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Title:	**Adults, Health & Public Protection Policy & Scrutiny Committee**
Meeting Date:	**Wednesday 29th March, 2017**
Time:	**7.00 pm**
Venue:	**64 Victoria Street, London, SW1E 6QP**
Members:	**Councillors:** Barbara Arzymanow Susie Burbridge Jonathan Glanz Patricia McAllister Jan Prendergast Glenys Roberts Barrie Taylor Gotz Mohindra

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall from 6.30pm. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Andrew Palmer, Senior Committee and Governance Officer.

Tel: 7641 2802; Email: apalmer@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Head of Legal & Democratic Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

4.1 CABINET MEMBER UPDATES

The update from the Cabinet Member for Adult Social Services & Public Health which was marked "to follow" is now attached.

7. UPDATE ON END OF LIFE CARE

The "Joint Strategic Needs Assessment End of Life Care: Key Themes and Recommendations" report that was referred to, is now attached.

Charlie Parker
Chief Executive
24 March 2017

City of Westminster

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	**29th March 2017**
Briefing of:	**Cabinet Member for Adult Social Services & Public Health**
Briefing Author and Contact Details:	**Madeleine Hale** **mhale@westminster.gov.uk** **0207 641 2621**

1 Actions requested by the Committee

The most recent KPI analysis of Adult Social Care (ASC) and Public Health programmes, submitted to the Audit and Performance Committee is attached in Appendix A of this report for the Committee's reference.

2 Adults

2.1 Better Care Fund (BCF)

2.1.1 As of 23rd March 2017, the national policy framework and planning guidance which were anticipated in November 2016, have not yet been released, and is not expected before the end of March. It is understood that the policy framework will be broadly similar to previous years and that the timetable will allow for an initial draft submission, and a second, final submission of the BCF plan, will be approved by the Health and Wellbeing Board. The timetable for the BCF plan will be contained in the Planning guidelines, when released.

2.1.2 The proposed 2017/18 BCF plan will build on previously agreed BCF plans, noting the development of the WCC Joint Health and Wellbeing (HWB) Strategy as an important point of reference. There is strong alignment between the approach to the BCF and the HWB strategy. During preparations, analysis of 2016/17 projects has taken place to determine which projects require further development and which are now embedded as business as usual. Once national guidance is received including national requirements, conditions and final financial allocations, further planning can take place. The financial arrangements will need to recognise the financial limitations of all organisations involved.

2.2 Home Care

2.2.1 100% of customers have now transferred to the new home care providers in the first 3 patches. The recently awarded final patch has 334 customers, of which approximately 23 customers remain in the transfer process. Therefore, overall transfer of customers within Westminster (for all 4 patches) is at 97.9% and it is expected that all customers (100%) will be transferred by the end of March 2017.

2.2.2 Comprehensive monthly contract meetings are being undertaken with all 4 providers who report on a weekly basis to the Commissioning and Contracts Team. By the end of March 2017, annual performance reviews will be completed for all four providers.

2.2.3 So far 550 customers (8,667 hours) out of 1,141 customers (16,898 hours), have opted for a Direct Payment in Westminster; this accounts for 51.3% of total customer hours. Therefore, commissioned hours in Westminster are 48.7%.

2.3 Inter-generational Initiatives

We are continuing to explore the feasibility of developing an intergenerational facility as part of the Specialist Housing Strategy for Older People (SHSOP) new build programme and discussions have been held with the Chief Executive of the London Early Years Foundation. More detailed work, including the development of a full business case, will be required.

2.4 Mental Health Day Services Consultation

2.4.1 Following our joint consultation about changes to our mental health services, officers and health colleagues are continuing to develop a specification for the new service that integrates with secondary and primary care mental health provision within the borough. This is a highly critical service and service users and stakeholders are involved in helping to design the new service. A number of well attended co-design workshops and market days have taken place and the model is currently being finalised in consultation with CCG colleagues. The aim is to reach more people, achieve better outcomes and create efficiencies.

2.4.2 The proposals are to replace underused existing day centres with a more flexible and tailored support service with more focus on early intervention and recovery. Assurance has been provided to current service users that no change will be made to current arrangements until other services are in place. A provider has been appointed to support current service users' transition to a more personalised service and to support any on-going needs. This will include providing peer support groups and "safe space drop-ins". A drop in service has commenced in South Westminster at Abbey Centre one day a week and the intention is to increase times from April 2017. A possible site has been found in North Westminster to begin in April 2017. Services users are also starting to use alternative services from those provided within the existing day centres. This service will ensure that people who have had multiple relapses and who find accessing mainstream services very challenging or are

transitioning from hospital to GP care can access support; at different times, in the community and at a range of locations. The proposals also give people increased choice and control of their mental health services through use of personal budgets.

3 Public Health

3.1 **0-5 Health Visiting and Family Nurse Partnership (FNP)**
The current contract with Central London Community Healthcare (CLCH) runs until 30th September 2017. The Health Visiting and FNP services are part of a collaborative commissioning programme and key officers from Public Health, Children's Service Commissioning and procurement teams are working together to re-commission services for children aged 0-5 (Health Visiting and Family Nurse Partnership). This collaborative approach is using whole system planning in the context of the development of Family Hubs and the restructure of the Public Health Directorate.

3.2 **5-19 School Health Service**
The contract for the school health service has been awarded to a new provider Central and North West London NHS Foundation Trust (CNWL). Public Health and Children's Services are working on the mobilisation of the service with the current and new providers to ensure safe transfer and continuity of service for schools, children and families. The new enhanced service will commence on 1st April 2017.

3.3 **Advice Services**
The review of Public Health advice services is underway, bringing the remaining services under the scope of Corporate Advice services or where, and if relevant, under the Voluntary Sector Support Service or the provision of services for Older People under the umbrella of Older People Hubs.

