North Lancashire NHS
Teaching Primary Care Trust

# Lancashire North CCG - Business Case

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| **Title of Proposal**<br>End of Life Care – community provision |
| **Commissioning leads**<br>Peter Nightingale, Helen McConville |
| **Work-stream**<br>Urgent Care |
| **GP Consortia lead**<br>Dr H Fairhurst |
| **Other relevant leads**<br>Gill Wildon, Integrated Service Manager, NHS North Lancashire<br>Anna Conlan, Hospice at Home service, St. John's Hospice<br>Jo Whincup, Marie Curie |

## 1. Overview

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| * **Area/Service to be commissioned** |
| A 24 hour End of Life care service |

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| * **What are the key objectives of the proposal?** |
| Systems in place for early identification of patients across primary and secondary care inc IT<br>Workforce skilled in Advanced Care Planning and end of life care<br>Provision of end of life care in the community across 24 hours<br>Achieve preferred place of death for patients<br>Reduction in hospital deaths (10% - 30%) by 2015<br>Palliative care consultant to support GPs and lead service development (Fulfil Guidance) – recruitment / training) |

## 2. Assessment of need

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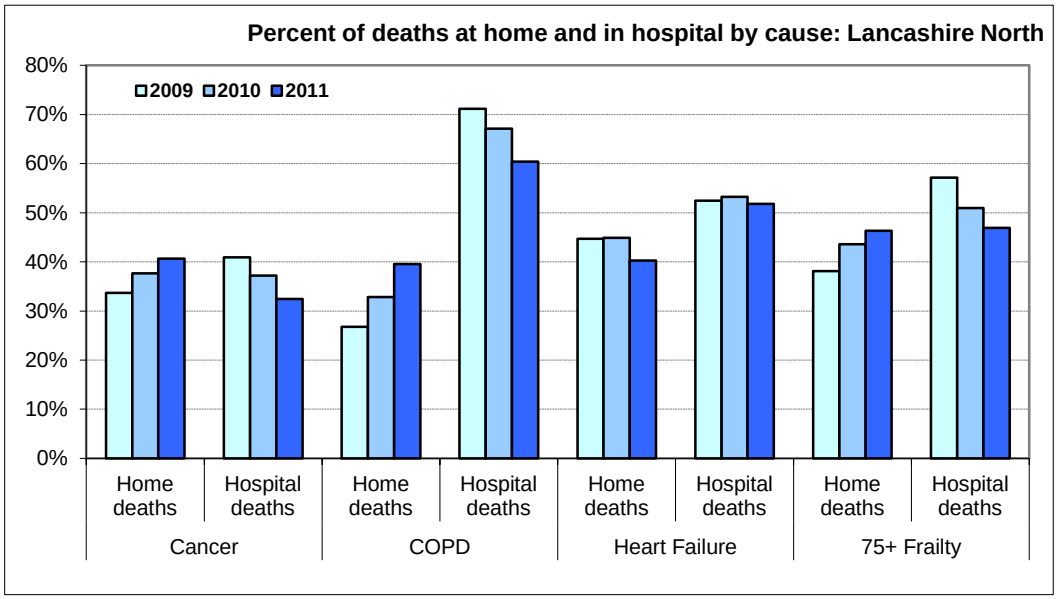
| **Provide a brief outline the *current* service provision including (where relevant) accessibility of service, effectiveness/outcomes, current cost of service and perceived deficiencies.** |
| Currently there are a range of services in the Lancashire North CCG area supporting people at the end of life. These comprise of a range of general services e.g. District Nursing, Care Homes, Primary Care and general hospital care, and more Specialist Palliative care services e.g. Macmillan nurses and Hospice services. The National end of Life strategy in 2007 launched a wave of work associated with enabling people to die in their own homes as this is the stated preference of the majority.<br><br>The Specialist Palliative Care services have their origins in the development of cancer services in the 1980s and some are not fully funded by the NHS; examples include St. John's Hospice and Cancercare. Other general palliative care services have developed incrementally over the years to respond to different local agenda e.g. COPD, National End of Life Strategy. However, given the expected rise in death in coming years, it is timely to review to review how the services work together.<br><br>In 2010 there were 1763 deaths in the CCG area; this will start to increase in 2012 and continue to rise.<br>We have evidence that home deaths are increasing slowly n the Lancashire North area in recent years and this is in line with national trends (58.3% in 2005, 53.3% in 2010) |




However existing community services are now functioning at full capacity and are unable to respond rapidly e.g. to facilitate rapid discharge (within 4 hours). We also recognise that there are significant limitations in the way that services have been organised which means that they will not be fit for purpose in the future; recent evaluation by local clinicians reached a consensus that they consistently experience gaps in provision; these are

- Lack of co-ordination of existing services
- Very limited provision out of hours – leading to a default of hospital admission
- Inability to rapidly respond to referrals
- Lack of early recognition and planning for end of life care
- Under-provision of specialist palliative care i.e. Palliative Care Consultant

A Review of Palliative Care Funding undertaken in 2010 found that an analysis of hospital use in England in the last year of life, almost a third (32.6%) of all hospital admissions in last year of life occur in the last 30 days before death.

