Croydon End of Life Care (EoLc) Strategy 2015 -2018

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Context

- The EoLc Strategy focusses on Adults with any advanced, progressive and incurable illness. It does not address children and young people, but it is recognised that further work needs to be done for children in relation to EoLC.
- The Strategy is set in the context of the JSNA findings: that Croydon's population is growing, life expectancy is increasing and that there is an ageing population, factors which will increase the demands on services. The JSNA 2011/12 on Dementia specifically highlights the need for Integrated services for early detection through to end of life across all agencies including health, social care and the voluntary sector.
- The Strategy is written in the context of National, London and local priorities.
- A significant transformation programme that focusses on working towards less reliance on hospital care.
- It also links to other strategies including the Health and Wellbeing Strategy, Cancer Strategy, the Urgent and Emergency Care Strategy and London ADASS Charter.
- Other related strategies include including Dementia, Carers and the Voluntary and Community Sector.
- Whilst the law regarding euthanasia and assisted suicide continues to be debated, these issues are beyond the scope of this Strategy.

Context

- Croydon has 44,375 residents over 65 years old, which is 12% of the overall population. This is predicted to rise to 56,000 by 2021, a rise of 8% per annum

- About 80% of all Croydon deaths are for people age 65 or over (1826 of 2287 deaths in 2013, Public Health).

- There are 144 Care Homes currently registered in Croydon. In 2014/15 there were 907 hospital deaths of over 65's population and 166 of over 65's had come into hospital from a care home, see table 1.

- Place of death for over 65s in 2014/15:

Table 1

Total deaths in hospital	Care Homes	Own Homes
907	166	741

Source: Croydon Hospital Service (CHS) data

- This means that about 50% of over 65 year old deaths occur in hospital. In the best performing local authority in England, 38.2% deaths occur in hospital (2010 – 2012 data).

- The National Audit Office suggests 40-50% of people who die in hospital wanted to die at home.

- Croydon aims to reduce the number of deaths occurring in hospital by 23% in 2015-16

Strategic Themes

The EoLc Strategy Key Themes:

1. To increase public awareness and discussion of death and dying to make it easier for people to discuss their own preferences around end of life care and which should also act as a driver to improve overall service quality;

2. To ensure that all people are treated with dignity and respect at the end of their lives;

3. To ensure that pain and suffering amongst people approaching the end of life are kept to an absolute minimum with access to skilful symptom management for optimum quality of life;

4. To ensure that all those approaching the end of life have access to physical, psychological, social and spiritual care;

5. To ensure that people's individual needs, priorities and preferences for end of life care are identified, documented, reviewed, respected and acted upon wherever possible;

Strategic Themes

6. To ensure that the many services people need are well co-ordinated, so that patients receive seamless care;

7. To ensure that high quality care is provided in the last days of life and after death in all care settings;

8. To ensure that carers are appropriately supported both during a patient’s life and into bereavement;

9. To ensure that health and social care professionals at all levels are provided with the necessary education and training to enable them to provide high quality care;

10. To ensure that services provide good value for money for the taxpayer.

Better Care Fund (BCF)

This funding will be used to provide:

- Enable greater choice over where people wish to die by promoting Advanced Care Planning (ACP) and additional support to nursing and residential homes and for people in their own homes.

- Workforce training and development, to ensure GPs, community matrons, district nurses, social care and other professionals that have a key role in supporting EoLC, are able to support care home and specialist palliative care staff to keep people out of hospital where it is safe and in line with the patient's wishes to do so.

- The training and development investment will also be focused on developing 'end of life doulas' – volunteers who can support people to die in their own homes by offering holistic support and advice in the last weeks of life.

- By focussing on end of life in care homes and in the individual's home, this promotes care in the community.

- Promoting forward planning for the needs and care of the individual will help people achieve their preferred end of life with dignity, rather than being reactive in the last days of life.

- To implement the "6 steps to success" programme and intensify the Gold Standard Framework (GSF) programme in all care homes (residential / nursing) and develop a care model within the persons' own homes. This will be delivered in phases in 2015/16.

Co-ordinate My Care (CMC)

- Coordinate My Care (CMC) has been developed to give people with chronic health care conditions and/or life-limiting illnesses an opportunity to create a personalised care plan in order that they might express their wishes and preferences for how and where they are treated and cared for.

- This care plan can be shared electronically with all legitimate providers of urgent care, especially in the emergency situation.

