Appendix A

Palliative care services

Executive Summary

Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster

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Penny Hansford - June 2019

Background

Central London Clinical Commissioning Group (CCG), on behalf of West London CCG and Hammersmith & Fulham CCG, commissioned Penny Hansford of PJH4 Consulting and former Hospice Director at St Christopher's Hospice to independently review palliative care services in the area, commencing November 2018. The aim being to deliver a report which provides a set of recommendations for a sustainable, clinically effective and cost efficient commissioning model for delivering Specialist Palliative Care Services (SPCS – both bed based and community provision), in order to achieve national strategic outcomes and best value.

Context
The review came as a result of the recognition that there were multiple providers of 'specialist' palliative care in three small boroughs with differing services and service specifications. It was also prompted by the temporary closure of the Pembridge Hospice In patient unit which occurred in October 2018, where adequate medical cover was unable to be recruited.

The current landscape
The tri-borough CCGs commission three specialist palliative care providers: Central London Community Healthcare Trust (CLCH) The Pembridge Hospice (PH), Royal Trinity Hospice (RTH) and St Johns Hospice (SJH). Central North West London (CNWL) deliver a community service to North East Westminster commissioned by Camden CCG. Marie Curie Hampstead deliver care for a very small number of patients (non-contracted). St Luke's Hospice is a peripheral part of the review as patients from Brent CCG also access the Pembridge Hospice.

Methodology.
The review included an analysis of national strategy and policy alongside local policy and context, a review of current service provision alongside what will be needed in the future. Investigating views of stakeholders via interviews with key professionals and groups and a public call for evidence via local groups and the media was central to the review.

Key findings

The review highlighted the following:

The most consistent feedback from professionals and the public was inequity of service provision across the boroughs and in the services, poor co-ordination and communication between services, lack of ease of access to services at the appropriate time and the lack of urgency of response of most services. Also consistent was the high levels of satisfaction of patients and families once they were being cared for by a specialist palliative care service.

Patients, families and carers report high satisfaction rates once they start receiving a specialist palliative care service.	*There are variations in services, contracts and performance across all providers.*	*There is no one commissioner with oversight of all specialist palliative care provision across the tri-borough.*	*The NHS contribution towards the care costs varies across providers.* *(range 18%-100%)*
There is a variation across providers in the ratio of specialist palliative care nurses in the community per head of population.	*The involvement of the community based palliative care teams significantly improves the likelihood of dying outside the hospital setting which is what patients say they want.*	*The palliative care services in the tri-borough reach approximately 48% of patients who have an expected death.*	*Getting a rapid face to face assessment from the specialist palliative care provider in the community is problematic.*
Access to a senior a specialist palliative care clinician to aid decision making for a GP or community nurse can be problematic and inconsistent.	*The Community Independence Service (Rapid Response team) are regularly called to patients who on initial assessment are in need of end of life care.*	*The model of daycare varies: Traditional model by St Johns and Pembridge saw a 47 new patients in 17/18. Trinity has a modernised day care and rehabilitative approach.*	*District Nursing services feel aggrieved that the Specialist Palliative Care services see themselves as advisory and not interventionist.*
Specialist Palliative Care nurses perceive District Nursing to be task orientated, not holistic and personalised.	*74% of the public who responded to the online survey reported poor co-ordination and communication between services for people at the end of life.*	*The percentage of deaths at home is higher in all 3 boroughs(28.2%) than London (23.8% or England* *(23.5%)*	*Deaths in hospital for the boroughs(48.9%) are higher than England(46.9%)but lower than London(52.8%)*
Referrers who interface with more than one provider for inpatient care have a perception that hospice A is better able to cope with complexity than hospice B and refer accordingly.	*The specialist palliative care services different IT systems that have no interoperability with primary care or the hospitals (exception Pembridge)*	*Based on the number of inpatient bed days available across the tri-borough, there is capacity in the system to admit more patients or close some beds.*	*Length of stay is above the London average of 14.6 days:* • *St Johns Hospice: 17.8 days* • *Pembridge inpatient unit: 17.8 days* • *Royal Trinity: 16 days*
There is a lower ratio of nursing care home beds in the tri-borough compared to the London region which may impact on the length of stay.	*The palliative care services still predominantly deliver care to people with a cancer diagnosis but this is steadily changing. (Average 70/30)*	*The balance of palliative care medical time is heavily weighted to inpatient beds and not the community*	*The occupancy of two of the three units is low:* *63% St Johns Hospice - 67% CLCH Pembridge Inpatient Unit (2017-8 figures)*

