

## Developing an integrated approach for End of Life Care in Kirklees – February 2017

Kirklees Council, North Kirklees CCG, Greater Huddersfield CCG, Locala and Kirkwood Hospice

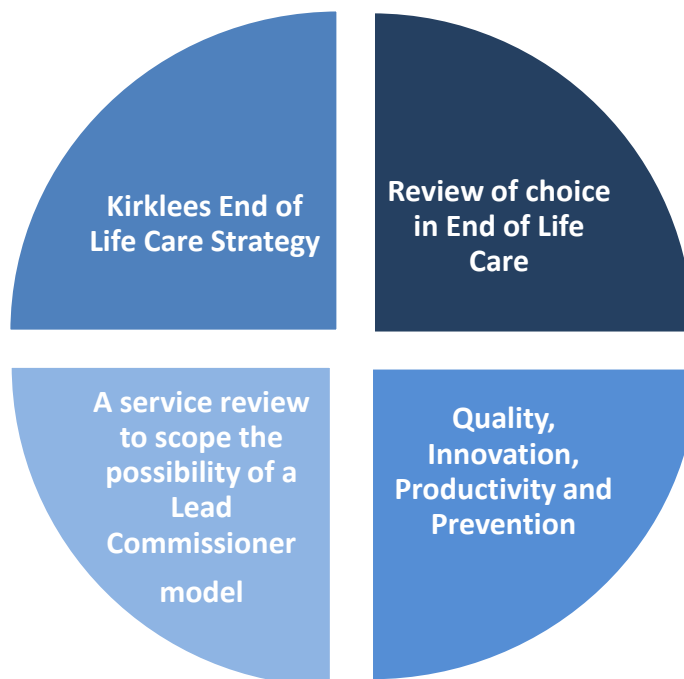
### Introduction

1. Work on End of Life Care has been undertaken to develop an integrated approach across Kirklees, with involvement from the Clinical Commissioning groups, the Council, Kirkwood Hospice and Locala. This paper provides:
  - An overview of the work that is being developed, with updates from key partners.
  - Assurance that the approach taken has ensured consistency in the standard of care and support across the district
  - Details of future plans

The CCG's currently invest £1.6m across a range of services which include a sitting service, hospice services, the 24/7 helpline and fast track services. There is an acknowledgement that the wider cost of end of life care is much higher, taking into account the impact across the entire health and social care system, which is why collaborative working between partners is essential. Kirkwood Hospice is also a key commissioner of palliative and end of life services for people in Kirklees and commission £3m of services on behalf of the local population in partnership with CCGs, from their share of the above funding and their own fund raising activities.

### Context

2. There are four key areas of activity currently being utilised to develop a Kirklees wide end of life offer. This work is taking place across all agencies linked to the provision of end of life care and includes the Local Authority, General Practice, the Clinical Commissioning Groups, Kirkwood Hospice and Locala. The four distinct areas of activity with the CCGs are:



- Kirklees integrated End of Life Care Strategy. (Local Authority / Kirkwood Hospice / GH & NK Clinical Commissioning groups)
- Review of choice in End of Life Care – the Governments response (Local Authority / Kirkwood Hospice / General Practice / GH & NK Clinical Commissioning groups)
- Provision of Comprehensive Care to meet the needs of those at End of Life (a review of services and to scope the possibility of the introduction of a lead provider model). (GH & NK Clinical Commissioning groups) **Note** as this develops all providers will be engaged and contribute to a full service specification.
- Quality, Innovation, Productivity and Prevention. – through admission avoidance and the roll out and use of the Electronic Palliative Care Co-ordination system. (GH & NK Clinical Commissioning groups, General Practice)

Although these are four distinct work streams they do not sit in isolation of one another, given that the objectives of the strategy are being incorporated into the service review; the choice at end of life recommendations have been incorporated into the strategy and that EPaCCS is referenced across both strategy and review of choice.

Both CCG's ambition for the future is to move towards population based commissioning where we break down silos in current service delivery so the focus is on patient centred care and health and wellbeing, while reducing health inequalities for our local population. This will include the development of integrated models of care provided by a collaboration of organisations, enabling and empowering patients and their carers to access care in the most appropriate place with a focus on integrated and holistic care pathways. This will be supported by population based budgets, with the intention of a resulting shift in activity out of hospital and into more appropriate settings, ensuring patients are managed more effectively at or as close to home as possible. This is in line with national imperatives to move to more integrated systems of care, with an evolving role and function of both Clinical Commissioning Groups.

## **Work stream activity**

### **3.1 Kirklees integrated End of Life Care Strategy**

The aim the integrated end of life care strategy and vision was to set out integrated strategic priorities for end of life care in Kirklees.

It has drawn on information from previous strategies, commissioning documents, existing knowledge, current work programmes and national guidance. Patients will be engaged in the implementation of the strategy making use of existing forums and reference groups.

