



Shropshire, Telford & Wrekin

Sustainability and Transformation Partnership

System End of Life (EOL) Care Review

Proposed approach for JHOSC

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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

Local Health Economy End of Life and Palliative Care Strategy

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

National Ambitions

Individual care

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

Fair access to care

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

Comfort and Wellbeing

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

Coordinated care

Work in partnership to ensure that care is coordinated between services

- Facilitated by Local Health Economy End of Life Group supported by CCGs
- Services complement 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

All staff care

Ensure a competent workforce

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

Caring Community

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