ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE

23 January 2024

REPORT TITLE:	**END OF LIFE CARE BEST PRACTICE**
REPORT OF:	**DIRECTOR OF CARE AND HEALTH**

REPORT SUMMARY

The report provides an update on Palliative and End of Life Care Services provided in Wirral. The report includes services commissioned by NHS Cheshire and Merseyside Integrated Care Board (ICB), Wirral Place and also activities undertaken by commissioned Adult Social Care providers in Wirral.

The report supports the following Wirral Plan priorities:

Active and Healthy Lives: Working to provide happy, active, and healthy lives for all, with the right care, at the right time to enable residents to live longer and healthier lives.

This is not a key decision.

RECOMMENDATION/S

The Adult Social Care and Public Health Committee is recommended to note the content of the report, and the Health and Care system work underway to support End of Life Care in Wirral.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 Adult Social Care and Public Health Committee requested a report on Palliative Care End of Life Care and dignity in dying initiatives for people in Wirral, and this report provides the update.

2.0 OTHER OPTIONS CONSIDERED

2.1 No other options were considered as this report is information provided to Adult Social Care and Public Health Committee on the current service offer for Palliative and End of Life Care Services for Wirral people.

3.0 BACKGROUND INFORMATION

3.1 Ambitions for Palliative and End of Life Care are set out in the NHS England Paper Ambitions for Palliative and End of Life Care. The six ambitions for all people are set out in the table below, which includes the "I" statements for individuals:

1	Each person is seen as an individual	I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.
2	Each person gets fair access to care	I live in a society where I get good End of Life Care regardless of who I am, where I live or the circumstances of my life.
3	Maximising comfort and wellbeing	My care is regularly reviewed, and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.
4	Care is co-ordinated	I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.
5	All staff are prepared to care	Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident, and compassionate care.
6	Each community is prepared to help	I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing, and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

3.2 The Wirral Place Palliative and End of Life Care Partnership (PEOLCP) promotes excellent equitable End of Life Care through local plans for the place-based area; it provides the strategic steer and is the body of expertise on PEOLC for the Wirral Place. It engages with the NHS Cheshire and Merseyside (C&M) Integrated Care System (ICS) PEOLCP and the C&M PEOLC clinical network through the Place Based Partnership representative on the Programme Board. Meetings are held bi-monthly.

3.3 Dr Maria Jones a Wirral based GP has been identified as the Palliative and End of Life Care lead for the Wirral system and plays a proactive role in leading good Palliative and End of Life Care.

3.4 The Wirral Place Partnership vision for Palliative and End of Life Care reflects local priorities and aligns to the strategic objectives for the C&M ICS PEOLC programme and best practice clinical guidance through the C&M PEOLC clinical network. Membership is representative of the health and care organisations who contribute to the commissioning and provision of local services and incorporates representation from those local people with lived experience to help with service review and service improvement.

3.5 The C&M ICS PEOLC programme supports Place Based Partnership reporting by providing a regular insight report for the locality. The Wirral Place PEOLC Partnership reports via the Chair to C&M PEOLC Clinical Network Group which meets quarterly.

3.6 The Wirral Place Palliative and End of Life Care Partnership (PEOLCP) works with and supports the ambition of Cheshire & Merseyside ICS to enable equitable access to high quality End of Life Care. The vision is for adults, children, and the young people of Cheshire & Merseyside at the end of their life to live well, before dying with peace and dignity in the place where they would like to die, supported by the people important to them.

3.7 The Wirral Place PEOLC Partnership is the body of expertise on PEOLC and provides the strategic steer for the locality. The group has developed and oversees a local delivery plan for promoting service improvement which reflects local need and C&M ICS PEOLC strategic priorities, which are:

- Early identification: People are identified as likely to be in the last 12 months of life and are offered personalised care and support planning (PCSP).
- Preferred Place of Care: Patients identified as probably being in the last 12 months of life to be supported to remain in the place of their choice and die in the place of their choice.
- Specialist Advice: Staff, patients and carers can access the care and advice they need, whatever time of day.
- Equitable access to PEOLC for all, focussing on locally identified under-served populations.