This overarching set of strategic priorities is based on an underpinning Outcomes Based Accountability analysis. The action plan described below sets out the response to the shared Kirklees priorities.

It has been developed by lead representatives for commissioning bodies in Kirklees including Kirklees Council, Kirkwood Hospice, North Kirklees and Greater Huddersfield and in consultation with provider organisations such as Locala.

Under five categories a set of objectives was defined by commissioners as the aspiration for a comprehensive end of life offer. These are reproduced below:

### **3.1.1 Discussions as end of life approaches**

- People, carers and their families are encouraged to discuss their end of life needs as early as possible with relevant professionals. Professionals need to feel able to broach this subject and have the skills to do this sensitively. This will facilitate the development of a timely co-ordinated care plan that most effectively meets their needs and wishes.
- Further steps are taken locally to tackle the taboo for the public and professionals around about discussing death and dying as a life event.

### **3.1.2 Assessment, care planning and review, co-ordination of care**

- People nearing end of life are identified and recorded in GP Practices so that a co-ordinated care plan is in place that can be shared by those staff and professionals supporting patient/ carer/ family, both in and out of hours.  
*GHCCG and NKCCG will continue to implement Electronic Palliative Care Co-ordination Systems (EPaCCS) (locality registers) or equivalent systems in Kirklees as a means of supporting this. Work is currently being undertaken to develop a frailty model within North Kirklees, of which a key component is earlier identification of those nearing the end of life.*
- People at the end of life have a care coordinator identified.
- End of life care pathways are incorporated into the Care Close to Home model, paying specific attention to requirements as part of implementation of the Care Act.

### **3.1.3 Delivery of high quality care in different settings, care in the last days of life**

- Improve where necessary, end of life care for those in residential and nursing homes by developing targeted information and training for staff within residential and nursing care homes.
- Improve where necessary, end of life care for those in acute hospitals by developing targeted information and training for staff.
- Ensure that people are not prevented from dying in a place of their preference by process/ systems barriers (e.g. lack of access to specialist equipment such as profiling beds).

### **3.1.4 Care after death**

- Ensure that recently bereaved people have timely access to information about relevant services such as bereavement support.

### **3.1.5 The whole end of life pathway**

- Ensure that individuals, carers and their families' experiences actively influence and shape local services.
- Ensure that non specialist staffs receive appropriate and effective education and training on an ongoing basis through a more co-ordinated approach across partners in Kirklees.
- Ensure that families and carers are supported through the whole end of life pathway.
- Develop use of End of Life Champions across Kirklees.

Under each of these criteria a set of actions was identified and has formed the basis to develop a consistent approach to end of life care. See table below.

### 3.2 Review of choice in End of Life Care – the Governments response- Document to be embedded

What’s important to me? - A Review of Choice in End of Life Care was published in February 2015.

30 recommendations were made within this paper and the Government responded to those recommendations in 2016.

As a means to gauge the Kirklees offer each recommendation was considered by all partners and a position was recorded against the recommendation, this is now being cross referenced to the strategy to ensure that the strategy remains current, reflects best practice and continues to be fit for purpose.

The six ambitions contained within the ‘Ambitions for Palliative and End of Life Care - A national framework for local action 2015-2020’ have also been incorporated into the strategic view:

Ambition	Description	Joint Strategy	Review of choice – local position
Each person is seen as an individual	<i>I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what’s possible.</i>	<p>Roll out EPaCCS across Kirklees, noting when full coverage of all GP practices will be achieved and any follow-up and/or which will be necessary in the future.</p> <p>Baseline assessment of bereavement support options available in Kirklees to identify any gaps and look at how support can be made more consistently available across Kirklees.</p> <p>Ensure local information for people, family and carers is available at all stages of the EOL pathway to support people to be able to come to terms with and plan end of life care, understand services that are available both during end of life and following death.</p>	<p>EPaCCS evidences the conversations around choice and preferred priorities of care. Currently incompletely applied, but continue to promote EPaCCS. The challenge for local authorities and is being flagged up at strategic joint Health and Social care forums.</p> <p>Enhanced SCR to make sharing EoLC choices easier for our EMIS practices, could use codes for Personal care plan as a mark of these conversations having happened and look to monitor and improve.</p> <p>Need to be clear where to signpost carers to - carers count or other relevant agencies. Kirkwood service designed to support carers:</p> <ul style="list-style-type: none"> <li>• pressure area care</li> <li>• moving and handling</li> <li>• monthly Coffee retreat</li> <li>• peer support and that of the professionals.</li> <li>• Care and Share’ group – info and networking for carer’s</li> <li>• bereavement support</li> </ul> <p>Carers work within GP practices for up-to-date figures of identified patients. This is monitored via Carers Champions PPT meetings.</p> <p>Carers Count and the route to accessing Carers Assessments in line with the Care Act.</p> <p>Practices across Kirklees have been encouraged to identify and record patients who are approaching the last year of life.</p>

