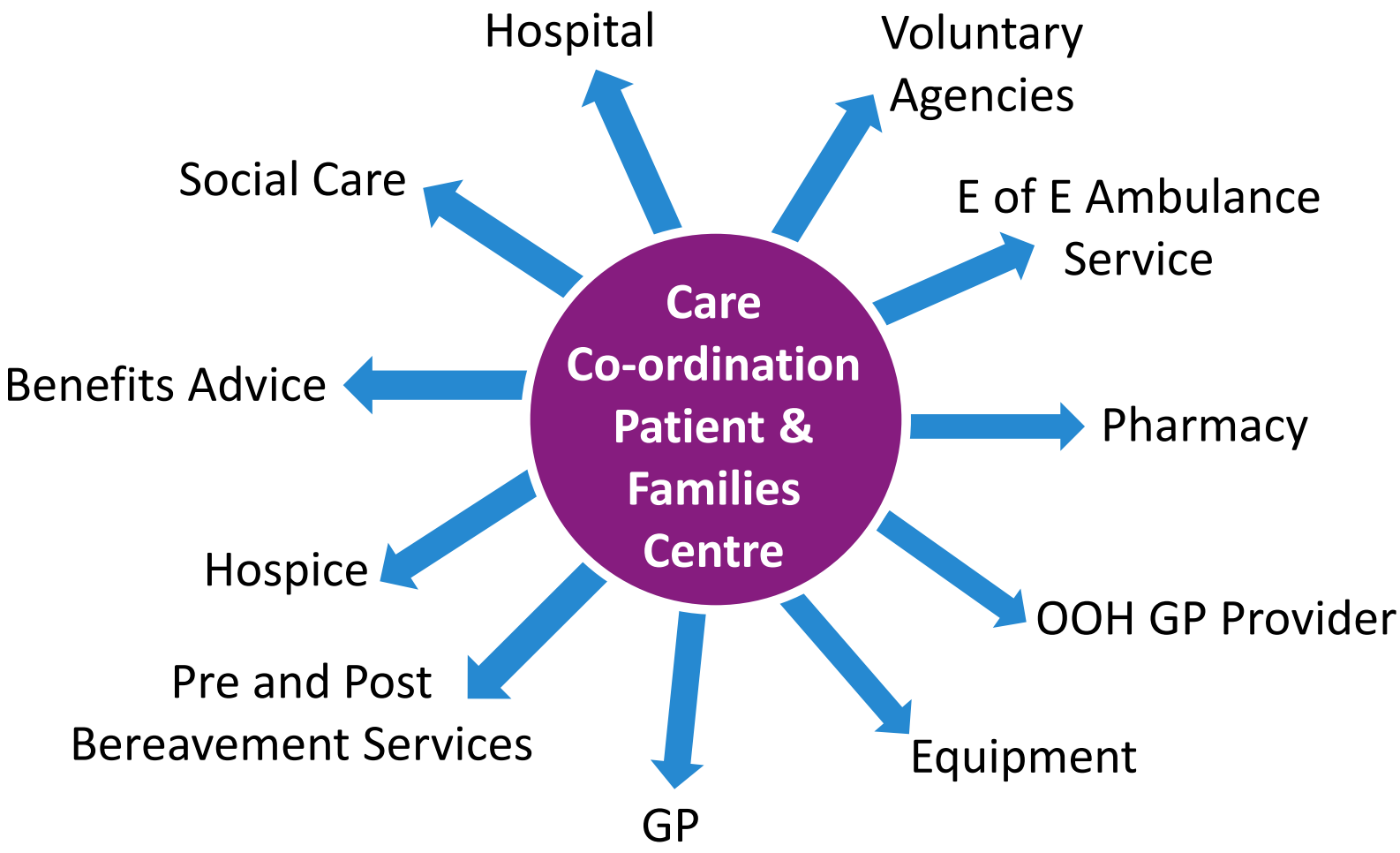
35% BME

220’000 Population (adult)

High Social Deprivation

1 Hospice
1 OOHGP
1 Community Provider
1 Local Authority
1 District General Hospital
1 CCG

Setting up the service



Challenges

Collaborative Working

- Lots of meetings
- Face to face discussion
- People involved from beginning
- Patient at focus
- Identified benefits