- Workforce: A confident workforce with the knowledge, skills and capability to deliver high quality PEOLC. The PEOLC workforce is fit for purpose, now and in the future.
- Strategy: High quality Palliative and End of Life Care for all, irrespective of condition or diagnosis.
- Sustainably commissioned: Safe specialist palliative care delivered through community specialist palliative care teams and hospices is sustainably commissioned across C&M.

3.8 The responsibilities of the PEOLC Partnership are as follows:

- Monitor progress of the local service improvement plan taking remedial action and escalating issues and risks to the Director/ clinical lead / governance group
- Consider clinical guidelines, policies, and procedures and endorse for recommended implementation across Wirral.
- Provide support, advice, and recommendations on PEOLC to Wirral Place including horizon scanning.
- Oversee a co-ordinated approach to stakeholder engagement and communication in relation to PEOLC for the Wirral Place Partnership
- Ensure a coherent and consistent approach to both locality development and activities with partner localities in neighbouring areas.
- Annually self- assess development of the Wirral Place PEOLC Partnership using a maturity matrix.
- Developing a local delivery plan which reflects C&M ICS PEOLC strategic priorities and C&M PEOLC clinical guidance agreed with the membership and the Wirral Place Partnership representative on the Programme Board.
- Reporting Wirral Place Partnership progress against the delivery plan through to Programme Board.
- Operating as an expert advisory group feeding through issues and challenges through to Programme Board.

3.9 Services commissioned by NHS Cheshire and Merseyside ICB for Wirral Place include:

- Marie Curie – Night Sitting Service
- Wirral Palliative Care Emergency Medicines Service
- Wirral Hospice St John’s – Hospice at Home, Palliative Personal Care Service, Wellbeing Unit, Inpatient Service, Outpatient Service, Interventional Pain Service
- Claire House – Rapid Response and Emergency Respite (dedicated to children and young people)
- Wirral University Teaching Hospital (WUTH) NHS Trust – Supportive and Palliative Care Service (for inpatients)
- Wirral Community Health and Care (WCHC) NHS Trust – Wirral Specialist Palliative Care Community Service, End of Life Care Service

3.10 There is an Education Hub for Palliative Care provided through WCHC and Wirral Hospice St John's. The hub provides free online training and can be found at https://www.wirralhospice.org/wirraleducationhub/. All care home providers are able to access this free online training, which is regularly updated. The online resource supports face to face training which is held on a request basis throughout the year.

3.11 The End of Life Care and Community Specialist Palliative Care Team can also offer training for:

- Communications skills
- Introduction to EOL care (1 day course)
- Symptom management (1 day course)
- Syringe driver training (bespoke for nursing homes)
- In house training for carers in care home settings

3.12 The local training offer is being enhanced to include the 'Mayfly' Advance Care Planning education and communication skills programme, which focuses on enhancing the skills and confidence of professionals delivering End of Life Care in all settings. It supports professionals to have "difficult conversations" around advance care planning.

3.13 Local intelligence indicates that an average length of stay in a care home in Wirral is 16-months and therefore it is important that staff are trained and supported to deliver the six steps programme, to ensure a consistent and compassionate approach for all people in care homes, who are approaching the end of their life.

3.14 All Wirral Council contracted services are commissioned to support End of Life Care initiatives, and this is reviewed as part of contract monitoring and quality improvement responses. The End of Life Care Team are commissioned to deliver the "six step programme", which is aimed at improving End of Life Care provided by a care home (and its workers) that encompasses the philosophy of palliative care. At the core of the Six Steps Programme is the nomination of two or three representatives from the service to act as champions. Having representatives for End of Life Care ensures each service has champions who have access to current national and local information. They are supported by the service to develop their knowledge and skills and encouraged to empower and educate staff within their organisation to deliver End of Life Care. Training locally is delivered by the End of Life Care Team to care homes and the care home can be accredited to the National six steps programme. The six steps are:

