Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

# System End of Life (EOL) Care Review

## Proposed approach for JHOSC

Aug 6 2020

Dr Jane Povey , STW STP Clinical Lead

Dr Julie Davies, Director of Performance for STW CCGs

# Background

- Questions to CCG and Shropcom Boards from Gill George with respect to:
  - EOL planning and provision in Shropshire, Telford and Wrekin
  - FOI questions about out of hours primary care provision to enable EOL Care
- System review of EOL care across Shropshire, Telford and Wrekin initiated by CCGs and supported by JHOSC
- Recent CQC concerns about EOL Care including ReSPECT at SATH
- Experiences of End of Life and Palliative Care in Shropshire ( Healthwatch Shropshire : Jan 2020)
- CCGs AO ( Dave Evans) and Shropcom CEO ( David Stout) providing Chief Executive leadership and support for the review
- Discussion today to agree scope and plan for the review

# What we have done as a system so far:

- Well established system EOL group with Strategy on a Page
- System – wide implementation of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
- System Advance Care Planning Framework with implementation workstreams
- EOL planning and care recognised as a system clinical priority as part of delivering our Long Term Plan

T&WCCG.SCCG/Councils? The Shrewsbury and Telford Hospital NHS NHS Trust | hope house we're here for children | Shropshire Community Health NHS NHS Trust | Severn Hospice | SPIC Shropshire Partners In Care | Shropdoc

# Local *H*ealth Economy *E*nd of *L*ife and *P*alliative Care *S*trategy

Caring, Responsive, Effective, Well-Led, Safe: A positive experience for patients, carers and families

## National Ambitions

- Individual care
- Fair access to care
- Comfort and Wellbeing
- Coordinated care
- All staff care
- Caring Community

**Facilitate effective personalised care planning and support of those important to the dying person**

- Documentation provides clarity to all regarding patients' preferences/goals for living
- Important conversations
- Identify key worker
- Patient and carer access to documentation
- Shared electronic records

**Ensure equal access to palliative and end of life care**

- Develop systems with prognostication to identify patients in last year of life
- Co-ordinated processes for referral: clear Access criteria and Co-designed referral documents
- Establish a needs based model that identifies phase of illness and a system for prioritization
- Links with non-cancer specialists
- All supported by GSF and Frailty registers
- Support Transitional Care Initiatives

**Establish 'Living Well' concept: support advance & anticipatory care planning & timely access to services**

- Culture of care is enablement
- Programs for palliative rehabilitation are established
- Expand homecare models to support a preference to die at home; further develop H@H service
- Provide necessary medication and associated documented administration authority

**Work in partnership to ensure that care is coordinated between services**

- Facilitated by Local Health Economy End of Life Group supported by CCGs
- Services compliment not replicate each other
- There is shared accessible documentation where possible (RESPECT, EOL care plan, PPC) and Flagging
- Integration of services and System learning from Significant Adverse Events

**Ensure a competent workforce**

- Identify education needs across services; Establish education programmes,
- Robust systems for appraisal and CPD including verification of death

**Recognise compassionate communities voluntary support as an extension to services**

- Severn Hospice continued roll out of coco
- Volunteering is seen as an arm to wider services
- Clinical services refer to established volunteer support
- Expand competencies in verification of death to facilitate this promptly and confidently

## National Foundations

- Personalised care planning
- Shared records
- Evidence and information
- Those important to the dying person
- Education and training
- 24/7 access
- Co-design
- Leadership

***Living Well HELPS ---> Dying Better***

# Purpose

- To review how the system organises itself to recognise when people are approaching end of life and to plan and deliver end of life care responsively , compassionately and in line with the wishes of patients ,their carers and and their families
- To identify what works well and what could be improved and the risks and constraints to delivering good care for patients during the end of their lives
- To plan how to systematically enable health and care staff to be able to deliver high quality, responsive and personalised  end of life care for all
- To deliver this plan through a continuous learning approach
- To demonstrate we have done so including using patient centred data based on patient/carer/family experience

# Principles

- Public, patient , family and carer involvement at the heart of our approach through co-production
- Focus on ensuring health and care workers and services are equipped and enabled to provide the EOL experience for people in our community and their families that we would want
- Aligned to national guidance/ best practice
- Towards  fully integrated, seamless EOL provision across Shropshire, Telford and Wrekin
- Enabling services to work well ; Not about blaming individuals
- Collaboratively designed and delivered between our public, JHOSC, Healthwatch, health and care providers and the CCGs
- Accountability to the STP CEOs and Shadow ICS Board

# Questions and Discussion including:

- Scope of system EOL review
- Leadership and Governance
- Public, patient, family and carer engagement
- Next Steps including timeframes