Ambition	Description	Joint Strategy	Review of choice – local position
Each person gets fair access to care	<i>I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.</i>	<p>Raise awareness to address public perceptions of the role of Hospices</p> <p>Review existing EPaCCS template and explore if necessary, whether the existing template meets the needs of all stakeholders.</p> <p>Develop central point of access for information and signposting on bereavement support.</p>	<p>24hr helpline for specialist palliative care advice. Kirkwood is now 'open' to admissions 7 days a week.</p> <p>Discussions and documenting the discussions, around preferred priorities of care is the key.</p> <p>Locally there is fast track funding approved. Fast track pathways manage and review for 8-12 weeks. Following this the service user will be allocated care via Brokerage.</p> <p>This function has been included within the Prior Information Notice- and will form a key element of the accompanying service specification.</p> <p>Locala End of Life Care Champions</p>
Maximising comfort and wellbeing	<i>My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.</i>	<p>Review assessment protocol for access to specialist equipment (e.g. profiling beds) for Fast track end of life care and amend if necessary to ensure appropriate and timely access to relevant equipment.</p>	<p>Although the commissioning of care co-ordinators differs across Kirklees, with North Kirklees commissioning care co-ordinators within Locala, the function is also covered by a variety of HCPs.</p> <p>Where these discussions take place they need to be documented and coded. Anecdotal information suggests that that this does happen, although is difficult to evidence.</p> <p>This will be influenced by using EPaCCS.</p> <p>Health care professionals need to have the skills and education to feel confident in having these conversations and also be able to recognise dying.</p>
Care is coordinated	<i>I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.</i>	<p>Explore access to EPaCCS template for all relevant health and social care across adult and children's services (including residential and nursing care), professionals including independent sector staff (dependant on access to SystemOne)</p> <p>Explore available data on conditions and care packages for people at the end of life.</p> <p>Explore which data could make up a meaningful 'Dashboard' on End of Life Care to inform commissioning,</p> <p>Map existing services, roles and responsibilities available to support end of life care across Kirklees Develop 'Dashboard' for ongoing monitoring of end of life care.</p> <p>Develop an integrated commissioning plan for training and education which looks at specific needs of different professionals. This will include the development of EOL Champions.</p>	<p>Included in EPaCCS as is the care co-ordinator information but not consistently completed. GP is usually the named responsible clinician and this overlaps with the requirement for all to have a named GP.</p> <p>Even though the GP is named responsible clinician, further work is required to develop co-ordinated care across different teams and workforces.</p> <p>Community services have a role to play, and this could be developed further</p> <p>Discussions and documenting the discussions, around preferred priorities of care is the key. Part of the EPaCCS template.</p> <p>In the core plus element of the primary care strategy we are looking to include EoLC in the LTC section especially for COPD, heart failure and dementia.</p>

Ambition	Description	Joint Strategy	Review of choice – local position
All staff are prepared to care	<i>Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.</i>	<p>Explore what training resources are currently available for professionals to help them to broach the subject and support people making decisions</p> <ul style="list-style-type: none"> <li>• Collate current resources.</li> <li>• Training leads to meet and share best practice.</li> </ul> <p>Identify variations in quality of end of life care across residential and nursing homes.</p> <p>Draw on any good practice to target training and other interventions where needed to improve quality.</p> <p>This will include:</p> <ul style="list-style-type: none"> <li>• Developing stronger links with Kirklees Residential Care team.</li> <li>• Exploring contract monitoring information in nursing homes.</li> <li>• Working with Kirklees Council to explore current issues and develop/source targeted information and agree how to disseminate</li> <li>• Reviewing training and education role of Kirklees Home Care Support Services.</li> </ul> <p>Links to wider piece of work on quality to be overseen by Physical Wellbeing, Ageing Well and Independence Integrated Commissioning Group.</p> <p>Links to training strategy.</p>	<p>Training is currently provided by Kirkwood who provide sessions on communications skills of varying length and depth. Also around care planning with the addition of HEE.</p> <p>There are ongoing training, monitoring and feedback to S1 practices relating to EPaCCS, its use and take up.</p> <p>The EOLC champions training for Locala is based on these core competencies and is underpinned by the Ambitions document</p> <p>Integrated End of Life Care action plan included an action to review existing training. This was completed and led by Kirkwood. The next step is to develop the integrated training plan which is also being led by Kirkwood.</p> <p>EoL community partnership funded groups exist.</p> <p>Taking training to practices. To work on opportunities for training – short courses / master class options / GP / junior doctor / locally.</p>
Each community is prepared to help	<i>I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways</i>	<p>Develop public information/ awareness-raising about end of life considerations to help to break down taboos etc.</p> <ul style="list-style-type: none"> <li>• Review existing national / local resources/ evidence available to explore what works.</li> <li>• b) Develop joint communications response and deliver as appropriate.</li> </ul> <p>Explore potential role of *Connect to Support online E Market place/ information resource and Gateway to Care as a means of raising awareness of end of life issues, breaking down taboos, providing information in one place.</p> <p>Identify, collate and share summary of existing feedback from individuals and their carers including the national voices survey, Kirkwood/ Forget Me Not Hospice/ Martin House patient engagement information, CCG patient engagement information.</p>	<p>EoL community partnership funded groups.</p> <p>List of voluntary organisations locally who have a particular role in EoLC are available. These are promoted via a poster within communities.</p> <p>Work has included setting up a dedicated EOL area on Connect to Support containing relevant info/ service etc. including bereavement services. Kirklees Community Partnerships have also been working on commissioning community contracts. Funding three organisations to establish community activity for people who have been diagnosed with a life-limiting condition and are within the last 12 months of their life.</p>

