Excellence in Commissioning
Through Excellent Primary Care

NHS
Birmingham CrossCity
Clinical Commissioning Group

Birmingham South Central
Clinical Commissioning Group

Caring for people at the end of their lives: Our integrated strategy

Faiths, Health & Wellbeing Seminar

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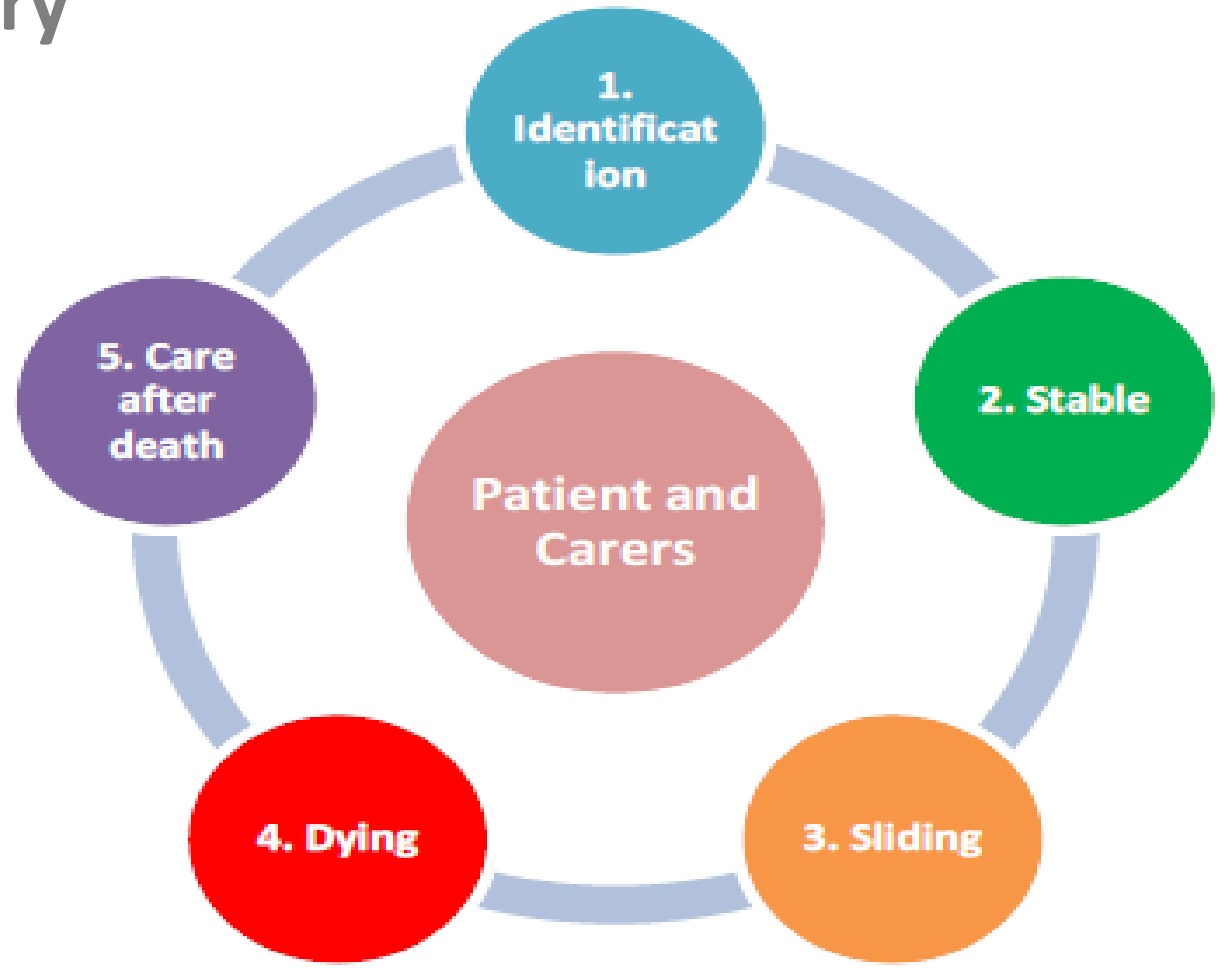
Purpose:

- Our vision is for people in Birmingham to die with dignity and in a place of their choosing
- There is a need for this type of service as people are living longer, and need support with their range of medical problems - some of which are incurable
- At the moment, palliative and end of life care services in Birmingham vary depending on where you live. This means that services are inconsistent and don’t meet the needs of the increasing number of people who need this type of care