3.4 **Childhood Obesity**

3.4.1 The Tackling Childhood Obesity Team (TCOT) is developing and strengthening engagement throughout the Council to accelerate progress on the programme. The aim of the partnership is to establish strong relationships across the council alongside targeted activities to reduce childhood obesity. The TCOT is also examining additional activities and will work with the oral health project to strengthen the sugar message.

3.4.2 An additional 13 businesses have signed up to the health catering commitment which aims to educate businesses in the nutritional properties of food and offer simple changes to make the food they serve healthier.

3.4.3 The TCOT has committed to offer community gardening and education at 11 additional sites. These sites will demonstrate the clear link between natural capital and healthy lifestyles.

3.4.4 The team is working with the NHS to design and facilitate My Time Active training for non-clinical workforce members, a GP surgery and on neighbouring estates.

3.4.5 18 primary schools are participating in the MEND (Mind, Exercise, Nutrition…Do it!) in schools programme from September 2016.

3.4.6 The family healthy weight services provided by My Time active are highly rated by residents. The food growing and gardening project is involving further schools and estates in setting up new plots. Westminster took part in the pan-London initiative, The Great Weight Debate which now has involved residents in local events and completed a survey to tell us how families and children can lead healthier lives.

3.5 **Community Champions**

3.5.1 The Community Champions now has comprises 5 Community Champions projects and a Maternity Champions pilot project. All 5 projects are delivering positive results. There has been good collaborative work with housing, particularly with City West Homes, Peabody and Sanctuary housing. The Queens Park Maternity Champions have regular weekly sessions involving 60 parents and babies.

3.5.2 An extension of the maternity champions project to all 5 projects and broader reach across the borough is planned and providers have been asked to tender for this work. The project will help to give children the best start in life through supporting expectant parents and children in their first year of life. Outcomes include improved maternal mental health, increased uptake of breastfeeding and immunisations, and improved oral health, as well as reduction in isolation for expectant and new mothers.

3.6 **Integrated service design update**

The first review stage for the integrated service design is being completed, with a stakeholder engagement event held on March 17th. A survey has been developed to consult with residents about their views. The procurement process is beginning with the expectation that there will be a new integrated healthy lifestyles service in place in October 2018. The new service will have at its core an interactive digital platform, to support self service and access to apps which support healthy lifestyle choices.

3.7 **Oral Health Campaign**

3.7.1 Tooth decay is the leading cause of hospital admission for 1-9 year-old children in Westminster, so the council is exploring ways of making the oral health campaign much more effective. Cllr Iain Bott has agreed to continue working on this.

3.7.2 An event for external stakeholders including school Headmasters, dentists, GPs and providers of community dental preventative services took place in the Mayor's parlour on 15th March. The purpose of the event was to share knowledge, ideas and gather intelligence to inform the forthcoming comprehensive campaign. This campaign will target young children and their parents, promoting the importance of good daily oral hygiene practice, regular

dental checks and reduction in sugar consumption at the age where habits are formed and preventative measures are most effective.

3.7.3 The event on the 15th March was very successful with attendees giving positive feedback and showing significant interest in being a part of the on-going oral health campaign. Full follow up and evaluation of responses from the event are currently being collated.

3.8 **Shisha Symposium**

On 22nd February, the Council held a Shisha Symposium to start work on tackling the problem of Shisha smoking, which has major public health implications, particularly for our young. The event was incredibly productive and work has already started on the actions arising from the event. I shall be leading a multi-disciplinary group to work with other interested Local Authorities in order to coordinate our approach and to lobby Government on policy issues. New regulations are coming in to place on 20th May which will affect shisha premises and with help from our Business Improvement Districts we shall be alerting all our known premises about these changes and working with them to ensure they are compliant.

3.9 **Prioritisation Framework**

If the Council is to achieve significant improvements in population health outcomes in the current economic climate, choices need to be made about how best to allocate Public Health resources to specific programmes or work/ services. Funding decisions for 18/19 and 19/20 will be informed by the output of a prioritisation framework which will enable the following:

i. A comparison of services (including existing and proposed services) across a range of dimensions (including health impact; finance; implementation; population coverage and strategic fit);
ii. Identification of gaps in service provision for prioritised Public Health outcomes. An assessment of how each borough is performing against each of these priority health outcomes forms another element of the prioritisation framework;
iii. Prioritising collaborative programmes of work across Council departments (e.g. obesity prevention, healthy homes etc.)

3.10 **Sexual Health**

3.10.1 The re-designed Adults Community Sexual and Reproductive Health Service is due to be implemented from April. Service user and stakeholder meetings are being held and been helpful in identifying areas of need to ensure a smooth transition. A new name for the consortium of LOT 1 community support provision is now called "SASH" (Support and Advice for Sexual Health).

3.10.2 The finalising of the procurement of the integrated Genito Urinary Medicine (GUM) Sexual and Reproductive Health (SRH) service is now progressing with the support of the London Sexual Health Transformation Programme. Final negotiations with the preferred provider will take place on the revisions to the

specification. The procurement of the London wide web based sexual health screening initiative is also progressing due to complete by July

3.11 **Staff Re-Structure**

3.11.1 Public Health's operating model has been re-designed to ensure the three Councils can maximise impact on population health whilst also meeting its savings targets for the medium term.

3.11.2 The re-structure will deliver a new service operating model and culture that provides more visible leadership and governance for each programme of work and a more collaborative model of working with other Council departments, particularly Children's and Adult Social Care.

3.11.3 The new structure and associated ways of working will go live from 3 April 2017. Staff were formally consulted about the proposed changes to the structure in November 2016.