Across England people average around 2.1 hospital admissions in the last 12 months of life accounting for on average 30 bed days. Admission rates are highest in young age groups.

Approximately 78% of people will be admitted to hospital at least once in their last year of life. 89% of those who die in hospital do so following an emergency admission. 32% of these people die after a stay of 0-3 days, 18% after a stay of 4-7 days and 50% after a stay of 8 days or longer.

Nationally 12% of those who die in hospital will have been admitted from a care home.

In order to understand the problem we face in greater detail, Lancashire North commissioners have participated, as an Early Adopter, in a National End of Life Intelligence Network project utilising the Yorkshire and Humber Financial modelling tool. The tool can be viewed on http://www.endoflifecare-intelligence.org.uk/end_of_life_care_models/commissioner_financial_model.aspx

The model identifies patients who die in hospital in a given year and sorts them in to 'types' as described below:
Type 1: the 60% appropriate to admit to hospital
Type 2: could have been managed in the community

Type 3: needed combined community and secondary care (possible turnaround within 4 hours or rapid discharge)
Type 2 and type 3 patients are the target for any community service we need to develop. Detail of the diagnoses of these patients can be found in the appendices.

The model has indicated the following for 2010-11:

| | Admissions | | Pts | | |
|---|---|---|---|---|---|
| | No | % | No | % | Average admissions per pt |
| Deaths in hospital | 899 | 100% | 450 | 100% | 2.0 |
| Type 1 | 527 | 59% | 276 | 61% | 1.9 |
| Type 2 | 172 | 19% | 103 | 23% | 1.7 |
| Type 3 | 200 | 22% | 71 | 16% | 2.8 |

The cost associated with all admissions for type 2 and type 3 patients in the last year of life is £1,614,851 – average cost of £3,589 per patient. These are some of the costs we could expect to see reduce with investment in to community services for end of life care.

Projecting forward, the patent numbers will grow as described below

| | | Current 2012/13 | 2013/14 | 2014/15 | 2015/16 | Future 2016/17 |
|---|---|---|---|---|---|---|
| Projected trend of spells/pts based on increase in population and model prediction | | | | | | |
| Type 2 | Spells | 172 | 178 | 184 | 189 | 195 |
| | Pts | 103 | 107 | 110 | 114 | 117 |
| Type 3 | Spells | 200 | 207 | 213 | 220 | 226 |
| | Pts | 71 | 73 | 76 | 78 | 80 |
| Number to be cared for in the community | | | | | | |
| Types 2 & 3 (100% of Type 2 & 50% of Type 3) | Spells | 272 | 281 | 290 | 299 | 308 |
| | Pts | 139 | 143 | 148 | 152 | 157 |

In line with the national data LMCG patients too have on average 2 hospital spells in the last 6 months of life. These 157 patients are additional patients to the ones who are already receiving care in the community.

*** What is the agreed baseline level of activity/referrals for this area. How will this information be gathered?**

The focus of this business case is to change the balance of provision for people who are expected to die from secondary care to the community. The End of Life PCT Profile for North Lancashire PCT produced by the EoL Intelligence Network (2012) indicates that our we score significantly higher than the national average for 'percentage of terminal admissions that are emergencies' (England average 89.7%, NLPCT 95.2%)

Utilising modelling techniques described above we have identified that 140 of the total 450 deaths in the Royal Lancaster Infirmary in 2010-11 could be cared for appropriately in the community if appropriately designed services were in place. This number will increase to 157 in the next five years. This business plan addresses the need to design community services now to support this volume of additional patients thus avoiding unnecessary hospital

admissions.

This incremental change to palliative care in the community would represent a shift to from 30% to 60% deaths occurring in usual place of residence over a five year period and a reduction in avoidable deaths in hospital.