Ambition	Description	Joint Strategy	Review of choice – local position
Each community is prepared to help - <b>continued</b>	<i>I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways</i>	Potential to link to development of Dashboard as noted above  Reps on Stakeholder groups to advise on appropriate information sources	In June 16 for organisations already running activity and those which would like to start activity, along with other stakeholders including Kirkwood Hospice and potentially Locala. The aim was to look at what the Kirklees offer would be and how we could promote it, including discussion on any barriers and how these may be overcome. Community Partnerships have produced publicity ( <b>Directory On-A-Page</b> , of activity groups for Kirklees residents living with life limiting conditions and illnesses.) for GPs and waiting areas/other public places has helped to get out and they are hoping that they will help with getting people into the activities.  More info available, voluntary sector can be great help in bridging the gap  Integrated End of Life Care Vision and Action Plan developed with Health and Wellbeing Board oversight.

### 3.3 Provision of Comprehensive Care to meet the needs of those at End of Life

Following a review of the end of life related grants it was decided that the scope to bring services across the whole of Kirklees under one commissioning arrangement be considered. This developed into the End of Life Prior Information Notice (PIN).

It was decided that a soft market test should be carried out to consider whether there were suitable provider/s and appetite within the market for this service area.

The purpose and content (abridged) of the PIN/RFI is articulated below, and was presented to market as follows:

- This is a Request for Information (RFI) published on behalf of the Clinical Commissioning Groups.
- The purpose was to gauge market interest and potential for introducing the development of a lead provider for End of Life services.
- The commissioners are seeking expressions of interest to meet the needs of the Kirklees community.
- The statutory duties of the CCG will remain with the CCGs with service delivery via a service specification and MOU.
- End of life care has been identified as a priority programme for the commissioning partners of Kirklees and any expression should reflect the objectives of the Kirklees strategy - 'High quality, person/family centred care for people at the end of life'.
- The service will operate, providing seamless high quality services to the population of Kirklees, demonstrating interdependencies with all sectors.
- Services will be delivered to meet the defined care pathway.

This exercise closed in November 2016, and resulted in 8 expressions of interest. A working group have met to discuss the results of the exercise. The next steps include making a recommendation to the joint SMTs to develop a collaborative approach to create a lead provider arrangement. The paper has been produced and will be on the agenda for 10<sup>th</sup> February 2017.