3.12 **Substance Misuse**

3.12.1 The evaluation of both the specialist Group Work Programme and Primary Care Support Service is now complete and recommendations will be made. It is intended that those elements of both programmes shown to have demonstrated positive impact on outcomes be embedded into the main core provision. It is clear that the primary care support service is not delivering the best possible service so it is intended that we will work with GPs and CCGs to identify how best to support primary care to deliver to those service users seen in primary care settings.

3.13 **Supported Employment**

3.13.1 **Westminster Employment Service**
The Westminster Employment Service (WES) is the new umbrella service for the Council and partners' employment activities focussed on supporting those who are long term unemployed or at risk. Through WES our ambition is to work more collaboratively with local agencies to help unemployed residents into work. In the next year the service will engage with more local employers, promote employer / business achievement, trial a new way of multi-agency working in the interests of residents and ensure that residents access the right service through a new web site and assessment process.

3.13.2 **Partnership with Groundwork and Paddington Development Trust**
The Economy Team has leveraged £50,000 from Jobcentre Plus to help residents with disabilities and health conditions into employment. The programme will support 76 residents and 24 residents into employment by the end of 2017.

3.13.3 **Specialist Employment Broker**

Through the Specialist Employment Broker based in Cross River Partnership, 33 individuals have progressed closer to employment this financial year and 16 people have been supported into employment opportunities.

3.13.4 **Support for residents with learning & physical disabilities**

Westminster Employment provides employment support to residents with severe physical and learning disabilities. Funded through Public Health and commissioned via Adult Services, the support has helped 83 residents move closer to employment this financial year. Of those, 12 have been supported into paid employment and a further three into voluntary work. 13 residents have remained in employment for at least six months. These outcomes reflect the quality of the employer relationships brokered by the team with many offering multiple opportunities to the service. These relationships include the Westminster Society, Origin Housing, Sweetree, Yarrow and Cooks and Partners.

4 Health and Wellbeing Board

4.1 The Health and Wellbeing Board met on 23rd March in private to plan ways of working together to implement the Health and Wellbeing Strategy, as described below.

4.2 **Health and Wellbeing Strategy for Westminster 2017-2022**

The Health and Wellbeing Strategy for Westminster 2017-2022 was published on 15 December 2016. An underpinning joint implementation plan, which will link the sub-regional STP work to the local strategy, is currently being developed by Westminster City Council and Central London Clinical Commissioning Group (CLCCG) and West London Clinical Commissioning Group (WLCCG). The delivery plan will draw in external partners and providers such as City West Homes and Westminster voluntary and community sector organisations and will be set out by themes and delivery areas rather than by organisations.

5 The North West London Sustainability and Transformation Plan (STP)

Work continues in North West London on the Sustainability and Transformation Plan which is developing a collaborative approach across 6 boroughs to plan for future demand for health and care services with constrained resources. The Council supported the ‘in principle’ submission for North West London in October subject to further detailed work required on services needed in the community and how increased community services would be funded. The Westminster, Health and Wellbeing Strategy which sets out our local implementation plan for the STP. An Older Person’s Care Reference Group has been established with membership including local people, voluntary sector organisations and clinical and social care experts which will provide leadership, advice and challenge on developing and implementing new models of care.

If you have any queries about this report or wish to inspect any of the background papers please contact Madeleine Hale x 2621 mhale@westminster.gov.uk

Appendix A – Quarter 3 Performance Summary of Adult Social Care and Public Health

1. KPI analysis of Adult Social Care and Public Health

The tables below provide an assessment of the Key Service Performance Indicators for each directorate. Detail has been provided for all indicators failing to meet targets. Please note figures reported are for April to December 2016, unless otherwise indicated.

Performance Indicator	2015/16 Performance	2016/17 Target	Quarter 3 position*	RAG Rating	Direction of Travel
	Last year's position	Targets	Apr 16 – Dec 16	Red, Amber, Green	Perf vs. last year

Performance Indicators flagged for attention:

ADULT SOCIAL CARE					
Proportion of adults with a learning disability known to Adult Social Care in paid employment	7.4%	7.5%	**5.5%** (22/398)	**Amber**	Stable
Reason for underperformance and mitigation: Some people with learning disabilities known to the team who have been in employment and were previously counted cannot now be included in the indicator as they have not received ASC funded support in the year. To meet the target (7.5%) about ten more people will need to have been in paid work by the year-end (about two people per month from Q2 - 32 people in total). The current rate (5.5%) is broadly similar to the London and England averages.					
Total number of new permanent admissions to nursing care of people aged 65 years and over	53	53	**42**	**Amber**	Stable
Reason for underperformance and mitigation: There have been more new admissions to nursing care compared to at this point last year (although the residential and nursing figure together is similar to last year). This reflects a shift in the type of care needed as people spend longer periods at home, requiring nursing care at a point when needs are more complex. Target is 'at risk' although combined residential and nursing target is likely to be met reflecting the change in supply to meet presenting need.					

Performance Indicators on track to achieve targets:

ADULT SOCIAL CARE					
Percentage of carers receiving an assessment or review	**87%**	90%	**55.8%**	**Green**	Improving
Reason for underperformance and mitigation: Carers assessments are slightly behind target for November 2016 (56% against Nov target of 60%). However, performance is much improved on November 2015 (39.5%). Many assessments carried out in the previous year were carried out in the latter part of the year, hence too soon to carry out another review. Performance is greatly ahead of performance this time last year (40%). The percentage will rise fastest in final 3 months. Timescales will be in line for Q4 (reviews carried out in Jan-Mar 17.					