The recommended model

The recommended model and options are derived from the views of key stakeholders, including – patients and carers, and clinical and managerial professionals and the professional experience of the reviewer.

The delivery of the model needs to be integrated with the multi-speciality provider models (MCP) being developed in other parts of the CCGs. The reconfiguration of services ae progressing at different rates within the CCGs and it has not been possible within this review to describe the methodology for integration.

Implementation of the recommendations will deliver a clinically and cost- effective commissioning model for palliative and end of life care, ensuring equity and service resilience for the future. For individual services it carries a level of risk.

A model fit for the future

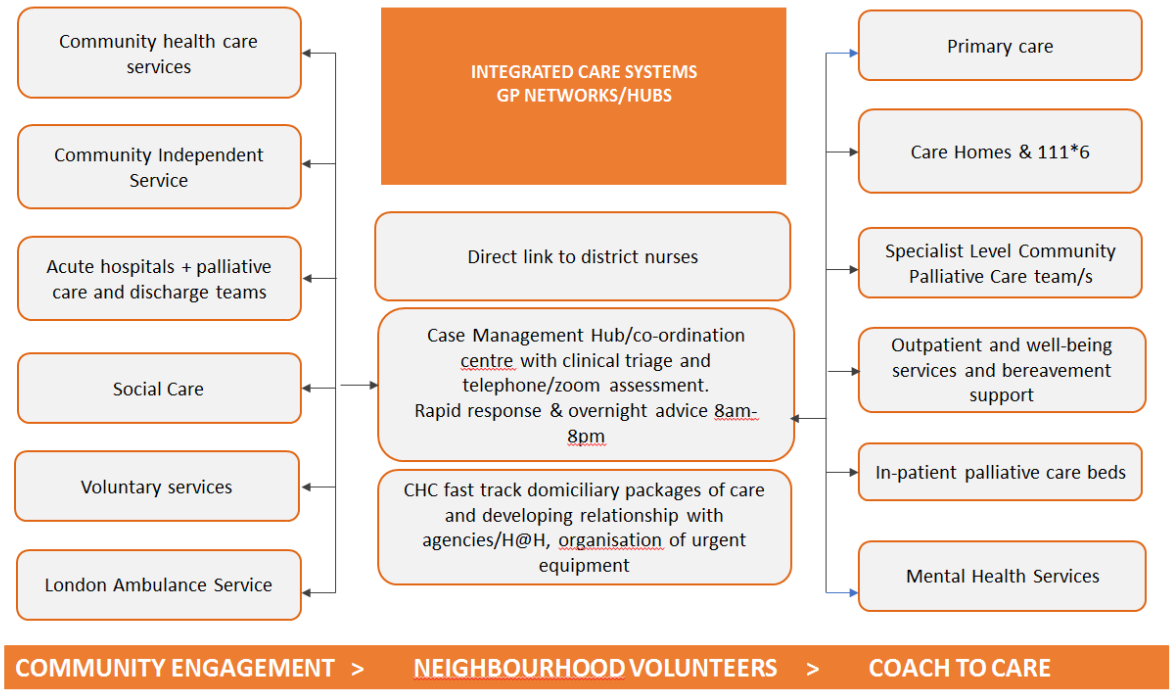

Figure 1: New model of community palliative and end of life care

Overarching Recommendation by Penny Hansford Independent Strategic Reviewer

In conducting this review it has become clear that the three major challenges for the CCG's commissioning services are:-