### 3.4 Quality, Innovation, Productivity and Prevention

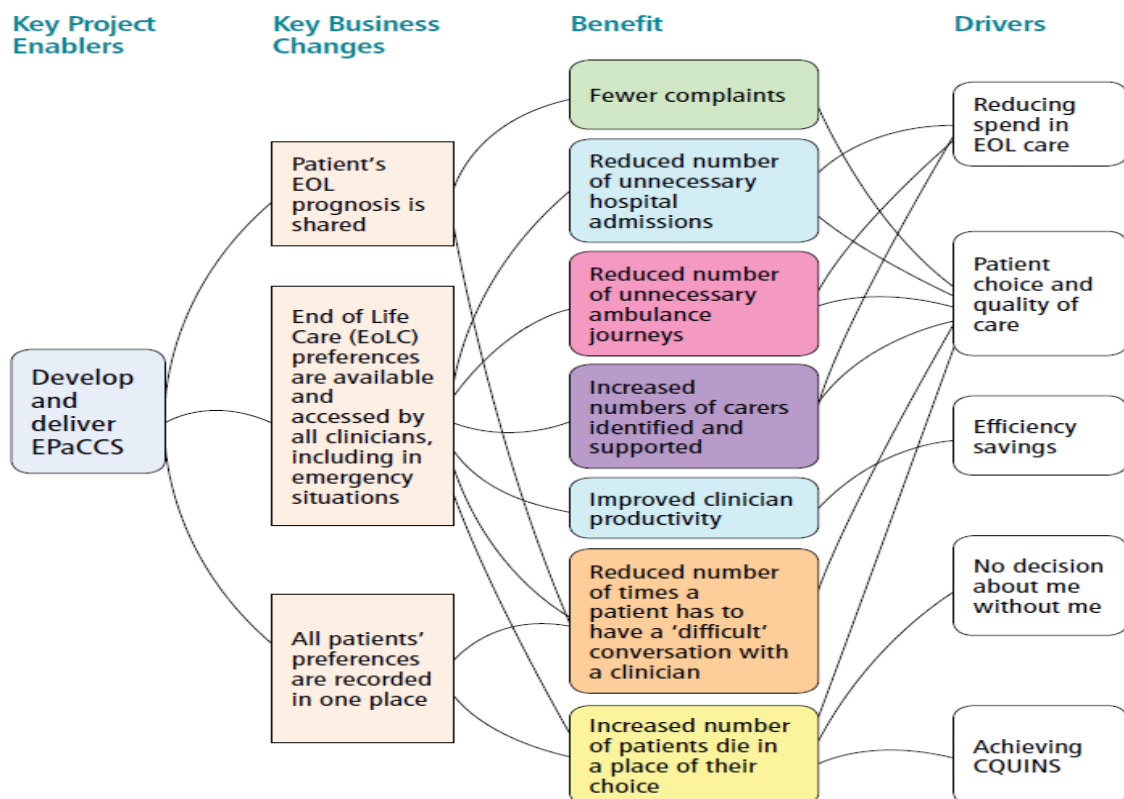
#### 3.4.1 EPaCCS

The End of Life Care Strategy (2008) identified the need to improve co-ordination of care, recognising that people at the end of life frequently received care from a wide variety of teams and organisations.

EPaCCS enable the recording and sharing of people’s care preferences and key details about their care with those delivering their care. The systems support co-ordination of care and the delivery of the right care, in the right place, by the right person, at the right time.

Statement 8 of the NICE Quality Standard for end of life care for adults published November 2011, also recognises the potential of EPaCCS, highlighting the importance of effective care co-ordination and of standardised documentation. The standard identifies locality registers or other systems as a mechanism for facilitating effective care co-ordination.

Key outcomes that the EPaCCS can deliver:



### **3.4.2 Local implementation – GHCCG**

The rollout for EPaCCS in Greater Huddersfield was carried out between February and April 2015 to all SystemOne Practices. All 23 practices received a practice visit from a multidisciplinary team.

EPaCCS records can be accessed by any professional who may be caring for a patient; including their GP, district nurses, specialist nurses, hospice services and some hospital services. The EPaCCS records are particularly useful for professionals such as out of hours doctors and night nursing services who may be less familiar with a particular patient. Recording this information in one place allows easy access to it, preventing repetition, duplication and aiding decision making. The EPaCCS also acts as a library for useful information that can be accessed by healthcare professionals either for their own use, or for patients and their carers to use.

Within Greater Huddersfield EPaCCS continues to be promoted within practices and a small increase (2.75%) in usage has been noted. The tool has also been marketed with Local Care Direct to ensure that the OOHs service is aware of and able to access the tool.

### **3.4.3 Local implementation- NKCCG**

The EPaCCS rollout was launched at a dedicated Practice Protected Time in July 2014. All 29 practices received a practice visit from a multidisciplinary team and provided positive feedback on the benefit they felt EPaCCS would bring. The practice visits also provided the multidisciplinary team the opportunity to promote relevant services and signpost practices to training and education opportunities.

From the outset, the agreed aims for the project were:

- Improving communication across boundaries of care– including handover to Out Of Hours, and anticipatory prescribing
- Improving and supporting early identification and intervention of patients at end of life, to reduce unnecessary A/E attendances, admissions and length of stay and improve planning for transfer of care.
- Enabling reliable data for strategic and transformational planning
- Improving the consistency of recording of EOL QOF indicators and CQUINs measures
- Improving the quality and efficiency of existing Gold Standards Framework meetings

Data from EPaCCS has been promising, showing that compared to the baseline (deaths in the last 12 months on the QOF register) EPaCCS deaths show:

- Increased percentage for those with an Advance Care Plan documented
- Increased percentage of patients with OOH Handover form completed recorded
- Increased percentage for those with DNACPR recorded
- Increased numbers of those with a preferred place of death recorded

In addition, a positive impact on GSF reported by practices and district nurses. Training sessions have been held for LCD and Locala district nurses, with EPaCCS referred to positively in the Mid Yorkshire CQC report (2014) for Community End of Life Care.

The work to embed EPaCCS within North Kirklees has been supported by the lead GP for EOL care, who has visited practices to discuss ways of improving the recording of patients approaching their last year of life and to ensure practices are completing the EPaCCS template correctly. All practices have received targeted resources disseminated through locality cluster meetings, and 8 practices have requested a follow up visit from the lead GP for EOL care, with a further 6 visits scheduled in 2017. All practices visited have received a resource pack and have provided positive feedback as to the value of the visits.

### **3.4.2 Admission avoidance**

North Kirklees CCG has undertaken a project with Kirkwood Hospice, to investigate the impact of the hospice's services upon unnecessary secondary care admissions. A monthly report is produced detailing the numbers of appropriate admissions prevented and patients supported to die in place of choice.