Performance Indicator	2015/16 Performance	2016/17 Target	Quarter 3 position*	RAG Rating	Direction of Travel
	Last year's position	Targets	Apr 16 – Dec 16	Red, Amber, Green	Perf vs. last year
Proportion of adults in contact with Mental Health services in paid employment	6.6%	6.6%	**7.2%**	**Green**	Improving
Percentage of people completing re-ablement who require a long-term service	28%	28%	**27.9%** (153/549)	**Green**	Stable
Total number of new permanent admissions to residential care of people aged 65 years and over	46	46	**23**	**Green**	Stable
Adults receiving a personal budget to meet their support needs	92%	90%	**91.5%** (1,466/1,603)	**Green**	Stable
Delayed transfers of care, acute days attributed to social care (cumulative)	1,002	924 (308 Apr – Jul 2016)	**601** (to end Oct 2016)	**Green**	Improving

PUBLIC HEALTH					
Service Commentary: Public Health performance indicators all have a lag reporting time of between 2 months to a year. However all indicators have been reported as being on track and to achieving their targets. The most up to date figures have been provided within the table.					
Percentage of children who received a 2-2.5 year review	53.1% (in Qtr1 2015/16)	69%	**86%**	**Green**	Improving
Number of residents reached through community champion activities	13,228 (global figure for all activity)	13,228	**9,782** (to end Sept 2016)	**Green**	Improving
Number of NHS health checks taken up by eligible population	7,784	8,330	**1,722** (to end Sept 2016)	**Green**	Stable
Service Commentary: Quarter 2 data reported. Quarter 3 data will be available mid-January. We have increased the target to 20% of the eligible population. We are on track to meet this.					
Stop Smoking Services – number of 4 week quits	1,467 (full year)	1,078 (Apr 2016 – Dec 2017)	**619** (year to date to end Sept 2016)	**Green**	Improving
tary: Quarter 2 data reported. Quarter 3 data will be available mid–February. Westminster is performing well and is in a much better position than they were this time last year. They are on track to meet the end of year target. The proportion of quitters coming from the most deprived areas (2 quintiles of highest deprivation) has improved.					

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	29 March 2017
Classification:	General Release
Title:	**UPDATE ON END OF LIFE CARE**
Report of:	Liz Bruce-Tri Borough Executive Director of Adult Social Care Services & Jules Martin - Managing Director of Central London Clinical Commissioning Group (CCG)
Cabinet Member Portfolio	Adult Social Services & Health
Wards Involved:	All
Policy Context:	Building Homes and Celebrating Neighbourhoods
Report Author and Contact Details:	Colin Brodie, Public Health Knowledge Manager, cbrodie@westminster.gov.uk Andrew Pike, Assistant Director of Communications, CWHHE CCGs andrew.pike@nw.london.nhs.uk

1. Executive Summary

1.1 This report summarises the work and findings of the Joint Strategic Needs Assessment (JSNA) on End of Life Care including the recommendations for key partners. The JSNA was presented for discussion and approved by the Westminster Health & Wellbeing Board.

1.2 The report also summarises the local direction of travel for End of Life Care in Westminster, and continuing progress made against the JSNA recommendations since publication of the report.

2. Key Matters for the Committee’s Consideration

2.1 The Adults, Health & Public Protection Policy & Scrutiny Committee are invited to consider and endorse the End of Life Care JSNA report and recommendations.

2.2 The Adults, Health & Public Protection Policy & Scrutiny Committee are invited to note progress made against the recommendations. The responses will form

the basis of recommendations that will be incorporated into a short report that will be submitted to the relevant Cabinet Member(s) for a response.

3. Background

3.1. People approaching the end of their life experience a range of physical symptoms, and emotional and spiritual needs. To manage these issues effectively requires integrated and multidisciplinary working between teams and across sectors regardless of whether the person is in their home, in hospital, a care home, or hospice.

3.2. Families and carers of people at end of life also experience a range of challenges and will have their own specific needs which must be addressed before, during and after the person's death

3.3. While some people experience good and excellent quality end of life care, many people do not. In order to address this variation and identify local issues for end of life care a request for a JSNA was submitted and approved by the JSNA Steering Group, a sub-group of the Health & Wellbeing Boards, July 2014

3.4. The JSNA provides a comprehensive evidence base to inform local strategic and commissioning approaches to end of life care. It draws on a range of information and data, both quantitative and qualitative, including national and local data, policy and strategy, literature, as well as views of patients, service users and the public. It provides an opportunity to understand the whole landscape for people approaching end of life, and their carers' and to highlight areas of improvement to be addressed in joint strategic planning.

Joint Strategic Needs Assessment Findings and Recommendations

3.5. ***Tri-borough Population and number of deaths***

The percentage of either gender at all ages over 65 for the three boroughs is significantly low compared with England. The exception is in the Royal Borough of Kensington & Chelsea for those aged 85+ for both genders, with the percentage of women over 85 years close to the England average, but with a significantly higher percentage of males older than 85 years because of the Royal Hospital Chelsea, a home for retired soldiers.

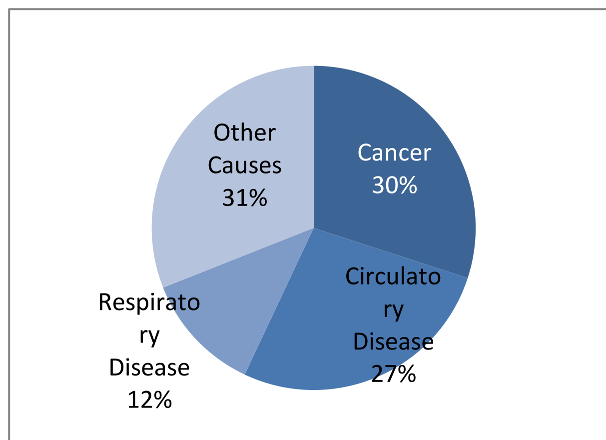
The death rate is low compared to other areas, even when taking into account the age distribution of the population. There have been an average of 2,815 deaths per year between 2006 and 2014. Despite an increasing and aging population the number of deaths has reduced by 19 each year.