- All the organisations involved have signed formal agreements that govern how care plan information is used and protected, and they undertake to provide CMC with updated lists of staff that are trained and authorised to access the system.

- At the heart of CMC is a care plan that is developed with a patient by their nurse or doctor if, and when both feel it is appropriate. The care plan contains information about them and their diagnosis, key contact details of their regular carers and clinicians, and their wishes and preferences in a range of possible circumstances.

- This care plan is uploaded to the CMC system to which only trained professionals involved in their care can have access. These include ambulance control staff, NHS 111 operators, GPs, out of hours GP services, hospitals, nursing and care homes, hospices and community nursing teams.

- **It is reported that Croydon tops the chart of having the most patients on CMC in London with 2351 as of 1st August 2015, which is 36.4% of the expected population.**

Current provision with Marie Curie

2014/15 :

- Of the 57 patients reported by Marie Curie in Croydon, 35 died and 33 patients had a specific place of death and preferred place of death recorded on our system; **91%** of those patients achieved their preferred place of death.

The **table** below is a breakdown of preferred place of death and actual place of death in 2014/15.

	Actual Place of Death		
PPoD (Preferred place of Death)	Home	Unknown	Total
Care Home	1		1
Home	30	1	31
Hospice	2		2
Unknown	1		1
Total	34	1	35

2015/16 year to date (at end June 2015):

- Of the 8 patients supported (as at end June 2015), 6 have died. All 6 patients had a specific place of death and preferred place of death recorded on our system, 100% of those achieved their preferred place of death.

The **table** below is a breakdown of preferred place of death and actual place of death in 2015/16 till end of June 2015.

	Actual Place of Death	
PPoD (Preferred place of Death)	Home	Total
Home	6	6
Total	6	6

Current provision with St. Christopher's

St. Christopher's has reported in the **table** below of nursing care home residents' place of death and completion of specific end of life documentation ; (Advance Care Plan (**ACP**), Do Not Attempt Cardio Pulmonary Resuscitation (**DNaCPR**) orders and an end of life care plan) for these deceased residents between 2007/08 and 2014/15. The percentage of deaths occurring in nursing care home in 2014/15 is **81%**.

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15*
Percentage of deaths occurring in nursing care home	**55%** 63/115 deaths (8 NHs)	**66%** 248/375 deaths (23 NHs)	**71%** 341/477 deaths (23NHs)	**76%** 331/435 deaths (25NHs)	**79%** 389/492 deaths (25 NHs)	**80%** 351/440 deaths (26 NHs)	**77%** 328/428 deaths (26 NHs)	**81%** 348/433 deaths (29 NHs)
Percentage of completed ACP documentation				**74%**	**83%**	**78%**	**77%**	**84%**
Percentage of decision with a DNaCPR order				**75%**	**86%**	**85%**	**82%**	**91%**
Percentage of residents with an end of life care plan				**60%**	**72%**	**68%**	**49%**	**49%**

Source: St. Christopher's *10 months data 1st September 2014-30th June 2015 (valid %)

Objectives & Initiatives of the Strategy

TABLE 1

Goals	Initiatives
Make talk of death and dying normal	Develop awareness
	Engage with ‘hard to reach group’s
	Establish ‘death’ cafes
Identify all people nearing the end of life	Local services proactively identify people
	Sharing of information on Coordinate my care
	All service providers share information electronically

Objectives & Initiatives of the Strategy

TABLE 2

Effective Care Planning	**Implementation of GSF across all services**
	All peoples wishes recorded in care plans
	All providers use care plans
	Develop local workforce
	Develop systems ensure assessment of continuing care needs
Care in the last days of life	Clinic teams have the necessary skills
	Clinical teams provide support to family and friends
	Monitor the quality and effectiveness of last days of life
	All services communicate and document treatment decisions
	All providers have end of life policies

Objectives & Initiatives of the Strategy

TABLE 3

Involve and support family and friends	**Family and carer involvement in decision making and planning**
	Carer assessments
	Information is available on all local services
Develop competencies of the workforce	All professionals will have a collaborative approach to care
	Minimum competency standards in place
	Monitoring and evaluation of skills
	Collaborative working when specialist advice required

Discussion

Q1: Are there any gaps in the implementation plan?

Q2: What can we do better?

Q3: What are the risks/issues to consider?

Q4: Any other ideas for implementing the goals?