## **4. Locala update**

### 4.1 Introduction

In Kirklees, approximately 3,800 people die each year. Based on national projections the number is expected to rise by 17% from 2012 to 2030. The percentage of deaths occurring in the group of people aged 85 years or more is expected to rise from 32% in 2003 to 44% in 2030.

Approximately three quarters of deaths are expected, which for Kirklees is 2,850 people, there is potential to improve the experience of care in the last year and months of life for these people, and those close to them, each year.

The approach to supporting patients, carers and professionals is multi-faceted to ensure we deliver quality evidence based care.

### 4.2 Integrated Community Care Teams (ICCTs)

The Locala ICCTs provide comprehensive assessment and planning throughout the individual's end of Life Care Pathway.

The principle of one co-ordinated care plan with a single professional care co-ordinator, co-ordinating care for end of life patients and their carers is in place. Specialist Palliative Care Nurses working with the hospice have access to System One and sharing modules between themselves and Locala colleagues, along with the implementation of the electronic palliative care co-ordination system (EPaCCS) will support improved communication.

### 4.3 Electronic Palliative Care Co-ordination system

Locala instigate the process of Advanced Care Planning by discussing the persons and their families end of life care needs. These discussions and wishes are recorded in the system. This ensures the individuals preferences are known and communicated.

#### 4.4 Individualised care of the Dying Document (ICODD)

The doctors and nurses in our hospitals, hospices, care homes and in the community are dedicated to caring well for people who are dying. We also want to support their families/carers at what can be a very difficult time. It is vital that we get the important things right for the dying person, which will be different for each one, so we use an individualised care document for people in the last few days of life.

The individualised care of the dying document is used when the team of doctors and nurses have treated any reversible causes for a person's deterioration, and consider the person to be dying from their illness and in the last few hours or days of life.

The ICODD which was created around the five priority areas as described by the Leadership Alliance in March 2014. These priorities which are of equal value cover:

- The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
- Sensitive communication takes place between staff and the person who is dying, and those identified as important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

The ICODD is being used with minor adjustments to each clinical setting across Kirklees and Calderdale within the hospice and acute setting and is being rolled out with in the Community/Primary care setting.

#### 4.5 Verification of Expected Death

Nurse verification of expected death commenced in Jan 2015 within Kirklees/ Calderdale. This is fully supported by the current Coroner Martin Fleming. Nurse verification has impacted upon family and carers support and welfare at one of the most emotive and difficult times during a person's dying pathway. This encompasses the Commissioning Carers principle 3 of the right care, at the right time, in the right place. We have had some fantastic feedback stories around this for example:

Just to let you know I verified my first patient death last week, I was a bit nervous at first. The patient had died at 5.30pm and I attended at 6.30pm, the funeral director collected the person at 7.15pm. The family were really pleased that everything was done quickly and efficiently and they weren't waiting around for hours for an Out Of Hours GP to attend.

#### 4.6 Care Homes Hospital Bag Scheme

The Care Home Transfer bags are used to transfer standardised paperwork, medication and personal belongings with the resident throughout their hospital episode and are returned home with resident. The standardised paperwork will ensure that everyone involved in the care for the resident will have necessary information about the resident's general health, e.g. baseline information, current concern, social information and any medications, on discharge the care home will receive a discharge summary with the medications

This is progressing to a trial pilot within Calderdale and Huddersfield Foundation Trust. The joint working of all health and social care colleagues will support transfer of residents from care home to acute trust setting.

#### 4.7 Care Homes

Consultant clinics held in care homes where complex residents can be referred for assessment and plan of care put in place.

Collaborative working with the acute trust has resulted in improved discharge summaries ensuring the care home has a written plan of care.

The Care Home Support Team have created a personalised information booklet to support Advanced Care Planning.

Education and training in care homes include a guide to advanced care planning for care staff in residential and nursing homes.

#### 4.8 Case Study

66 year-old resident with advanced dementia for 16 years, bed bound and reduced swallow reflex. History of weight loss - admitted with aspiration pneumonia.

Advice for care home and GP - After long discussion with the residents daughter and the medical consultant Dr Seebass, it was agreed that repeated hospital admissions are not in the best interests given the progressive and incurable nature of her condition. Admission to hospital causes unnecessary distress to her. In future if she exhibits new symptoms these should be managed by the GP. This includes oral antibiotics and symptomatic relief. Unfortunately the "111" service will not be aware of these complex care planning decisions and will in all likelihood call an ambulance, it is for this reason that she will always need to be reviewed by a GP (including out of hours) in order to treat her in the home and not in hospital. We have made the Care Home Support Team aware of this lady in the hope they can assist you with the management of this patient going forward. We have made a referral to the community Hospice team. If this lady develops symptoms we recommend that these are managed in the home with palliative care medicines and simple non-distressing medical interventions. Please ring the hospice hotline if you require help with this and cannot get advice from the GP.