The median age at death is 83 years for women and 76 years for men, compared to national figures of 85 for women and 82 for men. Median age at death varies from 66 years in Earl's Court to 88 years in Pembridge.

The number of deaths that occur is not likely to change significantly over the next ten years. This takes into account the small increase in the ageing population predicted by the Office for National Statistics and the expected reduction in death rates.

3.6 ***Cause of death***

On average there are 844 (30%) deaths per year due to cancer, 768 (27%) due to circulatory disease, 341 (12%) deaths due to respiratory disease and 863 (31%) deaths due to other causes. The percentage of deaths due to cancer is significantly higher in the north of Westminster City Council and is significantly associated with an older median age at death.



Examination of deaths in the three boroughs is complicated by the geography and the different populations of the organisations responsible for providing services. There are a number of different populations to examine: Resident, Registered, Residents who are Registered, and Registered who are not Resident. Additionally, those who die may do so anywhere in the country.

The overarching theme emerging from the JSNA (a joint local authority and Clinical Commissioning Group description of the current and future health and wellbeing needs of its local population, along with the priorities for action) is the need for a whole scale 'culture shift' for all practitioners that may come into contact with dying people, to consider End of Life care as 'everyone's business' and not just a service provided by specialist palliative care.

3.7. The recommendations were drawn from the evidence contained in the JSNA and in development with key stakeholders. Many of the recommendations cut across a number of different themes and service areas, and were presented in a format for commissioners to consider whether they are appropriate for local implementation.

3.8. Recommendation 1 refers to an ambition for the local delivery of high quality, person- centred end of life care designed to improve the experience of the dying person and their families, carers and friends. Recommendations 2 to 5 describe the culture, governance, processes and systems that need to be in place in order to achieve this ambition

3.9. The detailed recommendations are presented in the End of Life Care JSNA Key Themes document but are also summarised below.

Recommendation	**Summary**
Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination	Everyone with a life limiting long term condition should have care plans which address their individual needs and preferences, particularly as they approach the last phase of life. Their care must be coordinated, with a clear oversight of the respective roles and responsibilities of all health, social care and third sector service providers.
Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people	The overall focus of end of life care must be a community model, with input from specialist services when needed. Local leaders, commissioners, professionals and our populations should generate a culture where talking about and planning for the last phase of life is 'normal', and all practitioners are willing and able to give end of life care.
Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector	A lead organisation should be identified with responsibility for ensuring developments are cohesive. Leadership should reflect a community based model across a range of services, with a clearly articulated end of life care vision and ambitions.
Recommendation 4: Develop a coordinated education and training programme for practitioners, the person dying, carers and for family and friends (if they wish)	Formal and informal training and education programs for all frontline practitioners needs to be coordinated, systematic, visible and evaluated, in line with good practice guidelines.
Recommendation 5: Everyone should have easy access to evidence and information	More information needs to be easily available. Accessibility in terms of language, style, culture and ability should be reviewed. Evidence and information must be available to commissioners and providers and used to actively improve services.

4. END OF LIFE CARE IN WESTMINSTER LONDON/CURRENT WORK PROGRAMMES

4.1. Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination.

Central London CCG utilise the Co-ordinate My Care (CMC) system along with the other 31 CCGs across London to record the care plan of those identified as being at the end of life. The CMC platform has been updated to facilitate the creation and updating of records and the Three Borough End of Life Care Steering Group regularly review the reports and discuss what additional support can be provided to increase the number of patients whose care information is shared on the system.

4.2 Central London Community Healthcare (CLCH) have convened six working groups closely aligned to the recommendations of the JSNA with three groups looking at:

- High quality, relationship centred, compassionate care
- Advance care planning/risk stratification
- Assessment and care planning

The individual working groups report back on the progress of achievement against each of the outcomes, to the newly formed End of Life Care Operational Group.

4.3. Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people

Supporting people in the Last Phase of Life (LPOL), has been identified as a priority area in both the Health and Webbing Strategy for Westminster 2017-2022 and the North West London (NWL) Sustainability & Transformation Plan (STP) submitted in October 2016. The shift to consider people in the last phase of life rather than those at the end of life recognises the more gradual functional decline that characterises the progression of various long term conditions and increasing frailty. This reinforces the need to recognise when people are in the last phase of life and to have discussions at an early stage with them and their families regarding their preferences and what support is required. This will allow a shift from an existing hospital- based model of care, often through emergency services, to a new community and person-focused model of delivering care with input from specialists when needed.

4.3 The CCG are also working with the new provider of the Community Independence Service to consider how the service can work alongside local hospices, district and community nursing, primary care practitioners and specialist palliative care teams to provide support to those in the last phase of life.

4.5 Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector

In the North West London area, a programme of work is being undertaken as part of the STP to improve the quality of care for people who are in their 'last phase of life'. This includes patients in Westminster.

4.6 Providers working across Westminster have end of life care strategies with key leaders within the organisations identified and governance mechanisms in place for monitoring progress.

4.7 Imperial College Healthcare NHS Trust (ICHT) and Chelsea & Westminster NHS Foundation Trust both have organisational end of life care strategy documents. The CLCH End of Life Care Strategy (2015-2018) was launched in March 2015 and sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

4.8 The strategy covers generalist and specialist palliative care, including care given in all settings of CLCH (at home, all community based services, in-patient, specialist in-patient palliative care services, day Hospice, specialist community palliative care services, prison health, nursing and residential care).

4.9 The Health & Wellbeing Board approved the End of Life Care JSNA at their meeting on 21 January 2016 and agreed to take on a leadership role for End of Life Care, providing a steer for local implementation.

4.10 The inpatient and community End of Life Care services are monitored regularly, through a number of quality indicators that include using carer feedback to improve services. In 2017/18 the CCG will build on these indicators by introducing a new Commissioning for Quality & Innovation (CQUIN) to specifically measure carer feedback.

