COMMISSIONING ARRANGEMENTS ON BEHALF OF ISLINGTON CCG
PEOPLE AT THE END OF LIFE

The End of Life Care (EOLC) Strategy 2008-13 set out the strategic direction for the NHS with two key aspirations: to improve the quality of care for people at the end of life and to support more to die in their preferred place of care, usually at home.

A multi agency Steering Group was set up to oversee the implementation of the strategy. This has clinical input from both the GP Macmillan Facilitator as well as palliative care consultants from University College Hospital and Whittington Health integrated Care Organisation. The group meets quarterly and is currently chaired by the Assistant Director for Strategic Commissioning (a joint post with the Council). As we move forward the CCG Lead for Palliative Care will take over this role. The group sits under the auspices of the Service Improvement Group (SIG) within the shadow CCG governance structure.

The purpose of the Steering Group is both to take oversee the delivery of the strategy and harness the experience of front line practitioners to inform commissioning. It has been important to bring colleagues together so that issues can be shared and improvements embedded into commissioning. For example, it was recognised that care home staff often lack the confidence to care for people at the end of life and this can lead to emergency admissions and poorer outcomes. As a result, the decision was made in the Steering Group that the community palliative care team (Elipse) should establish link worker roles for each care home in the borough to support staff to care for residents at the end of life.

At present there is no representation at the group from LINK or other user representation but as with all groups under the direction of the SIG structure we aim to have a way of representing patient views in the future although given the nature of the cohort this will present unique challenges.

Some key achievements include:

- The tender of a new community palliative care service (Elipse)
- The roll out of the Gold Standards Framework (GSF) across care homes. Although not all homes went on to achieve the award the GSF brought with it an intensive training programme aimed at improving the standards of care across homes
- The contribution to a Cluster wide programme to develop a hospice tariff –this helped us to benchmark the price paid by different purchasers and has supported the local case to increase the bed day rate from £236/bed day in 2011/12 to £300/bed day in 2012/13 across two hospices (we have highlighted further work for 2012/13 to identify financial risk if a national hospice tariff is developed)
- The development of a training programme for front line staff across care homes, district nurses, GP’s, other care staff – initially delivered through St Joseph’s hospice, now by Elipse
- Appointment of a general practice facilitator by Macmillan Cancer support to work with primary care (Dr Patrick McDaid of The Miller Practice).
- Islington became one of four sites for a study on experience of End of Life care led by Kings College. This supported evidence to suggest that those most likely to die in their preferred place of care had social networks that could support them with choices around their care. It also highlighted the importance of well planned, co-
ordinated care particularly between primary care, community providers and acute hospitals.

Possibly one of the most significant achievements was the development of a GP End of Life Care Local Enhanced Service (LES) that saw improvement in both GP registers (from 214 registered patients to 447 over the two year period 2008/09 and 2009/10) and more deaths out of hospital (a statistically significant drop in the proportion of deaths occurring in hospital from 61.6% to 54.8%). It was estimated that whilst driving up these quality improvements this programme also delivered savings approaching £300,000 per annum.

The EOLC LES included educational events that practices attended and encouraged community multi disciplinary team (MDT) meetings within practices with Community Nursing and Palliative Care teams with an emphasis on action points for each meeting. An 'after death analysis' was encouraged to generate practice action plans to identify areas of learning.

The LES is currently being re-launched recognising the unique role of the GP in caring for a patient in their last year of life through having a knowledge and trust engendered by familiarity with the patient's past and their local area. It aims to motivate and support and will again have a focus on advance care planning, having difficult conversations and learning through after death analysis. It is hoped that the after death analysis in particular will identify gaps, opportunities and solutions around end of life care and for this to inform future service development.

Through the LES we will increase the size of practice palliative care registers and by default will increase the profile of End of Life Care. It will promote the use of the 'Quick Guide to identifying patients for supportive and palliative care' developed in Camden and Islington (one of three recommended tools for identification in the '2011 NICE Quality Standard for End of Life Care' and through focused and documented MDT meetings will aim to support better and more co-ordinated care.

We also aim to improve the confidence of GP’s to start end of life conversations – this is a prerequisite to formal advance care planning and documentation.

The palliative care budget supports a contract with Central and North West London NHS Foundation Trust who provide the community service, Elipse, and three hospices; St Johns and Elizabeth based in Westminster, Marie Curie in Camden and St Josephs in Hackney. One requirement of the community palliative care team tender was to have a local site within Islington and so Elipse are based in the north of the borough.

We have worked closely with the CCG Palliative Care Lead, as part of the Steering Group, to develop a work plan for 2012/13 and to identify resources to take forward areas of work. Key aspects of the work plan for 2012/13 include:

- The rollout of ‘Co-ordinate My Care’, a pan-London electronic end of life register, replacing the out of hours handover form and acting as a single point of access for all health care professionals including the London Ambulance Service. ‘Co-ordinate my Care’ will be able to hold personal care plans created by clinicians in partnership with patients. This launch is currently timetabled for September 2012
In addition to the IT system the ‘Co-ordinate my Care’ roll-out includes training provided by the team that covers relevant communication skills, an update on formal advance care planning and use of the ‘Co-ordinate my Care’ register.

Public Health colleagues have been asked to produce an updated needs assessment. This will support work going forward particularly the updating of the specification for community palliative care services in preparation for a tender in 2013 as well as the development of commissioning intentions for hospices going forward.

An analysis of demand including demography, length of stay, place of death and impact of continuing health care decisions.