#### 4.9 MDT Collaboration

Care Home Support Team (CHST) arranged MDT – Daughter, care home and GP – agreed palliative plan. Resident died in care home peacefully

Daughter contacted CHST following relative's death to thank team for their input and professionalism – it made all the difference to ensure a peaceful death.

GP noted excellent, informative and clear discharge letter from CHST (evolutionary process with working with consultants and being clear about escalation plan).

GP – without consultant support difficult to make decision about ongoing care, young age and time constraints.

#### 4.10 Training

Macmillan Nurse Specialist provide Gold Standards Framework Training to designated care homes. End of life Care training and support is provided to all care homes, these training sessions range from one off sessions to a structured programme.

EOL Champions training is available to 25 staff per year within Locala over a five year period.

EOL care training is offered to all Locala colleagues with a range of options.

Care Home Support Team provide training to the care homes in south on a range of subjects which includes EOL. This is linked to the Macmillan nurse specialist training.

### **5. Kirkwood Hospice update**

Kirkwood Hospice (KWH) provides a broad, comprehensive range of services to people in Kirklees. The services which the Hospice delivers (and commissions) provide holistic care including practical, social and psychological, spiritual and religious support as follows (see Appendix One) for further details of these services and their impact:

- In-Patient Hospice Care - 16 beds at our purpose built site in the centre of Kirklees\*
- Support and Therapy Centre for Day Attendance
- Support and Therapy Centre Drop-In service for patients and carers
- Educational / Support Programmes for those with life-limiting conditions
- Community Specialist Palliative Care Team including Admiral Nursing for people with dementia at end of life.
- Lymphoedema Follow-Up clinic
- Out-Patient Consultant Clinic
- Specialist 24/7 Advice Line for professionals, patients and carers
- Family Care Team - specialist emotional and psychological support including counselling for adults and children before or after bereavement

As well as providing outstanding care for people with life-limiting illnesses, their families and loved ones, we also support fellow professionals through education, training and advice. Whether colleagues are looking for information, advice, care or support, KWH is on hand to help.

KWH has been involved in the development of the Kirklees Strategy for End-of-Life Care and, having made significant contributions to the progress made to date, is very supportive of the direction of travel. In addition, KWH is committed to increasing the level of its voluntary funding to grow investment in local services. KWH believes that this commitment will create opportunities for service developments in the future in collaboration with its partner CCGs.

- KWH successfully coordinates the care of nearly 1400 people every year – nearly 90% are supported to die without requiring Hospital admission at the end of their life
- KWH has been leading the development and delivery of end-of-life care services in Kirklees for nearly 30 years
- KWH is held in the highest regard by the local community for the quality of care that we deliver. Local people are very protective of what is an important local charity
- KWH provides almost £3million of voluntary funding to commission our palliative and end-of-life care services for people in Kirklees
- KWH delivers significant social value in the local economy deploying a network of 800 volunteers (the largest in Kirklees) delivering benefits for people with life limiting illness

KWH continues to innovate and improve the quality of end-of-life care that is delivered and is completely embedded within the local system, working in partnership with all local providers and commissioners.

The KWH strategic plan [Let That Moment Be Now](#) illustrates the priority for the Hospice to reach more people who have palliative care needs before the end of life. The plans which are well underway are to reach more people with diseases other than cancer and to reach people from different parts of the community in Kirklees that have not traditionally accessed Hospice or palliative care services. One example is that In 2015 KWH commissioned a [report](#) from Healthwatch Kirklees regarding the understanding and perceptions of South Asian groups on end of life services in Kirklees.

KWH has continued to influence local services and strategy through its involvement, with other commissioning partners, in developing the Kirklees Integrated End of Life Care vision and also shaping the services offered through the Care Closer to Home contract. The Pathway objectives described in the CCGs' Prior Information Notice were developed as part of this vision, which we contributed to. Of all the organisations involved in providing End-of-Life Care in Kirklees, KWH is confident that it is achieving most of these objectives already, for the people that are known to us.

- I. People are informed as early as possible about the approach of end of life to enable informed decision making about their preferences.*

As a specialist provider KWH does this as standard. KWH is the local expert in Advanced communication skills and Advance Care Planning, we provide education to other professionals (e.g. Locala, CHFT and YAS) to enable improvement in the practice of generalist professionals.

- II. End of life care is timely, compassionate and reflects their needs and wishes as far as possible with respect to physical, social, psychological, cultural and spiritual aspects.*

This objective describes the ethos of Hospice care that Kirkwood has developed over the past 30 years. A comprehensive Multidisciplinary team (MDT) gives us the ability to meet the full range of needs more comprehensively than any other provider in Kirklees.

*III. People during end of life phase remain in a place of their preference where possible avoiding unnecessary hospital admissions.*

KWH continues to be successful in supporting people to avoid a Hospital admission at the end of life. In 2015-16 of all the people that KWH cared for, 725 died, all but 77 (11%) were supported to die away from Hospital.