Referrals

- Promotion at every opportunity by team
- CQUIN
- Literature
- Pens, screen savers

How we make a difference to patients and professionals

We were lost, no idea what to do. The MCCT enabled us to make the right decision for our palliative patient.
Paramedic Team

The team work hard for patients and families.
Luton & Dunstable Hospital

I cannot put into words what it meant to my family to have such wonderful, warm and caring people around to help.
Daughter of patient

8-5pm
Care Co-ordinator
Weekends & B/H
Specialist Nurse
24hr District
Nurse Service
Mon-Fri
MacMillan Nurse
PCSW 9am-9pm
7 days a week
24hr
Advice
line

Facts and figures

During a 6 month period **93** patients avoided hospital
(against an agreed criteria)

If on register **63%** die in PPC

40 deaths monthly average

Length of time on register **344** days

31% BME

Cancer **42%** non- cancer **27%** Unknown **1%**

Tel: 01582 492339
info@keech.org.uk
www.keech.org.uk

Hospital deaths reducing since 2013, now **49%** (down from 53%)

85yrs + most significant reduction now **46%** (down from 52%)

1’878 Patient's supported since the start

350 average monthly phone calls (office hours, 7 days a week)

Out of hours phone calls **43** monthly average

Future plans

GSF Template

- GP's
- Co-ordination team
- Hospice
- Community services

Digital developments

- Skype consultations
- Texting

Nursing care

- Enhanced rapid response with community services

Elaine Tolliday
Clinical Director
Keech Hospice Care
etolliday @keech.org.uk

Sarah Myford
MCCT Clinical Lead
Keech Hospice Care
smyford @keech.org.uk

St Luke's HOSPICE

NHS
Harrow
Clinical Commissioning Group

Harrow Single Point of Access Service
May 2015-

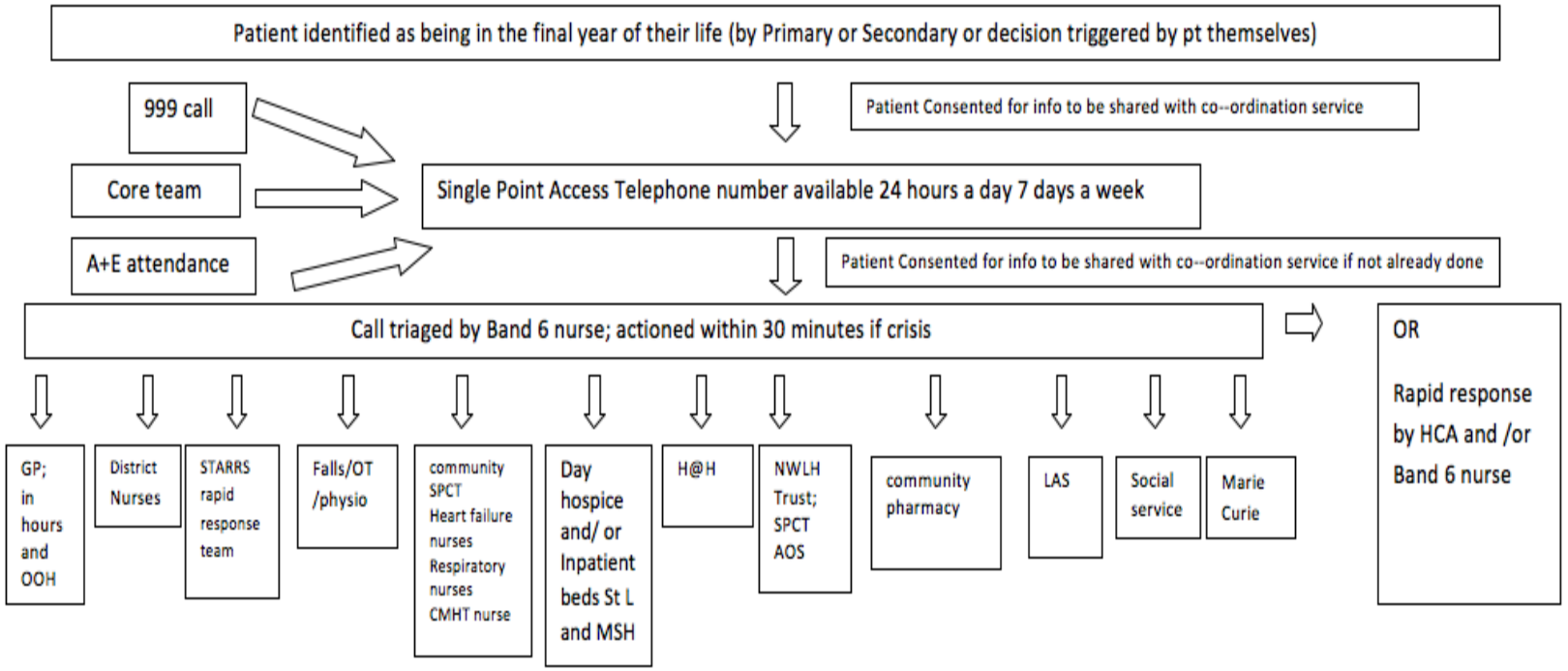
The Challenge

- Large number of providers involved in EOL care; specialist and generalist.
- Increasing numbers of patients; both with cancer and non-cancer.
- Not all EOL patients needed specialist input; these patients were being discharged from specialist palliative care team and other needs not always being met.
- Nearly 60% deaths in Harrow were in Acute Trust.

- Gaps in DN service.
- Many services had limited hours of operation; no formal 24/7 services (NICE guidelines).
- No Specialist Palliative Care evenings or weekends.
- Challenges with rapid response to patients in crisis.
- Patients/carers phoning multiple telephone numbers.
- 999 calls as a result of poor response.
- Extended hospital stays due to delayed discharges.

Working together to do it differently