4.10 Recommendation 4: A coordinated education and training program for practitioners, the person dying, carers and for family/friends (if they wish)

The NWL LPOL programme has identified consistent training and education across the NWL Collaboration of CCGs as one of the six key interventions and discussions have been initiated with HENWL to agree a funding mechanism.

4.11 The CLCH EOLC Strategy includes a working group dedicated to training and education which categorises staff groups and supports the delivery of appropriate training in relation to the end of life care components of their jobs.

4.12 ICHT and CLCH have delivered end of life care training to staff including difficult conversations training.

4.13 The dementia workforce development programme is due to commence in February 2017. It will include a range of modules, including a focus on end of life care and dementia. The modules will include a range of learning approaches including e-learning, workshops, training and a communication strategy.

4.14 The module will focus on living well with dementia and supporting a person with dementia to die well, or as they would have wished. It will include exploring advanced decision making, the range of symptoms that a person with dementia may experience at the end of life. It will also include supporting family carers and help them to understand what is happening at the end of life.

4.15 Recommendation 5: Everyone should have easy access to evidence and information

One of the interventions which has been recommended and prioritised by the North West London Last Phase of Life programme, is to deliver a telemedicine clinical support facility to help staff in care homes (initially) to be able to access generalist healthcare and end of life care advice and support

4.16 The service will be staffed by experienced, clinical professionals who are capable of providing rapid triage and advice / guidance to both clinical and non-clinical staff. Best practice from elsewhere, particularly Airedale - http://www.health.org.uk/gold-line - has shown that this model allows professionals and carers to better facilitate the wishes of patients at the end of their life. It also helps support them to enable people to die in their preferred place and can also reduce inappropriate A&E attendance and hospital admissions. Working with Social Finance, we will be looking to implement something similar in our care homes, in the first instance. The next phase of the programme will then be to focus on the CCG's wider cohort of residents, including those people being cared for by district nursing, intermediate care services and by formal and informal carers. One of the interventions which has been recommended and prioritised by the North West London Last Phase of Life programme is to deliver a telemedicine clinical support facility, to help staff in care homes (initially) to be able to access generalist healthcare and end of life care advice and support. The next phase of the programme will then be to focus on the wider cohort of residents, including those people being cared for by district nursing, intermediate care services and by formal and informal carers.

4.17 The service will be staffed by experienced clinical professionals who are capable of providing rapid triage and advice / guidance to both clinical and non-clinical staff. Best practice from elsewhere has shown that this model allows professionals and carers to better facilitate the wishes of patients at the end of their life and support them to die in their preferred place, and can also reduce inappropriate A&E attendance and hospital admissions

5. CONSULTATION

5.1. A workshop was held at the Black & Minority Ethnic Health Forum in June 2015. Feedback from the workshop was incorporated into the findings, particularly the Policy and Evidence Review (Supplement 2)

5.2. A workshop was held at the End of Life Care Steering Group in September 2015 to inform the development of the recommendations. The End of Life Care Steering Group consists of CCG and GP End of Life Care leads as well as community and secondary care providers

5.3. CCG and GP End of Life Care leads were interviewed for the JSNA.

5.4. The draft JSNA was disseminated to key stakeholders in November 2015, including colleagues in Local Authority, Adult Social Care, CCGs, Central London Community Healthcare, Hospices, Specialist Palliative Care Teams, Healthwatch, and Community and Voluntary organisations. Feedback was collated and reviewed by the Task and Finish Group and informed the final report.

6. EQUALITY IMPLICATIONS

6.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life.

6.2. The “local area” is that of the borough, and the population living in or accessing services within the area, and those people residing out of the area for whom CCGs and the local authority are responsible for commissioning services

6.3. The “whole local population” includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs etc.)

7. LEGAL IMPLICATIONS

7.1. The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities, CCGs and the Health & Wellbeing Boards.

7.2. Section 2 Care Act 2014 imposes a duty on local authorities to provide or arrange for the provision of services that contribute towards preventing, delaying or reducing care needs.

7.3. Section 3 Care Act 2014 imposed a duty on local authorities to exercise its Care Act functions with a view to ensuring the integration of care and support provision with health provision to promote well-being, contribute to the prevention or delay of care needs and improve the quality of care and support.

7.4. JSNAs are a key means whereby local authorities work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of local authority s2 and s3 Care Act duties.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Report Author:

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APPENDICES:

Joint Strategic Needs Assessment - End of Life Care Key Themes Report

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LONDONASSEMBLY

Health Committee

END OF LIFE CARE IN LONDON

End of life care in London

The London Assembly Health Committee has been investigating the quality of care people receive at the end of their lives. This report summarises our key findings and suggests some areas for further investigation.

Key findings from our investigation

There is huge variation in the quality of care people receive at the end of their life in London. Statistically, Londoners receive some of the very best and the very worst end of life care in the country. Overall, London performs poorly in end of life care compared with the national average.

Access to services is unequal. Some people are less likely to receive good quality specialist end of life care. Their diagnosis, whether they live alone, their cultural background and sexual orientation all affect the chances of a person receiving the care they need and want.

Older people struggle to access the care they need, particularly if they live alone. As the number of older people who live alone grows, this will place further strain on hospital services.

Fewer than half of London local authorities include end of life care as part of their Health and Wellbeing Strategies. Without this focus on end of life care provision, services struggle to meet local needs.

Many people, including medical professionals, find discussions of death and dying very difficult. But communication between individuals, families, and health and social care providers is an essential part of good end of life care.

What is end of life care?

A person approaching the end of their life will have a range of needs that can be met by family and friends, and health and social care providers.

The best care will be a package of care measures, tailored for the individual, that could include:

- Managing symptoms, including relief from pain
- Supporting with practical arrangements to reduce anxiety
- Helping to achieve a sense of resolution and peace
- Providing practical support with daily activities such as washing or dressing.