**Current baseline**
The NHS resources currently deployed in end of life care that cannot be easily quantified include

- Out of hours medical provision
- Ambulance costs
- Nursing contribution to care homes
- Continuing Care funding (including Fast Track funding for EoL)
- Community services including District Nursing, Specialist Nurses

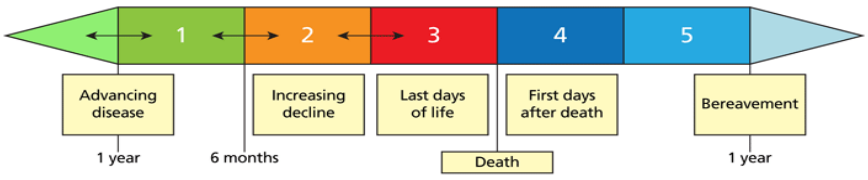
Current baseline information from our **Community services** provider is via PCIS; however we can only extrapolate on costs of care in the last three months of life as a proxy for end of life care.
St **John's Hospice** collect NCPC minimum dataset and have recently developed unit costs for their services. However, they are only part funded via a Section 64 Grant arrangement so NHS cannot be accurately calculated.
The **Marie Curie** service currently commissioned provides a planned support service for patients in their own homes at night and in 2011-12 89% of patients they cared for died in their own homes. The Marie Curie services is usually delivered as part of a shared package of care working with District Nursing and other providers.
People who live in **care homes** until the end of their lives may have an element of NHS funding either via NHS Continuing Care or funded nursing care and double funding can occur during periods of hospital admission.
It is also difficult therefore to identify where some patients may receive services from **multiple providers** and others from just one, or even none.
Given the lack of co-ordination and panning in the current system, we are confident that this new model will generate savings some saving and lead to better utilisation of services

**3. Planning**

***Scope of service being commissioned**

- Key service details
- Target population
- How the new service improves patient care

**Service Description**
The model is one of a range of co-ordinated services coming together to meet the needs of the patient at the different stages in the last year of life. The services will use common terminology and ensure identification, planning and co-ordination of individual care. Service will cross refer and work in partnership with shared documentation held with the patient where this is appropriate.




The service will be influenced by modelling local data informing of the numbers of patients expected to require the service on an annual basis. There will be incremental development of the service to allow for change in practice and service re-design.
At present approximately 760 people die each year in the LMCG area. This is due to

increase in the coming years. In 2010-11, 450 of these died in the Royal Lancaster Infirmary and our information tells us that 140 of these could have been cared for in a community setting.
The target population for this service is frail elderly people who have a range of underlying diseases, primarily respiratory disease, organ failure and cancer. We expect that the additional capacity in community services will enhance the services available to all people at end of life.

**What consultation (if any) with key stakeholders and service users has there been specific to this proposed development?**

All the national guidance has been developed with stakeholders
The proposed model will be presented to a local group of service users

**Provide a detailed service specification**
**(NB the proposal will need to be supported by the participating practices cluster)**

- What pathway redesign is required
- Evidence base
- **Adherence to national guidance (NICE) and NSFs**
- What clinical standards need to be met?
- Will the proposed scheme involve other practices in the cluster?

**Service specification attached**

This business case addresses the first 4 components outlined in Section 2 above.

1. Lack of co-ordination of existing services
2. Very limited provision out of hours – leading to a default of hospital admission
3. Inability to rapidly respond to referrals
4. Lack of early recognition and planning for end of life care

Lack of Specialist palliative care medicine is also a factor locally. A new Consultant in Palliative Care medicine who will work across the hospital, community and hospice settings is addressed separately but will work as part of the overall model.

The currently commissioned services are not co-ordinated, have very limited provision out of hours, and cannot be deployed rapidly (within 4 hours for avoiding admissions). There is no system for early identification and planning to patients' end of life care

The service specification addresses the need to a central co-ordination function where enhanced staff with more EoL skills can be rapidly deployed. We anticipate a central hub which receives referrals and co-ordinates care, deploying staff to best effect over a 24 hour period.

***Impact and 'fit' with National and Local targets and priorities**

The requirement for 24 hour end of life care in the community to be commissioned is clearly documented in the following guidance:

*'End of Life Care'* National Audit office 2008
*'Delivering better care at end of life - The next steps'*, Kings Fund 2009
*'Commissioning end of life Care – initial actions for new commissioners'* NHS National End of Life Care Programme 2011
*'Manual for Cancer Services, Draft Specialist Palliative Care Measures'* National Cancer Peer Review Programme 2012

The 'Palliative Care Funding review – funding the right care and support for everybody' was published in 2011. It describes the proposal to develop a range of tariffs for end of life care which will follow the patient. This service development will begin to shape services in the community in readiness for the expected outcome of pilots that are running in 2012-14.

The need to develop 24 hour Palliative Care services the community id defined in the local End of Life Strategy for

*** Resources Needed**

- What clinical time/expertise will be required
- What support/information will be required from the PCT (Informatics, Finance, Commissioning, Public Health etc)?

