Brent
Clinical Commissioning Group

Overview and Scrutiny Committee March 2013

End of Life Care

INTRODUCTION

The Overview and Scrutiny Committee have made a request for information regarding the services commissioned by NHS Brent for End of Life Care. In particular they have asked some specific issues,namely :

- What services are provided and by whom
- How are the services generally run
- How are the services funded
- What are the policies around people having to pay towards these services

This is a short briefing paper detailing the responses to the issues raised.

OVERVIEW

Currently, 64% of people in Brent die in hospital, a higher proportion than the English average, and 19% die at home, a lower proportion than the English average Brent's has an End of Life Care Strategy which seeks to reduce the number of those patients with an end of life need dying in hospital by 70% (over the duration of the strategy)

Brent has invested in the following areas during 2012/13.

- Roll-out the London-wide End of Life Register called Coordinate my Care across Health and Social care
- Building up workforce capacity and capability of all staff involved in the delivery of end of life care across health and social care. Increasing the skills of practitioners is an essential element of the strategy to improve End of Life Care in Brent. We have developed an outcomes based Service Specification for training. This is based on the National Guidelines for training in End of Life Care which includes the Gold Standards Framework. We are increasing skills across all staff groups in Brent including Nursing Home staff.
- Supporting primary care clinicians in building up their capacity and capability to improve their current management of end of life care patients in primary care During 2012/13 we are incentivising Primary Care and have developed a Locally Enhanced Service for End of Life Care which focuses on the identification of patients in the last 12 months of their life irrespective of diagnosis and the subsequent management of these patients until their death

  We are also working with the relevant Contracts Leads to examine any need to incentivise other providers from 2013/14 onwards

Communications with Stakeholders Part of the success of improving End of Life care for patients and their families depends on their involvement. They need to be made aware of, and discuss the options with their clinicians for, better End of Life Care, and avoiding issues surrounding the adverse publicity re the Liverpool Care Pathway (Appendix A). Therefore, we are developing awareness through press publicity, through engagement with relevant patients' and faith groups, and by making suitable literature[1] available to end of life patients detailing the support available. This will ensure patients know that an End of Life pathway is available, and know what care they can expect, from whom, where, and when and most importantly that they have a choice

In addition to these investments NHS Brent also commission End of Life Care Services from a number of providers. End of Life Care is provided in a number of settings and by a range of stakeholders such as Primary Care, Nursing Homes, Acute Hospital Trust, Community Services and Specialist Palliative Care from Hospices. The purpose of the Register is to ensure that all agencies that have an interaction with the patient and their families during their illness have access to the same care record and information.

WHAT SERVICES ARE PROVIDED AND BY WHOM? In terms of Specialist provision for End of Life Care these are commissioned through the following agencies:

South Brent
St Johns Hospice
Pembridge Unit
Marie Curie
North Brent
St Lukes Hospice

Services commissioned include Specialist Palliative Care, Hospice at Home and they also provide respite services. The clinicians working within these organisations also provide support and advice to other clinicians across Brent when needed i.e. advice re pain relief etc.

Pembridge Unit is an NHS organisation, whereas St John's, St Luke's and Marie Curie are charitable organisations.

We also commission an organisation called Cancer Black Care which provides support and advice services on cancer for Black Minority and Ethnic (BME) name patients.

HOW ARE THE SERVICES FUNDED?
NHS Brent has formal contracts with the providers and funding is through this route.

WHAT ARE THE POLICIES AROUND PEOPLE HAVING TO PAY TOWARDS THESE SERVICES
All service are provided at 100% of the cost for all Brent patients through NHS Brent funding

Appendix A

Liverpool Care Pathway

The Liverpool care pathway is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the final days or hours of life.

It is a means to transfer the best quality for care of the dying from the hospice movement into other clinical areas, so that wherever the patient is dying, there can be an equitable model of care.

The LPC has been implemented into hospitals, care homes, in the individuals own home/community and into hospices.

The Liverpool Care Pathway was developed by Royal Liverpool University Hospital and Liverpool's Marie Curie Hospice for terminal ill cancer patients. Since then the scope of LCP has been extended to include all patients deemed dying.

Steps

1) Clinical decision Making:A multi-professional team caring for the patient agree that all reversible causes of the patient's conditions have been considered and that the patient is in fact "dying".

2)The assessment suggests what palliative care options to consider and whether non-essential treatments and medications should be discontinued, and addressing physical, psychological, social and spiritual domains of care.

3) The programme suggests treatment provision to manage pain, agitation, respiratory tract secretions, nausea and vomiting, or shortness of breath (dyspnoea) that the patient may experience and hence enhancing patient dignity and symptom management including nutrition and hydration.

4) the approach is communicated with families/carers.

5) there will be initial assessment, on going assessment and care after death

6) system in place to review the appropriateness of continuing on the pathway at any time if concern is expressed by either the patient, a relative or a team member