End of Life Care (EOLC) Update

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Introduction

One person dies every minute in the UK. With an ageing population, deaths (along with a greater need for palliative and end of life care and support) are set to rise by 17% by 2030.

• 0.5% of Kingston population die each year. = 1,096 deaths per annum in 2017. So about 3 people per day.

• Approximately 54% will die in the community and 46%(504) in hospital.

• Of the 46% that die in hospital, at least 40% of these are expected deaths (Public Health England 2014).

• Patients in their last year of life will have had 2-3 hospital admissions in the previous year (NHS SUS+).
To improve the patients’ experience and outcomes by offering the opportunity to share their preferences with all those that may need to support them at this critical and important stage of their lives we have supported increased care planning on the Coordinate my Care (CMC) portal.

- 1,341 patients have an advance care plan on CMC, of which 197 were created in 2017/18 and 504 in 2018/19.

- Of the patients who died, with a preferred place of death recorded, 247 (74%) died in their preferred place.

- 21% of Kingston patients with a CMC advance care plan spend their last days in hospital compared to 47% nationally.
**Kingston and Richmond EOLC Strategy**

**Vision**

All local people can be confident that the health and social care system will give them and those important to them the right care and support to live well and die well.

**Core approach**

Evidence-based using Quality Improvement methodology and SMART objectives Participation and co-production with frontline staff, people who are in the last phase of their life and those important to them.

1. Local people can live well in the way they want to when they are approaching the end of their life, and after bereavement.
2. Local people in the last phase of their lives receive good quality coordinated care, where possible, aligned with their holistic preferences, enabling them to have a peaceful and dignified death.
3. The local community will be more resilient to care by developing partnerships between the community and professional services.

**Outcomes**

- **Compassionate Community Development:**
  - To build local resilient community networks to help support people through life crises, loss, dying and death, both inside and outside of health and care services.

- **Advance Care Planning:**
  - To achieve, that all people who have predictable deaths, including frailty, will be offered and be involved in their advance care planning (2018-2020).

- **Experience:**
  - To achieve qualitative feedback each year on care, experience of death, dying and loss across settings in order to improve experience or health and care services.

- **Equality:**
  - To reduce inequalities in variations of end of life care.

- **Vulnerable and hard to reach groups**

**Objectives**

- 1. Local people can live well in the way they want to when they are approaching the end of their life, and after bereavement.
- 2. Local people in the last phase of their lives receive good quality coordinated care, where possible, aligned with their holistic preferences, enabling them to have a peaceful and dignified death.
- 3. The local community will be more resilient to care by developing partnerships between the community and professional services.

**Work streams**

- **Community development Companionate City Charter Workforce Transformation**
- **ACP s in primary & community care**
- **ACP s in secondary care**
- **Patient Family & Carer Staff**
- **Vulnerable and hard to reach groups**

**High Quality Commissioning**

- **Education and Training**
- **Data Analysis**
<table>
<thead>
<tr>
<th>Achieved evidence of ground up frontline change with collaborative and participatory development of care and services</th>
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| • Cross organisational work has been undertaken to improve discharges and fast track processes.  
• Our local hospitals are working with stakeholders to develop a volunteer programme to support more advance care planning.  
• 59 Kingston residents have been referred to the Compassionate Neighbours Programme led by Princes Alice Hospice. 27 residents have been trained as a Compassionate Neighbour with 24 successful matches. |

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<tr>
<th>Make available access to training for advance care planning to all primary care, community and hospital staff</th>
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| • We commissioned Princess Alice Hospice to deliver training on advance care planning and supporting those at the end of their life.  
• Princes Alice are also piloting the 6 week virtual ECHO programme in Kingston.  
• The palliative care teams at our local hospitals have been training hospital staff on end of life care needs and advance care planning. |

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<th>Supported clinicians to feel more confident in earlier identification of people approaching the last phase of life</th>
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| • We have facilitated discussions on end of life care with primary care clinicians.  
• We have developed guidance for primary care to support advance care plans and management of patients. |
Progress against planned 2018-19 strategy priorities and actions

Support all GP practices, community and hospital providers to be actively accessing shared advance care records such as coordinate my care (CMC)

- The CCG has worked with the CMC team at The Royal Marsden to ensure clinical staff have access to CMC web portal and are able to use it.
- We routinely review CMC data and share this data with practices.

Increased the numbers of people that are offered the opportunity to have a Coordinate my Care record which provides an opportunity to discuss and document choice

- 504 more Kingston patients had a new CMC advance care plan created in 2018/19 (an increase of over 250% when compared to 2017/18).
- 354 (70%) of these were created by Primary Care.
- The number of patients leaving Kingston Hospital with a fast track who had a CMC ACP in place rose from 4/11 (36%) in January 2018 to 15/16 (94%) in September 2018.