- inequity of specialist palliative care service provision in the three boroughs
- inequity of access to the services, with only 48% of people who have an expected death having any contact with community palliative care services
- inequity of funding arrangements for the services from the CCG's which ranges from 18-100%

Once in contact with a specialist palliative care service patients and families report high levels of satisfaction. In order to significantly improve the specialist community service I have suggested a 8am-8pm palliative care hub with skilled clinicians that can ensure patients get the right repose by the right person at the right time. The hub will also have a rapid response service. I have also recommended that the community services are retendered with a lead provider model to enable better co-ordination and accountability.

I am also recommending a reduction in specialist palliative care beds. These are not currently fully utilised. Bed modelling in appendix L has demonstrated that there is some capacity in the system and that more could be created by extra provision of continuing healthcare beds.
Since the Pembridge Hospice inpatient unit has been closed the majority of patients have been successfully admitted to surrounding hospices. This, combined with the block contracting arrangement that the CCG's have with CLCH who manage the Pembridge Hospice leads me to recommend that the Pembridge inpatient unit is decommissioned and the monies used to purchase provision in other local hospices and in the re tendering of enhanced community services.

Recommendations based on seven key areas identified in the review:

	Area	Recommendations
1.	Case Management	• To co-ordinate care from a central hub that operates from 8am-8pm, seven days a week, with access to advice outside of these hours. • Clinical triage and assessment and reassessment with competent senior staff to manage routine and urgent referrals. • Joint decision making and coordination of care between District Nursing and the Specialist Palliative Care teams. • Rapid response service, a key element of case management. • Response times from specialist level services should be in line with the degree of urgency and of patients need; this should be measured. • Bridging care packages to be offered until a continuing heath care package can be mobilised. • Rapid accessibility to equipment. • The integration and coordination of fast track care and placements (including night care). • An agreed End of Life Care plan should be implemented across the tri-borough with all health and social care providers including the acute sector. This should include the patient's wishes and preferences for care and guidance for deterioration (escalation plan) • The service provision is the patients GP and not where the patient resides. • Joint visits with the GP in complex cases (home/care home). • For specialist community providers to be equipped to respond to the nursing needs of patients if they have a planned or unplanned visit. • Link service with the 111*6 care home initiative.

2. Planning	• To have a single End of Life Care commissioner for the tri-borough CCGs. • To commission specialist palliative care services to include the case management/care co-ordination model. • To better understand bed provision in hospices across the tri-borough including; reasons for the long length of stay, issues with transfer to a care home settings and patient complexity and intractable problems. • To reduce the numbers of specialist beds that are not being utilised and reinvest the money into the community provision which will further reduce the need for as many beds over time. Bed modelling in appendix L of the main report suggests that it may be possible to close between 4 and 10 beds. This modelling is however based on a series of assumptions and is linked to further work that needs doing regarding the adequacy of CHC fast track care home bed provision. • To better understand the need for CHC fast track beds for the future as it seems likely that increased bed provision in this area would allow for better patient acuity. • Specialist palliative care provision is targeted at complex patients and hard to reach groups (mental health, homeless and learning disability). Their work should be episodic where possible, but they should be case managed even when they are not directly involved, in order to recognise when their involvement is needed and to support GP's and community nurses. • The provision should include coaching and training for the wider community teams and this should be a major focus. • To commission new community palliative rehabilitation health and well-being services to replace traditional day care. • To integrate the community specialist palliative care provision with integrated care systems (including co-location). • To better utilise IT programmes like e-shift which enable a senior clinician to supervise a group of nurses/care workers via video link. • Hospices to review the balance of community and hospice work; moving to support the wider system including some bed management to be led by senior nurses. • When recruiting, consideration should be given to the balance of medical staff with some consultants, doctors in training to be palliative care consultants, speciality doctors as well as GP's with a special interest in palliative care. • Staff work across the communities and cross cover for one another. • CCGs to review the provision of nursing care home beds across the tri-borough. • CCG's within the NW London 'Sustainability & Transformation Partnership' (STP) footprint should ensure similar models of service provision are standardised and implemented throughout. • There should be an agreed mechanism for medical staff to cross cover 24/7 to ensure service resilience in the tri-boroughs.