- Established End of Life Stakeholder group
- Considered options for streamlining the pathway.
- Early discussions only considered those already referred to specialist palliative care.
- Recognition we needed to target those not currently being referred; support all patients in LPOL.
- PEPS model in Bedfordshire.
- Summer of 2014 stakeholder group agreed in principle to a similar model.



Advanced Care Planning

Coordination and communication between Providers; CMC

Clinical governance

The Solution?

- St Luke's offered to run a 12 month pilot
- Embedded in the existing Hospice at Home service
- Takes advantage of an existing team of Registered Nurses and Healthcare Assistants
- Able to offer 24 hour telephone support through the in-patient unit
- Gateway to other services

St Luke's HOSPICE

Registered Charity No. 298555

HARROW SINGLE POINT OF ACCESS (SPA) END OF LIFE CARE

NHS Harrow Clinical Commissioning Group

SERVICE DESCRIPTION

Based at St Luke's Hospice there will be a Single Point of Access (SPA) telephone line which will be staffed by SPA trained registered nurses.
The service is available to both patients and a wide range of Health Care Professionals who need advice and support regarding End of Life Care.
Direct care can be delivered in the home through an end of life rapid response team between
07.00 –23.00 hrs.

Our team is comprised of:

- **Trained Palliative Care Registered Nurses**
- **Health Care Assistants**
- **Project and Administrative Support**

OUR AIM:

To improve patient experience by providing better coordinated care for those in the last year of life and facilitating real choice over the place of care and death.

- Increasing the percentage of patients at the end of life achieve their preferred place of care and death.
- Supporting organisations and teams to work together and develop the Harrow Palliative and End of Life Care Partnership.

HOURS OF OPERATION

24 HOURS PER DAY/ 7 DAYS PER WEEK (Including Bank Holidays)

Referral advice, visiting and support lines open 07.00-23.00 hrs

Advice and support always available via telephone between 23.00–7.00 hrs

Visiting service NOT available during the hours of 23.00-07.00 hrs.

REFERRAL CRITERIA:

1. **Identified as being within last 12 months of life**
2. **Adults 18 years and over**
3. **Must be registered with a Harrow GP AND live within 1 mile of Harrow border**

IF YOUR PATIENT FITS THESE CRITERIA PLEASE CONSENT THEM FOR INFORMATION SHARING AND SEND THE LCA SPECIALIST PALLIATIVE CARE FORM WITH SPA COVERING PAGE BY EMAIL OR FAX.