Support care home staff and GPs to identify residents who are entering last year of their life and offer advance care plans that are recorded and shared on Coordinate my Care(CMC)

- The community matrons in the care home support teams are working with care homes to identify patients and develop care plans.
- Across SWL there is work being undertaken to support Care Homes with meeting CMCs Information Governance requirements so care homes can access the CMC portal to create, share and review advance care plans.
# Progress against planned 2018-19 strategy priorities and actions

| Have reduced the episodes of unplanned hospital care that patients experience in their last year of life | • We have seen 29 less admissions for patients in the last year of life when compared to 2017/18.  
• In Kingston, a snap shot mortality review audit undertaken with 4 practices to build a deeper understanding of reasons for unplanned hospital care for this in their last year of life. |
| Have reviewed the bereavement and carer support available outside of hospices | • NHS England (London region) End of Life Care Clinical Network has reviewed bereavement and carer support. Their Enhancing Physical and Mental Wellbeing working group developed an A5 leaflet signposting people to key resources related to bereavement. The Network has sent this leaflet to all Registrars in London. The CCGs are sharing it with partners for local use.  
• A more in-depth local review to be completed in 2019/20. |
| Have sought feedback from patients and carers on their experiences | • We received feedback to support development and implementation of the strategy.  
• There is patient representation on the joint EOLC steering group.  
• We are developing our approach to gain feedback on patient and carers’ experiences. |
We are supporting London’s Strategic Clinical Network for EOLC with developing EOLC outcome metrics that will be collected across London. The metrics will include those listed below.

Actual data will be available at the Governing Body meeting.

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<tr>
<th>Workstream</th>
<th>Indicator</th>
<th>Data source</th>
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<tr>
<td>Community Development</td>
<td>Compassionate Neighbours – No of referrals received</td>
<td>Princes Alice Hospice</td>
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<td>Compassionate Neighbours – No of volunteers recruited</td>
<td>Princes Alice Hospice</td>
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<td>No of people matched with a Compassionate Neighbour</td>
<td>Princes Alice Hospice</td>
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<td>Advance Care Planning</td>
<td>New advance care plans created on CMC</td>
<td>CMC</td>
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<td>Total active advance care plans on CMC</td>
<td>CMC</td>
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<td>Quality completeness of care plans on CMC</td>
<td>CMC</td>
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<td>No of times CMC ACP accessed/viewed</td>
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<td>% of people on the GP Palliative Care Register</td>
<td>NHS Digital</td>
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<td>Experience</td>
<td>Non-elective admissions for those in the last year of life</td>
<td>NHS SUS+</td>
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<td>% of people with three or more emergency hospital admissions within the last 90 days of life</td>
<td>NHS IAF</td>
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<td>Emergency admissions from care homes</td>
<td>NHS SUS+</td>
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<td>% of Fast Tack Patients which have an advance care plan in place at referral</td>
<td>YHC</td>
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<td>% of care homes with Red Bag Scheme in Place</td>
<td>SW London HCP</td>
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<td>% of deaths in hospital</td>
<td>PHE Finger Tips</td>
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<td>Equality</td>
<td>% of deaths in the usual place of residence for people with dementia &amp; Alzheimer's disease</td>
<td>PHE Fingertips</td>
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<td>% of deaths in the usual place of death for people with cancer</td>
<td>PHE Fingertips</td>
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<td>% of patients with a CMC record who died in their preferred place of death</td>
<td>CMC</td>
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Since 1st April 2019, the new five-year GP Contract in England has been in place. Practices will be focusing their quality improvement activities in four key areas:

1. Early identification of patients,
2. Seamless, planned and coordinated care; offering patients timely and relevant personalised care and support plan discussions; documented and shared electronically,
3. Carer support – before and after death; and
4. Systems in place to monitor and improve, based on timely feedback of the experience of care from staff, patients and carers.

These four areas also align perfectly within with the eight core areas of quality improvement of the Daffodil Standards.

The Daffodil Standards, a free voluntary resource with attributable CPD points, are designed to be completed over the course of three years. Once practices sign up on the Royal College of General Practitioners (RCGP) website, they receive a welcome pack, including a Daffodil Mark to display in their practice. Practices self access against the criteria.

Combined, both initiatives represent the most significant change in end of life care in general practice for a decade.
Activities to include:

- Website page for CCG
- News article for CCG
- Launch myCMC (press release, leaflets, posters, postcards, social media, infographics, videos, pop-up banners)
- Obtain local patient and family case studies
- Identify patient groups and forums to explore conversations around end of life
- Communications to GP practices
- Communications toolkit for use by partners, providers and voluntary sector
- AGM feature topic
- Support of Princess Alice Hospice compassionate communities initiatives
- Support of Daffodil standards amongst GP practices
- Support Dying Matters Awareness Week 2019
- Leverage Kingston & Richmond Communications and Engagement group
- Learning from national insights on introducing EOLC conversations with patients
- Working with providers around a campaign for frontline staff support (wellbeing)

Following discussion, the top three objectives and outcomes for communications and engagement to focus on are:

- **Increase and improve quality advance care planning** = increase number of advance care plans on CMC; increase number of advance care plans on CMC created by patients.
- **Support compassionate communities and awareness of the offering** = system wide support of the compassionate communities approach.
- **Capture patient and carer experience** = improve experience of patients, their families and carers during the last phase of life and after their death.