End of life care: a) where are we now – programme update summary

EoLC Programme Board

6 February 2018
End of life care
b) The Universal Model of Personalised Care

EoLC Programme Board
6 February 2018
End of life care: c) Refreshing our programme narrative

EoLC Programme Board

6 February 2018
Six ambitions to bring that vision about

01. Each person is seen as an individual
02. Each person gets fair access to care
03. Maximising comfort and wellbeing
04. Care is coordinated
05. All staff are prepared to care
06. Each community is prepared to help

“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).”

National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk
EoLC: 6 point commitment

• Honest conversations
• Informed decision making
• Develop and document personalised care plan
• Share plan with care professionals
• Involve family to the extent they wish
• Know who to contact for help and advice
EoL Programme: how it all fits together

WS 3: commissioning

WS2: the place (and in between)

WS1: the person

6 point commitment

Honest conversations, informed decisions, PCSP and shared with professionals, family involved, know who to contact
Six ambitions to bring that vision about

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Unpacking that vision: what does this mean for the person?

1. Deteriorating condition is recognised
2. Personalised planning - leading to action - is offered for treatment, care and support
3. High quality experience anywhere anytime
   • Staff who know what they are doing
   • Access to medicines, equipment, etc.
   • Feel safe physically and emotionally
   • Family/those important to me are supported
An all age, whole population approach to personalised care

**TARGET POPULATIONS AND OUTCOMES**

- **People with complex needs**
  - Intensive approaches to empowering people, integrating care and reducing unplanned service use.

- **People with long term physical and mental health conditions**
  - Proactive approaches to supporting people to build knowledge, skills and confidence and to better manage their health conditions.

- **Whole population**
  - Universal approaches to supporting people to stay well and building community resilience, enabling people to make informed choices and decisions when their health changes.

**PRIMARY INTERVENTIONS**

- **Specialist (Universal and targeted interventions plus)**
  - Integrated personal commissioning including, proactive case finding and personalised care and support planning through Multi-Disciplinary Teams, Personal health budgets & integrated personal budgets.

- **Targeted (Universal interventions plus)**
  - Proactive case finding and personalised care and support planning through General Practice. Self-care support (including health coaching, self-management education and tools such as the Patient Activation Measure).

- **Universal**
  - Enabling Choice (e.g. in maternity, elective and end of life care. Shared Decision Making. Social prescribing and community connecting roles. Community capacity building.

A flexible system allows for free movement within the triangle according to user requirement.

www.england.nhs.uk
End of life care:

d) Key programme priorities for 2018/19

EoLC Programme Board

6 February 2018
End of Life Care Objectives

• Proposed Mandate commitment:

  Increase the percentage of people identified as likely to be in their last year of life, so that their End of Life Care can be improved by personalising it according to their needs and preferences.
End of Life Care Objectives

- Proposed High Level Business Planning Objective

Work with the regions to enhance personalised, integrated and coordinated end of life care for people approaching their last year(s) of life through strong clinical engagement.
Aim: Increase the percentage of people identified as likely to be in their last year of life and work with the regions and partners to enhance personalised, integrated and coordinated end of life care for people approaching their last year(s) of life through strong clinical engagement.

1. Improving identification incorporating SDM (PAM and health literacy)
2. Greater use of personalised care and support planning (+/- PHB)
3. Reducing variations in care and inequalities (LD, Dementia, Homeless and Prisons)
4. Developing metrics and currencies
5. Responding to urgent unscheduled needs (link to UEC)
6. Improving access to medicines
7. Electronic Palliative Care Coordination Systems (EPaCCS)
8. Demonstrating place-based approach – working with ICSs
9. Increasing awareness of the Choice Commitments
10. Delivery and adoption of associated training
11. Alignment of partners and roles
12. Regional work through strong clinical engagement
End of life care: e) Partnership working and measures of success
Potential Measures of Success

- Increase in the number of people identified, offered personalised care and support planning, included in the GP’s supportive/palliative care register and offer for inclusion in local EPaCCS –
  - Identified - number of people on GP palliative care register per 100 people who died
  - Offered PCSP – recorded with EPaCCS standard
  - Choice- number of patients end-of-life preferences are recorded in accordance with the Palliative Care Co-ordination: Core Content (SCCI1580) national standard (EPaCCS)

- Reduction in the number of people who have 3 or more emergency admissions in the last 90 days of life

- Improved outcomes and experience (ONS-VOICES) in end of life care for people within any of the following groups:
  - people with cancer
  - people with dementia
  - people with learning disability
  - people requiring urgent and emergency care,
  - people who are homeless
  - people in secure and detained settings
End of life personal health budget project 2016/18 objectives

• Test where PHB’s improve outcomes for people and their families.
• To see how PHBs improve choice and what these choices are.
• To develop good practice guidance to inform other CCGs how to develop their PHB offer in end of life.
5 sites- Different approaches

- Warrington and NEW Devon CCGs – focussed on Fast Track NHS Continuing Healthcare (CHC).
- Southern Derbyshire CCG – earlier in end of life pathway outside CHC.
- East Lancashire CCG – worked with GPs and aligned with Gold Standard Framework register.
- Mid Sussex with Horsham & Crawley CCGs – to establish a financial case for change & address a local deficit in commissioning gap for end of life pathway.
## Data we are requesting

<table>
<thead>
<tr>
<th>Data</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>Number of PHBs</td>
<td>• How widespread PHBs are</td>
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<tr>
<td>Cost comparison – Traditional offer vs PHB</td>
<td>• Are PHBs cost effective/cost neutral (including on costs for PA)</td>
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<tr>
<td>Number of unplanned admissions - Number of GP appointments</td>
<td>• Do PHBs affect use of these resources</td>
</tr>
<tr>
<td>How and what are people spending PHB on?</td>
<td>• How this alters commissioning patterns. Informs CCGs of services chosen</td>
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<tr>
<td>Case studies</td>
<td>• Brings data to life</td>
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Outcomes to date

• Over 150 PHBs
• Cost effective when a PHB is delivered well.
• Early indicators that PHBs improve chance of preferred place of death.
• Films and case studies about how people are making different choices about care and support and having better outcomes.
• New NHSE programme of learning about how to deliver Fast Track PHB’s.
Right to Have Consultation

At the November Board meeting, the board agreed that the following should be included in the up-coming “Right to Personalisation” consultation

“The Government Response to the Review of Choice in End of Life Care details the government’s commitment for end of life care. This commitment maintains that people approaching the end of life should be supported to:

• Have honest discussions with care professionals about their needs and preferences
• Make informed choices about their care
• Have the option to develop and document a personalised care plan.

Do you agree that these aspects of the commitment should be given regulatory footing?”
Exploring new rights to PHBs

The consultation will be launched in the next few months. This will include consulting on a right to have a PHB for a range of people including those with a learning disability and those receiving section 117 aftercare.

Following on from the success of the End of Life PHB testbeds NHS England would like to strengthen current draft wording to consult on introducing a right to have a PHB to **everyone who needs palliative care at the end of life**.

If the consultation supports this new right, DH would need to introduce a new clause in the Standing Rules, which may take time due to Brexit.

**The End of Life Board is asked to note this change in consultation question and feedback any concerns they may have.**