Phone: 03000 200 224

Fax: 020 8382 8091

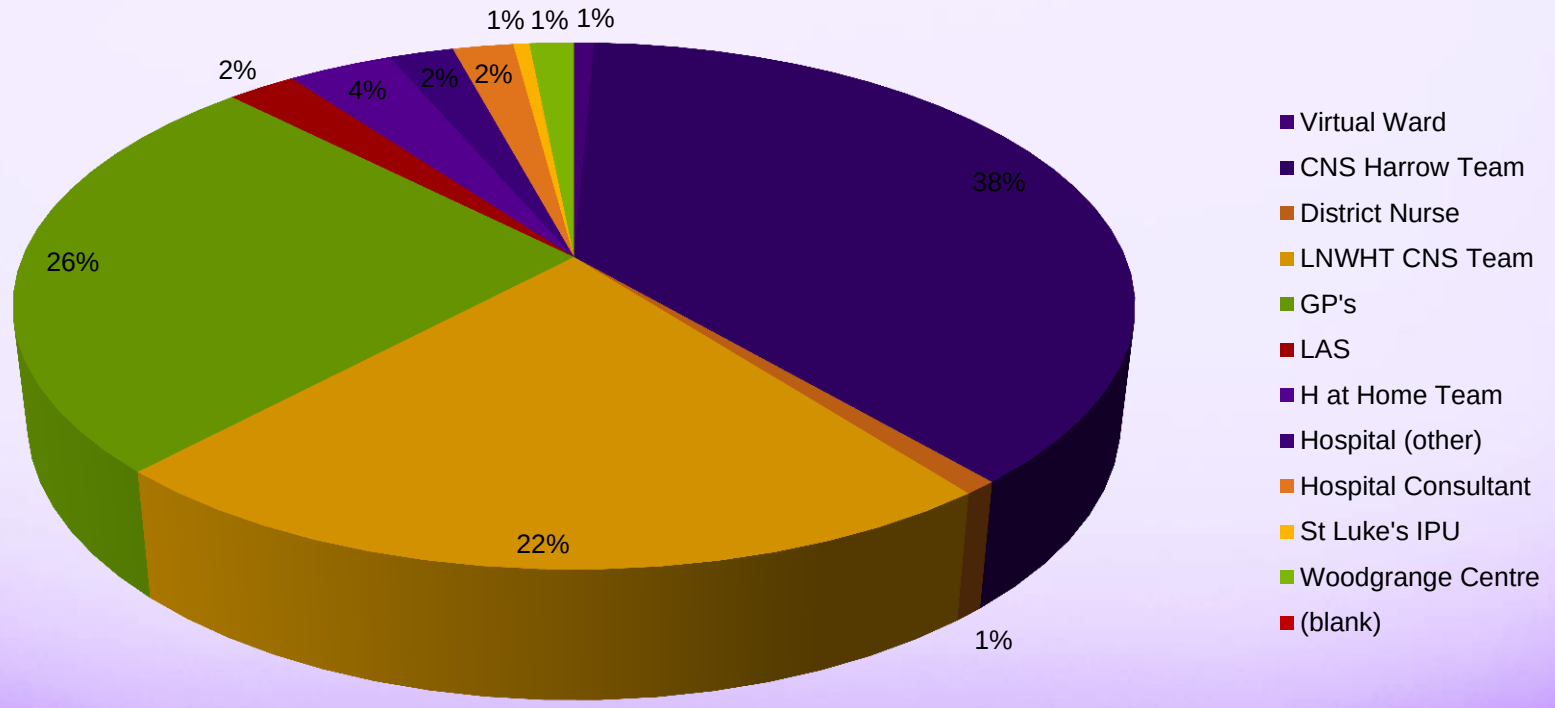
Email: HAROCCG.EOL-SPA@nhs.net

Service Aims

- Provide a single point of access for patients who have been assessed as being within the last 12 months of life
- Impact upon the use of acute services by providing better coordinated primary care for patient in the last year of life
- Facilitate real choice at end of life
- Reduce use of urgent care service and hospital admissions when this is not the most appropriate response to need
- Facilitate rapid discharge to preferred place of care
- Facilitate effective use of resources and provide management information on service utilisation
- Contribute to the maintenance of the locality palliative care register – CMC
- Increase the percentage of patient at end of life who achieve their preferred place of death