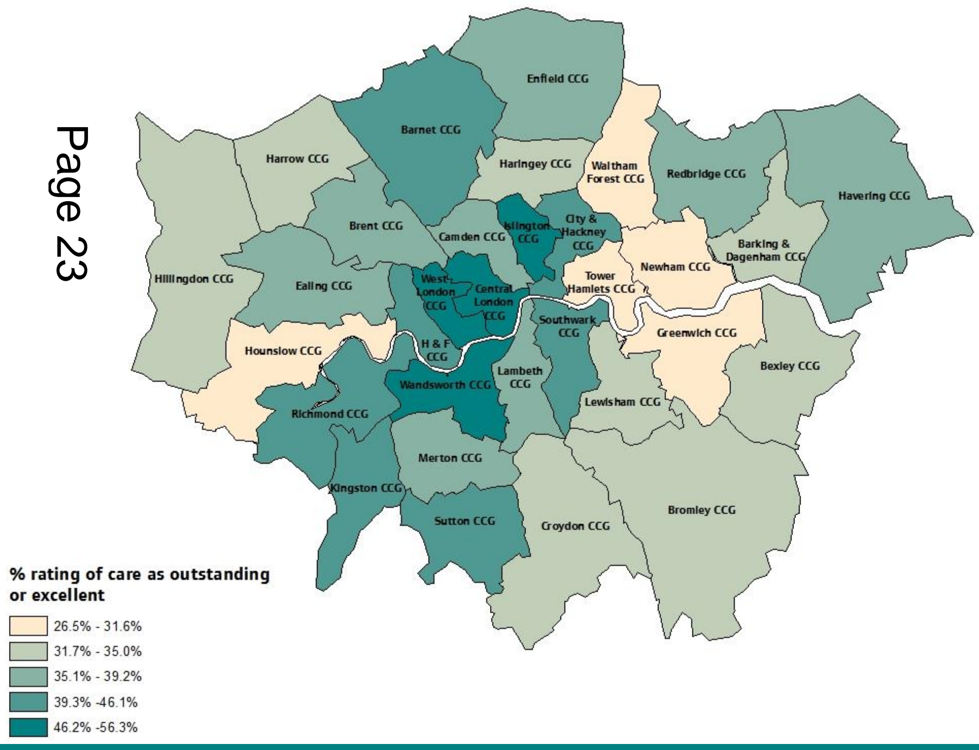
Expert guests at our meeting in October 2015 made a joint statement setting out their six ambitions for delivering better end of life care:

- Each person is seen as an individual.
- Each person gets fair access to care.
- Comfort and wellbeing are maximised.
- Care is coordinated.
- All staff are prepared to care.
- Each community is prepared to help.

LONDONASSEMBLY

End of life care across London

There are significant variations in the provision of end of life care services across London. Even where services exist, these cannot be accessed at all times and by all who need them. In the absence of other options, many people will end up in hospital when they neither need or wish to be there.



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Only 8 out of 33 London Clinical Commissioning Groups (CCGs) scored above the national average for end of life care quality indicators.

London CCG spend varies from £540 to £3,740 per death.

70% of London hospitals cannot provide specialist palliative care services seven days a week.

One in five community palliative care services is unable to provide out-of-hours services.

Figures from the Pan-London End of Life Alliance

"Each CCG has an end of life care lead; the challenge is to help them understand what a good death looks like, help them see where they stand on that benchmark, and encourage them to shift the funding."

Dr Caroline Stirling,
Clinical Director for End of Life Care, NHS England (London)

Access to services

Evidence shows that certain groups of people are less likely to access specialist end of life care. Factors include:

Age: Older people are less likely to access specialist care. This may be in part because they are unaware of services that are available to them.

Diagnosis: The majority of palliative care services in London are geared towards cancer patients. People with other conditions, such as motor neurone disease and chronic obstructive pulmonary disease are less likely to receive specialist care.

Who you live with: If a person lives with family or a carer they are more likely to have an advocate for their care and wellbeing, as well as assistance with transport, treatment, organisation and personal care. They are also more likely to discuss their wishes for their end of life care.

Beliefs: Some religions and cultures do not believe in predicting death or planning for it. This can make it difficult or impossible to create effective care strategies.

Deprivation: The relationship between deprivation and access to health services is complex, but evidence suggests that people in poorer postcodes are less aware of end of life care options and how to access them.

Health inequalities persist across London. Commissioning the right services will depend on accurately assessing the needs and priorities of local communities, including the marginalised.

33% of people who die are over the age of 85, but this group makes up just 15% of hospice users.

Only 24% of London patients accessing palliative care have a non-cancer diagnosis.

70% of LGBT people surveyed felt isolated from end of life services by the language used.

"We know that hospices provide the gold standard for end of life care and deliver high quality care across London, yet…poorer people die in a hospice less frequently than their well-off peers."

Dr Jonathan Koffman, Kings College London

"BAME groups … face several challenges in relation to end-of-life care including language barriers, cultural differences around talking about the end of life and preparing for death and – for some – low trust in health services leads to them not accessing services and not planning ahead."

Compassion in Dying written response

End of life care for older people

Older people, and especially the very old, face additional challenges towards the end of life. Often they have multiple health conditions, and they are more likely to be socially isolated and lonely. This can lead to increasing practical challenges in looking after themselves and managing their conditions.

Older people are more likely to have multiple health issues. There are additional challenges to good end of life care when a person has multiple health conditions, such as cancer with dementia. These include predicting when death will occur and ensuring that wishes are established before capacity is lost.

Suitable housing allows older people to stay at home while they receive end of life care. But much of London's current housing stock is not fit for this purpose, and with a shortage of hospice and care home places, hospital can be the only remaining option.