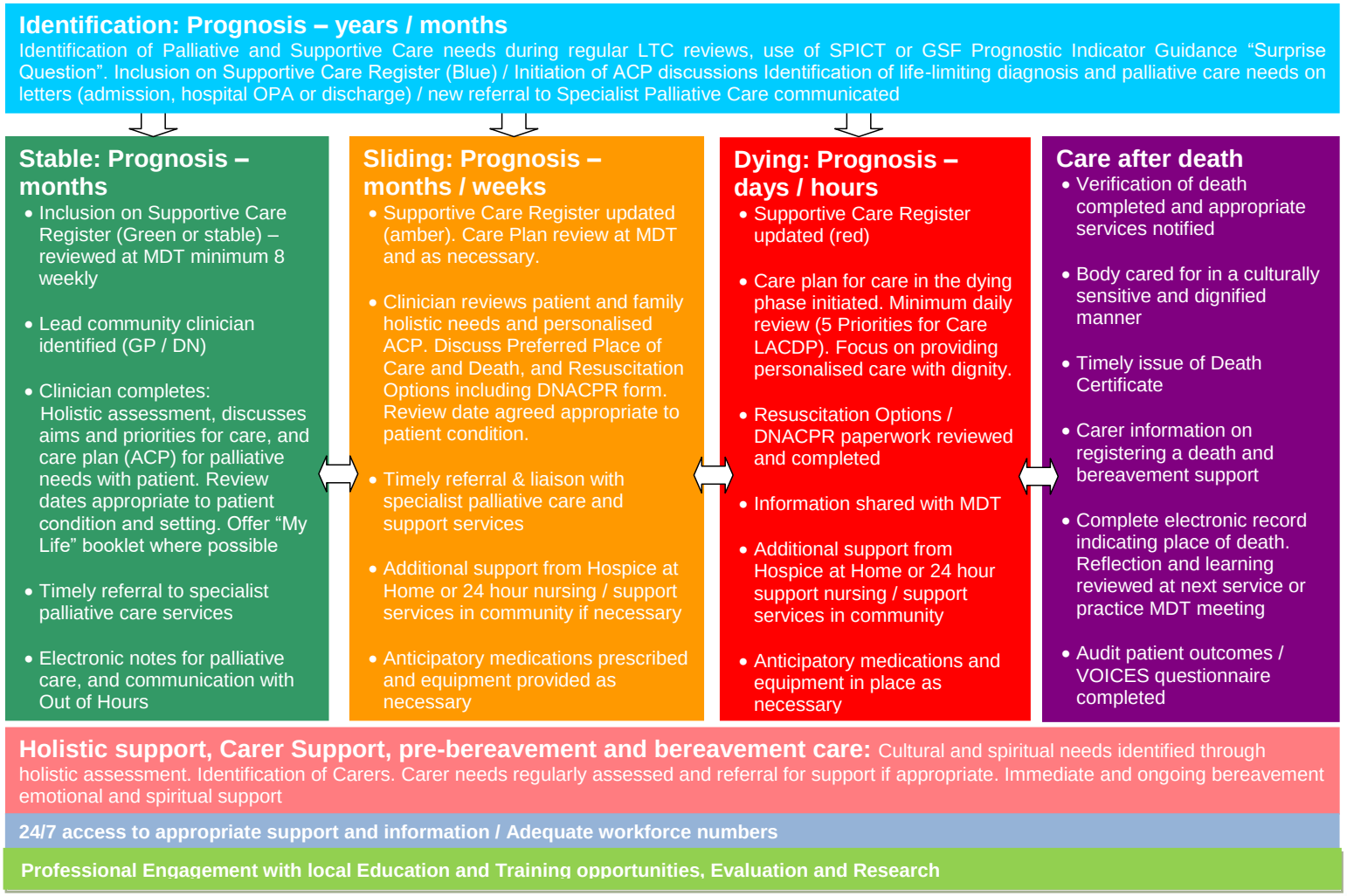
Purpose:

- We would like to improve these services so that they are co-ordinated, consistent, of high quality and available to everyone who needs them. Your two local clinical commissioning groups (CCGs), Birmingham Cross City and Birmingham South Central, are working together to come up with solutions
- We asked for views as part of our formal consultation process 30 June – 20 October 2014.
- Use of “Jean’s Story” to show the pathway
- Survey
- 23 separate engagement events

Delivery


1. Identification
2. Stable
3. Sliding
4. Dying
5. Care after death
Patient and Carers
The delivery of person centred care in Palliative & End of Life

Model of care



Integrated Palliative and End of Life Care Commissioning Strategy 2014/15 to 2017/18

Our Vision is for all patients and their carers across Birmingham to have 24/7 equitable access to high quality, consistent Palliative and End of Life Care when they need it, with accurate identification and proactive management of all of their palliative care needs: physical, social, psychological, spiritual and cultural.