Source of referrals

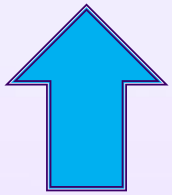
The service has received 718 referrals since launching in May 2015



Call Activity

2423

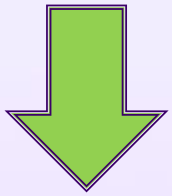
Incoming calls since the service launched in 2015



- **58% Relative / Carer**
- **8% GP**
- **5% District Nurses**
- **4% Patient**

3581

Outgoing calls since the service launched in 2015

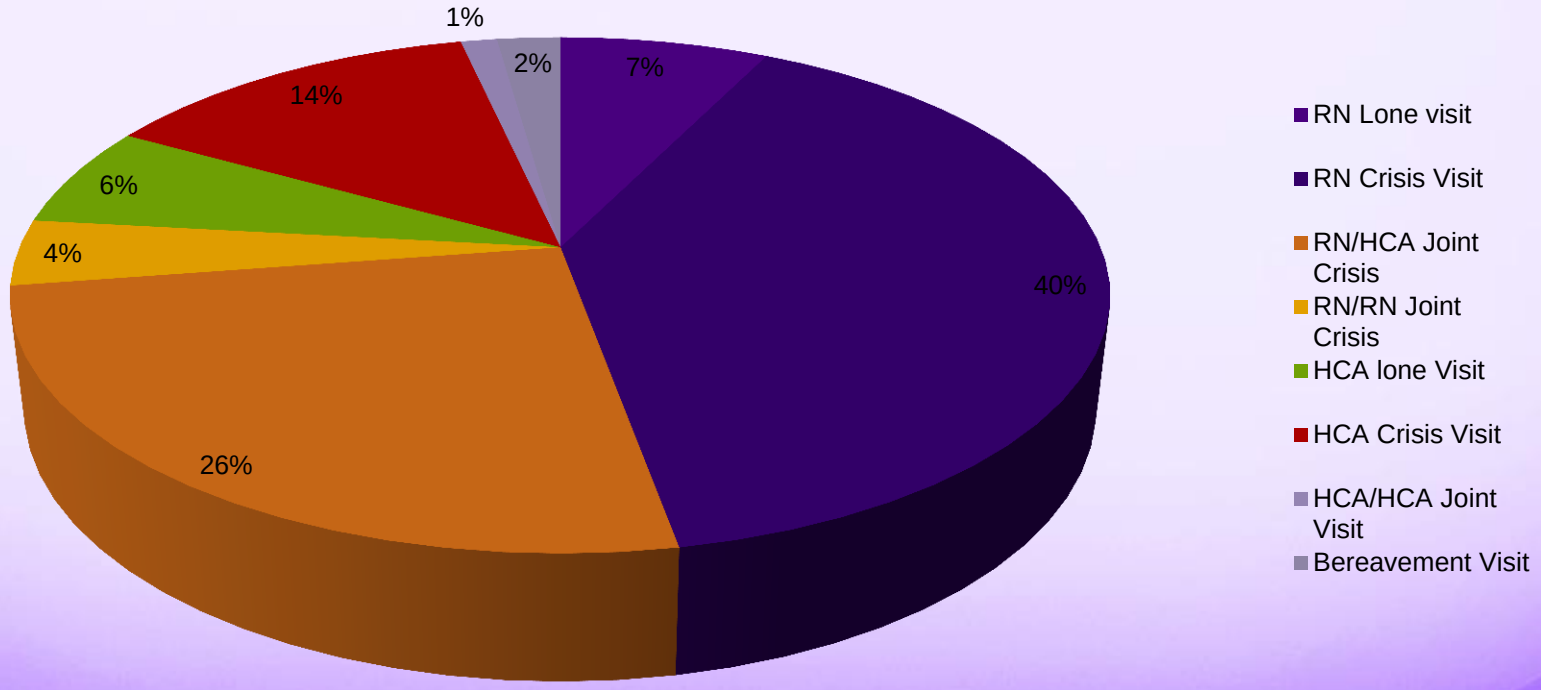


- **52% Relative / Carer**
- **11% Patient**
- **9% District Nurses**
- **GP OOH's**

Rapid Response Team

The rapid response team provides direct care to patients in their home usually visiting less than hour from point of contact.

