**JOINT REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP, NORTH & WEST READING CLINICAL COMMISSIONING GROUP & READING ADULT SOCIAL CARE**

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| **TO:** | **HEALTH AND WELLBEING BOARD** | |
| **DATE:** | **27TH Jan 2017** | **AGENDA ITEM: 5** |
| **TITLE:** | **End Of Life Care Briefing** | |
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## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide an update to the Health and Wellbeing Board members following on from the previous report presented on 9.10.15. This includes an overview of End of Life Care locally and will aid discussion on how the Reading locality can now further develop our care and support for those at the end of life.

1.2 This report covers end of life care for people of all ages (from birth).

1.3 It should be recognised that End Of life care is a crosscutting theme across a wide range of conditions. For this reason, a Berkshire West wide End of Life Steering group meets quarterly and has representation for all key stakeholders. This includes representation from RBC and the Reading CCGs, with Dr Barbara Barrie (N & W Reading) as the chair. This group reports into the Long Term Conditions Programme

Board. This ensures that all the Long term Conditions work also aligns with the ambitions for End of Life as well as other programmes of care.

1.4 A Reading End of Life working group was set up following the recommendation from the Nov 2015 Health and Well Being Board. This group sponsored a local conference involving a range of stakeholders. The meeting highlighted services available locally and some of the service gaps. It is now proposed to convene a multi -agency task and finish group to develop an implementation plan for service development locally and to ask the group to report back on its work to a future Health and Well Being Board.

## 2. RECOMMENDED ACTION:

**2.1 To note the report**

**2.2. To agree to setting up of an end of life task and finish group to produce an integrated implementation plan for the development of end of life care services locally.**

**2.3 To report back to a future Health and Well Being Board on the work of the task and finish group.**

## 3. UPDATE REPORT

3.1 There are a number of initiatives in place across Berkshire West and within Reading, which support proactive approaches to the management of end of life care.

3.2 End of life care is locally commissioned and locally provided. A wide spectrum of care is commissioned, from generic end of life care and support such as that delivered by primary care teams, hospital teams and social services, through to hospice care and specialist palliative care services.

3.3 Reading Borough Council and the Reading CCG's are currently working together to ensure that care and health services are safe, timely, appropriately commissioned and delivered in a way that enables a personalised and proportionate approach.

3.4 Reading's Reablement and Intermediate Care teams play a role in offering high quality social care.

3.5 Continuing Healthcare is small part of wider services, including social care, which may provide care and support to people at the end of their lives. Where an individual with an end of life prognosis has been found to have a primary health need, care funding should be applied for either through a full continuing healthcare assessment or a fast track referral to ensure clinically appropriate care is offered, which is free at the point of delivery to the individual.

3.6 It is important that processes locally are robust and timely to ensure individuals are offered clinically appropriate care in their preferred choice of residence at the end of their life. This issue, and in particular planning for discharge from hospital,

has been identified locally as requiring a comprehensive joint effort and cooperation between RBC Adult Social Care and Reading CCGs.

3.7 The CCGs have recently commissioned a new 24 hour, 7 days a week Palliative care co-ordination and support service called **"PallCall."** The service, provided by Sue Ryder, through a single point of contact for patients, families and healthcare professionals, is available to anyone in their last 12 months of life with a Berkshire West GP, or to anyone who is providing support to those people. The service is designed to support End of Life patients to die in their preferred place and to prevent avoidable, unwanted admissions for that patient group. PallCall launched in mid-October 2016 and has in its first six weeks, dealt with 100 calls from patients, families, GPs, care homes, district and community nurses, and the ambulance service. They have prevented 19 admissions and supported 6 patients to die in their preferred place. The service is still developing and we plan to build on these early successes to deliver in home assessment directly, and to ensure GPs caring for palliative patients have considered medication well in advance of it being needed.

3.8 Relevant information at end of life is a key factor in managing care well and ensuring the needs and wishes of people are addressed. In Berkshire West we use a system known as "Adastra" to allow co-ordination of medical/clinical patient care. All GPs have access to this as do the local Accident & Emergency Departments and the ambulance service (SCAS). Work is underway as part of the Better Care Fund to develop IT integration between social care and health services. There is additionally access to specialist palliative care "Hospice" and day care facilities as well as a dedicated hospital based palliative care team.