Loneliness can make it harder for older people to get the care they need. Three in ten people over the age of 80 are lonely.[6] Without supportive networks and relationships, it can be difficult for them to navigate the health and care system or to make their wishes known. Loneliness also increases pressure on local authority services, and can be the tipping point for an individual being referred to adult social care. [7]

Currently there are around 124,000 people aged 85+ (the 'oldest old') living in London. By 2035 this figure is projected to have more than doubled to around 266,000.[2]

75% of people aged 75 or over who live alone are women.[3]

Around 10% of London households are occupied by a person aged over 65 who lives alone.[4]

1 in 3 people over 65 will die with dementia (but not necessarily *of* dementia).[5]

"Assumptions around older people and the frail elderly need to be challenged: typically, that they are more accepting of their fate and circumstances."

Dr Jonathan Koffman,
King's College, London

"The [people] we have – the majority are over 75 – do not receive any visitors at all, have nobody to get their shopping, nobody to pop in and have a cup of tea with, to share concerns with or any happy memories."

Deborah Hayes, Age UK

Talking about end of life care

Involving people in decisions about their end of life care options is critical. But many people, including medical professionals, find discussions of death and dying very difficult. This needs to change if we are to support people to plan for the end of life.

Effective communication is an important component of good end of life care. Joined-up communication between service providers is vital. But conversations between individuals and their families, and more widely in society, are just as necessary. These conversations need to start early so that individual care plans can be developed, recorded and shared to ensure seamless care.

Health and care professionals: We need more skilled staff in all primary care settings (including nursing and care homes) who can initiate sensitive conversations about end of life and establish a trusting relationship to enable further discussion. They should aim to establish preferences and priorities for place and care of death, extent of treatment, and support for those important to the dying person. Ensuring that wishes are recorded and can be shared across care providers and services would greatly improve end of life care.

Communities: Increasing public discussions about death and dying, in culturally appropriate ways, can break down the barriers that prevent some people accessing the care that is right for them. Many people do not get the care they want because they do not know who to ask. Local strategies should identify ways to make sure that information reaches people who need it most.

Mandatory staff training in end of life care is only available in one in five hospital trusts.

24% of Londoners have asked a family member about their end of life wishes.

71% of Londoners agree that if people became more comfortable discussing dying it would be easier to have end of life wishes met.

"It takes communities working together to ensure that people who are dying receive the care and support that is right for them."

Claire Henry, Chief Executive, National Council for Palliative Care

"It requires an overt conversation with the patient and their loved ones, saying "We are having this conversation. We have made this decision".

Dr Caroline Stirling, Clinical Director for End of Life, NHS London

Next steps

We have written to the Mayor urging greater focus on end of life outcomes in developing mayoral policy. But much more can be done at a local level to improve end of life care across London. Local authorities are best placed to understand the needs of their local communities. By developing clear strategies and sharing good practice at a local level, more people will receive good end of life care in London.

Health and Wellbeing Boards can:

- **Ensure that end of life care is included in their Health and Wellbeing Strategy.**
- **Work with local partners to raise awareness of the services available in their areas, particularly for marginalised groups.**

Health Overview and Scrutiny Committees can:

- **Examine end of life care in their area or sub-region, to determine whether services are meeting local needs, and how effectively they are engaging with individuals and communities.**

The evidence base from our investigation is available to support future work at a local level. Please visit www.london.gov.uk/endoflifecare

How can end of life care in London be improved?

- Increase the focus on end of life care in Health and Wellbeing Boards and CCGs.
- Provide end of life care training to all social and healthcare staff.
- Ensure equitable access in boroughs to community nursing and specialist palliative care.
- Highlight the need to shift resources from acute and community providers to manage care out of hospital.
- Assess and respond to the need for housing and support for the increasing number of older people in London.
- Raise awareness of end of life care options locally.

"How we care for people at the end of life is a measure of the compassion of our society. It is vital that here in London we make quality of death, as well as quality of life, the best it can be."

Dr Onkar Sahota, Chair of the London Assembly Health Committee

About the investigation

The Health Committee issued a call for evidence and held a public meeting to discuss end of life care in London. At the meeting, the Committee was joined by a panel of experts:

- Dr Caroline Stirling, Consultant in Palliative Medicine and Interim Clinical Director, End of Life Care, NHS England (London region)
- Claire Henry, Chief Executive, National Council for Palliative Care
- Brian Andrews, Chair, Pan-London End of Life Alliance Lay Representatives Board
- Deborah Hayes, Director of Individual Services, Age UK East London
- Dr Jonathan Koffman, Senior Lecturer in Palliative Care, Kings College London
- Meeta Kathoria, Head of Programmes- Service Development, Marie Curie

The Committee is grateful to our guests and to all the organisations who submitted information to our review and also to John Powell, ADASS National Lead on End of Life Care, for his contributions.

End notes

1. Unless otherwise stated, figures and statistics in this document are taken from the Pan-London End of Life Alliance written submission to the Health Committee investigation November 2015
2. Office for National Statistics census data 2011
3. Age UK statistics 2015
4. Office for National Statistics census data 2011
5. The Alzheimer's Society 2015
6. Office for National Statistics "Nine things you might not know about older people in the UK" October 2015
7. The Campaign to End Loneliness 2015

About the Health Committee

The London Assembly Health Committee scrutinises the work of the Mayor and reviews health and wellbeing across London, with a particular focus on public health issues and reviewing progress of the Mayor's Health Inequalities Strategy.

Its members are:

- Dr Onkar Sahota AM (Chair)
- Andrew Boff AM (Deputy Chair)
- Kit Malthouse MP AM
- Murad Qureshi AM
- Valerie Shawcross CBE AM

You can find out more about the work of the committee at http://www.london.gov.uk/about-us/london-assembly/health-committee

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