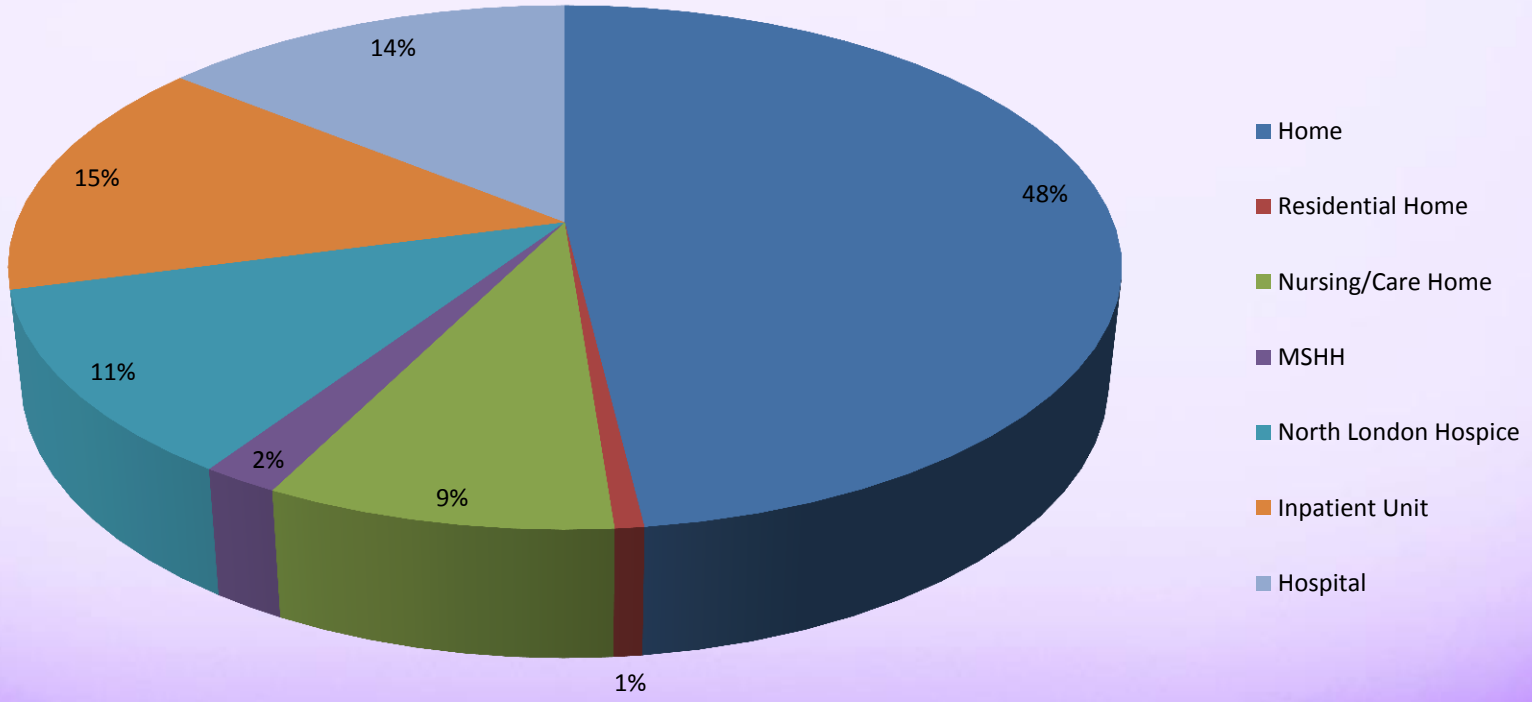
Since the service launched 711 visits.



www.stlukes-hospice.org

Place of Death

Since launch, 416 patients have died while on the SPA caseload. 86% have died in a setting other than an acute hospital.



Additional Outcomes

- Referrals to the hospice generally have increased
  - 804 new referrals in year before SPA
  - 1028 in 2015
- LAS Appropriate Care Pathway
- Urgent packages of care; Same day.
- Work with Harrow's Virtual Ward.
- Strategic plans for ACO.