IT systems	• To ensure IT systems that have interoperability across the central co-ordination hub, Community specialist palliative care provision, primary and nursing homes. • CCG's to ensure the prognostic indicator tool (SPICT) is embedded in SystmOne to aid patient identification at end of life.
Funding	• To ensure that core aspects of community provision are fully funded to address inequitable funding between providers. • To review the operation and expenditure of the Continuing Health Care team and the care home contracts. • To have a common understanding of the cost of a bed day and an inpatient bed tariff between the providers and the CCG.
Outcome measures	• To ensure Community specialist palliative service specifications are standardised across providers. • To ensure Community specialist palliative services reach 75% of expected deaths either by direct provision or case management or advice. • To ensure there is a reduction in hospital admissions for those in their last 90 days of life. • To ensure more patients die at home or in their care home. • To ensure all patients at the end of life have an accessible care plan e.g. CMC as it can be shared across providers. • To ensure specialist palliative care services include a rapid response that is measured. • To increase attendance at primary care multi professional meetings and assist GP's in the identification of patients in the last phase of their life. • To implement the Outcomes Assessment and Complexity Collaborative (OACC) in all palliative care settings. • To ensure that the patient feedback is collected using a validated tool as part of the outcome measures. • To develop measures for the delivery of education and training.

Training and Review	• To ensure that education and training is a core part of the provision with adequate time and resource. This should particularly include the social care workforce in domiciliary care and care homes. This should also include the development of a 'coach to care team' that will be part of the rapid response and work with domiciliary care agencies. • To maintain and develop multi professional forums (including social care and eventually the voluntary sector) in primary care to review patients in their last year of life and on the palliative care registers. • To develop joint operational guidance to ensure that there is understanding of roles and responsibilities between community specialist palliative services, GP's and district nursing. • The tri-borough CCGs and NW London STP to agree the palliative care nurse responsibilities and skill sets to work as advanced nurse practitioners.
Other	• To include joint working with the voluntary sector in service specifications. • To collaborate with the local authority to commission a lead provider to integrate and standardise the many small bereavement services that exist in the tri-borough and a new model developed. • To ensure re-commissioned community nursing services include rapid response. • To standardise models of service provision across the tri-borough and the NWL footprint. • CCG's to work towards a lead commissioner for palliative and end of life care across the NWL STP footprint. • To review nursing care home provision to ensure it is fit for purpose now and in the future. • To invest in an advance care planning programme in the memory clinics to capture the wishes and preferences for care and death at an early stage • Primary Care contracts to include monthly multi professional reviews for people at the end of life. • Referrals for the hospice inpatient care should also be directed to the care co-ordination/case management centre and forwarded to the appropriate unit. (or a joint in box for hospices to access) • Changes in operational policies of the specialist palliative care providers to enable anyone to refer to their services. • Subcutaneous fluids should be available in the community and not require a hospital admission.

Commissioning options

Option One	• Tender a new community service with one lead provider. • This would not preclude subcontracting arrangements. • To provide an 8am-8pm co-ordination/case management centre. • Out-patient, rehabilitation and well -being services should be easily accessible to patients and be located within the boroughs. • Renegotiate bed-based care with separate providers.
Option Two	• Tender a new service and reduce the number of providers to two. • All providers to have the same service specification and contract. • The service specification should stipulate a partnership to provide a 24/7 co-ordination/case management centre. • Out-patient, rehabilitation and well -being services should be easily accessible to patients and be located within the boroughs.
Option Three	•Tender the service based on one community service per borough with the same service specification (including a co-ordination centre/case management centre per borough).