3.9 There are a number of additional schemes which support and enable patients to remain in their preferred place of residence (including care homes) and where possible reduce the need for admission to hospital and/or A&E attendance. As well as the provision of inpatient beds people and specialist hospital palliative care , we also have access through our community teams to a Rapid Response Team (RraT) for patients in their own homes as well as those in care homes (nursing and residential).

3.10 Local GPs through an enhanced are service (CES) actively provide care planning, education in EOL for the primary care staff team , audit quality of end of life care at GP practice level and support of bereaved carers and families. A Berkshire West Anticipatory CES also further supports care planning for those individuals at highest risk of an emergency admission , putting into place arrangements in advance to support people to remain at home.

3.11 We also plan to further build on initiatives put into place in 16/17, with our community providers (Berkshire Healthcare Foundation Trust). This has improved the recognition of those patients who are entering their last year of life and are on the caseload of a community service (e.g. District Nurses, Community Nurses, Community Matrons, & community Inpatients). People once identified as entering the last year of life are then flagged to ensure the teams work effectively with GPs and the palliative care hub to support co-ordinated working for that patient.

3.12 Increasing access to healthcare education and shared learning has led to the development of a rolling programme of education across all CCGs. Practices can benefit from the local Palliative Care Consultant for case based discussion teaching. This has included managing difficult conversations and/advanced care planning, ultimately supporting the overall approach to improving patient care and outcomes. Going forward social care staff including front line carers would benefit from an education programme.

3.13 In summary, meeting the palliative and end of life (EOL) care needs of patients (and their carers) along a continuum of care, as appropriate, is critical to our overall vision and approach to integrated long term conditions management. This enables us to drive forward patient centred, holistic end of life care regardless of specific conditions, with services wrapped round the patient and where possible provided at or closer to home. It also focuses on a planned and proactive approach, minimising reactive and crisis response which often leads to hospital admission as the only option.

## 4. POLICY CONTEXT

The Berkshire West CCG Operational Plan 2017-2019 reflects the achievements and ambitions locally for end of life care. This was submitted on 23rd Dec 2016 as part of the NHS England planning for Clinical Commissioning Groups (CCGs).

The Reading Joint Strategic Needs Assessment highlighted national and west of Berkshire needs based on National End of Life Care Data. This identified that 48% of deaths took place in hospital and 45% of people died in their or place of residency. These figures are consistence with the national picture.

In September 2015 the National Palliative and End of Life Care: A national framework for local action 2015 – 2020, was launched.

The National Palliative and End of Life Care Partnership, is made up of statutory bodies including NHS England, the Association of Directors of Adult Social Care Services, charities and groups representing patients and professional and has developed a framework for action in making palliative and end of life care a priority at a local level.

The national framework sets out six 'ambitions' – principles for how care for those nearing death should be delivered at a local level:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

## 5. CONTRIBUTION TO STRATEGIC AIMS

The importance of the delivery of high quality End Of Life Care has been identified as an area of high importance for the Reading Health & Wellbeing Board and aligns with the Health and Wellbeing Strategy.

Safeguarding and protecting those that are most vulnerable.

## 6. FINANCIAL IMPLICATIONS

There are many routes to receiving palliative and end of life care, and with this a range of funding streams which can prove complicated, including; Continuing Health Care funding, through national and local charities (some supported by national funding), such as MacMillan and Duchess of Kent, and through the Local Authority care provision. The importance of robust processes and access to appropriate funding is essential to the delivery of care at the end of life and to provide support to carers.

## 7. BACKGROUND PAPERS

**7.1** Berkshire West CCGs operational Plan 2016/17 as a separate agenda item
**7.2** Once chance to get it right. (Leadership alliance for the Care of Dying people).
**7.3** Dying without dignity (Parliamentary and Health Service Ombudsman)
**7.4** More Care, Less Pathway, A review of the Liverpool Care Pathway
**7.5** Ambitions for Palliative and End of Life Care: (A national framework for local action 2015 – 2020). Association of Directors of Adult Social Care Services 2015.