Palliative care team of the year finalists 2016

Nigel Hawkes finds out how the nominees for the palliative care award are working to improve care and keep people out of hospital

hospiceUK

The Palliative Care Team of the Year award is sponsored by Hospice UK. The awards ceremony takes place on 5 May at the Park Plaza Hotel, Westminster. To find out more go to **thebmjawards.com**

HARROW END OF LIFE SINGLE POINT ACCESS

For people in their last year of life, fragmentation of care is a burden they can do without. "When we looked at care for this group, we found no continuity, nobody to take responsibility, and nobody to turn to in a crisis, particularly at the weekend," says Nicola Davies, end of life lead for Harrow clinical commissioning group (CCG) in north west London.

The answer was to set up a single point of access—a telephone number available 24 hours a day and seven days a week for patients, carers, and healthcare professionals. Operated by St Luke's Hospice, the number can be used to summon a rapid response team between 7 am and 11 pm for any patient registered for more than a year with a Harrow GP and identified as being in the last 12 months of life.

As well as providing a better service, the new system reduces hospital admissions and increases the proportion of patients able to die at home to almost 90%. "Nationally, in their last year of life people are admitted to hospital an average of three times," Davies says. "If we could reduce that to two, we could save £1m a year. I hope we can do that—we've had a good start." The service cost £246 000 in its first year and the CCG has agreed to extend it for a second year.

Feedback from patients and carers is good, but more needs to be done to explain it to GPs, she says. Currently most referrals come from palliative care teams, with GPs providing only 22%. A GP education programme has been launched.

> As well as providing a better service, the new system reduces hospital admissions and increases the proportion of patients able to die at home to almost 90%

TRANSFORMING END OF LIFE CARE

Patients in hospital nearing the end of life may go unidentified, with little attempt to understand their wishes or those of their families. Some are repeatedly admitted and discharged in their final months when a better anticipation of their care needs could have prevented it. Many die in hospital when they would have preferred to die at home—though for some, says Harriet Preston, consultant in palliative medicine at Blackpool Teaching Hospitals NHS Foundation Trust, hospital may be the right place to die.

> We have trained 7000 members of staff, increased staff confidence, and increased the use of the rapid discharge pathway

As part of a national plan to improve end of life care, the team at Blackpool first identified the wards where improvements would have the greatest effect. Staff were trained to deliver end of life care and in communication skills. "As a palliative care team we do this day to day," she says, "but there are some wards where they don't get that many deaths." Ward based training was provided, with one of the education team covering for the nurse being trained to overcome the difficulty of releasing nurses from clinical duties.

During the project 1779 people were identified as suitable for the "amber care bundle," a tool for promoting advance planning. Readmission rates for this group fell from a trust average of 33% to 8.3%, and length of stay was also reduced, saving the trust £84 000 over six months. "We have trained 7000 members of staff, increased staff confidence, and increased the use of the rapid discharge pathway. The patient and relative survey results show that patients rate the communications with staff as either excellent or good," she says.

The project was funded through the multiprofessional education and training levy, matched by funding from the CCG, mostly used for staff salaries.

Ongoing challenges

- Encouraging referrals (including GPs).
- Staffing.
- Relationships with community nurses and other organisations.
- Multiple forms and contacts for HCPs causing confusion.
- CMC usage.
- The future.

Case Study

- Saturday morning
- LAS called the SPA service as they attended a call out to a gentleman who had fallen.
- The crew identified that the patient would meet the SPA criteria and felt the service would be able to assist as they reported the patient had abnormal breathing.
- The patient was not known to the SPA but was on Icare, as they had been a previous inpatient at St Luke's.
- The rapid response team advised they would attend within the hour.
- This enabled the ambulance crew to leave after one hour and ensured the patient was not admitted into hospital as their preferred place of care (PPC) was home.
- The team nursed the patient into bed and arranged Hospice at Home care for the same evening.
- Equipment was put in place and a Co-ordinate my Care (CmC) record completed.
- The patients PPC was home and this was made possible as the gentleman died in the early hours of the next morning.

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Q & A

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Coffee & Workshop

What does 'good' look like for end of life care services in the community and how do we make that happen??

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Princess Alice Hospice Ward Student Volunteer Programme

Zoe Byrne

Head of Volunteer Development,

Princess Alice Hospice

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Closing Remarks

Dr Sarah Cox,

Chair of LCA Palliative Care Group