Supporting Our System Outcome Ambitions…

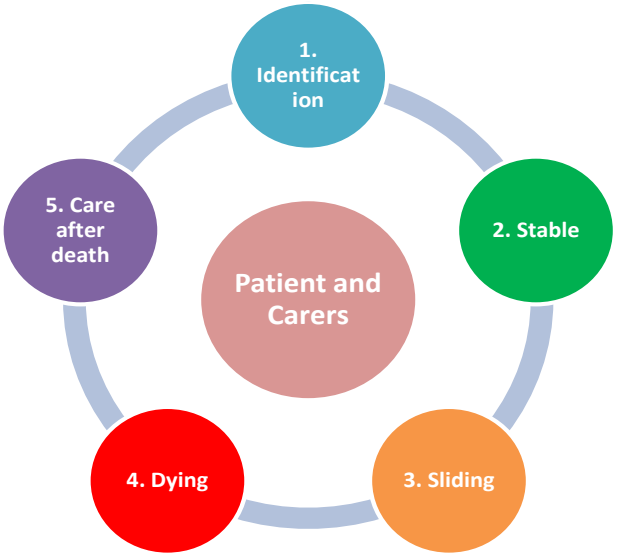
- Improving the health related quality of life of people with one or more long-term conditions, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

NHS Outcomes Framework

- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill-health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in safe environment and protecting them from avoidable harm

Adult Social Care Outcomes Framework

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support for Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm



The delivery of person centred care in Palliative and End of Life

Recommendations:

Patients and carers feeling supported and able to cope

Addressing inequity and differences in practice

Professionals feeling supported and able to learn and provide care

Developing and improving systems that support efficient and effective palliative and end of life care

Engaging with local communities

Key Outcomes

Identification of patients We will ensure that the number of patients who are identified as having palliative care needs increases, and that these patients have access to, and receive appropriate high quality palliative and end of life care.

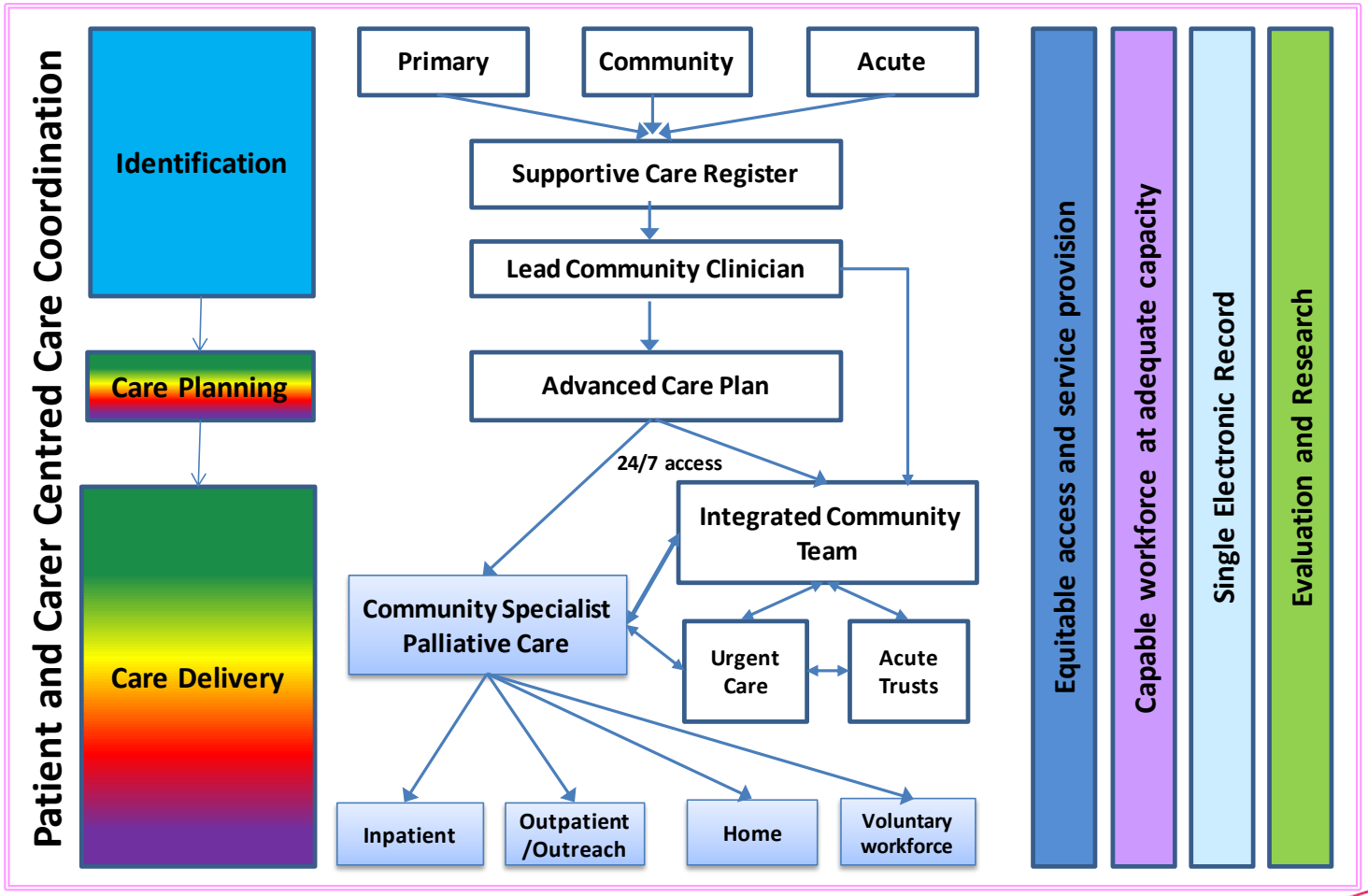
Care planning We will ensure that patients and their carers receive the information and support to manage care according to their choice and needs.