Summary

The recommended option from the options above is number one. The rationale for recommending option one, to have one lead provider in the community, is due to the significant transformational change needed in the specialist palliative care services to enable them to use their resources in a focussed way, acting in a consultative and training capacity to the wider care system whilst managing a small number of highly complex patients themselves, alongside case management for all expected deaths. Achieving the recommended outcomes for the new model of care will be challenging and most likely achieved with a systems leader 'driving' change.

There is also an imperative to become part of the emerging integrated care systems in the tri-borough CCGs and to provide an equitable service throughout. The reviewer believes this is best achieved by an overall lead provider, accountable for the change needed. The integrated care systems are progressing to different timescales and slightly different models in each CCG and so it has not been possible for the reviewer to make a recommendation on how the palliative care co-ordination centre will integrate, only that it will need to.

The idea of a co-ordination centre, single point of access with extended hours and rapid response was consistent feedback from many of the patients. 76% of public respondents (n46) rated co-ordination and communication between the services as very poor to fair and 64% of the same group (n42) rated access to services as fair to very poor. Rapid access to care both in and out of hours were also marked with similar scores by the public.

Contracting the beds separately to the community contract is a pragmatic approach as the provision of care in this setting requires less change management. Since the closure of the Pembridge inpatient unit it appears that patients have been successfully admitted to other units who have had capacity. There does appear to be a lack of continuing health care (CHC) fast track provision across the boroughs. Although further work needs to be done it is likely that there could be a reduction in commissioned hospice beds and consolidation on less sites with a greater provision of CHC fast track beds for dying people to improve patient flow and the correct level of acuity.

Contracting the specialist palliative care beds separately is likely to reduce the instability, both financial and operational to the provider services.

All of the recommendations in this review are in line with the vast majority of feedback from both the public and professionals.

Policies guidance and reports underpinning the recommendations

NICE Quality Standard for End of Life Care for Adults[1]
One Chance to Get it Right: Improving people's experience of care in last few days and hours of life, One year on Report[2]
Ambitions for Palliative and End of Life Care: A national framework for local action 2015- 2020[3]
Cost Effective commissioning of End of Life Care[4]
Shifting the Balance of Care [5]
Specialist Level Palliative Care, Information for Commissioners[6]
Enhanced End of Life Care in the Community[7]
Business Care for Specialist Palliative Care Provision Across London[8]
Joint Strategic Needs Assessment (JSNA) for the Royal Borough of Kensington and Chelsea, Westminster and Hammersmith and Fulham End of Life Care: Key Themes and Recommendations[9]

[1] Nice Quality Standard for End of Life Care for Adults (QS13) November 2011 https://www.nice.org.uk/guidance/qs13
[2] Department of Health (July 2015): One Year on Report to the 'Once Chance to get it Right : Improving People Experience in the Last Days and Hours of Life.' https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/450391/One_chance_-_one_year_on_acc.pdf.
[3] Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2015-20 http://endoflifecareambitions.org.uk
[4] Public Health England, Cost Effective Commissioning of End of Life Care (2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/612377/health-economics-palliative-end-of-life-care.pdf
[5] Nuffield Trust, Shifting the Balance of Care (2017) https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf

[6] NHS England, Specialist Level Palliative Care, Information for Commissioners. April 2016 https://www.england.nhs.uk/wp-content/uploads/2016/04/speclst-palliatv-care-comms-guid.pdf
[7] RM Partners, Enhanced End of Life Care in the community. August 2018 http://rmpartners.nhs.uk/wp-content/uploads/2017/03/Enhanced-EOLC-community-project.pdf
[8] RM partners, Business Case for Seven day Specialist Palliative Care Provision Across London , June 2018 http://rmpartners.cancervanguard.nhs.uk/wp-content/uploads/2018/09/7daySPCReport_Final_060918.pdf

[9] Joint Strategic Needs Assessment (JSNA) for the Royal Boroughs of Kensington & Chelsea, Westminster & Hammersmith and Fulham. End of Life Care , Key Themes and Recommendations , October 2016 https://www.jsna.info/endoflifecare