- Step 1 - Discussions as End of Life approaches
- Step 2 - Assessment, care planning and review
- Step 3 - Co-ordination of care
- Step 4 - Delivery of high-quality care in care homes
- Step 5 - Care in the last days of life
- Step 6 - Care after death

3.15 The care home has to build and maintain a portfolio of evidence that shows excellent delivery of End of Life Care. Feedback is sought from the End of Life Care Team from other services, e.g. community nursing and the tele triage team on the performance of the service. A certificate is issued to the care home once competencies are well evidenced and to be maintained this is checked every 12-months but can be checked prior based on any concerns or intelligence received that would indicate an earlier intervention.

3.16 As of November 2023, of the 74 care homes, 56 have a six steps certificate, 18 do not have a valid certificate, but 6 of these 18 are working towards the certificate. It is important to note that the numbers can change monthly dependent on the care homes having their portfolios assessed to check they can maintain their certificate. Our Quality Improvement Team is working in partnership with the End of Life Care Team to support the providers who have not yet achieved it.

3.17 Every care home has a named contract manager and quality improvement practitioner allocated to them from the Council, and there is also a dedicated End of Life Care Practitioner identified within the Quality Improvement Team who is a practice lead.

3.18 There is an expectation that care homes complete an end of life register on a monthly basis and return form to the End of Life Care Team at each submission period.

3.19 As part of the enhanced health in care homes programme, General Practice (GP) will put in place an Emergency Health Care Plan (EHCP), to support people to stay in their preferred place of care and avoid any unnecessary acute admissions. A separate form can be completed which includes any wishes in relation to attempts at resuscitation.

3.20 The End of Life Care Team can provide syringe driver training for nursing homes to support them with medication for End of Life Care patients and will also loan the syringe driver (nursing homes are expected to provide the consumables to be used with this) to support patients.

3.21 There is a dedicated “Record of care” document which is in use for the last days of life, and all professionals: care home staff, social care staff, GP, and health professionals will all record on the same ‘record of care’ document.

3.22 There is a 24-hour palliative care advice line in place for Wirral – 0151 343 9529 and posters are displayed in care home settings.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no financial implication arising as a result of this report, current services are delivered within available resources.

5.0 LEGAL IMPLICATIONS

5.1 Health and Social care providers undertake regulated activity which is monitored by the Care Quality Commission.

5.2 The Local Authority has a duty under the Care act 2014 to assess and meet a person's needs, where they are eligible.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 No implications as a result of this report

7.0 RELEVANT RISKS

7.1 There is a risk that people will not live well or have a dignified death at the end of their life. This risk is mitigated by having the Palliative and End of Life Care Partnership (PEOLCP) in operation locally, supported by national, regional, and local priorities.

7.2 There is a risk that care service providers will not be able to support providers with compassionate end of life care, this is mitigated by providers following the "six step" programme and accessing free training via the local palliative care education hub. This risk will be further supported by the annual checks undertaken with providers.

8.0 ENGAGEMENT/CONSULTATION

8.1 The Palliative and End of Life Care Group is a multi-stakeholder group and includes the views of people and their carers who are experiencing End of Life Care.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help Council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

9.2 Equality implications are part of the commissioning process, and all partner agencies are expected to provide a service to all, that does not discriminate. This is part of the contract review process.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 No environmental or climate implications arise as a result of this report.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 Social care providers locally employ in the region of 8000 staff.

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APPENDICES

N/A

BACKGROUND PAPERS

NHS England Paper Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026. The paper can be found here: https://www.england.nhs.uk/wp-content/uploads/2022/02/ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf

Six Steps to Success in End of Life Care: https://eolp.co.uk/SIXSTEPS/

Mayfly Training https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/education/

TERMS OF REFERENCE

This report is being considered by the Adult Social Care and Public Health Committee in accordance with Section 2.2(a) and (b) of its Terms of Reference: adult social care matters (e.g., people aged 18 or over with eligible social care needs and their carers) and promoting choice and independence in the provision of all adult social care).

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
N/A	