Dividing the patients in to types 1, 2 and 3 (defined in Yorkshire 7 Humber model) our target patients are those who are types 2 & 3.
**For type 2 and 3 patients the cost of final admissions was £563,473. This is figure against which savings are anticipated.**

With improved recognition and better planning some patients may have fewer than 1 admission in the last year of life with associated costs of secondary care.

| | Service | Cost | Procurement |
|---|---|---|---|
| 1 | Augmentation of existing Hospice at Home to operate from 07.00 to 22.00 over 7 days | £97,009 | Voluntary ex ante notice to extend existing contracting arrangement |
| 2 | Education programme for patients with life limiting illnesses (initially COPD) to support them in considering future care options and preferences | £16,000 | Voluntary ex ante notice to extend existing contracting arrangement |
| 3 | Development of a new service 'hub with a nursing and administration resource that supports co-ordination and rapid deployment of staff to meet planned and un-planned need and to maintain a Locality end of Life | Expected to be circa £115,000 | Single stage tender |

| | | | |
|---|---|---|---|
| | register | | |
| 4 | Development of new planned care at night time | Expected to be circa £107,000 | Single stage tender |
| **Total** | | **£335,009** | |

There will be costs associated with the delivery of care outside the hospital setting including the continuous delivery of core community health services, social services and jointly commissioned packages of care, roles of informal carers and some care home placements in the community. It is not possible to state with any degree of accuracy how avoidance of hospital admission will impact on all of these services but we expect that the

Modelling indicates, over time that good end of life care services in the community could result in the reduction of 12 beds on the RLI site.

**How will the effectiveness of the redesigned pathway be monitored/evaluated? (Please consider the data monitoring requirements of the programme)**

- Changes in activity- what data needs to be collected?
- User views

The PCT receives ONS data on death for the CCG area so we are able to monitor home deaths. The Y+H model could be re-run annually to monitor reduction of type 2 and type 3 patients dying in hospital over time.

We propose that the activity information is utilised to monitor the service. KPIs to be determined.

1. ONS data on home deaths
2. Re-run of Y+H model annually to monitor numbers of type 2 and 3 patients dying in secondary care against activity of the community service
3. Monitoring against population demographics…
4. Patients on Locality register receiving care from the service

**Risk assessment- some areas to consider**

| Risk Element | Contributing factors | Impact | Likelihood | Monitoring Mechanisms | Actions required |
|---|---|---|---|---|---|
| Procurement process | Range of tendering options | Low / medium | Low | Processes in place | Close working with H Lewis, Deal Close manager |
| Collaboration of providers | Providers may compete to tender and erode current partnership working | Medium | Medium | Clear initial briefing. Thereafter formal processes followed | Service specification and other communications are clear, process are followed. |
| Providers able to recruit suitable staff | | Medium high | Low | Part of single stage tender | Include in tender |

| | | | | | |
|---|---|---|---|---|---|
| Delay in development of Locality register | Need to develop local solution to EoL register | Medium | Low medium | | Close links with new service and development of EoL Register |
| Suitable base for staff to be co-located | Provider identified premises – no NHS premises locally | Medium | Medium Low | Part of single stage tender | Bidder identified premises required |
| Change to contracting arrangements with different providers | Current providers who may tender are commissioned under a variety of arrangements | Medium Low | Low | | |
| Multi-agency working | New services will need to be well understood and | | | | |
| | | | | | |

**Finance**

| **How much will implementation of the new service cost**<br>• **Expected Non recurrent/start up costs.** eg project management, equipment, training<br>• **Recurrent annual costs** eg Salaries, on-costs, training, equipment maintenance, audit, other non pay |
|---|
| Final cost will only be known at outcome of tender process.<br><br>1. **Will the proposal be contained in the current envelope given to your work stream?**<br><br>**2. Please state the name of the Financial Accountant who has costed the scheme.**<br>Deidre Lewis |
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**Exit Strategy**

If the scheme does not deliver the expected savings the following will be undertaken as an exit strategy.

This scheme is primarily about delivering high quality patient care and patient choice.
The scheme will be closely monitored to ensure that it is targeting the most appropriate patients.

*** 4. Implementation Plan**

| **Action to be taken** | **Named Lead** | **Timescale (Year and Quarter)** | **Key Outcomes to meet the stated objectives **** (eg pathway redesign, procurement of service, implementation of new service, clinical outcomes, referral reduction in relation to baseline) |
|---|---|---|---|
| Prepare and upload information on to Supply 2 Health website | Howard Lewis | Q2 | Service elements to be tendered will be up-loaded to the Supply 2 Health website |
| Extension of Hospice at Home service | Helen McConville | Q2 | Extension to existing Hospice at Home service can lead the development of services and can be operational ahead of other new aspects of the service. |
| Appointment of Providers | Howard Lewis, Cliff Elley, Hilary Fordham, Peter Nightingale | Q3 | To be detailed in tender process. Selection of provider of providers with suitable background and business experience to deliver the services. |
| Development of detailed implementation plan, operational policies etc. | Helen McConville Peter Nightingale | Q3-4 | |