Providing choice We will enable more people nearing the end of their life to make the choice to die at their preferred place.

Delivering choice Improved care planning and the provision of choice will result in a reduction of the number of avoidable emergency admissions to hospitals for patients receiving palliative or end of life care.

Focus on Quality: NICE Quality Standard for End of Life Care and the 16 Statements which form the Quality Standard

Proposed delivery model



Implementation workstreams

1.Specialist Palliative Care : Community

- Community Specialist Complex and Palliative Care Service Specification
- Opportunity for innovation with third sector / voluntary services
- Inpatient services
- Outpatient services and community outreach

2.Specialist Palliative Care : Acute Care

- Introduction of KPIs / CQUINs

3.Care Coordination: Primary Care

- Palliative and End of Life Care in ACE and LIS
- Parallel planning process and multi-disciplinary approach in General Practice
- Communication with Out of Hours services
- 24/7 care coordination facility (urgent care centre/ 111)

4.Care Coordination: Community Services

- Integration of health and social care through Better Care Fund Workstream
- District Nursing Service

5.Care Coordination : Single Electronic Record

- IT ("Your Care Connected")

6. Care Coordination: Education and Training

- Sustainable and continuing programme of professional education and support
- Training of workforce - enhanced awareness of roles and responsibilities

1. Specialist Palliative Care : Community

- Discuss and agree outcomes based specification with existing providers for 2015/16 contracts. (January/February 2015)
- Inclusion of expectations to deliver “One Chance to get it right” actions within 15/16 contracts
- Test draft palliative care development currency (2015/16)

2. Specialist Palliative Care : Acute Care

- Meeting with providers to establish baseline (Nov/Dec 2014)
- Negotiations with providers as to further actions required (Dec 2014)
- Inclusion of expectations to deliver “One Chance to get it right” actions within 15/16 contracts (April 2014)
- Development of KPIs/CQUINs *(as required)*

3. Care Coordination : Primary Care

Care Co-ordination Facility (Urgent Care/111)

- NHS 111. Update current WMAS model January 2015
- Input to new service specification for the contract September 2015, completed November 2014
- Input into new community model to work alongside the NHS 111 and DOS systems, January 2015

4. Care Coordination: Community Services

Better Care Fund: Generalist palliative care

- Agree roles and responsibilities for members of MDT March 2015
- Agree assessment and care planning processes March 2015
- Consider CQIUN/SDIP for 15/16 – December 2014
- Work to be undertaken to understand the Community Trust provision - is it equitable across the CCG (January/February 2015)

5. Care Coordination : Single Electronic Record

as part of ACE EXCELLENCE

- Unified templates based on read codes to be made available for inputting across Primary Care (GP Practices) by Jan 2015

“Your care connected “ TIMELINE

- Proof of concept mail out 24/11/14
- Proof of concept go live 19/01/15
- Proof of concept evaluation mid April 2015
- Phase 1 rollout May/June 2015

Practical progress:

- Primary Care Initiatives (ACE)
- Collaboration with Better Care Fund
- District Nursing Review (BSC)
- My Life Booklet
- Macmillan Specialist Care at Home Pilot (£250,000 and national evaluation)
- Paediatric Palliative Care Strategy
- Medicines Management

Opportunities:

- Developing a new approach to palliative care funding: a first draft for discussion
- NCPC Public Health Pathfinder Charter Community

Primary Care Initiatives (ACE)

- Early identification of patients with palliative care needs (use of Supportive Palliative Care Indicator Tool – SPICT Tool)
- Use of the Palliative / Supportive Care Register
- Minimum 2 monthly multi-disciplinary Palliative Care meetings
- Proactive Care Planning and Adoption of the Advance Care Planning “My Life” Booklet
- Identification and management of the dying phase (as per the Joint Statement by the Leadership Alliance for the Care of Dying People 20.3.14)
- Development of a bereavement protocol
- Measured on Outcomes