*IV. Pain and other symptoms are managed as effectively as possible.*

KWH has developed a system of recording Patient Reported Outcome Measures (PROMs), which effectively capture symptoms and functional status of people accessing specialist palliative care services. This development is at the forefront of practice nationally and is not replicated elsewhere in Kirklees. Appendix six is a paper that provides a summary of this development and how it relates to pain and other patient needs.

*V. All people in Kirklees die with dignity and in a place of their preference.*

KWH leads the practice of advance care planning in Kirklees and as part of this establishes the preferred place of care for people at the end of life. At Appendix Eight there is information regarding the achievement of preferred place of care. 81% of the people we care for achieve their preferred places of care.

*VI. People and their carers feel supported both during end of life care and after the person has died.*

KWH provides support to everyone who is significant to the dying patient, this support is provided both pre and post bereavement. People are supported to continue to function as well as possible when they have been affected by the death of someone after a life limiting illness.

*VII. People and their carers are engaged in the co-production of services and service developments linked to end of life care.*

KWH was born out of the Kirklees community's desire to have high quality care for people at the end of their lives. Our board of Trustees are the representatives of the local community who direct and shape services to meet the needs of local people. In addition, every two months we hold the Kirkwood Future Forum, which invites service users to feedback and contribute to ideas for service development.

## **6. LA update**

The joint work relating to the End of life Strategy has already been described above.

In addition to this the Council has supported a number of community grant funded initiatives to improve services to those people at the end of life and their carers.

Updating the connect to support and the Kirklees website to be an accurate reflection of the services available and an effective signposting service to the residents of Kirklees.

## 7. Future areas of work

- Continued implementation of EPaCCS- associated governance routes/joint working across Kirklees despite there being separate acute footprints for NK/GH
- Training and education
- Care closer to home
- Delivering against the strategy
- Lead Provider Framework

## 8. Other initiatives

### ▪ Admiral Nurses

Jacqueline Crowther has recently been appointed at Kirkwood Hospice in a 2 year fix term post. The new service is a first of its kind in Yorkshire, made possible thanks to an innovative partnership between Kirkwood Hospice, Dementia UK and Kirklees Council. Jacqueline will work closely with GPs and Community Nurses across Kirklees to offer support when it is needed, when dementia advances or when end of life approaches. Training will also be offered to organisations that support people and families living with advanced dementia. There are currently 9 admiral nurses in the area (including Jacqueline's post,) 184 admiral nurses in total in the UK.

The only other gap identified at the launch of this service was to have an admiral nurse within the acute setting, as we don't have this at the moment.

### ▪ Learning Disabilities – EoL Care

The CCG commissioned St Anne's to produce a short video and training package 'Doing It My Way,' a comprehensive guide in End of Life Care for people with learning disabilities. The guide and DVD are part of an End of Life pack –also including the Probabilities of Life Expectancy tool and the Standards we aim to meet. I have attached the training document but as you know we are still 'looking' for the short film on the shared drive.

There is also the LeDeR Mortality review process which has started recently – reviewing all deaths of people with a learning disability (4-74.) This is led by the University of Bristol and we have people within the CCG/SWYPFT who have been trained as reviewers. Further training is to be scheduled as the time capacity for reviews is quite demanding alongside peoples day jobs. I can give much more info on this if you need it.

## Table of Progress and Amendments

Version	Date	Created by / Amendments made by	Comments
1 Initial draft	10 <sup>th</sup> Jan 17	Peter Kirkman	Initial draft
2	11 <sup>th</sup> Jan 17	Sadaf Adnan	Amends and NK additions Version circulated to partner organisations for input (12 <sup>th</sup> Jan 17)
3	16 <sup>th</sup> Jan 17	Peter Kirkman	To incorporate <b>Vicky Dutchburn's</b> comments and amendments.
4	19 <sup>th</sup> Jan 17	Peter Kirkman	To incorporate <b>Rachel Foster's</b> input into the paper to reflect Locala activity.
5	19 <sup>th</sup> Jan 17	Peter Kirkman	To incorporate additional info provided by <b>Nikki Gibson-Windle</b> on other initiatives.
6	19 <sup>th</sup> Jan 17	Peter Kirkman	To incorporate <b>Michael Crowther's</b> input into the paper to reflect Kirkwood activity.
7	20 <sup>th</sup> Jan 17	Sadaf Adnan	To incorporate <b>Dr Bilal's</b> comments and amendments from a NK perspective as well as minor formatting amendments.
8	20 <sup>th</sup> Jan 17	Sadaf Adnan	To reflect appropriate elements of NKCCG's Operational Plan.
9 Final draft	23 <sup>rd</sup> Jan 17	Peter Kirkman	Formatting and addition of Council references based on known activity and telephone conversation with <b>Phil Longworth</b> .